



## The meeting of the Board of Directors

To be held on Tuesday 25 July 2017 at 2.00pm  
in the Boardroom, Doncaster Royal Infirmary

### **AGENDA** **Part I**

#### **Enclosures**

- |    |                                   |             |
|----|-----------------------------------|-------------|
| 1. | Apologies for absence             | (Verbal)    |
| 2. | Declarations of Interest          | (Verbal)    |
| 3. | Actions from the previous meeting | Enclosure A |

#### **Reports for decision**

- |    |  |             |
|----|--|-------------|
| 4. | ACS Memorandum of Understanding<br>Richard Parker – Chief Executive                                      | Enclosure B |
| 5. | Doncaster Place Plan<br>Anthony Fitzgerald – Doncaster CCG   | Enclosure C |
| 6. | Strategy & Improvement Report<br>Marie Purdue – Deputy Director of Strategy and Improvement              | Enclosure D |
| 7. | Winter Plan<br>David Purdue – Chief Operating Officer  | Enclosure E |
| 8. | Diversity and Inclusion Action Plan<br>Karen Barnard – Director of People and Organisational Development | Enclosure F |

#### **Reports for assurance**

- |     |   |                            |
|-----|---|----------------------------|
| 9.  | Chairs Assurance Logs for Board Committees held 20 July 2017<br>Neil Rhodes – Chair of Finance and Performance Committee<br>Philippe Serna – Chair of Audit and Non-clinical Risk Committee | Enclosure G<br>(to follow) |
| 10. | Finance Report as at 30 June 2017<br>Jon Sargeant – Director of Finance   | Enclosure H                |
| 11. | Business Intelligence Report as at 30 June 2017<br>Led by David Purdue – Chief Operating Officer  | Enclosure I                |
| 12. | Nursing Workforce Report<br>Moira Hardy – Acting Director of Nursing, Midwifery & Quality   | Enclosure J                |
| 13. | Patient Experience and Complaints Quarterly Report – Q1 2017/18<br>Moira Hardy – Acting Director of Nursing, Midwifery and Quality  | Enclosure K                |

- |  |                                     |
|--|-------------------------------------|
| 14. NHSI Undertakings Tracker<br>Matthew Kane – Trust Board Secretary                                | Enclosure L<br>(appendix to follow) |
| 15. Board Assurance Framework and Corporate Risk Register Q1<br>Matthew Kane – Trust Board Secretary | Enclosure M                         |

### Reports for information

- |  |             |
|--|-------------|
| 16. Chair and NEDs' Report<br>Suzy Brain England – Chair   | Enclosure N |
| 17. Chief Executive's Report<br>Richard Parker –Chief Executive  | Enclosure O |
| 18. Committee Annual Reports<br>John Parker – Non-Executive Director<br>Philippe Serna – Non-Executive Director                          | Enclosure P |
| 19. Minutes of Finance and Performance Committee, 23 June 2017<br>Neil Rhodes – Chair of Finance and Performance Committee               | Enclosure Q |
| 20. Minutes of Audit and Non-Clinical Governance Committee on 24 March and 26 and 30 May 2017<br>Philippe Serna – Non-Executive Director | Enclosure R |
| 21. <b>To note:</b><br>Board of Directors Agenda Calendar<br>Matthew Kane – Trust Board Secretary  | Enclosure S |

### Minutes

- |  |             |
|--|-------------|
| 22. To approve the minutes of the previous meeting held 27 June 2017   | Enclosure T |
| 23. <b>Any other business (to be agreed with the Chair prior to the meeting)</b>   |             |
| 24. <b>Governor questions regarding the business of the meeting</b>  |             |
| 25. <b>Date and time of next meeting</b><br>Date: 29 August 2017<br>Time: 9.00am<br>Venue: Boardroom, Bassetlaw Hospital   |             |
| 26. <b>Withdrawal of Press and Public</b><br><br>Board to resolve: That representatives of the press and other members of the public be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest. |             |

A handwritten signature in black ink, appearing to read 'Suzy Brain', with a long horizontal flourish extending to the right. The signature is positioned above a vertical line.

Suzy Brain England  
Chair of the Board



**Doncaster and Bassetlaw  
Teaching Hospitals**  
NHS Foundation Trust

## Action Notes

**Meeting:** Board of Directors  
**Date of meeting:** 27 June 2017  
**Location:** Boardroom, DRI  
**Attendees:** SBE, RP, KB, MH, DP, SS, JS, AA, MM, LP, JP, NR, PS  
**Apologies:** None

No.	Minute No	Action	Responsibility	Target Date	Update
1.	17/01/13	Director of Education to share the Teaching Hospital phase two development plan at a future Board.	MK	September 2017	Identified as item for future Board strategy work.
2.	17/03/07 & 17/06/3	A paper be prepared on how the Trust can assure itself that support is in place concerning changes to NHS Protect.	JS/KEJ	September 2017	Letter from NHS Protect received on 18 July. To be considered by ANCR on 20 July.
3.	17/04/32	Timetable six month review of CIPs.	MP	November 2017	Action not yet due.

No.	Minute No	Action	Responsibility	Target Date	Update
4.	17/04/54	Invite NEDs to future quality summit.	MH	August 2017	A quality summit has not been arranged since the last Board meeting. Target date updated to August 2017.
5.	17/04/61	Bring Learning from Deaths report back to Board in May.	MK	August 2017	Deferred until August 2017. Target date updated.
6.	17/05/30	Once the Emergency Planning Officer had considered the existing business continuity plans, a presentation would be brought to Board and the plans would be tested by internal audit.	DP	September 2017	Action not yet due.
7.	17/05/51	Work on complaints and the DNA working group would be brought to Board through the Finance and Performance Committee following quarter two.	DP	October 2017	Action not yet due.
8.	17/03/07 & 17/06/3	Medium Term Financial Plan to come to Finance and Performance Committee.	JS	September 2017	Complete. On agenda for F&P July 2017.



**Doncaster and Bassetlaw  
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No.	Minute No	Action	Responsibility	Target Date	Update
9.	17/06/8	Provide details of applications the Trust has developed to the Board.	SM	July 2017	Details to be emailed to Board.
10.	17/06/34	Board to meet with care group directors regarding EEPs.	MK	July 2017	To be arranged.
11.	17/06/42	Details of stroke discharge performance to be shared with Finance and Performance Committee.	DP	July 2017	Complete.
12.	17/06/46	QEC approach to assurance reporting to be shared with Board.	LP	September 2017	Action not yet due.
13.	17/06/56	Risk around failure to adequately prepare for CQC inspection be added to the corporate risk register and board assurance framework.	MK	July 2017	Complete. The risk is on the BAF. It did not achieve the required score to be included on the CRR.
14.	C17/06/11	Add a separate risk relating to risk of fire to the corporate risk register and board assurance framework.	MK	July 2017	Complete. The risk is on the BAF and CRR.



**Doncaster and Bassetlaw  
Teaching Hospitals**  
NHS Foundation Trust

No.	Minute No	Action	Responsibility	Target Date	Update
15.	C17/06/12	Board receive a further update following notification from SYFR of the outcome of their review.	KEJ	July 2017	Complete – update contained in Chief Executive's report.

Date of next meeting:

25 July 2017

Action notes prepared by:

M Kane

Circulation:

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



**Doncaster and Bassetlaw  
Teaching Hospitals**  
NHS Foundation Trust

Title	ACS Memorandum of Understanding		
Report to	Board of Directors	Date	25 July 2017
Author	Richard Parker, Chief Executive		
Purpose		Tick one as appropriate	
	Decision	X	
	Assurance		
	Information		

**Executive summary containing key messages and issues**

The report presents the South Yorkshire and Bassetlaw Accountable Care System Memorandum of Understanding for adoption. The final document takes account of comments on previous drafts.

The MoU does not replace the legal framework or responsibilities of our statutory organisations but instead sits alongside the framework to complement and enhance it.

It is important to note that by approving this document the Trust becomes one of the 'parties to' the agreement.

'Parties to' have majority relationships (patient flows and contracts) within and across SYB. The Trust is signing the agreement to be part of the emerging ACS in SYB. Accordingly DBTH will be subject to delegated NHS powers and a new relationship with other Parties and with both of the NHS regulators.

The Trust's adoption of the MoU is required to give SYB ACS access to the national funds available for first wave ACS. If the requirements change as the ACS develops, then it will come back to board for discussion.

**Key questions posed by the report**

- Is the Board content to agree the attached Memorandum to allow the SYB ACS to move forwards?



<b>How this report contributes to the delivery of the strategic objectives</b>
The report sets in motion, on a formal basis, the partnership between the Trust and other organisations in the SYB ACS. It is in line with the Trust's aim to increase partnership working to benefit people and communities.
<b>How this report impacts on current risks or highlights new risks</b>
Not agreeing to the partnership arrangements may risk the future of partnership working across the SYB and ACS funding.
<b>Recommendation(s) and next steps</b>
The Board is asked to adopt the attached Memorandum of Understanding for the SYB ACS.



**South Yorkshire and Bassetlaw Accountable Care System**

PMO Office: 722 Prince of Wales Road

Sheffield

S9 4EU

0114 305 4487

23 June 2017

Letter to: South Yorkshire and Bassetlaw Accountable Care System Chief Executives

Dear Colleague

**Re: South Yorkshire and Bassetlaw Memorandum of Understanding**

Following discussions at our boards, governing bodies and in council meetings on the draft Memorandum of Understanding (MoU) for South Yorkshire and Bassetlaw (SYB), I am pleased to attach the revised, final document.

The final version takes into account your comments and feedback and reflects the changes you requested. In addition to the changes, you also raised questions about some of the detail in the MoU and involvement of your organisation and Place in how the processes might develop. These are now incorporated in a separate document which will be shared with you and we will be working through these important questions in the next phase and as our Accountable Care System (ACS) matures.

If we are to achieve our ambitions, then we must always start with Place, allowing local areas to flourish as we collectively take on the challenges across our System. I would like to reiterate that the MoU does not replace the legal framework or responsibilities of our statutory organisations but instead sits alongside the framework to complement and enhance it. I would also draw your attention to your role within the Agreement.

As a core partner, you are a 'party to' the Agreement

'Parties to' have majority relationships (patient flows and contracts) within and across SYB and you are signing the agreement to be part of the emerging ACS in SYB. You will be subject to delegated NHS powers and a new relationship with other Parties, with both of the NHS regulators and are assured a package of support to transform health and care.

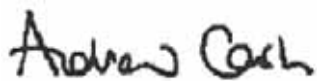
Your feedback and questions have been extremely valuable and as well as strengthening the document, will continue to shape our direction. I would like to thank you and your executive, non executive, lay colleagues and members for getting us to this point.

The documents reflects a point in time. We are still in negotiation with NHS England and NHS Improvement and the Arms Length Bodies on our MoU and are looking to take it to the 12 July Collaborative Partnership Board with a view to having support by the end of July.

The nature of our collective governance cycle means that it has taken us some weeks to get to this milestone but I am sure you will agree that it has been a thorough and valuable process. Our success to date is undoubtedly down to the strong relationships that exist between us and a proven history of working together. As we continue on our journey, we are building on very strong foundations and I look forward to working with you as we strengthen our position to bring about better health, care and life chances for the people of South Yorkshire and Bassetlaw.

We will be communicating about the ACS and our plans more widely in September and so the ask is that you now seek support for the direction of travel with your board, governing body and council meetings by the end of July.

Yours sincerely,

A handwritten signature in black ink that reads "Andrew Cash". The signature is written in a cursive, slightly informal style.

Sir Andrew Cash  
ACS Lead

# Health and Care Working Together

South Yorkshire & Bassetlaw  
Accountable Care System

Memorandum of Understanding  
'Agreement'

June 2017

Title	Memorandum of Understanding for South Yorkshire and Bassetlaw Sustainability and Transformation Partnership		
Drafting coordinator	Will Cleary-Gray		
Target Audience	SYB Collaborative Partnership Board Membership, Place Partnership and Boards, statutory organisation Boards, Governing Bodies, Councils, NHS England, NHS Improvement and the ALBs and the Department of Health		
Version	V 0.3		
Created Date	10 April 2017		
Date of Issue			
Document Status	Final Draft for adoption by local governance		
To be read in conjunction with	Health and Care Plan Submission, November 2016, 5 Place Plans, individual statutory organisational plans and 5YFV Delivery Plan – next steps		
Document History:			
Date	Version	Coordinating Author (s)	Details
10 April 2017	0.1	Will Cleary-Gray	Creation of document
28 April	0.2	Will Cleary-Gray	Updated following CEO / AO Timeout on 28 <sup>th</sup> April 2017
15 June	0.3	Will Cleary-Gray	Updated following feedback from Boards, Governing Bodies and Councils Foreword from STP lead
23 <sup>rd</sup> June	0.4	Will Cleary-Gray	Initial feedback from CPB members
Approval by:			

## Foreword

*This document has been developed with South Yorkshire and Bassetlaw Health and Care partners. It is not a plan or a legal contract. We have already published our Plans across the five local Places and system in South Yorkshire and Bassetlaw. At the same time, each of our individual organisations has contracts in place.*

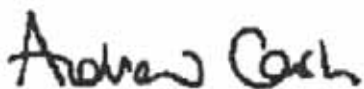
*It does not replace the legal framework or responsibilities of our statutory organisations but instead sits alongside the framework to complement and enhance it. This document recognises the complexity of how health and care organisations currently work and interact together to provide the best possible care and services. It is also mindful of how health and care organisations are coming together to form partnerships locally in place; integrating health and care, commissioning and providing, including voluntary, community, GP, mental health and hospital services. At the same time, some of those same organisations have formed partnerships and are coming together across South Yorkshire and Bassetlaw to plan and commission strategically to ensure safe, sustainable and equitable acute services. In short, we are seeing increased collaboration, joint planning and integration of services that are focused entirely on bringing the greatest benefits to our population.*

*It is a complex picture and one which we must work through together as we continue to focus on what matters – the people in the populations we serve. This means constantly reviewing our approach, together with our staff, patients and citizens. We will also continue to build trust between us, working through what is best for our populations while using best practice where it exists and national guidance and support where we need it.*

*This document summarises and sets out our shared commitment to continue to work together on improving health and care for the people of Barnsley, Bassetlaw, Doncaster, Rotherham and Sheffield and collectively South Yorkshire and Bassetlaw. We still have much to work through and our plans and our approaches to delivering them continue to evolve.*

*This is our best assessment for 2017-19 on how we will work together, what we will work on and what we need to accelerate our vision and plans – the ‘Give’ and ‘Get’ which lies at the core of this MoU.*

As we are in transition it is helpful to clarify how we are using terminology and acronyms for the purposes of this document. Sustainability and Transformation Plan (STP), Accountable Care System (ACS) and South Yorkshire and Bassetlaw Health and Care Partnership (SYB) are used throughout and they refer to the same thing – our SYB Partnership and our collaborative approach.



Sir Andrew Cash, ACS Lead

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## 1. Introduction and context

1.1. This document has been developed with South Yorkshire and Bassetlaw Health and Care partners. **It is not a plan** or a **legal contract**. We have already published our Plans across the five local Places and system in South Yorkshire and Bassetlaw. At the same time, each of our individual organisations has contracts in place.

1.2. It does not replace the **legal framework or responsibilities of our statutory organisations** but instead sits alongside the framework to complement and enhance it, setting out **the framework** within which our organisations will come together to establish how we will develop as **an Accountable Care System**.

1.3. South Yorkshire and Bassetlaw has **five strong health and social care communities** of **Barnsley, Bassetlaw, Doncaster, Rotherham and Sheffield** which have a long history of **working together** in each local **Place and across South Yorkshire and Bassetlaw** (SYB) to achieve positive change and improvements for local people.

1.4. The links between **poverty** and **ill health** are well established and are the driving force behind our joint working. Creating **jobs**, ensuring availability of affordable, good **quality housing** and targeting resources towards areas of **greatest need and reducing inequalities** are all important to **reduce poverty** and **improve our health and wellbeing**.

1.5. Our collective and collaborative approach is increasingly focused therefore on **prevention, integration, physical and mental health** and crucially, **co-production** with **citizens and communities**; addressing the **wider determinants of health together**. These are inextricably linked and include:

- **Employment**, opportunity and business
- **Adult and child health and social care**, enabling independence
- Raising levels of **education and skills** to improve opportunity
- Safe, clean and green **environment**
- **Life chances** for all

1.6. Each health and social care organisation in each Place **already has plans** which have been developed in partnership and in some cases, for example the **Better Care Fund Plan**, these plans are **jointly owned** between health and social care.

1.7. There is a shared view that in order to transform our services to the degree required to achieve **excellent** and **sustainable services** in the future, we need to have a single shared vision and single shared plan both for each Place and for South Yorkshire and Bassetlaw. For this reason, **leaders** from across health and social care in each Place have come together to develop a **single shared vision** and **single shared plan** which has resulted in **Place Plans** and the SYB Plan.

1.8. South Yorkshire and Bassetlaw is therefore in a good position with a single shared vision and plan in each Place. This is made possible by the commitment and significant contributions of each constituent organisation.

1.9. This puts each of our localities, and system as a whole, in a **strong position** to develop and realise an ambitious set of health and social care services for our patients and service users; ensuring the best possible quality of care within available resources.

1.10. In developing a joint vision and plans in each Place, we intend to maximise the value of our collective action and, through our joined up efforts, accelerate our ability to transform the way we deliver services. Our **Plans** are not starting from scratch or replacing individual partners' plans- they build on existing plans, taking a common view and identifying areas where it makes sense for us to work together and collaborate.



1.11. Central to these ambitions is developing different relationships with each other in Place, across the system and with those that assure and regulate our health services. This will enable us to focus on integrating health and social care services and ensuring safe, sustainable and equitable hospital services for everyone.

1.12. We are committed to ensuring citizens and staff have the opportunity to be involved in conversations to help shape the direction of travel in the ACS and in Place. This ranges from their role in wellness, prevention and self-care; identifying what's important to them in the delivery of services; as well as more specific consultation about service changes; and on the ongoing transparency and opportunity for them to hold us to account for delivery.

1.13. A key test of our new relationships will be the extent to which we adopt, as a first principle, an altruistic approach to each other as partners 'working as one'. How we respond as partners in times of need will be crucial and we must always put the needs of individuals, patients and the public first.

1.14. This document sets out how we propose to **organise ourselves** to provide the best health and care, ensuring that **decisions** are always taken in the **interest of the patients** we serve. It allows us to push even further beyond organisational need and allows us to build on **working together in each Place and working together across SYB** - to take collective strategic decisions across the whole of South Yorkshire and Bassetlaw to **lift the standard of care** no matter where people live or the organisation charged with planning or delivering care.

1.15. South Yorkshire and Bassetlaw set out its **strategic ambition** and **priorities** to improve health and wellbeing for all local populations in the **Health and Care plan published** in November 2016, together with how this will be implemented in each of the five **Place Plans** across Bassetlaw, Barnsley, Doncaster, Rotherham and Sheffield.

1.16. Following publication of the Next Steps in the Five Year Forward View, South Yorkshire and Bassetlaw has been confirmed as a **high performing system** and named as one of the eight Accountable Care Systems nationally. This means being supported centrally with additional funding, capacity and capability to be able to have more local control over health and care resources and in the delivery of transformational changes to services for people of South Yorkshire and Bassetlaw. This ability to have more local control is mainly reflective of the potential devolved responsibilities from health, its regulatory and assurance framework and health funding and resources.

1.17. This 'Agreement' sets out the framework within which our partner organisations, including NHS England and NHS Improvement will come together 'working as one', in 2017/18 to establish how South Yorkshire and Bassetlaw will develop as an Accountable Care System. We will agree together the delegated powers and new relationships we adopt between partner organisations, health regulators and health assurers to better achieve ambitions set out in the Plan and five Place plans.

1.18. The MoU sets out the approach to collaborative working and ambition to work as a **shadow Accountable Care System in 2017/18**, together with **key milestones** to move to a full ACS in 2018/19. SYB will engage with **NHS England centrally**, the **Department of Health** and the national **Arm's Length Bodies (ALBs)** to work through in 2017/18 **how** and **what** devolved **NHS powers** it will receive in 2018 as an Accountable Care System and which will be reflected in and **subject to separate and specific agreements** both with NHS England and local statutory organisations. Throughout this process we will be mindful of the legal duties placed on each partner organisation.

1.19. This 'Agreement' should be read in conjunction with the **Plan**, published in November 2016 and the **five local Place plans** across South Yorkshire and Bassetlaw. It should be viewed as a **framework** to **enable** collaborative working, **secure central funding** and support **new**

**relationships** with Arms Length Bodies (ALBs) in the pursuit of becoming an ACS to better deliver **improved health and care for the population** of South Yorkshire and Bassetlaw.

1.20. This 'Agreement' recognises the importance of integration of health and social care in each *Place* and that this will be an important factor in working through how the **emerging Accountable Care Partnerships** - which are being developed in each Place across partners and complement the ACS - develop to deliver improved care.

## 2. Parties to and partners in the Agreement

2.1. In developing this Agreement consideration has been given to the different relationships with constituent member organisations within the SYB ACS and the different relationship that organisations may wish to have with it. There are many partners working together - **NHS** and **non NHS** including **local authorities** and the **voluntary sector** each have respective governance, accountabilities and in many cases regulation responsibilities.

2.2. It is accepted that not all partners would want to be subject to many aspects of this agreement or indeed it would not be appropriate. **NHS England** and **NHS Improvement** have assisted SYB to establish clarity on which organisations should be **Parties** to and which might be **Partners** in this Agreement in context of NHS governance, accountability, regulation and assurance. For clarity, collectively, Parties to and Partners in are all members of the **SYB Collaborative** and its associated **Partnership Board**.

2.3. **STP geographies were, in the large part, nationally defined.** **Core** and **associate** partner terminology has been established over the course of developing the Plan to describe different partners and to support a wide and diverse partnership and to enable cross geographical boundary relationships and working.

2.3.1. For the purposes of this MoU core partners ('Parties to' the MoU) are NHS partners who have the **majority relationships** (patient flows and contracts) within and across SYB while Associate partners ('Partners in' the MoU) have majority relationships (patient flows and contracts) as core members of **neighboring STPs**, and relationships in SYB generally confined to a *Place* or **Accountable Care Partnership (ACP)**. Associate partners are also likely to be subject to collaborative agreements in neighboring STPs or local ACP and receive support consistent with respective STPs. For clarity, collectively, 'Parties to' and 'Partners in' are all members of the **SYB Collaborative** and its associated **Partnership Board**

2.3.1. **In the case of Chesterfield Royal Hospital NHS Foundation Trust**, the trust became a core member in the partnership on the basis of its **strong history of clinical networks** within and across South Yorkshire and Bassetlaw including the Cancer Network and more recently the **Cancer Alliance** and its history of collaboration with acute trusts as part of the **Acute Vanguard, resulting in significant acute flows into SYB**. Early on in the plan development process, formal representation was made to NHS England and NHS Improvement jointly between the Partnership and Chesterfield Royal Hospital NHS FT for it to become a **full partner in SYB** which was supported.

2.3.1. It is recognised that Chesterfield sits within a neighboring STP and likely that it may be subject to agreements with the neighboring STP which will need to be worked through to establish the medium and longer term relationships with **SYB ACS which may change**. There may also be changes to the way other organisation engage in the MoU as we develop and mature as an ACS. This also applies to emerging organisations, federations and legal partnership including primary care federations and therefore we will need to review as we develop.

2.4. It is anticipated that **Parties 'to' will sign the agreement as** an emerging ACS in SYB, be subject to **delegated NHS powers** and a new relationship with each other, with both **NHS regulators** and **assures** and package of support to transform health and care.

2.5. It is anticipated that **Partners 'in'** will **support the direction of travel** and work in partnership with SYB ACS. In some cases they may be subject to separate agreements in neighboring ACS and aligned agreements in ACP in Place within SYB.

**2.6. The Parties to this agreement are:**

**2.6.1. Commissioners**

- NHS Bassetlaw Clinical Commissioning Group
- NHS Barnsley Clinical Commissioning Group
- NHS England
- NHS Doncaster Clinical Commissioning Group
- NHS Rotherham Clinical Commissioning Group
- NHS Sheffield Clinical Commissioning Group

**2.6.2. Healthcare Providers**

- Barnsley Hospital NHS Foundation Trust
- Chesterfield Royal Hospital NHS Foundation Trust
- Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust
- Sheffield Children's Hospital NHS Foundation Trust
- Sheffield Teaching Hospitals NHS Foundation Trust
- The Rotherham NHS Foundation Trust
- Sheffield Health and Social Care NHS Foundation Trust
- Rotherham, Doncaster, South Humber NHS Foundation Trust
- Yorkshire Ambulance Service NHS Trust

**2.6.3. Health Regulator, Assurer, Education and Training**

- NHS England
- NHS Improvement
- Health Education England
- Public Health England

**2.7. The Partners in this agreement are:**

**2.7.1. Local Authority partners**

- Barnsley Metropolitan Borough Council
- Doncaster Metropolitan Borough Council
- Nottinghamshire County Council / Bassetlaw District Council
- Rotherham Metropolitan Borough Council
- Sheffield City Council

**2.7.2. Provider partners**

- Nottinghamshire Healthcare NHS Foundation Trust
- South West Yorkshire Partnership NHS Foundation Trust
- East Midland Ambulance Service NHS Trust
- Doncaster Children's Services Trust

### **3. Scope**

3.1. The scope of South Yorkshire and Bassetlaw's transformational plan covers all aspects of health and care, specifically:

- Public health
- Social care
- Primary care (including GP contracts)

- Community services
- Dental and screening services
- Mental health services
- Acute services
- Specialised services
- Research and development
- Health education and innovation
- Governance
- Assurance
- Regulation
- Resources and finance
- Capital and estate
- Information sharing and digital integration
- Workforce
- Communication and engagement

### 3.2. Key enablers to include:

- Appropriate governance and regulation
- Delegation of resources from relevant national partners in line with the delegation of statutory functions
- Access to fiscal and regulatory levers that enable the improvement of health and wellbeing outcomes through wider determinants e.g. education, employment etc.
- Empowered system leadership, supported by effective governance and accountability arrangements
- A shared strategic approach to capital and estates planning
- A shared strategic approach to communications and engagement
- A shared strategic approach to workforce planning (clinical and non-clinical)
- Development of new payment mechanisms that remove perverse incentives and encourage/ support new models of care
- Development of new information sharing system/ processes

3.3. Operating as a shadow ACS through 17/18, will require flexibility in terms of ways of working. As a result, it is expected that the scope will remain fluid over this time period, to allow arrangements to be tested and amended as required to secure the optimal outcomes.

## 4. System objectives

4.1. In our STP submission we set out the objectives for the SYB systems aligned to the dimensions of the triple aims of the STP. These are summarised below:

### 4.2. The parties share the following system objectives

#### 4.3 Care and quality

- Joined up, high quality services across hospitals, care homes, general practices, community and other services
- Easy and convenient access to services across settings and times of day
- Greater availability of services closer to home
- Better quality, more specialised hospital based care
- Greater availability and variety of non-health services that enhance people's health

#### 4.4 Health and wellbeing

- Better support for individuals in relation to physical and mental wellness and prevention
- A wider variety of healthy living schemes aimed at all communities within the population
- Active networks and links that connect people across communities and provide support
- Greater collaboration across the public sector relevant to the wider determinants of health

#### 4.5 Finance and sustainability

- High quality, efficient services which provide good value for money for tax payers
- Reduced waste and greater efficiency in service delivery
- Greater use of available funding in enabling individuals to stay well and providing care closer to their homes
- A workforce and service that works flexibly to respond to individual needs and how people live locally, ensuring that the right skills and services are present in the right place and the right time

**4.6** The NHS Constitution and Mandate sets out clearly what patients, the public and staff can expect from the NHS. SYB wants to build upon the rights and pledges of the Constitution and provide further opportunities for patients and the public to be involved in the future of their NHS - building on the Plan and the early conversations we have had with the citizens, patients and staff on these ambitions during February and March 2017.

**4.7.** The NHS Next Steps on the Five Year Forward View articulates why change is urgently needed, what that change might look like and how it can be achieved. It describes various models of care which could be provided in the future, defining the actions required at local and national level to support delivery. It sets out the development of new models and SYB is committed to being an early implementer and a test bed for new, innovative approaches of:

- a. An Accountable Care System **across SYB**, with devolved freedoms, accountabilities and responsibilities and **new relationships with member organisations**, including NHS England, NHS Improvement and the ALBs
- b. A **closer relationship between commissioning and providing**, integrating and aligning approaches to strategic planning and transformation of services
- c. Accountable Care Partnerships with **providers across SYB**, delivering new models of acute and specialist care
- d. New models of **commissioning at system level** for acute services, reducing variation and duplication and minimising transactional activity
- e. Operating and managing a system **control total** for health
- f. Accountable Care Partnerships in each local **Place** delivering **integrated health and social care aligned to an overall SYB ACS**

**4.8.** SYB needs to develop different relationships and have freedoms and responsibilities to optimise its potential. This Agreement builds the collaborative partnership established to develop the Plan, creates the platform for SYB to build on these to implement its ambitions through the invitation to SYB commissioners and providers to develop an emerging ACS.

## 5. Overarching principles

5.1. In the documents that were submitted as part of the STP submission on 21 October 2016, STP partners made a commitment to upholding the principles summarised below:

- **Improving quality and outcomes** - As a system, partners will work collectively to improve quality and population outcomes for people and reduce health inequalities for all of our local populations.
- **'No worse off' principle** – Decision making will be focused on the interests of people in SYB and our collaborative partnership will work to ensure those interests are served. We will ensure that our collective working and decisions do not lead to increased health inequalities or a worsening of health outcomes for any of our populations across SYB
- **Inclusiveness** - All stakeholders (including commissioners, providers, patients, carers and partners) will be included in decision making and empowered to shape the system as it continues to develop. This will require active and sustained communications and engagement, informing and involving people early and in ways that allow them to get involved and help shape the direction of travel as we tackle the challenges
- **Participation** - SYB will be involved in all decisions that materially impact on the health and care provided to its population or by its local partners
- **Integration** - Partners will work to support improvements in outcomes through increased integration
- **Subsidiarity** - Partners will work to support delegation of decision making to the most appropriate level, subject to robust governance and accountability mechanisms
- **In the NHS family** - Healthcare services in SYB will remain part of the NHS. All the commitments described in this Agreement aim to (i) strengthen health and care in SYB and (ii) uphold the NHS values and standards
- **Transparency** - Decision making will be underpinned by transparency and open information sharing between and amongst local and national partners
- **Co-production** - National partners will take a co-production approach with SYB, in which decision making is facilitated by national partners to devolve and by local partners to 'receive' and deliver delegated functions
- **Form aligned to function** - the delivery of shared outcomes will drive changes to organisational form where appropriate
- **Wider system (NHS) focused** - Further delegation decisions will continue to be subject to consideration by national partners.
  - Local partners commit to working with national partners to ensure alignment between national policy objectives and the strategic direction taken locally.
  - Local partners will continue work to support nationally agreed priorities, including those set out in the Five Year Forward View.
- **Accountability** - All organisations will retain their current statutory accountabilities for health and social care and any commitments made will remain subject to organisations' continuing ability to meet these accountabilities.

## 6. Direction of travel and key milestones

6.1. This document outlines our desire, individually and collectively, to achieve our vision of health and care in SYB. A significant amount of work has been delivered through working together locally to progress the system to its current state. However, we know that more work remains to be done and that a clear roadmap, agreed with all parties, will provide a clear and transparent way forward. We will continue to work together as local partners and with national colleagues to define the specific mechanisms and timescales associated with any further delegation of responsibilities and associated funding. Delegation of functions



from national partners to local partners on behalf of the “system” will take place in a series of agreed steps, the speed and scale of which will likely be determined by:

- The achievement of assurance criteria determined by national partners
- Demonstrated capability
- The strength/ appropriateness of governance arrangements
- The clarity of the delivery plan
- Suitability of gateway milestones

**6.2.** This approach will ensure that the system will only take on greater responsibilities and powers when it has the capability and resources to manage them appropriately.

Key milestones in the process include:

- By end **July 2017**, an MoU **Agreement** between SYB Parties giving the **Framework** by which SYB will ‘**work as one**’ to develop as an Accountable Care System and implement its Plan.
- **By September 2017**, taking staff and public feedback into account, we will refresh and rebrand the STP from a communications and engagement perspective to reflect becoming an ACS and what this means for the future of health and care
- **By September 2017** we will **agree a delivery plan for 2017/19** for SYB ‘working as one’ to include priority areas including **urgent and emergency care, primary care, mental health and learning disabilities and cancer** to demonstrate delivery and enable testing of key ACS objectives outlines in 4.7.
- **By September 2017**, governance and an approach for agreeing and monitoring investment decisions within the ACS will be agreed
- **By the end of October 2017**, with capital and transformation funding, we will agree how we will operate a system control total for health in 18/19
- **By end October 2017**, we will agree a new **NHS single oversight and assurance framework** for SYB to be operational by April 2018 with aligned resources to support an integrated SYB ACS oversight and assurance function which will work with **streamlined regional and national oversight arrangements**.
- **By end of October 2017**, we will agree system and place commissioning responsibilities for agreed functions and services to enable alignment for ACPs to focus on new ways of contracting and allocating resources including **population budgets, population health management** and segmentation approaches for Place tier 0 - 1 and a system commissioning function for tier 2 and 3 services (all to be agreed).
- **By April 2018**, we will agree governance and approach for delivery of tier 2 services following the **hospital services review** outcome to support a **horizontally integrated accountable network of hospital based services**.
- Each of the five Places has confirmed they wish to continue to develop their Accountable Care arrangements and it is anticipated that these will be in **shadow form in 2017/18**.
- **By October 2017**, SYB ACS will be ‘working as one’ with NHS England and NHS Improvement and working with ACPs in shadow form to provide support so that they will be **legally constituted partnerships by April 2018** (at the latest).

## 7. Governance, accountability and assurance

**7.0.1.** This MoU **does not replace the legal framework or responsibilities** of our statutory organisations but instead sits alongside the framework to complement and enhance it. It recognises the complexity of how health and care organisations currently work and interact with each other to provide the best possible care and services.

**7.0.2.** Our health and care organisations are already coming together to **form partnerships in Place**; integrating health and care, commissioning and providing, including **voluntary, community, GP, mental health and hospital services**. These are taking varying forms and the governance and how this best supported in an overall ACS will be a **key priority in 2017/18** and will be an area for which we will receive national guidance and support.

**7.0.3.** At the same time, some of these same organisations are forming necessary partnerships and coming together across South Yorkshire and Bassetlaw, either our hospitals, to ensure safe, sustainable and equitable acute services as a **'group of hospitals'** or our health commissioners to make consistent strategic planning and commissioning decisions as a **system commissioner**. In all of this, how the traditional separation between health commissioning and providing and the focus on competition is giving way to a focus on collaboration and integration.

**7.0.4.** All of this **'pushes'** at the boundaries of the **existing legal frameworks** but other systems have found ways to work where there is evidence that it better serves to make improvement to the populations we serve.

### 7.0.5. Current statutory requirements for CCG assurance

**7.0.5.1** NHS England has a duty under the NHS Act 2006 (as amended by the 2012 act) to assess the performance of each CCG each year. The assessment must consider, in particular, the duties of CCGs to: improve the quality of services; reduce healthy inequalities; obtain appropriate advice; involve and consult the public; and comply with financial duties. The 2012 Act provides powers for NHS England to intervene where it is not assured that the CCG is meeting its statutory duties.

**7.0.5.2** NHS England must publish a report each year which summarises the results of each CCG's assessment. The detail of the CCG assurance framework which underpins the publication is NHS England policy rather than set in statute or regulation.

### 7.0.6. Current statutory requirements for Foundation Trust oversight

**7.0.6.1.** NHS Improvement (NHSI - the operational name which brought together Monitor and the Trust Development Authority (TDA) and their associated teams on 1 April 2016) has a duty under the NHS Act 2012 to ensure the operation of a licensing regime for Foundation Trusts (and other providers of NHS services). The licensing regime covers requirements on FTs in relation to: general conditions; pricing; choice and competition; integrated care; continuity of services; and governance. The 2012 Act provides powers for NHS improvement to enforce or set conditions on a provider's license.

**7.0.6.2.** The licensing regime is underpinned by the NHS Improvement Single Operating Framework which aims to help providers attain and maintain CQC ratings of good or outstanding. The framework is NHS Improvement policy rather than set in statute regulations.



## 7.1 Principles and underpinning assumptions

7.1.1. The Agreement is drafted by all **Parties** including NHS England, NHS Improvement and the ALBs where this is appropriate. The Agreement is intended to be **flexible** to achieve the right balance of **'Give' and 'Get'** - financial, capacity, capability or devolved freedoms and flexibilities in return for improved delivery, operational, financial, quality, and transformational change.

7.1.2. There will be continual **engagement** and **consultation** with **Boards, Governing Bodies and Councils** throughout development. ACSs are **not statutory bodies** - they supplement accountabilities of individual statutory organisations. 2017/18 will be the first phase of SYB ACS and statutory organisations will **continue** with statutory accountabilities and relationships with NHS England and NHS Improvement, which will retain legal responsibility for CCG assurance and FT oversight respectively.

7.1.3. From September 2017, SYB Health and Care Partnership will adopt the 'Working Together' brand and as such will continue to deliver NHS Constitution and Mandate commitments in full and remain part of the wider NHS System. **The Health and Care Working Together Partnership** will deliver the FYFV ambitions through the development of an **Accountable Care System with five constituent Accountable Care Partnerships** and implementation of its **Health and Care Working Together Plan** (October 2016, revised April 2017) and **five Place Plans**.

7.1.4. The development of the Accountable Care System during 2017/18 will establish how individual organisations will be **held to account** for their contribution to the delivery of NHS Constitution and Mandate and the Health and Care Working Together Plan. Each of the five Places has confirmed they wish to continue to develop their Accountable Care arrangements and it is anticipated that these will be in shadow form in 2017/18. What constitutes 'shadow' is to be worked through and to be discussed and agreed with statutory organisations. SYB ACS 'working as one' with NHS England and NHS Improvement will work with ACPs providing support where required, especially where ACPs look to move to legal forms.

7.1.5. **Operational management** of the **assurance** and **oversight processes** will be through SYB working together and we will deliver the principles of the two national frameworks with a **locally developed model** with an **integrated single** oversight and assurance process within the ACS.

7.1.6. SYB will be **assured once**, as a place, for delivery of the NHS constitution and mandate, **financial** and **operational control** and **quality**.

## 7.2. NHS assurance, regulation and accountability

7.2.1. We would expect to move to a **SYB relationship** with NHSI and NHSE providing a **single 'one stop shop' regulatory relationship** with NHSE and NHSI in the form of **streamlined oversight arrangements**. An **integrated CCG Improvement Assessment Framework (IAF)** and **Trust single oversight framework**. CCGs will still require an annual review with NHSE. This will be in place from April 2018.

### 7.2.2. Single Accountability Framework

Within 2017/18, SYB working with NHS England and NHS Improvement will establish a Single Accountability Framework (SAF) which brings together the NHS England CCG Assurance

Framework and the NHS Improvement Single Operating Framework at a local level. The SAF will be implemented from 1 April 2018 and will set out:

- The **roles and responsibilities** of the parties to this Agreement (CCGs, providers, NHS England and NHS Improvement)
- The **scope of the SAF** including NHS constitutional commitments, national targets, quality indicators and productivity measures
- The **internal governance, assurance and reporting** system within SYB to support delivery of the SAF
- The **external assurance** and reporting system for SYB to NHS England and NHS Improvement
- The **agreed trigger points** and **process** where NHS England and NHS Improvement may **exercise their statutory responsibilities for intervention**.

**7.2.3.** The **Single Accountability Framework** will operate in shadow form within 2017/18. In shadow form, its scope will reflect the priorities of SYB (for example, cancer and urgent & emergency care).

**7.2.4.** The scope of the SAF **will widen as the ACS matures** until it covers the full range of NHS responsibilities. The timeline for the development of the scope of the SAF will be agreed between the Parties to the Agreement.

**7.2.5.** In 17 / 18 we will **align NHS England and NHS Improvement functions** and resources to support delivery of the 'integrated within SYB ACS' element of the Single Accountability Framework.

### **7.3. Quality and safety**

**7.3.1.** South Yorkshire and Bassetlaw has a well established quality and safety approach at, organisation, Place and System level. Very much of what is described in this MoU is about **improving quality and safety**. This is both through our organisations choosing to work together on common challenges and on those issues which are most in need of a different way of working or most likely to deliver improvements through our joint efforts.

**7.3.2.** We commit to reviewing our approaches in light of developing as an ACS in 2017/18 to ensure our **quality and safety oversight and assurance** best supports how we are coming together in Place, as emerging ACPs and across SYB as an overall ACS.

**7.3.3.** There is growing evidence that the improvements we are aiming to achieve within our plan will give measurable **improvements in quality** ahead of any financial efficiency improvements. We would therefore want to develop clear quality metrics for SYB to enable us to track these quality improvements.

### **7.4. Financial**

**7.4.1.** There are a number of areas that the ACS wishes to develop in conjunction with NHS England and NHS Improvement to support robust governance, accountability and assurance. The proposals will be developed through the SYB Directors of Finance Steering Group and ultimately approved by the Collaborative Partnership Board. The areas to be considered are outlined below.

#### 7.4.2 How a system control total would work across the ACS?

This would focus on the following areas:

- How to create in year flexibilities including the potential use of a contingency or other specific business rules?
- How to reflect the impact of an agreed transformational scheme which differentially impacts organisational financial performance?
- Consideration of Place based control totals?
- Consideration of monitoring, management and reporting arrangements?
- Whether a set of efficiency indicators could be used to inform the application of a system wide control total?

#### 7.4.3 Consideration of moving to a risk based approach to contracts?

Consideration will be given to developing a risk based approach to contracts where risks are identified and aligned to the organisation best placed to manage the risk and which supports the development of a system wide solution.

#### 7.4.4 Investment decisions and business case development?

Agreeing a process to ensure investment decisions are optimal for the ACS footprint and are consistent with the ACS strategy. This will include a process on how any additional capital, transformation and any other external funding can be best deployed across the ACS. Developing a process to agree financial principles and assumptions to be used in ACS business cases

#### 7.4.4 Agreeing a process for business planning, financial reporting and performance

To develop an ACS business planning process including agreement to a consistent set of planning assumptions, where appropriate, and taking into account national guidance. To develop in partnership with NHS England and NHS Improvement a monthly ACS report which covers both financial performance and performance against key operational targets.

### 7.5. Operational

**7.5.1.** In 2017/18 and as part of our approach to developing an integrated single oversight and assurance approach within SYB, we will review operational assurance and oversight including our approach to planning and delivery assurance so that it is integrated within SYB. We will also align NHS England and NHS Improvement functions and resources.

### 7.6. Shadow Accountable Care System

**7.6.1.** In 2017/18, SYB will develop as an **Accountable Care System**. This will include collective decision making, governance and a **single accountability framework** which will align the individual statutory responsibilities of Parties to the Agreement to the delivery of the Health and care Plan (November 2016).

**7.6.2.** Where it serves to improve population health outcomes and to meet the needs of patients, we will develop integrated working between commissioners and providers to transform services and reduce transactional costs in the system.

**7.6.2.** Each of the five Places will develop an **Accountable Care Partnership** (ACP) to deliver the ambition set out in its **Place Plan** and the **wider Health and Care Plan (2016)**. The five ACPs will operate in shadow form within 2017/18 and will **be legally constituted partnership by 1 April 2018**, at the latest.

**7.6.3.** The five ACPs will bring together health and care services from statutory and non-statutory organisations to create a **vertically integrated care system** in each Place. This will include hospital services from tier 1.

**7.6.4.** Each of the five Places will explore new ways of contracting and allocating resources to its ACP including **population budgets, population health management** and segmentation approaches.

**7.6.5.** The five ACPs will connect between the five Places and with a horizontally integrated network of hospital based care (tiers 2 and 3) to support seamless care for patients and to create the overall accountable care system (ACS) for South Yorkshire and Bassetlaw.

**7.6.6.** A system wide commissioning function will be in place within 2017/18 which will result from a reform of commissioning. We will build on approaches we have established in SYB, integrating approaches to planning and transformation and explore new ways of contracting and allocating resources to network of hospital based care. From April 2018, we will start to test the **'contract once' with the 'network of provider'** to support sustainable services and drive improved outcomes for patients.

## **7.7. ACS governance**

**7.7.1.** South Yorkshire and Bassetlaw has established collaborative governance. This governance **recognises statutory governance** of member organisations and where statutory organisations have come together to formally delegate to **a joint committee or Committees in Common**. It serves to support and supplement where agreed and appropriate, statutory governance and is the basis from which we will develop as an ACS.

**7.7.2.** A summary of SYB governance includes an **Oversight and Assurance Group**, a **Collaborative Partnership Board**, an **Executive Steering Group** and a range of programme Boards and project Boards.

### **Summary schematic - South Yorkshire & Bassetlaw Health and Care Working Together Partnership Governance**



**7.7.2.1. Oversight and Assurance Group:** membership includes chairs from constituent statutory bodies including providers, commissioners, and Health and Wellbeing Boards with chief executives (CEOs) and accountable officers (AOs) in attendance.

**7.7.2.2. Collaborative Partnership Board:** membership includes CEOs and AOs from partner organisations including mental health and primary care, commissioning and local authority organisations, voluntary action groups, Healthwatch, NHS England and the ALBs. We also have clinical membership from primary and acute care. We plan to strengthen our Collaborative Partnership Board and review primary care input and wider clinical input and with lay membership.

**7.7.2.3. Executive Steering Group:** this group combines both the former STP executive steering group and the former finance oversight committee. Membership includes CEO and AO representation, together with directors of strategy, transformation and delivery and directors of finance.

**7.7.2.4. Programme Boards:** we have a range of programme boards delivering key priorities which are all led by a CEO and AO senior responsible officer (SRO). Each has a director of finance lead and a programme manager supporting.

**7.7.3.** This governance will remain in place for 2017/18 and during this time SYB will work with the Department of Health, NHS England, NHS Improvement and the ALBs as an ACS to review and establish governance that will best support us. This will be in place for 1 April 2018.

## **7.8. Joint Committees and Committees in Common**

**7.8.1.** SYB CCGs, in partnership with North Derbyshire and Wakefield CCGs, have already established a joint committee and CCG governing bodies have **delegated authority** for the review of children's surgery and hyper acute stroke services. The membership includes accountable officers, clinicians and lay members. During 2017/18, we will review the scope of delegation to reflect the outcomes of the Hospital Services Review and the Commissioning Review so that formal governance arrangements are in place by 1 April 2018.

**7.8.2.** SYB acute providers, in partnership with Chesterfield Royal Hospital NHS Foundation Trust and Mid Yorkshire Hospital NHS Trust, have established a **Committees in Common (CiC)** to better support collaborative working between trusts including streamlining decision making. The collaboration has already supported changes in a number of programme areas including support services (back office functions) and a number have been joint with commissioners working together across the same geographical area.

**7.8.3.** During 2017/18, we will review the scope of delegation to reflect outcomes of the Hospital Services Review and Commissioning Review so that governance arrangements are in place by 1 April 2018. At this stage, the wider acute provider partnership includes both acute providers and community mental health providers. However the CiC does not currently extend to community mental health providers

**7.8.4.** The two programme offices and teams supporting commissioning and provider collaborations have now co-located to provide a joined up approach to planning and transformation delivery of acute services across SYB.

## 7.9. Place and accountable care development

**7.9.1.** CCGs and local authorities will continue to receive their respective health and care funding and to be statutorily accountable for their allocation.

**7.9.2.** Within 2017/18 each CCG will agree with its corresponding local authority the integrated governance structure which will support the **allocation of resources** to their ACP based on delivery of their agreed Place plan, wider Health and Care plan and agreed local outcomes.

## 8. Delivery improvement 2017/18-19

**8.0.1.** South Yorkshire and Bassetlaw has developed a number of priorities to support delivery of its Plan. These are led by chief executives and accountable officers with strong input from senior clinicians, public health, senior finance and operational colleagues from member organisations.

### 8.0.2. Transformation priority workstreams include:

- Urgent and emergency care
- Cancer
- Healthy lives, living well and prevention
- Primary care
- Mental health and learning disabilities
- Elective care and diagnostics
- Maternity and children's

#### 8.0.2.1. Enabler workstreams

- Workforce
- Digital and IT
- Carter, estates and shared services
- Finance
- Communications and engagement

**8.0.3.** For 2017/18 – 19 South Yorkshire and Bassetlaw has identified a focused number of key priorities for delivery improvement 'working as one'. We will align resources and priority workstreams to support delivery of these key priorities at all levels within the emerging Accountable Care System and we will use these priorities to test new ways of working together and with NHS England and NHS Improvement to show additional benefits to patient and service delivery:

1. at organisational level
2. at Place (ACP) level
3. at System (ACS) level

**8.0.4.** Catalyst for change – in 2017/18 we will focus delivery improvements in urgent and emergency care, primary care, mental health and learning disabilities and cancer (or subsets of these priority areas) where we plan to make tangible improvements which will serve as a real catalyst for change across SYB. Each of our transformational workstreams has taken a unique perspective on how best they can contribute to delivering the 'key improvements' set out in the Next Steps on the Five Year Forward View. We will also take a unified approach to tackle efficiency improvement 'working as one' where this makes sense to do so.



## 8.1. Efficiency programmes, back office, Carter, Naylor

8.1.1. The efficiency programmes agenda is being addressed through two workstreams.

8.1.2. Firstly; The Provider Efficiency Group, which is responsible for the oversight of the acute and mental health trust providers' programme and is addressing the eight nationally defined corporate service areas to ensure that collaborative opportunities are identified and maximised, including consolidation where appropriate. Its strategic objective is to develop systems that capture and optimise the cost effectiveness of corporate services so that services are assessed not only on direct costs and non financial quality indicators, but in relation to professional influence in driving efficiencies across trust systems, policies and processes. Its key aim is to reduce service costs with the summary data for showing the SYB position as 27/44, with potential savings of £4.4m to £10m, taking into account the national median and upper quartile benchmarking data from 2015/16. This is in line with estimated savings contained in the case for change submission October 2016.

8.1.3. The workstream's immediate priority is to achieve efficiency savings that will help to reduce the financial gap and, in particular, focus on savings and innovations that can be delivered during 2017/18. To enable effective oversight and delivery of collective solutions, a phased approach has been agreed on the key service areas that have shown, through the benchmarking data, the greatest saving opportunities, and which take into account the synergies and dependencies between these service areas. These are **HR services, finance including payroll, and procurement**.

8.1.4. The ambition and commitment is to have regional networked arrangements using the same financial, HR and procurement solutions that will use consolidation and integration of transactional services as an enabler for common standardisation and streamlining of e-processes across all trusts to make efficiencies. Where and when appropriate, market testing may be undertaken.

8.1.5. The focus is therefore not just on changes to operating models but where with the use of technology and removal of transactional activity, significant efficiencies could be made. This is also reflected through formal HR streamlining and standardisation of priorities that target reduction of unwarranted variation and duplication across: workforce systems and compliance (including collaborative commercial relationships); general recruitment; bank and agency management (phase one focusing on medical agency including case for collaborative bank); occupational health/absence management; mandatory and statutory training; common bandings/gradings.

8.1.6. Secondly; there is a system wide Strategic **Estates** Group, the role of which is to provide strategic oversight, planning and direction to SYB clinical workstreams and the CCG Local Estate Forums (LEFs), enabling the delivery of more effective, Place based health facilities, property assets and health/public land across South Yorkshire and Bassetlaw. This workstream will support the implementation of a sustainable estate strategy that will help to deliver those objectives and also consider the findings of the Hospital Services Review and support the development and implementation of estates strategies arising from it. This will ensure a more integrated approach through the delivery of a smaller, more cost effective and efficient estate which is aligned more closely with the delivery of frontline public services.

8.1.7. The Strategic Estates Group brings together organisations which own health facilities, property assets and health/public land to facilitate the better use of all health and public

sector estate and will review principles for collaborative use of built assets. Its immediate priorities for 2017/18 – 2018/19 are based on three themes: strategic estates planning; aligning investment and disinvestment; and estates intelligence and spatial mapping.

**8.1.8.** Key outcomes are the production of a strategic estates plan and accompanying action plan, which sets out clear priorities for the delivery of better use of all local public land and property assets within respective geographical areas to deliver the estate objectives highlighted within the Health and Care Plan . It will also review the findings of the Naylor Review of surplus land and challenge partner organisations to address any recommendations, which will support the development of affordable estates and infrastructure plans and associated capital strategy

## **8.2. Managing demand and optimising care**

**8.2.1.** The elective and diagnostic care workstream will be responsible for the planning, oversight and governance of a regional or sub regional elective and diagnostic care system. Closing the elective workstream's gap will be achieved by focusing on two priorities: reducing system demand and improving efficiencies in how we deliver our services. These themes will be delivered at Place and System levels through eight interventions; however, immediate priorities for 2017-2019 are described below.

**8.2.2. Correct referral pathway** – we will implement best practice demand management approaches that will reduce unnecessary or inappropriate referrals and ensure patients reach their most appropriate treatment first time. This will be achieved by piloting local solutions to advice and guidance and referral support with consideration to developing a regional solution. We will undertake local place based reviews of clinical pathways to reduce demand and attendance in hospital by developing community based services. We will support local organisations to improve utilisation of non face-to-face clinic delivery, alternative workforce models to drive efficiency and ensure effective access and discharge policies are in place to reduce unnecessary follow up appointments.

**8.2.3. Procedures of low clinical value and clinical thresholds** – we will develop a SYB policy for effective commissioning including a common set of controls and clinical thresholds for procedures to ensure adherence to best practice guidance.

**8.2.4. Diagnostics** – we will implement workforce and IT solutions that will reduce the demand and capacity gap in radiology reporting. We will work with the cancer workstream to develop diagnostic solutions that support early diagnosis.

**8.2.5. Clinical efficiency** – we will use benchmarking analysis (Getting It Right First Time) to identify and target variation along clinical pathways in order to deliver efficiencies. We will ensure our surgical activity is aligned to the appropriate setting and we will identify and transfer activity that can be delivered closer to home in the community.

## **8.3. General practice and primary care**

**8.3.1.** Supporting and investing in general practice and primary care is a national priority mirrored by key priorities for all of our local Places. During the course of 2017 -19 we will deliver extended access to general practice for 100% of the local population by March 2019 and where possible, take steps locally to boost GP numbers including improving retention.



**8.3.2.** Expand multidisciplinary care including clinical pharmacists, mental health therapists, physician associates and increase the number of nurses in general practice.

**8.3.3.** Ensure 100% of GP practices are working together in hubs or networks by March 2019 that offer a greater scope of services which are increasingly capable of taking on population health responsibilities.

**8.3.4.** Expand multi-disciplinary care by deploying SYB's share of 1300 clinical pharmacists and 1500 mental health therapists, as well as physicians' associates and increase the number of nurses in general practice.

## **8.4. Urgent and emergency care (UEC)**

**8.4.1.** We will continue to develop and strengthen the urgent and emergency care networks and partnership working through the UEC Steering Board, which builds upon the UEC Network established in 2015. A programme of work is currently being developed to take account of national requirements and the case for change described in the Health and Care Plan, with delivery models developed at place with a joint focus on redesigning the urgent and emergency care system and developing out of hospital services to reduce demand on A&E and acute beds.

**8.4.2.** The Five Year Forward View identified seven UEC priorities which will be included in the work programme. Specific priorities for 2017/18 include;

- We will work within Place and collectively across the System to ensure delivery of the four hour A&E standard and we will work as one with NHSE/I to agree improvement trajectories at System level with oversight on place delivery.
- We will work with Place to ensure the implementation of primary care streaming for each emergency department and with NHSE/I to agree at system level targets for activity flows through primary care streaming.
- We will work with Place to develop and identify the requirements for a clinical advisory service at three levels, 1) Place, 2) System 3) Regional to develop a hub and spoke arrangement to clinical advice using local clinicians/services where possible and scaling to system level where it is more efficient to do so.
- We will work as one with NHSE/I to agree at System level a realistic improvement trajectory to increase the volume of calls transferred from 111 to a clinician, working with providers of 111, out of hours and with place to deliver the ambition of 50% by March 2018 ensuring that NHS 111 connects into the appropriate clinical services and patients are directed to the most appropriate clinician/service.
- We will express an interest in becoming a pilot at system level for NHS 111 online in 2017/18 subject to the national roll out plan.
- We will work with Place to develop a plan to have at least one designated urgent treatment centre established by March 2018, which will include a review of existing urgent care centres, minor injury and walk in services to establish the baseline position and develop a plan to have a model for urgent treatment centres across the System in place by 2019.
- We will work with ambulance providers to implement the ambulance response programme and work as one with NHSE/I to develop realistic implementation plans. This will include working with Place to develop consistent offers on alternative pathways to conveyance to A&E.

- We will work with Place to improve patient discharges and flow through hospitals, including the establishment of a pilot to roll out the use of care home electronic bed states.
- We will work with Place to establish a common and shared approach to escalation management developing a plan to roll out a single system for better connections between Place and allow System level oversight of pressures in the UEC system.
- *We will work as one with NHSI and NHSE to align differential standards to secure delivery of integrated urgent care between 111 and out of hours providers.*

## 8.5. Mental health and learning disabilities (MHL D)

**8.5.1** A number of priorities for the MHL D workstream have been identified, reflecting the requirements set out in *Implementing the Five Year Forward View for Mental Health* and identifying where and how a System level approach offers opportunities for improvements in service development and delivery. Key objectives for the workstream are:

- Development of core 24 liaison mental health services in all acute hospitals to support a reduction in pressure on the urgent and emergency care system, including reducing emergency admissions and length of stay for people with mental health problems.
- Providing support across all areas to develop integrated improving access to psychological therapies (IAPT) to ensure that people with long term conditions have their mental health needs met, reduce presentations for people with medically unexplained symptoms and improve patients' ability to self manage to reduce reliance on healthcare services.
- Taking a collaborative approach to developing perinatal mental health pathways and services.
- Working with specialised commissioning on specialist beds and community alternatives across children and young people's and secure mental health services.
- Improving the management of people with complex dementia needs, as part of moving care closer to home across the mental health and learning disabilities health and social care system.

**8.5.2** In addition to supporting delivery of national objectives, the workstream is proactively addressing local issues, including gaps in services for adults with autism spectrum disorder (ASD) and attention deficit hyperactivity disorder (ADHD) and workforce issues. It will also work closely with the healthy lives, living well and prevention workstream to roll out innovations around social prescribing and employment support.

**8.5.3** SYB will also oversee and support delivery of national objectives around access to services, including increasing access to psychological therapies, delivery of the 18 week referral to treatment target, and access to physical health checks for people with severe mental illnesses.

**8.5.4** The workstream is also looking to explore opportunities for alternative commissioning and provider models where these will improve outcomes for patients, secure efficiency savings and secure service capacity and quality across SYB; including provider alliances and system commissioning.

## 8.6. Cancer

**8.6.1.** We will strengthen the newly formed **Cancer Alliance** by working with member organisations and at Place across the Cancer Alliance footprint; South Yorkshire, Bassetlaw and North Derbyshire. Our mandate and deliverables are explicitly articulated through the

Next Steps on the Five Year Forward View, the Cancer Taskforce strategy and our own Cancer Alliance Delivery Plan. Immediate priorities are outlined below:

- We will work to **deliver the 62 day referral to treatment standard at System level** as a single measure across our provider organisations by March 2018. This will create capacity to focus not only on the target but also enable us to focus on measures which hold the greatest significance to people affected by cancer such as quality of life, whilst also working to improve inter provider transfers within 38 days and improve earlier diagnosis.
- We will work with Place to **implement interventions to achieve earlier diagnosis of cancer** through raising awareness of signs and symptoms and maximising uptake in screening. We will understand capacity and demand across our diagnostics services, priorities in access to diagnostics and explore new models of access to diagnostics.
- We will support the delivery, through the local Cancer Alliance, of the strategic priorities to improve early diagnosis, services and outcomes for cancer patients as per the Cancer Taskforce report and facilitate the introduction of bowel cancer screening and primary HPV testing for cervical screening.
- We will continue to work with Place to fully deliver person centered care for people affected by cancer by **implementing the living with and beyond cancer (LWABC) model of care**.
- We have established an **'advisory board' of people affected by cancer to support decision making** as part of our Living With and Beyond Cancer programme, one of our four Cancer Alliance workstreams. The Cancer Alliance board will also access this group on a topic by topic basis to support decision making on a range of issues such as performance.

## 8.7 Children's and maternity care

**8.7.1** We have established a Children's and Maternity Delivery Board to support system transformation across three initial priority areas:-

1. Following public consultation, to reconfigure children's surgery and anaesthesia, developing new models of care with consistent management across providers, with sustainable care pathways that meet the newly specified standards of care.
2. For the acutely ill child, there is variation in the provision of care, and local assessment (in line with the national picture) identifies the current models are not sustainable, particularly in terms of workforce sustainability and coordinated care pathways. Therefore, there is a need to plan across a larger footprint and network provision. The immediate priority is to work together to develop sustainable new models of care for acute paediatrics, ensuring equity for children right across the SYB area through the adoption of a consistent 'blueprint' for services in each Place. This will be supported by a managed clinical network (MCN), ensuring a strong clinical input throughout. The blueprint will include paediatric acute services and consistent management across hospital settings, promoting demand management and supported discharge models in community settings, and the use of short stay assessment models.

3. For maternity services, we will work together to review the current offer and develop a single implementation plan for maternity care across SYB proposing changes in line with the implementing better births, through our Local Maternity Systems (LMS).

## 8.8. Workforce

**8.8.1.** The Local Workforce Action Board (LWAB) is the main vehicle for driving and managing the workforce work stream. There is an overarching aim and ambition to make SYB an attractive place to work to both attract and retain staff.

The LWAB is focusing on three initial priorities:

- **Development of the South Yorkshire and Bassetlaw region excellence centre (1 of 7 in England)** which aims to raise the standard for support staff by promoting vocational education including focusing on apprenticeships, sharing resources and acting as a vehicle for innovation.
- **Creation of a faculty of advanced clinical practice** for the region which aims to ensure consistent practice standards and secure resources for advanced clinical practitioners (ACPs) and physician associates (PAs).
- **Sustainable primary care;** plans include an increase in GP, practice nurse and clinical support worker numbers, plus further development of physician associates, AHP practitioners, care navigators and clinical pharmacists.

**8.8.2.** As an enabling work stream, the LWAB is committed to supporting the SYB workstreams to identify their workforce requirements and transform their services.

## 8.9 Digital and IT

**8.9.1.** We will be relentless in focusing on the needs of our citizens and our patients and will seek opportunities for technology to improve the ability of our staff and our partners to meet those needs. Therefore, on the journey towards achieving our vision we will:

- Directly support and influence the work of the SYB priority and enabling workstreams to ensure they are able to maximise the benefit of digital solutions.
- Transform the way in which we engage with patients and citizens, supporting them to maintain their own health and wellbeing through digital solutions.
- Improve the way in which health and care providers engage at all levels to ensure an integrated approach to digital transformation.
- Accelerate mechanisms that promote record and data sharing as more care is delivered outside a hospital environment, enabling clinicians to provide the best care in all settings, particularly via the use of mobile technology.
- Exploit big data analytics to inform frontline clinical decision making, provide real time system level management information and better targeting of prevention initiatives.
- Support and empower our staff, patients and citizens so they can maximise the potential of new technologies as they become available to them.
- Invest in interoperability and infrastructure to enable change

**8.9.2.** Focus areas from a recent development workshop (and a draft programme of interventions) are:

- Digital inclusion
- Self help connect
- Wellbeing and recovery
- Healthcare co-ordination

- Sharing data, predictive analytics
- Shared services and information governance
- Technical interoperability
- Digital health innovation

## 8.10 Development of accountable care in Place and System

**8.10.1.** In 2017/18, SYB will develop as an **Accountable Care System**. This will include collective decision making, governance and a **single accountability framework** which will align the individual statutory responsibilities of Parties to the MoU to the delivery of the Health and Care Plan (November 2016).

**8.10.2.** Where it serves to improve population health outcomes and to meet the needs of patients, we will develop integrated working between commissioners and providers to transform services and reduce transactional costs in the system.

**8.10.3.** Each of the five Places will develop an **Accountable Care Partnership (ACP)** to deliver the ambition set out in its **Place Plan** and the **wider Health and Care Plan (2016)**. The five ACPs will operate in shadow form within 2017/18 and will **be legally constituted by 1 April 2018**, at the latest.

**8.10.4.** The five ACPs will bring together health and care services from statutory and non statutory organisations to create an **integrated care system** in each Place. This will include hospital services from tier 1 (to be determined).

**8.10.5.** Each of the five Places will explore new ways of contracting and allocating resources to its ACP including **population budgets, population health management** and segmentation approaches.

**8.10.6.** The five ACPs will connect between the five Places and with a **horizontally integrated** network of hospital based care (Tiers 2 and 3 to be determined) to support seamless care for patients and to create the overall accountable care system (ACS) for South Yorkshire and Bassetlaw.

**8.10.7.** A system wide commissioning function will be in place within 2017/18 which will result from a reform of commissioning. We will build on approaches we have established in the STP, **integrating approaches to planning** and **transformation** and we will explore new ways of contracting and allocating resources to the integrated network of hospital based care.

## 8.11. Commissioning reform

**8.11.1.** During 2017/18, we will undertake a review of commissioning as part of our system reform. This will consider the development of ACP in Place and the developing ACS and will need to influence and respond to:

- a. The five ACPs bringing together **health and care services** from statutory and non statutory organisations to create a **vertical and horizontal integrated care system** in each Place, include hospital services from tier 1 (to be determined).
- b. Developing new ways of contracting and allocating resources to its ACP including **population budgets, population health management** and segmentation approaches.
- c. Connect between the five Places and with a horizontally integrated network of hospital based care (tiers 2 and 3 determined by the hospital services review and

delivery of safe and sustainable services) to support seamless care for patients and to create the overall Accountable Care System (ACS) for South Yorkshire and Bassetlaw.

- d. Having a **system wide commissioning function** in place within 2017/18 with new ways of contracting and allocating resources to the integrated network of hospital based care. From April 2018, contracting once for a range of agreed services with the network to support sustainable services and drive improved outcomes for patients.

Organisations have agreed to fully engage in the review to support the objectives and also to support implementation of the **review recommendations**.

## 8.12. Specialised services

**8.12.1.** In many clinical areas, including cancer, mental health and learning disabilities, the commissioning of services is often split across a number of different organisations, which makes it much more difficult to plan the provision of integrated care. Different sets of commissioners make separate decisions about areas of provision which – for the patient – combine to form their whole patient journey. In children and young people’s mental health, for example, young people move between types of provision that are commissioned and provided by separate organisations.

**8.12.2.** Whilst commissioning responsibilities have become more dispersed over recent years, our collective responsibility is to ensure that any differentiation in the commissioning of services does not manifest itself in fragmented services for patients. The development of the ACS gives the opportunity for specialised commissioners to work with local systems to ensure that joined up pathways are both commissioned and delivered across multiple health and social care settings and that the transitions between services are explicitly supported.

**8.12.3.** Commissioning specialised services across SYB helps remove some of the structural barriers that reinforce the separation between different elements of provision. It means that integration – for example between inpatient services and community services in mental health, or between chemotherapy and follow-up care in cancer – is ‘designed-in’ to local NHS services by joining up the commissioning processes across specialised and non specialised services, and across NHS and local authority care. Decision making is shifted as far as possible from the national to the local, to ensure it is based on the specific requirements of that geographical locality, giving local systems more say on how specialised budgets are spent in their area, making use of their deep understanding of their local population and giving them a voice in how resources are used locally in line with the established national service specifications.

**8.12.4.** The specialised services commissioned by NHS England include a diverse range of services, from the rare and highly specialised to more common/higher volume services. It follows that the most appropriate footprint for planning these services also varies (depending on a range of factors such as: patient numbers, shape of provision, financial risk, service specifications, strategy). NHS England has worked with its regional teams to undertake an initial segmentation of the services. This has resulted in developing a list of 20 services that are suitable for planning at populations up to 2.5m and thus at SYB level. During 17/18, work will take place with SYB and specialised commissioners to explore areas of focus that would be most relevant to work towards being part of the ACS.

### 8.12.5. Milestones:

- Areas of focus for specialised services to be planned at an SYB level agreed - Mar 18
- Shadow run budget for areas of focus for specialised services agreed - from Apr 18



- Ensure that for areas of focus agreed, any decisions on changes to services is made in partnership with SYB – from Apr 18
- 18/19 – work towards integration of services within ACS.

Further work is still required to understand the staff resource implications of this work and this will be explored during 17/18.

### 8.13. Hospital services review

**8.13.1.** Both commissioners and acute providers across South Yorkshire and Bassetlaw, North Derbyshire and Wakefield have all committed to support an independent review of hospital services. The review will be completed in 2017/18. The terms of reference have been established and include the following key review objectives:

- a) Define and agree a set of criteria for what **constitutes 'Sustainable hospital services'** for each **Place** and for South Yorkshire and Bassetlaw, North Derbyshire and Mid Yorkshire (in the context of South Yorkshire and Bassetlaw).
- b) Identify any services that are **unsustainable and not resilient against** these criteria, in the short, medium and long-term, including tertiary services delivered within and beyond SYB.
- c) Put forward a future service **delivery model or models** which will deliver sustainable hospital services.
- d) Consider the future role of a **district general hospital** in best meeting patient needs in the context of the aspirations outlined in the South Yorkshire and Bassetlaw Health and Care Plan and emergent models of sustainable service provision.

## 9. National and regional support from the Department of Health, NHS England, NHS Improvement and the Arms Length Bodies

### 9.1. Capacity and capability

**9.1.1.** To support SYB ACS development there will be a process of aligning resources from ALBs to support delivery and establishing ACS integrated single assurance and regulation approach.

**9.1.2.** National capability and capacity will be available to support SYB from central teams including governance, finance and efficiency, regulation and competition, systems and national programme teams, primary care, urgent care, cancer, mental health, including external support.

### 9.2. Financial including transformation and capital funding

**9.2.1.** In year one, an allocation of central funding has been ring fenced for the eight accelerating ACSs only.

**9.2.2.** SYB will therefore receive **a share of the £450 million transformational funding** allocated for the eight high performing systems and a **share of the £325 million capital funding**. How this funding is allocated to deliver our system plan is to be worked through and agreed.

**9.2.3.** Bespoke support to work through financial governance and operating a shared system control total and alternative payment models.

### 9.3. Nationally supported workstreams and peer support

9.3.1. National ACS workstreams/learning set have been established to work with and support the eight named Accountable Care Systems including:

- Communications and public engagement
- Leadership
- Scaling up primary care
- Urgent and emergency care
- Devolved transformation funding
- Spreading new care models and integrating care
- Capital funding
- Shared system control totals
- Alternative payment models
- System wide efficiency opportunities
- Governance
- Streamlining oversight
- Future of commissioning functions
- External partnerships to support population health.



## 10. Glossary of terms and acronyms

ACP	Accountable Care Partnership. The partnerships forming in each of the five local places of Barnsley, Bassetlaw, Doncaster, Rotherham and Sheffield.
or	Advanced Clinical Practitioner
ACS	Accountable Care System; here covering South Yorkshire and Bassetlaw with five constituent Places of Barnsley, Bassetlaw, Doncaster, Rotherham and Sheffield
ALB	Arm's Length Body; see <a href="https://www.gov.uk/government/publications/arms-length-bodies/our-arms-length-bodies">https://www.gov.uk/government/publications/arms-length-bodies/our-arms-length-bodies</a>
AO	Accountable Officer at a Clinical Commissioning Group
Carter	Lord Carter's review: 'Unwarranted variation: A review of operational productivity and performance in English NHS acute hospitals' (2016)
CCG	Clinical Commissioning Group
CEO	Chief Executive Officer
CIC	Committees in Common
CPB	Collaborative Partnership Board
CQC	Care Quality Commission, the independent regulator of all health and social care services in England
DoH	Department of Health
FT	Foundation Trust; a semi--autonomous organisational unit within the NHS
FYFV	Five Year Forward View; a strategy for the NHS (2014)
GB	Governing Body - governance of Clinical Commissioning Groups
GP	General Practitioner
GPFV	General Practice Forward View
HEE	Health Education England
HSR	Hospital Services Review
IAPT	Improving Access to Psychological Therapies
JC CCG	Joint Committee of Clinical Commissioning Groups - a statutory body where two or more CCGs come together to form a joint decision making forum. It has delegated commissioning functions.
LA	Local Authority, an administrative body in local government

LWAB	Local Workforce Action Board sub regional group within Health Education England
MCP	Multi-specialty community provider
MHLD	Mental Health and Learning Disabilities
MoU	Memorandum of Understanding; a formal agreement between two or more parties to establish official partnerships
Naylor Review	Sir Robert Naylor's review of NHS property and estates and how to make best use of the buildings and land (2017)
NHS	National Health Service
NHS 111	A national free to call single non-emergency number medical helpline
NHSE	NHS England
NHSI	NHS Improvement; operating name for Monitor, NHS Trust Development Authority and teams from 2016
PA	Physician's Associate
PACS	Primary and Acute Care System
Place(s)	One of five geographical subdivisions of SYB with the same footprint as the ACPs
SAF	Single Accountability Framework
SRO	Senior Responsible Officer, the visible owner of the overall business change, accountable for successful delivery
STP	Sustainability and Transformation Plans (2016); the NHS and local councils have come together in 44 areas covering all of England to develop proposals and make improvements to health and care
SYB	South Yorkshire and Bassetlaw
TBA	To be announced
TBC	To be confirmed
UEC	Urgent and emergency care
Vertical integration	<b>FYFV delivery next steps:</b> horizontally operating provider organisations simultaneously operating as vertically integrated care system, partnering with local GP practices formed into clinical hubs serving 30,000 – 50,000 populations
Horizontally integrated	<b>FYFV delivery next steps:</b> Where provider organisations collaborate to form care systems. There are different forms; from virtual to actual mergers, for example, having 'one hospital on several sites' through clinically networked service delivery



**Doncaster and Bassetlaw  
Teaching Hospitals**  
NHS Foundation Trust

Title	Doncaster Place Plan		
Report to	Board of Directors	Date	25 July 2017
Author	Anthony Fitzgerald, Doncaster CCG		
Purpose		Tick one as appropriate	
	Decision	X	
	Assurance		
	Information		

**Executive summary containing key messages and issues**

In 2016 Health and Social Care organisations across Doncaster developed the Doncaster Place Plan. The joint vision was that:

"Care and support will be tailored to community strengths to help Doncaster residents maximise their independence, health and wellbeing. Doncaster residents will have access to excellent community and hospital based services when needed."

The Doncaster Place Plan was approved by NHS Doncaster CCG Governing Body in October 2016.

In January 2017 Health & Social Care partners appointed Ernst & Young as a strategic partner to facilitate implementation of the Place Plan. The attached report is the phase 1 assessment of the Health and Social Care partnerships ability to implement the Place Plan. It includes an assessment of readiness state across 6 key areas, and describes the key areas of focus for Phase 2 of implementation.

## The key summary areas are shown below

### What did we find in Phase 1?

The assessment focused on some key areas that we believe are the 'get it rights' for taking this forward

What do we need to get right?	What are we doing well?	What do we need to focus on?
1. Leadership	<ul style="list-style-type: none"> <li>There is strong commitment to the proposals and an eagerness to progress</li> </ul>	<ul style="list-style-type: none"> <li>Strengthened system leadership is needed and a clearer understanding of Doncaster's role within South Yorkshire &amp; Bassetlaw</li> </ul>
2. Culture	<ul style="list-style-type: none"> <li>There is a culture of honesty and transparency</li> </ul>	<ul style="list-style-type: none"> <li>There is a need to develop a common language and continue to build understanding and trust</li> </ul>
3. Governance	<ul style="list-style-type: none"> <li>There has been strong engagement with regards to governance processes</li> </ul>	<ul style="list-style-type: none"> <li>Strengthened processes are required to drive the programme forward effectively</li> </ul>
4. Services	<ul style="list-style-type: none"> <li>There is a clear direction of travel and view on what should be included</li> </ul>	<ul style="list-style-type: none"> <li>Benefit and working frameworks need agreement</li> </ul>
5. Finance	<ul style="list-style-type: none"> <li>Strong relationships and a willingness to share information in a transparent way</li> </ul>	<ul style="list-style-type: none"> <li>There is a need to devise a collaborative approach on group accounting</li> </ul>
6. Operational and Commercial	<ul style="list-style-type: none"> <li>There is good alignment of plans and ambitions</li> </ul>	<ul style="list-style-type: none"> <li>There is a need to form a collaborative approach and refinement of focus</li> </ul>

### What are we doing now?

- ✓ **Setting up a programme approach:** to develop a project management office meaning better coordination, transparent reporting and more streamlined robust governance to support rapid decision making.
- ✓ **Energising and evidencing the Case for integration:** by ensuring the benefits for the local health and social care economy for each change are clearly described and aligned to neighbourhood needs.
- ✓ **Working out some of the technical arrangements to deliver new services:** developing the appropriate operating model for the integrated services in 6 defined areas of opportunity (for example the type of contract we need).
- ✓ **Planning our approach to leadership development:** developing programme to support system leaders who work closer together
- ✓ **Looking at how best to communicate & engage:** to develop a collective voice and make sure the answers are coproduced

## Key questions posed by the report

N/A

## How this report contributes to the delivery of the strategic objectives

The report contributes to the Trust's third strategic aim: increasing partnership working to benefit people and communities, by providing a structure through which partnership working with various local bodies can develop.

## How this report impacts on current risks or highlights new risks

The item provides assurance in respect of a key risk relating to the breakdown of relationships with key partners and stakeholders leading to negative impact on strategic objectives and negative impact on reputation.

## Recommendation(s) and next steps

Board is asked to note the phase 1 state of assessment and support the recommendations and work programme for phase 2 of implementation.

# End of Phase Report

## The Doncaster Place Plan

May 2017

DRAFT FOR CIRCULATION

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# 1. Executive Summary

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# Executive Summary

## Context and Purpose:

The Doncaster Health and Social Care Economy has significant challenges with regards to it's local population in terms of Social economics, life expectancy and growing financial pressures on the system. System leaders within Doncaster have recognised the need to modernise and improve services for residents through greater integration via a place based accountable care system.

## Headline Assessment:

## This report aims to:

- ▶ Set out where Doncaster is in terms of its readiness for the next phase of delivery
- ▶ Set out practical steps and key considerations for phase 1 and Phase 2 and the journey to accountable care
- ▶ Set out the approach to the phase 2 work
- ▶ Technical skills required through the journey to accountable care
- ▶ Focus for the next seven weeks and an outline plan for the future

## Progress has been made...

## ...but more needs to be done

Leadership	All leaders demonstrate commitment to the direction of travel	Further progress needed on leadership across the system and individuals
Commercial	Commissioners are engaged with new go to market specifications	Refinement of how and what will be done
Finance	Joint forums have been held and a shared vision is being developed	Defining the financial envelope and practicalities of group accounting
Programme architecture	The need for strong Programme management is understood	Programme set up and mobilisation
Case for Implementation	A case for Implementation has been developed, particularly for intermediate care	This needs to be further developed, especially outside of intermediate care and complex lives
Finance	Shared understanding of the collective financial problem	Better understanding of the scale of the future scope
Neighbourhoods	It has been agreed a Neighbourhood model would be the start of the Journey to Accountable Care	Defining the scope and models
Communications and Engagement	It is understood there exists a need for a uniform and transparent communications and engagement strategy	Defining the methods and mobilising a joint team

## Approach:

The Cohorts have been devolved into 17 area's of opportunity which have been aggregated up to a tiered approach. The 3 tiers are; Strategic – which will drive the design of the Neighbourhood Model, taking a system wide approach. Operational – where an integrated approach will complement the design and inform the development of the Neighbourhood Model (5 high priority immediate areas have been agreed; Intermediate Care, Complex Lives, Starting Well, Starting Well, Children – Edge of Care)

Functional – Quick wins; which will progress & facilitate closer working relationships, streamline processes, patient & Financial benefits which aid in culture change.  
Five key workstreams for phase 2:  
The five workstreams for phase 2 are: (These are explored further within this report) 1. Programme Set Up 2. Case for Implementation & service model. 3. Operating framework 4. Leadership Development 5. Communications and Engagement



## 2. Introduction & Context

1. Executive  
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# Introduction & Context

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## Introduction

Doncaster is one of the 20% most deprived areas in England c.24% (13,300) of children live in low income families. Life expectancy for both men and women is lower than the England average and the health of people in Doncaster is generally worse than the England average. The Monitor BCF 2014 cost model, applied to the current spend profile across age groups, coupled with the impact of population growth means Doncaster will need to find an additional £61m to meet the needs of the population by 2018 unless action is taken.

What is the ambition for health and care services in Doncaster?

Even without the imminent demographic and financial challenge, system leaders have recognised the need to modernise and improve services for residents. Over the summer of 2016, leaders set out a vision for health and care that drives:

- ▶ Improved health and wellbeing outcomes
- ▶ A focus on prevention
- ▶ A better experience of care
- ▶ Better value for money by optimising the what we do and the way we work

How will it be different and better?

Doncaster spends over £500m annually on health and social care services. Changing the system perspective to view this as the Doncaster £, sets the context for the challenge we are trying to address through this work.

How can we most effectively spend our collective resources to improve outcomes for the local population?

This question formed the basis for the development of the Doncaster Place plan – an approach that has been developed jointly and approved through each participating bodies governance process.

It sets out a set of proposed changes to the system that will, if progressed effectively have a profound impact on how all stakeholders experience the system.

Residents: Will have a more seamless experience of care, will be able to access care closer to home, will be supported to understand, maximise and grow their strengths and assets in relation to improving outcomes and will be more informed, involved and responsible for their health and wellbeing.

Workforce: Will have more opportunities to work across organisational boundaries, creating new and exciting career paths, spending increased time with the people they are supporting, engaging more in designing the services they deliver and are supported to innovate and collaborate.

Providers: Are supported to collaborate to drive improved outcomes, can have a more open conversation with commissioners regarding viability, are more engaged in the development and deliver of new services and are party to the development of the commercial strategies that will govern new contracting arrangements to ensure flexibility is inbuilt.

Commissioners: Are able to engage with providers in a more streamlined governance arrangement that supports system commissioning. Simplified commissioning processes and increase market management capability. An opportunity to evolve insight and intelligence capability.

---

# Introduction & Context

## Context for this report

Doncaster's place plan set out an ambitious plan for making the change described.

Considerable work and commitment has been shown by all involved to get to this point. The jointly approved plan sets the direction for all involved and as well as addressing local priorities is in line with national drivers such as the Five Year Forward View Update.



## Achievements of note:

- ▶ The strong case for change for Intermediate Care
- ▶ Acknowledgement of the need to explore the move towards Integrated Commissioning and a provider partnership that supports accountable care
- ▶ The move to aligned boundaries for providers across 4 neighbourhoods



The Team Doncaster Partnership board oversees four thematic partnerships that direct activity to where it is needed the most. Each theme board is responsible for delivering a section of the Borough Strategy - a key document that sets out an aspirational vision for improvements to the quality of life for Doncaster's residents.

## ▶ The establishment of three cohorts to focus on:

- ▶ Early intervention and prevention
- ▶ Intermediate Health and Social Health
- ▶ Enablement and Recovery

Since the development of the place plan South Yorkshire and Bassetlaw STP has been identified as an exemplar. This provides Doncaster with a unique opportunity to build on its progressive place plan work to really define the local way of working and be a leading light within the STP footprint for accountable care locally delivered.

## Community Led Support

Community Led Support is focused on implementing a fundamental change to the customer journey, building community capacity and resilience, early intervention and prevention work, introducing a three conversation model for customer contact, reshaping the front door, developing community hubs and supporting reconfiguration of a number of teams and culture change in social care staff.

Doncaster has already embarked on the development of a community led support model through raising awareness of a community led approach, starting to redesign the front door, the development of the 3 different "conversations" and the creation of innovation sites and community hubs aimed at diverting people away from social care and towards community based support mechanisms.

# Introduction & Context

EY has been commissioned as the Doncaster Place Plan strategic partner. As part of the initiation of this relationship, this report sets out a maturity assessment that identified the key strengths and areas of focus for the local economy to achieve its ambition. The key findings are summarised below;

	Progress has been made...	...but more needs to be done
Case for change	A case for change has been developed, particularly for intermediate care	This needs to be further developed, especially outside of intermediate care and complex lives
Leadership	All leaders demonstrate commitment to the direction of travel	Further progress needed on leadership across the system
Culture	Commitment & honesty has been demonstrated	More work is needed on to 'test' the relationships with more tricky situations and at additional levels in orgs
Governance	The importance of governance is understood	There lacks an 'engine' room to really move projects forward
Services	Progress has been made on the areas of opportunity for services	Need to prioritise what is done first to ensure can test model
Operational & Commercial	Alignment of plans around integrated commissioning	Lack of common language, appetite and parameters in the development of accountable care principles/provider form.

## Purpose of this report

The health and care economy jointly specified and commissioned EY as their strategic partner to achieve three key ambitions:

1. To test readiness
2. To develop a practical plan to move forward
3. To provide technical skills as required through the journey

## Scope and Navigation

The scope of this report is to provide maturity assessment, a scope and approach for phase 2 of Doncaster's place plan implementation. This includes a proposed programme scope, architecture and outline workplan. It also sets out the key activities required in the next seven weeks to progress mobilising the programme at pace and generate further buy in from the range of stakeholders engaged in the process.

This document is not intended to be a case for change/ case for action for the programme. It is a management product to initiate further activity and convene a greater level of focus and rigour to drive forward the ambitions set out by all partners.

## Timeline of this work

This report has been in development between February and April 2017.

## Approach:

Data collection and validation  
Define initial list of areas for opportunity  
Opportunity scoping  
Challenges sessions with task and finish group  
Prioritisation  
Review maturity assessment recommendations  
Design programme scope  
Define additional mobilisation activity  
Test phase 2 approach with HSC transformation group  
Consolidate phase 2 scope and approach report

# Introduction & Context

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## Report Navigation:

The scope of this report is to provide a current state assessment and to set out the detailed scope or approach for phase 2.

Section 3. Current state assessment: This section sets out the current baseline and assess the readiness for change.

Section 4. Good practice examples: This section sets out national examples of health and social care integration.

Section 5. Programme scope: This section sets out a logic flow of choices the programme will need to navigate across services, commissioning approach and contracting models.

Section 6. Work streams: This section sets out the workstreams within the programme that will enable the system to deliver.

Section 7. Implementation plan: This section sets out the high level route map for the programme over the next 9 months.



### 3. Current State Assessment



# Introduction and analysis of case for Implementation



## Introduction

Doncaster is seeking to engage in a change programme of a significant size and complexity – and one which is vital to get right for its residents. There are a key set of success factors which a programme such as this needs to consider to increase the chance of success.

These should be seen as key building blocks for the journey that all individuals and organisations in the Doncaster Health and Care Economy will need. For this report we have assessed the Doncaster Health and Care Economy against each of these factors. The subsequent pages summarise the assessment against each of these factors.

## Case for Implementation analysis

	What is currently not working? What needs to change?	What is the Doncaster ambition?
Population Segmentation & Needs	There has been recognition, both locally and nationally, that there is not a “one-size fits all” approach that can cater for the needs of the population. Currently in Doncaster, there is a fragmented approach to delivering health and social services, which is leading to a care and quality gap across Doncaster. As a result, health is not improving as quickly as the rest of the UK, with significantly reduced life expectancy in the most deprived areas of Doncaster.	To improve the health and wellbeing and quality of care of Doncaster residents, a cohort model has been adopted with the aim of creating community resilience and maximising existing strengths. This will enable residents to stay at home and will also aid in the re-ablement of patients coming out of hospital. In addition to the three cohorts, Doncaster has been split into four neighbourhoods in order to tailor services in each of the geographic areas. This will allow the adoption of a universal and universal plus care model – the majority of services within each neighbourhood will be the same, with some services focussed locally where appropriate.
Finance	With the increasing cost of provision of care and constrained public resources there is an expected financial gap of £139.5m by 2021. There is currently no pooling of budgets, so services are often commissioned by the CCG or council without an understanding of what the other commissioner is doing. This is leading to duplication of effort and ineffective use of the money available in Doncaster.	The place plan has been developed to help close ~£60m of the expected financial gap. This will require initial investment to implement changes within the neighbourhoods, but once the services and ways of working are running there should be a significant reduction in hospital admission and length of stay through a focus on prevention and re-ablement.

# Overview of the Case for Implementation



	What is currently not working? What needs to change?	What is the Doncaster ambition?
National Direction of Travel	The NHS is struggling to respond to rising demand for its services and its senior leaders are increasingly concerned about service provision. The King's Fund Quarterly Review published in March reported that 63% of trust finance directors and 56% of CCG finance directors believe that care in their local area has deteriorated over the past year.	The NHS has developed STPs to address the problem of increasing demand and reduced budget. In line with the national direction of travel Doncaster has signed up to the South Yorkshire & Bassetlaw sustainability and transformation partnership. This partnership supplements rather than replaces the accountabilities of individual organisations. Doncaster has been selected as an exemplar so must ensure the place plan aligns with the wider STP and demonstrates the benefits of integrated care. There also needs to be consideration of how the STP boards will be formed with senior leaders from across health economies.
Current Issues in Baseline	This report looks at six of the building blocks required to implement the place plan. These include: leadership, culture, governance, services, finance and operational & commercial environment.	Through several discussions with providers and commissioners there appears to be a shared vision to improve the service provided to Doncaster residents. The six building blocks are discussed in this report and linked to the strengths and Area of focus for both commissioners and providers.
Sustainability	If Doncaster continues along the current path there will be a large financial gap and workforce shortage leading to unsustainable provision of services. It's vital that Doncaster and the wider partnership find new ways of working that make better use of the money available and develop plans to create future leaders.	The vision for sustainable and effective integrated care is shared across Doncaster and the wider STP – the implementation of this vision must now be agreed by partners.



# Leadership - Headlines



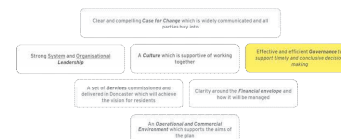
Definition	Leading Practice Pointers
Leadership describes both leadership of the individual organisations involved in the Doncaster Place Plan and also System Leadership. System Leadership describes the leadership over all the organisations and individuals within the Doncaster Place Plan. Leadership includes setting a clear vision, sharing that convincingly, delivering against it and managing conflicting interests.	<ul style="list-style-type: none"> <li>▶ Clear &amp; Consistent leadership at both organisational and system level recognised by all involved</li> <li>▶ SRO in place with recognised authority</li> <li>▶ Clear links back to each statutory organisation's board/decision-making structures</li> <li>▶ Clarity on STP inter-dependencies</li> </ul>
Doncaster Strengths	Doncaster Area of Focus
<ul style="list-style-type: none"> <li>▶ Demonstrating commitment in the room to moving forward together</li> <li>▶ Demonstrating positive working relationships in shared forums</li> <li>▶ Formation of the GP Federation</li> <li>▶ Keenness to engage with staff and residents but need narrative to support</li> </ul>	<ul style="list-style-type: none"> <li>▶ How to operate as system leaders to progress detailed work</li> <li>▶ Connectivity with levels within organisations on this agenda</li> <li>▶ Clarifying role within STP and each other roles within the place plan</li> </ul>
Evidence	
<ul style="list-style-type: none"> <li>▶ A System Leadership Maturity Framework was developed, based on the main stages of effective partnerships (preparing, partnering, delivering and learning) as well as integrating aspects of the 'Stepping up to the Place' assessment. This was used as the basis for interviews with key stakeholders.</li> <li>▶ All leaders are in slightly different places, despite some clear strengths in a shared commitment, with a marked difference between providers and commissioners.</li> <li>▶ Commissioning – there is currently some joint commissioning through the Better Care Fund and a strong shared vision.</li> <li>▶ Providers – each organisations leadership team's lead their own organisation and workforce.</li> <li>▶ System leadership – there is currently limited system leadership in place.</li> <li>▶ More detailed information is found at appendix I.</li> </ul>	

# Culture - Headlines



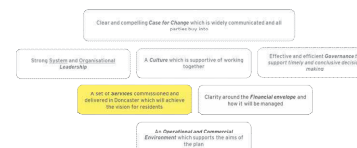
Definition	Leading Practice Pointers
Culture describes the customs, beliefs and behaviours across those individuals and organisations delivering the Doncaster Place Plan. It includes the language, trust and ways of working together.	<ul style="list-style-type: none"> <li>▶ Blended culture where both commissioners (local authority &amp; CCG) speak similar language and respect each others distinct &amp; complementary roles</li> <li>▶ Similar mature relationships amongst providers based on mutual respect between all parties and understanding of the unique strengths of each to the system</li> </ul>
Doncaster Strengths	Doncaster Area of Focus
<ul style="list-style-type: none"> <li>▶ Level of honesty that has developed over past three months on readiness and understanding</li> <li>▶ Senior leaders spend lots of time talking and working together</li> </ul>	<ul style="list-style-type: none"> <li>▶ Developing a Common Language</li> <li>▶ Need to engage frontlines further to be part of the design</li> <li>▶ Find barriers</li> <li>▶ Conversation and action not always linked</li> </ul>
Evidence	
<ul style="list-style-type: none"> <li>▶ The leadership readiness assessment, along with observations during phase 1 showed that there were some differences in culture across and among providers and commissioners.</li> <li>▶ Examples of mismatches with language include understanding of models such as ACP.</li> <li>▶ There are also differing levels of tolerance of risk, although these have yet to be fully tested.</li> <li>▶ Some stakeholders are more ready to engage in the process than others. For example, commissioners tend to be more aligned with each other than providers. There is a particular issue with GPs being able to fully engage in the process, given that the Federation is emerging as an organisation. A shared understanding of the role of the Acute trust in out of hospital care is a problem. As is the potential conflict for the Children's Trust in terms of their position of being commissioned by the Secretary of State for Education directly.</li> </ul>	

# Governance - Headlines



Definition	Leading Practice Pointers
Governance refers to both the Governance of the final state of the Doncaster Place Plan (e.g. the services which will be commissioned) and also the Governance to get there – i.e. the programme to deliver this.	<ul style="list-style-type: none"> <li>▶ Clear governance which promotes timely and considered decision making at all levels: system, organisational, project</li> <li>▶ Clarity on migration required from plan development to service delivery phases</li> <li>▶ Delegated authority to joint arrangement which support integrated action with a clear scope and terms of reference</li> </ul>
Doncaster Strengths	Doncaster Area of Focus
<ul style="list-style-type: none"> <li>▶ Leaders are relatively engaged in governance processes</li> <li>▶ Keenness to participate in strategic decision making and place shaping</li> </ul>	<ul style="list-style-type: none"> <li>▶ Relationships between individual bodies, collective decision making, HWWB board</li> <li>▶ Ownership is unclear</li> <li>▶ Missing the 'engine' – require a more detailed programme plan that is actively managed to make this happen</li> </ul>
Evidence	
<ul style="list-style-type: none"> <li>▶ Despite engaged and extensive governance arrangements the routes to decision making are unclear with those arrangements which are advisory vs decision making unclear.</li> <li>▶ Senior leaders are spending significant time on governance arrangements, however this does not translate into on the ground action to move the place plan forward. For example, there is a lack of effective programme management to drive decisions through to action.</li> <li>▶ Further information is found at appendix II.</li> </ul>	

# Services - Headlines



Definition	Leading Practice Pointers
The services describe what will be done (and how that will be different to what is currently available in Doncaster). These are built on the opportunities for Doncaster and relate back to the Cohorts described in the Doncaster Place Plan.	<ul style="list-style-type: none"> <li>Services clearly defined and linked to populations and their needs</li> <li>Service scope and specifications which drive an outcome focused approach and system commissioning</li> <li>Integrated pathways</li> </ul>
Doncaster Strengths	Doncaster Area of Focus
<ul style="list-style-type: none"> <li>Begun to identify the areas of opportunity that have buy in across commissioners and providers</li> <li>Aligned neighbourhoods but not using them</li> <li>Aligned view on the focus on prevention and EI</li> </ul>	<ul style="list-style-type: none"> <li>Not always clear on the cohorts ambition and definition</li> <li>Require some structuring and prioritisation of activity</li> <li>Lack of clarity on the scope of the place plan</li> </ul>
Evidence	
<ul style="list-style-type: none"> <li>There is some agreement regarding the key areas of opportunity. However it has not been possible to get data from the council on some of these areas, which will need to be addressed before moving forward with the next phase of work.</li> <li>The link between cohorts and services is not clear with some difficulty in fully defining cohorts at this stage.</li> <li>Further information on defining the cohorts and areas of opportunities can be found in the phase 2 report.</li> </ul>	

# Finance - Headlines



Definition	Leading Practice Pointers
The financial quantum which commissioners will commit to the Doncaster Place Plan (which may be phased over several years) and the financial mechanisms by which this will be shared and governed.	<ul style="list-style-type: none"> <li>▶ Collective and individual financial positions understood and respected</li> <li>▶ Range of mechanisms for financing integrated services understood and employed</li> <li>▶ Group accounts used to track collective action</li> <li>▶ Risk sharing supporting a common financial strategy</li> </ul>
Doncaster Strengths	Doncaster Area of Focus
<ul style="list-style-type: none"> <li>▶ Good relationships – built on trust and transparency e.g. BCF</li> <li>▶ Shared understanding of the collective financial problem and “conflict” caused</li> <li>▶ Information sharing</li> <li>▶ Established transformation plans within organisations with solid evidence base</li> </ul>	<ul style="list-style-type: none"> <li>▶ No Group approach to accounting</li> <li>▶ Lack of sense of scale of investment required</li> <li>▶ Availability of information</li> <li>▶ Measurement of impact and benefits tracking needs to be stronger to show the progress</li> </ul>
Evidence	
<ul style="list-style-type: none"> <li>▶ There is a lack of transparency across stakeholders regarding their shared financial position – although all have agreed the shared approach.</li> <li>▶ Commissioners, due to their existing relationships around joint commissioning are more open to sharing financial information with each other, but there have been difficulties in getting information from the council (thought to be due to process rather than intent). Providers are more distrustful of an open book approach and have not always seen a compelling case for why they should do this.</li> <li>▶ There is an issue with the sovereignty of GPs as independent businesses – while GPs are more likely to speak as one when planning future services, the separate approaches are more evident when the finances are being discussed.</li> </ul>	

# Operational & Commercial Environment - Headlines



Definition	Leading Practice Pointers
The market, workforce and commissioning environment which will support the Doncaster Place Plan.	<ul style="list-style-type: none"> <li>Operational &amp; commercial environment understood and shaped as appropriate</li> <li>Workforce plan which supports and promotes new roles and skills</li> <li>Consideration of new ways of working for operational managers</li> </ul>
Doncaster Strengths	Doncaster Area of focus
<ul style="list-style-type: none"> <li>Recognition that the form needs to be around something that works</li> <li>Relative alignment on plans for integrated commissioning</li> <li>Understand that we need to define where we focus efforts and when</li> </ul>	<ul style="list-style-type: none"> <li>Principles to agree risk/benefit share prior to joint working</li> <li>Some fundamental misunderstandings about the principles</li> <li>Confusion on the proposed provider 'form' Lack of discussions on form have resulted in confusion</li> <li>Ability of the Children's Trust to join a new form</li> <li>Ability of GPs to speak as one</li> </ul>
Evidence	
<ul style="list-style-type: none"> <li>Transformation plans – there are a range of transformation plans &amp; programmes across all commissioner and provider organisations. Some of these are in line with the Place Plan but most are about efficiencies or improving the current state, rather than being truly transformational. This potentially adds up to a lot of change, which needs to be better managed.</li> <li>Workforce – the total workforce likely to be impacted by this change is somewhere in the region of 8,500 WTE, although it is impossible to make a full assessment at this stage due to lack of detail around scope of future services - see appendix IV for more details.</li> </ul>	

# The Stakeholder Landscape

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## Introduction

The effective delivery of the Place Plan will be highly dependent on the successful interaction of a wide range of stakeholders from the public, private, voluntary and community sectors.

This section looks specifically at the strategic stakeholder environment for the Place Plan, providing an introduction to the key strategic level partners involved, and specific stakeholder interests, priorities and current pressures.

The implementation of the Place Plan will need to operate flexibly within this context, adding value and taking full account of the issues and incentives all partners bring to the table.

There is already a relatively complex change environment in play both overall across the Borough and within individual partners organisations.

This is laced with ambition and a strong shared sense of the need for Doncaster to continue its economic and public service recovery by working together in partnership.

An outline of existing transformational plans and the details is highlighted in this section.

## Key Questions and Next Steps

As we enter the next stage of focus on specific opportunity areas, we will need to establish if the current plans for each stakeholder align with this

We need to ensure that the current transformation plans and programmes do not duplicate or double count potential benefits

We need to clearly audit the current plans to ensure that we understand the co-dependencies and inter-relationships.

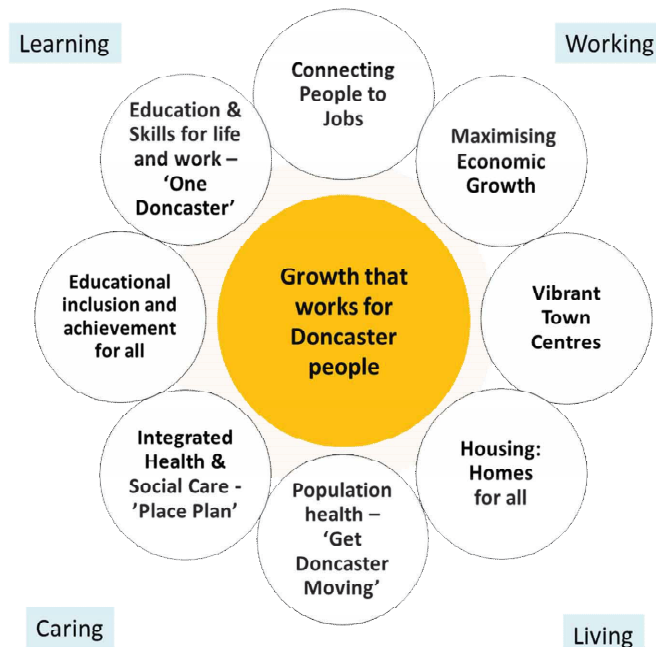


# Growing Doncaster Together

## Borough Strategy - Doncaster Growing Together

- ▶ The Team Doncaster Strategic Partnership has agreed the framework of a four year reform programme called Doncaster Growing Together.
- ▶ This is focused on achieving economic and social growth, and developing a laser like focus on a relatively small number of key reform priorities and new partnership delivery models
- ▶ These reforms are grouped into four broad policy priority areas:-
  - Caring
  - Working
  - Learning
  - Living
- ▶ The Place Plan focus on integration of Health and Social Care is the delivery process for the 'Doncaster Caring' policy priority.
- ▶ The Place Plan will also benefit from and contribute to reforms in the other three policy priority areas
- ▶ Work is currently under way to define the detail of the specific reforms across the policy priority areas.
- ▶ There is close coordination and tracking to ensure that this fully incorporates and aligns with the emerging focus of the Place Plan.

## Current view of policy priorities and reform focus





# Stakeholder Analysis

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## NHS Doncaster Clinical Commissioning Group

- ▶ Purpose: The CCG is the strategic commissioning body for Health Care in Doncaster. It has a commissioning budget of just under £500m.
- ▶ Current/planned reforms: The CCG currently have 11 delivery plans:
- ▶ Planned care, Mental Health, Cancer, Community & End of Life, Children's Intermediate Care, Urgent Care, Primary Care, Medicines Management, Learning Disability and, Dementia
- ▶ Most of the above are planned collectively with the Council.
- ▶ These reforms are at differing levels of maturity

## Doncaster Metropolitan Borough Council

- ▶ Purpose: DMBC is the Local Authority, providing Democratic political leadership including a directly elected Mayor.
- ▶ The Council both commissions and provides a range of social care services for adults and children – now led collectively by an interim 'People' Director. It also commissions supported and specialist housing and manages the ALMO relationship with St Leger Homes and Leisure/healthy lifestyles provision through Doncaster Community Leisure Trust. A range of wider functions also impact on the Place Plan, including housing developments and economic development.
- ▶ The statutory Director of Public Health is part of the DMBC Senior Leadership Team, and Public Health commissioning and development is embedded within the Local Authority.
- ▶ Key strategic priorities/pressures: The key challenge for DMBC is to continue to lead and deliver economic and social progress in light of continued budget constraints. The next four years sees a further £70m budget reduction which will need to be managed through new delivery models and a shift to prevention and demand reduction and citizen contribution.
- ▶ Current/planned reforms:
- ▶ DMBC is leading and engaged in delivery of a range of Strategic reform programmes, covered in Growing Doncaster Together (previous slide)
- ▶ This includes a major Adult Health and Well Being Programme and Education and skills and inclusion reforms

# Stakeholder Analysis

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## **Rotherham, Doncaster & South Humber NHS Foundation Trust (RDaSH)**

- ▶ Purpose: RDaSH is the Community Health Provider Trust covering Doncaster as part of a wider footprint
- ▶ Current/planned reforms:
- ▶ RDaSH currently have a range of improvement projects which fall into the following headings:
  - Transforming Service
  - Corporate Review
  - Estates (over 200 buildings to rationalise)
  - Agile Working (hot desking and electronic devices)
  - Unity (Electronic Records)
  - Information Management

Each project has a project lead and a report is produced to show project progress monthly. This monthly report is sent to the Senior Leadership Team and then the Board for review.

## **St Leger Homes Doncaster**

### **Purpose:**

- ▶ SLHD is the Arms Length Management Organisation (ALMO) set up to manage the DMBC Housing stock. It also has the statutory duty for discharging the Homelessness duty.

### **Key strategic priorities/pressures:**

- ▶ National housing and welfare reform policies are placing social housing under significant pressure. In particular, the rise of homelessness and rough sleeping are major concerns and pressures on resources. St Leger has a key priority to shape and respond to the need for appropriate accommodation to enable frail, elderly and disabled people to remain at home for longer, and to provide suitable accommodation options for vulnerable young people, particularly care leavers.

## **Fylde Coast Medical Services**

### **Purpose:**

- ▶ FCMS deliver 3 unplanned care services in Doncaster. These are:
  - Urgent Care Centre and GP out of hours service
  - Emergency Practitioner Service
  - 12 hour Primary Care Centre

# Stakeholder Analysis

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## Doncaster & Bassetlaw Teaching Hospitals NHS Foundation Trust

- ▶ Purpose: DBH is the major acute NHS Trust covering the population of Doncaster
- ▶ Key strategic priorities/pressures: The Trust has recently been focussed on turnaround measures and is currently in the process of updating it's strategic direction.

### Current/planned reforms:

- ▶ DBH are currently working on updating the strategic direction and the following 4 themes are the current draft proposals:
  - Optimise Elective Capability
  - Maximise capacity for emergency and specialist care
  - Increase self care and community care (prevention)
  - Develop Partnership working
- ▶ These are currently emerging themes but appear to be consistent with the goals of the Place Plan.

## Doncaster Local Medical Committee/GP Federations

- ▶ Purpose:
- ▶ The LMC represents over 40 GP practices across Doncaster. In early 2017, Doncaster developed a GP Federation to cover it's locality.

## Doncaster Children's Services Trust

- ▶ Purpose: DCST was created in 2015 as a result of Government direction in Children's services in Doncaster. Its services are commissioned by DMBC and the Trust has a line of accountability directly to the Department for Education
- ▶ Key strategic priorities/pressures: The Trust's operational priorities are:
  - Safeguarding the most vulnerable
  - Reducing domestic abuse
  - Supporting children in care and care leavers
  - Reducing child sexual exploitation
  - Making sure people get support when problems start, and before they become really serious (Early Help)
- ▶ DCST has an immediate priority to achieve at least a 'good' rating in an OFSTED inspection in Autumn

## 4. Good Practice Examples

1. Executive  
Summary

2. Introduction  
& Context

3. Current  
State  
Assessment

4. Good  
Practice  
Examples

5. Programme  
Scope/Operati  
ng Framework

6.  
Workstreams

7.  
Implementatio  
n Planning

# Good practice summary

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## Areas of national practice considered:

Doncaster wants to base its development of the Place Plan on examples of good practice where these exist. These examples have been selected as those which are most relevant to Doncaster's situation and based on the aspirations of the Health and Care Economy as a whole.

This does not seek to be an exhaustive list of every scheme but does aim to set out some of the key themes Doncaster should be considering based on an emerging evidence base:

- ▶ Population health and prevention
- ▶ Early intervention at all ages
- ▶ Out of hospital care interventions
- ▶ Accountable care options

## Population Health and Prevention

Greater Manchester Health and Care Partnership launched their 'Taking charge' programme. A fundamentally different approach to engaging citizens in improving their health and wellbeing.

The approach focused how to create a positive shift in the whole population of GM health, a slightly different approach to delivering only targeted programmes to those in the 'poor outcomes' categories. This was underpinned by the evidence that linked improved health to improved economic prosperity.

This regional approach improving population health is delivered in tandem with local offers focused on more targeted prevention.

## The approach had some key elements:

- 1) Understand 'What mattered to people' – using genuine customer insight to understand people's ambitions and barriers to improving their health
- 2) Getting people engaged in a conversation about health – raising the profile of its importance
- 3) Using a number of different media, including staff, which had the knock on impact of triggering broader healthy living conversations with residents
- 4) Generating insight that challenges perceptions on 'norms' and also informed the more considered commissioning and resource allocation of 'Public Health' programmes

Further information can be found on the taking charge microsite:  
<https://takingchargetogether.org.uk/>

## Relevance for Doncaster:

- 1) Building this type of engagement and insight capability into the new integrated commissioning function
- 2) Utilising the engagement approach in the design of the neighbourhood model
- 3) Opportunity to look at improving population health through this approach, with a potential link to Early Intervention and prevention cohort
- 4) Engaging in a conversation with the STP footprint to identify if the approach to population health could be scaled up
- 5) Opportunity to under

# Good practice summary

## Early intervention at all ages

There are a number of models for Early Intervention across the country, varying across age groups. Within this section we will explore:

- ▶ Predictive analytics
- ▶ Integrated family support
- ▶ Support for SEN and LD across the life course
- ▶ Assistive technology

### Predictive analytics:

Predictive analytics can be used to identifying children, young people and families early before needs escalate. A number of London Boroughs are exploring the use of this capability to support Early Identification and Early Help, through the London Ventures programme. The approach will focus on using data more intelligently to:

- ▶ Improve the early identification of children most at risk of maltreatment
- ▶ Provide a risk profile of the most vulnerable families
- ▶ Ensure the service offer within the complex level of need is focused on those most in need
- ▶ Support continuous improvement through redesign and innovation to change how services are delivered
- ▶ Support smarter commissioning that is proven to be effective, improving the role of partners to collaboratively build and improve the Early Help offer
- ▶ Support the development of demand management strategies and approaches



Relevance for Doncaster

This is about working with partners to share data to proactively identify children with a number of risk factors and where EIEH support could be provided to prevent needs from escalating. This will involve sharing data amongst partners to view the child and family as one unit and ensure key indicators are picked up. The move to integrated commissioning and provider collaboration creates a positive platform for a more data driven approach to intervention that supports the targeting of activity and resource.

### Integrated family support

A number of areas are beginning to develop fully integrated offers for Early intervention. The focus has been to create a holistic offer across Health, Public Health and Social Care, with a view to potentially moving to a place based approach that incorporated access to relevant adult services. The offer would bring universal services, case management and targeted interventions together to build on the learning from the Troubled Families evaluation

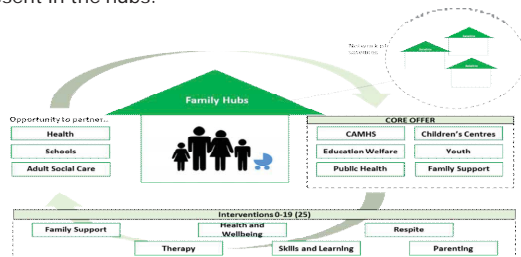
# Good practice summary

## Integrated Family support

Notable examples include:

East Sussex: 0-5 offer has been integrated across public health and children's services (Children Centres and Health Visitors), creating additional health checks pre-5 years old and encouraging volunteers and community groups to take over running some of the previous 'drop in' services – allowing the Health Visitors to be more focused on specific outcomes. This has been described in further detail below

Surrey County Council and Hammersmith and Fulham: Creation of integrated family hubs. Combining a number of existing services into a locality offer Universal, Targeted and targeted plus) that is accessed via self referral, outreach as a result of predictive analytics early identification, MASH, Edge of Care team. There is the intention to extend some adult services interventions being present in the hubs.



Wolverhampton: Think Family A service that support families at risk to access appropriate adult and public health services

## Relevance to Doncaster:

In Doncaster, c.8 Integrated Early help Hubs have been established that provide a strong platform for evolving a place based approach to early intervention. It would be an opportune time to review progress on these and identify further benefits from expanding the approach.

## Life Course management of SEN/ Learning Disabilities

Learning Disabilities and SEN is an acknowledged high cost area, particularly for the local authority with a combined spend of c.£28m. Research also suggests that GP registration amongst people with LD is poor and they experience worse health outcomes than the rest of the population. Moving to an all age service is a solution a number of authorities have looked at. However there are some key lines of enquiry within this that are of particular interest:

SEN: Work in Barnet and the Tri-borough identified that the statement process (now replaced by EHCP but with the same issues) created an adversarial relationship with parents, and engagement with medical professionals resulted in referrals for significantly higher packages that were actually required or requested by the family. The interventions being considered are twofold: Review the referral process to facilitate access to Early Help more readily at two year checks, or through children centres and school nursing and; provide access to some low level therapy services and equipment/ technology straight away (pre plan) to try and prevent a EHCP referral (where appropriate) and needs escalating.

# Good practice summary

Transitions: Encourage and incentivise informal carers to care for longer and helping families lead a normal life, such as supporting ownership through equity release schemes or mortgage/rent support and other utilities support (for example council tax exemptions) in exchange for informal care.

Relevance for Doncaster:

Doncaster have identified LD as a strategic area of priority. Given the high spend in this area, a move to a neighbourhood model and the move to integrated commissioning. There is potential to review the end to end approach, changing the conversation with services users regarding the local offer within the context set by the Place plan case for change.

Assistive Technology:

East Thames Housing association and Wigan council are looking at pioneering approaches with the use of modern assistive technology. A combination of room sensors, communication devices, online command devices, video keys etc are been used to significantly reduce the cost of waking nights, sleeping nights, avoid residential care and more generally support people to live independently, as well as provide additional customer insight for both commissioning and predictive analytics. Key to the approach is a different way of working with Extracare, supported living, flexi care and homecare. Savings of £2-3m on care packages have been identified.

Relevance for Doncaster:

Integrated commission and the move towards a new way of developing customer insight and predictive analytics – coupled with a assets led, neighbourhood delivered approach could add an innovative angle to this established form of prevention.

Through the development of the accountable care system, there is a potential to work with providers early on this agenda and increase the pace of benefit realisation.

Out of hospital support

The key aspects of an integrated out of hospital model have been articulated as part of the place plan. Some schemes to consider as part of this development are:

- ▶ A holistic intermediate care approach that links access and capacity for both step up and step down support, this should include rapid access packages and have clear link with community based re-ablement
- ▶ Residential health care – linked to a new model for nursing care that incorporates primary care and support more effectively and utilises community capacity across the nursing bed base
- ▶ Integrated, risk based case management led by primary care and linked into neighbourhood teams
- ▶ Exploring community access to consultant – potential using technology to overcome some of the logistical challenges that can increase costs – evolution of the virtual ward
- ▶ Loaning falls equipment to care homes to reduce admissions and to generate provider buy in to the use of technology
- ▶ Workforce remodelling to create sustainability in the health and care workforce by creating alternative career pathways and forming closer links with higher education entities

Some of the supporting case studies for these initiatives are outlined in appendix 2



# Good practice summary

## Relevance for Doncaster:

Work on intermediate care is already underway and will form a core focus of the next phase. As part of the wider neighbourhood redesign and to complement the staff engagement approach, the discussion regarding workforce should be prominent once the case for Implementation has been refreshed. Collaboration on CHC has also been identified as a priority, coupled with the formation of the GP federation, this could provide a new opportunity to refresh the approach in this area of out of hospital care.

## Accountable Care:

A common understanding of accountable care is essential, and has been an integral part of the discussion among both commissioners and providers in this work.

Accountable care	The alignment of incentives, budgets and decision making to promote greater co-ordination of and integration by providers of health and social care provision for a defined population. Focus on health as well as services.
Accountable care system	An evolved version of an STP, with system partners taking collective responsibility for resources and population health, and having the ability to create their own decision making and governance structures, and agree accountable performance contracts with NHS/II
Accountable care organisation	A provider-led organisation (integral or networked) delivering accountable care to a defined population, holding financial risk through a global budget (+/- risk gain share arrangements) and required to deliver improved outcomes and quality

## Key features of accountable care v. the NHS status quo

- ▶ Contracts are let for population cohorts not care settings
- ▶ Contracts incentivise outcomes rather than measures
- ▶ Integration is fundamental to achieving successful outcomes
- ▶ Providers are accountable achieving outcomes

• Accountable care has reduced costs in the US modestly to start with (1-2%) but savings may increase over time. Commercial ACO arrangement delivered 6.8% lower spending and net savings by year four (Song et al 2014). For integrated care, a Powel Davies 2006 review, suggested only 18% of interventions impacted favourably on cost. EY/Rand Europe (2012) evaluation of integrated care pilots showed overall significant saving of 9% in hospital costs where case management implemented (driven by reductions in outpatients and elective admissions). But the early results from MCP/PACS encouraging (1-2% lower growth in UPA) (Next Steps on 5YFV).

• Interventions that worked included GP access to specialists, ambulance triage, nursing/care home support, end of life care in community, remote monitoring of some LTCs, support for self care. In terms of scale smaller hospitals fared better on spending and readmission rates in the US and larger independent physician groups had lower spending and better quality than small. A stronger primary care orientation led to lower spending and fewer readmissions (McWilliams et al 2013). From a patient point of view accountable care has had positive results in terms of access and feeling informed but there were some negative impacts seen in the ICPs on involvement.

# Good practice summary

## Live examples:

Although there is limited evidence from the UK, a number of areas are now seeking to implement accountable care arrangements:

<b>Northumbria CCG and Northumbria Healthcare</b> <ul style="list-style-type: none"> <li>• A primary and acute systems vanguard that is seeking to develop an ACO with agreed outcomes for a population of 330k</li> <li>• The ACO would involve mental health and social care services</li> <li>• Initial work involved the transformation of urgent and emergency care via the Northumbria Specialist Emergency Care Hospital</li> <li>• Key to its development is the creation of primary care hubs and seven-day services in primary care</li> </ul>	<b>Manchester City CCGs</b> <ul style="list-style-type: none"> <li>• Seeking to procure a local care organisation based on the MCP model</li> <li>• The ACO would include some local authority services and children's services</li> <li>• The work is also aligned to the city's Single Hospital Service and the potential to integrate the city's three CCGs.</li> </ul>
<b>Tameside Care Together</b> <ul style="list-style-type: none"> <li>• ACO led from the previous acute trust</li> <li>• All DGH and community services currently integrated</li> <li>• Adults social work and commissioning of community services will be transferred within next 12 months</li> <li>• Joint CEX of CCG and Council, single commissioning budget but managed through 3 main arrangements (E.G S75 and aligned budget)</li> <li>• Contract in development, performance levers key points of discussion at present</li> </ul>	<b>Dudley</b> <ul style="list-style-type: none"> <li>• Seeking to procure an accountable care organisation based on the MCP model</li> <li>• Focusing on three key areas: Integrated Care, Planned Care and Urgency and Emergency Care</li> <li>• Within these areas services to be covered include primary care, A&amp;E, ambulatory care and out-patients</li> <li>• The MCP will create a series of integrated MDTs across physical and mental health and the voluntary sector</li> </ul>

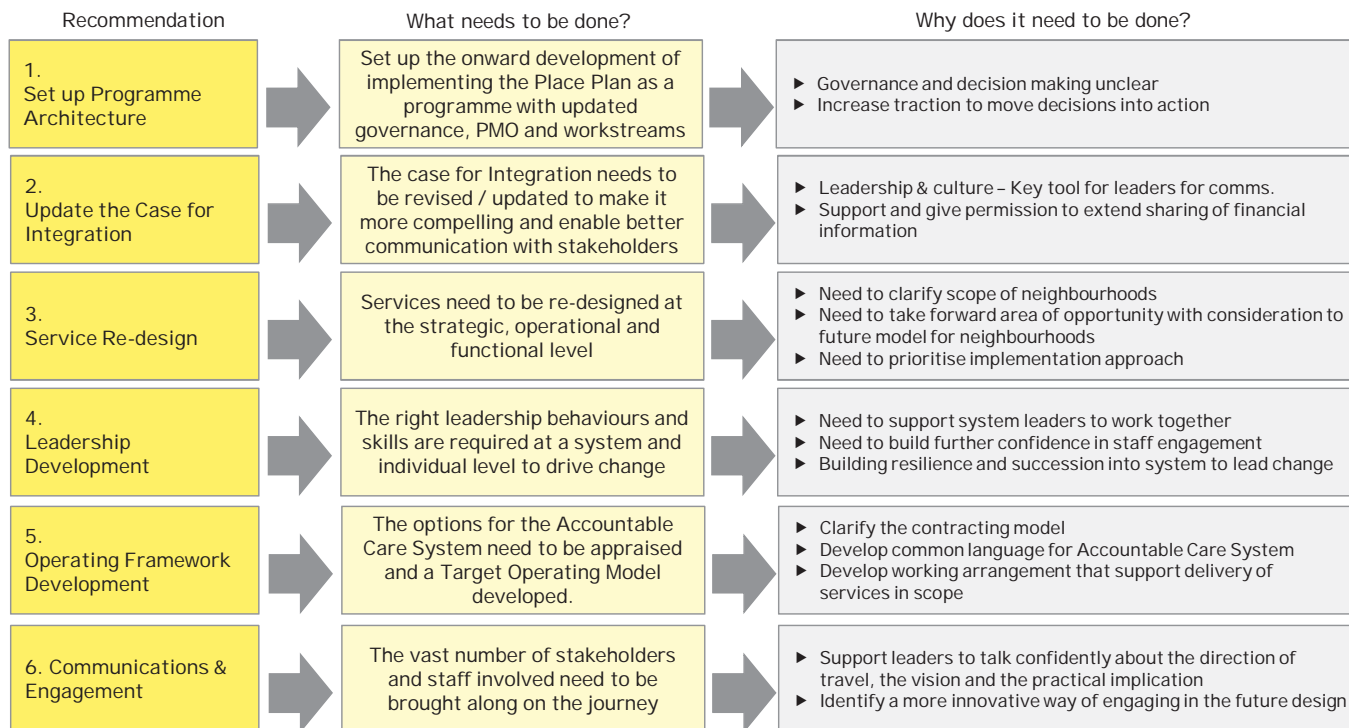
## Relevance for Doncaster

The Place plan set a direction of travel towards accountable care and a provider partnership approach. Within this there will be a number of choices to make. Some of these approaches can be tested in specific services, for example intermediate care. However it is key that the discussion regarding form more broadly aligns to the scope of the neighbourhood model. Other considerations locally:

- ▶ Primary Care and non NHS providers: Contracting model needs to be cognisant of business viability – for example independent providers and GPs will have different working capital requirements. This must be considered to maintain buy in and sustainability
- ▶ Acute providers: may need to develop new skills in commissioning community services if they become responsible in the selected model. Also required to develop and establish local care networks and potentially shift their operating model to accommodate. This may impact on estates utilisation and will need to be modelled in the context of the service requirements
- ▶ Mental Health providers: Interface with secondary mental health services
- ▶ Commissioners: Work is required to define what services are required at a local level and the resulting requirements of and implications for providers. It is also essential this conversation happens in the context of commissioning at an STP level, that may drive quality improvements and economies of scale. Doncaster has the opportunity to define its agenda and it's local scope. This should be an immediate action for phase 2.

# Results from Phase One

The key recommendations concluded from the current state assessment are outlined below. These are discussed in more detail in the Phase Two Scope Report document.



## 5. Programme Scope/Operating Framework



# Programme Scope Introduction

## Introduction

The Doncaster Place Plan set out the ambition to move towards accountable care. Current practice and evidence relating to implementing this model was outlined in the phase 1 maturity assessment. This section is focused on the scope of work required to move to an Accountable Care System based on the Neighbourhood model.

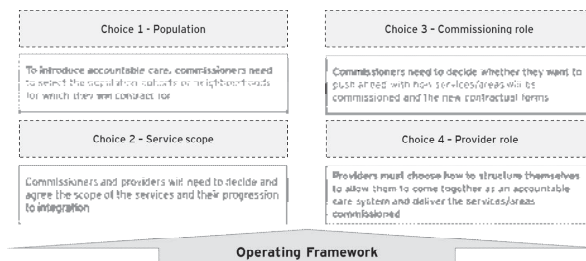
## What is accountable care?

Type	Description
Accountable Care	The alignment of incentives, budgets and decision making to promote greater co-ordination of and integration by providers of health and social care provision for a defined population. Focus on health as well as services.
Accountable Care System	An evolved version of an STP, with system partners taking collective responsibility for resources and population health, and having the ability to create their own decision making and governance structures, and agree accountable performance contracts with NHSE/.
Accountable Care Organisation	A provider-led organisation (integral or networked) delivering accountable care to a defined population, holding financial risk through a global budget (+/- risk gain share arrangements) and required to deliver improved outcomes and quality.

## Key features of accountable care v status quo

- ▶ Contracts incentivise outcomes and integration rather than operational measures
- ▶ Integration is fundamental to achieving successful outcomes
- ▶ Providers are accountable for driving integration and achieving outcomes

Based on our experience, to deliver improved outcomes through a move toward accountable care, there are four key choices the system needs to work through. Once these decisions have been worked through, the supporting operating framework will need to be developed to sustain the systems new operating model.



The approach to this section has been developed and considered the outputs from the Maturity Assessment and Current State Assessment undertaken during the work in Phase One.

For choice 1, the Doncaster neighbourhoods are identified and aligned. This means the focus is now on the scope of services delivered at a neighbourhood, which must be decided in the context of the evolving STP and regional commissioning approach. In addition, there is a need to demonstrate some quick wins, agree the prioritisation and accelerate delivery to produce benefits and test the approach to system commissioning and contracting. This has been addressed through the identification of 17 areas of opportunity and the prioritisation of 3 to move forward on through the summer, developing the contracting model. In the subsequent pages, we have outlined the programme scope across these choices, and the operating framework in further detail.

# Choice One – Population

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## Introduction

Accountable care has some key features which are fundamentally different from current NHS contracting and delivery.

Below we have outlined and explored the findings from the phase one Maturity Assessment of how commissioners intend to contract for the local population of Doncaster.

## Population Choice

The phase one maturity assessment reflected on the 3 cohorts (Prevention & Early help, Intermediate Health & Social Care and Enablement & Recovery) of the local population with a remit of improving Health and Social care across the Doncaster region.

In order to deliver the ambition of accountable care for the Doncaster population, it was mutually agreed that this would be delivered via a neighbourhood model and these cohorts would need to be refined and defined so that immediate focus and change implementation steps could be drawn out.

## Population Health

There is a recognition that within the system design a focus on improving population outcomes whilst delivering financial sustainability is required. This means changing the approach to population health and moving to what matters to people as opposed to what is the matter with people.

## Neighbourhoods


Whilst the neighbourhoods have been agreed in principle there are further considerations:

- ▶ does Primary care align with Neighbourhoods
- ▶ will universal care and universal care plus be offered in the neighbourhoods,
- ▶ are the hubs physical or virtual in nature,
- ▶ what are the care provisions required for the different neighbourhood

## What will be different

The neighbourhood model should be supported by localised, system commissioning, This means service design being support by insight, and analysis of the ambitions, outcomes and needs of the different localities. This will allow for greater targeted resource in the right area at the right time; which will result in qualitative benefits for residents and reduced demand on inappropriate secondary service demand, furthermore a move to a more enhanced preventative health and care system which builds strength and resilience within the community setting.

## Next Steps

- ▶ Needs analysis of neighbourhoods to identify likely volumes and nature of services based on current model
  - ▶ Customer insight approach proposal developed to define outcomes and support system delivery and service redesign
- 

# Choice Two – Delivery Systems and Services

## Introduction

Engagement with stakeholders at the joint commissioner and providers sessions highlighted that the development of integrated pathways is the most important element of redesigning the service.

The development of the neighbourhood model is a high priority for all Partners and as part of the scoping and design, all of the areas for opportunity will be evolved further. The model will develop integrated pathways for the other services set out in the context of the case for change and broader system redesign.

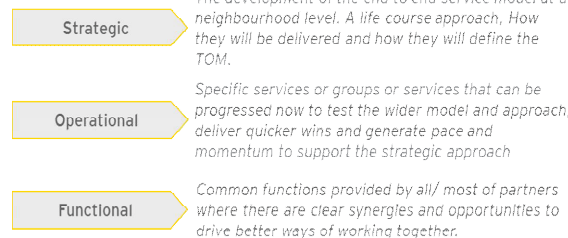
Relevant findings in the maturity assessment:

- ▶ Neighbourhoods have been agreed but the scope of services provided at this level has not. Work is required to define the scope, in the context of both the STP and the wider Council services.
- ▶ The scope of neighbourhoods may initially be ring-fenced to 'health and care' but should be able to expand to other relevant areas in line with the Team Doncaster approach
- ▶ The Cohorts from the Doncaster Place Plan are wide ranging and cover a multitude of Departments and Services – this system wide approach is critical to the ambition and vision, but does not provide the required immediate focus to implement the change.
- ▶ There is an appetite to 'get on with it' and test the model, as well as move forward on some quick wins.

How have we addressed the findings in the way we move forward?

To support the system to make progress, a tiered approach to service design has been developed with the task and finish group, built on the identified Areas of Opportunity.

## The tiers include



Within the strategic tier, Learning Disabilities, Mental Health, Primary Care (excl. GMS) and CHC have been identified as key areas of focus to evolve the service design. LD due to the high life course cost of this user group and the current disjointed approach. Mental Health due to the interrelationship with pressure on other areas of the system where MH may not be the presenting need but is the underlying cause. Primary Care because of the fundamental role it plays in the success of a community based model and reducing pressure on acute services. CHC due to the opportunity to align activity and streamline processes. On the subsequent pages, a summary of the operational and functional areas of opportunity described. A full description of each opportunity is included in Appendix I.

## Next Steps

- ▶ Refresh the case for Integration and confirm the scope of neighbourhoods in the context of the STP
- ▶ Prioritise operational areas to test the model
- ▶ Set up the Design Groups to take the activity forwards
- ▶ Mobilise activity on the functional areas
- ▶ Agree insight approach on development of neighbourhood model

# Strategic work-stream

Strategic

## Introduction

The Strategic Workstream will drive the design of the Neighbourhood Model, taking a system wide approach to reflect the ambition and vision of the partners. The Neighbourhood approach is intrinsic in the way delivery systems and services will be designed and commissioned.

Some of the agreed Areas of Opportunity will be critical to the Neighbourhood Model Design Work during Phase Two as they will be used to inform the development.

### Key Features

The Neighbourhood Model for Doncaster is built around the communities within it, representing a holistic integrated approach to service delivery; specifically to:

- ▶ Support people and families to support themselves – This means investing in low level support to reduce the demand on high end care. It also requires staff to identify at risk group, intervene early and build resilience through enhancing a person or families own skills to manage their condition/situation.
- ▶ Deliver a better resident experience through more seamless care delivery. This means fewer referrals and hands offs, better continuity of care across different services and making every contact count.
- ▶ Drive quality, accountability for statutory responsibilities and delivery of outcomes and ensure the involvement of individuals in service design.
- ▶ Provide a different configuration of services, building on what works well already, to ensure the right care is delivered, in the right place at the right time.
- ▶ Deliver the necessary cost efficiencies without compromising care and support.

## High Level Descriptions

**Learning Disabilities:** Delivery of the core principles of Building the Right Support in Communities of People with a Learning Disability and / or ASD. Enhancing community provision for people with learning disabilities and prevent people from going into crisis and support people to live as independently as possible

**Mental Health:** People with mental health problems will have sustained recovery, have access to information and peer support in order to maintain their wellbeing. People with a mental health problems will enjoy good physical health and emotional wellbeing

**Primary Care (excl. GMS):** Primary Care is fundamental to the Neighbourhood Model and will be engaged to deliver on the commitments in the Place Plan. The newly established GP Federation will build on the engagement and Areas of Opportunity will be impacted by the role of Primary Care in the wider system

**Continuing Health Care -** A co-ordinated approach to CHC will ensure that decisions are always made in the best interests of the individual and not related to budget ownership. Co-ordinated market management will ensure that the most competitive price is procured each time. Consistency of paperwork, reviews, process and decisions will reduce waste, lost time and duplication of effort

## Neighbourhood Profiles

The development of the Neighbourhood Profiles will be critical to the new delivery model; to ensure that services are commissioned to reflect neighbourhood need where relevant as this can be different to Doncaster wide need in some instances.



# Operational work-stream

Operational

## Introduction

The work over the previous three months has identified a number of priority areas for commissioners and providers.

In addition to the Strategic work-stream there are a number of operational areas where an integrated approach will complement the design and inform the development of the Neighbourhood model.

Six of the areas on the table opposite have been categorised as "high priority" due to them being more ready/more urgent and can be progressed faster.

These areas will be used to test the emerging operating model and the operating arrangements; involving a good range of providers to test the design of the contracting model/s required to deliver the services.

The six agreed areas of immediate focus are:

- ▶ Urgent & Emergency Care (developed specification exists, contracting model to be determined)
- ▶ Complex Lives
- ▶ Intermediate Care
- ▶ Starting Well (1001 days)
- ▶ Vulnerable Adolescents (Tier 4 Specialist Services)
- ▶ Dermatology

Area of Opportunity	Where does this find efficiency / enable redesign?
Urgent & Emergency Care	<ul style="list-style-type: none"> <li>This will reduce costs by moving patients into more appropriate services</li> <li>Reduction inappropriate patients hitting the core bed base</li> </ul>
Intermediate Care	<ul style="list-style-type: none"> <li>Patients have a more 'joined up' service and get out of Acute hospital sooner and inappropriate admissions are avoided</li> <li>This will reduce costs by early discharge and admission avoidance from the acute sector</li> </ul>
Starting Well (1001 days)	<ul style="list-style-type: none"> <li>By intervening in children's lives sooner, where required, the cycle of lifelong intervention can be avoided and overall costs reduced</li> <li>This is a preventative measure to reduce future reliance on support</li> </ul>
Continuing Healthcare (CHC)	<ul style="list-style-type: none"> <li>Removal of duplication</li> <li>Better market management</li> <li>Improved review and assessment processes</li> </ul>
Dermatology	<ul style="list-style-type: none"> <li>The scope of this project will be around reducing the beds, outpatient attendances, outpatient procedures and excluded drugs from the acute setting and moving this activity to the community settings, where it is safe to do so.</li> <li>Patients would be able to access services more locally. Referrals to secondary care would reduce.</li> </ul>
Vulnerable Adolescents (Tier 4 Specialist Services)	<ul style="list-style-type: none"> <li>Reduce adolescents transitioning into adults dependent on support.</li> <li>Develop co-ordinated support which can steer adolescents away from a lifetime of support.</li> <li>Improve outcomes for adolescents and reduce future reliance on support</li> </ul>
Complex Lives	<ul style="list-style-type: none"> <li>Improving outcomes for people with complex needs and reducing overall demand on services by breaking the cycle of need.</li> </ul>
Children on the Edge of Care	<ul style="list-style-type: none"> <li>Avoiding high cost LAC</li> </ul>
Domestic Abuse	<ul style="list-style-type: none"> <li>Improve outcomes - The numbers of high risk cases referred are well above the average against both regional and national figures.</li> <li>This is a preventative measure to reduce future reliance on support</li> </ul>

# Functional Workstream

Functional

The areas below can be progressed and will facilitate closer working relationships across organisations, streamlined processes for end users and possible financial benefits which will all contribute to the change in culture required to deliver on the integrated working. The additional Areas of Opportunity on Community Led Support and Single Point of Access will be integral to the design and delivery of the Neighbourhood Model – integrating Neighbourhood Pathways to achieve the outcomes for the residents of Doncaster.

	Infection Control	Safeguarding	Estates	Community Led Support	Single Point Of Access
Why?	Common function, multiple approaches.		Unnecessary costs/ cross charging/ under utilisation.	Local people, community groups can all work together much more effectively	The current entry points to services are fragmented and difficult to navigate
What?	Develop common approach, paperwork procedures etc. to reduce duplication and costs and increase quality		Rationalisation and use of assets could realise efficiencies	Keeping people within their own community and helping them to remain independent	Streamline access through integration of current SPAs and/or creation of new
What needs to happen Next?	<ul style="list-style-type: none"> <li>▶ Conduct a mapping exercise in order to understand; what/where services are offered, maturity of services with regards to integration and the scale of the opportunity</li> <li>▶ Develop common processes and approach to reduction in duplication of work/effort</li> </ul>		<ul style="list-style-type: none"> <li>▶ Develop baseline of current estates</li> <li>▶ Agree policy re charging</li> <li>▶ Id quick wins</li> </ul>	<ul style="list-style-type: none"> <li>▶ Develop Community assets and resilience</li> <li>▶ Staff will have more flexibility and freedom to innovate leading to increased morale</li> </ul>	<ul style="list-style-type: none"> <li>▶ Detailed population trends of service users aligned to neighbourhoods to be produced</li> <li>▶ Governance Arrangements to be put in place</li> </ul>
How & When?	<ul style="list-style-type: none"> <li>▶ Identify lead organisation and project manager (Suggest Local Authority and Children's Trust)</li> <li>▶ Agree scope, objectives, deliverables and timelines</li> <li>▶ Identify approval required for changes</li> <li>▶ Work should begin in May</li> </ul>		<ul style="list-style-type: none"> <li>▶ Engage with strategic estates group</li> <li>▶ Agree timelines</li> </ul>	<ul style="list-style-type: none"> <li>▶ Identify project leads and resources</li> <li>▶ Kick off Meetings (Scoping/sign up)</li> <li>▶ Define governance</li> <li>▶ Agree level of consultation required</li> <li>▶ Work should begin in June following programming into wider programme planning activity</li> </ul>	

# Choice Three - Commissioning Role

## Introduction

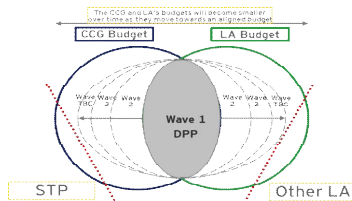
This element of scope is to define the approach to Commissioning within the Doncaster Place plan and to support the Accountable Care System.

Currently the commissioning activity takes place separately within the CCG and DMBC.

- ▶ Within the Council there are three separate teams, these are; Adults, Children's and Public Health.
- ▶ These teams are supported by a central strategy and performance unit, responsible for the development of management intelligence and other corporate functions such as finance who also support other aspects of the council.
- ▶ The CCG is a single commissioning unit, with strategic and operational commissioning functions, contract management, finance and performance and analytics capability.
- ▶ Some services are jointly commissioned, governed within the Better Care Fund.

## Direction of travel

There is a shared ambition between the council and CCG to move towards integrated commissioning. This model will evolve over the next 9 months, initially taking a system commissioning approach to the areas of opportunity and subsequently leading to a fully integrated model.



## Required activity

### Wave 1:

- ▶ Develop a joint committee with delegated responsibility to commission the services outlined in the area of opportunity
- ▶ Define the budget in scope and the specification for services
- ▶ Agree the investment model
- ▶ Resource the management activity required for the contract (potentially as a programme role)
- ▶ Begin provider engagement to implement the services
- ▶ Agree performance/contract management approach and responsibilities

## Commissioning redesign

- ▶ Scope and value of commissioning fund (inc STP link)
- ▶ Governance arrangements and relationship statutory commissioning bodies
- ▶ Team structure and sizing
- ▶ Hosting arrangements and transition plan
- ▶ Combined commissioning strategy
- ▶ Estates plan
- ▶ Aligned Finances and mechanisms e.g. Section 75, Pooled Budgets, etc.
- ▶ Driving a more innovative approach to customer insight and engagement as part of the new function

## Next steps

- ▶ Specifications and system commissioning approach for prioritised area of opportunity
- ▶ Set up joint committee for these services
- ▶ Outline proposals for broader redesign
- ▶ Proposal developed for customer insight approach

# Choice Four - Provider Role

## Introduction

There are currently 6 main providers in Doncaster:

- ▶ Doncaster Children's Trust
- ▶ Doncaster and Bassetlaw Hospital
- ▶ Rotherham, Doncaster and South Humber FT
- ▶ FCMS
- ▶ Doncaster Council
- ▶ Primary Care Doncaster

In addition, there are number of private and 3<sup>rd</sup> sector providers (for example homecare) that support service delivery across the health and care economy.

## Direction of travel:

The place plan set out a direction of travel towards an accountable care system. To deliver this, work will be undertaken to define the structure that will drive the required changes. There are four broad contracting options available to providers to come together.





The early discussions in the Doncaster Transformation Group have shown a preference for "Alliance Contracting" in the short term. As the scope of services subject to a system commissioning approach increases – this may be revisited to achieve further benefits.

The agreed work-streams to accelerate delivery involve some early work on three agreed Opportunity Areas – these are:

- ▶ Intermediate Care
- ▶ Complex Lives
- ▶ Vulnerable Adolescents

## Next steps

- ▶ Establish provider forum
- ▶ Providers need to agree how they are going to work collectively and what delegated authority/decision making powers the provider forum will have
- ▶ Develop specifications for three areas
- ▶ Work with providers to develop service delivery model, contracting relationships between providers
- ▶ Performance metrics
- ▶ Funding flows, financial forecast and investment model
- ▶ Viability assessment and risks

<b>Alliance Contracting</b> 	Providers enter an agreement to work cooperatively and to only share gains if everyone achieves the objectives. This consists of an overarching contract between providers and commissioners and bilateral services contracts.
<b>Joint Venture</b> 	Providers come together as equals in a new corporate entity, requiring some form of multilateral decision making.
<b>Lead Provider</b> 	A lead provider is commissioned to provide services and sub-contracts with other providers as needed.
<b>Single integrated provider</b> 	Single integrated provider is formed to all services.

# Operating Framework

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## Introduction:

To support the move to an accountable care system, there are a number of additional principles and practicalities that need to be established. This is the operating framework, that defines and supports the relationship between all parties in the delivery of improved outcomes in a more financially sustainable way.

These are:

### Strategic Leadership

This will define the relationship between system leaders and their collective role in shaping the place plan and interacting with STP.

- Why: It is essential the relationship between commissioners and providers does not become transactional.
- How: The governance arrangements set up for the programme and for the future accountable care system will need to incorporate this 'function'. For example this could include a review of the Health and Wellbeing Board at a strategic level and a stronger role for the HSC transformation group. It should also include the development of capability in system leadership as a group

### Commercial Strategy

This will define commercial principles and approach that will govern the accountable care system. Taking a system commissioning approach will have implications for how commissioners 'go to market' and how the market is managed.

- Why: Asking providers to operate in a more collaborative and transparent way must be supported by some assurances from Commissioners with regards to how services will be commissioned. Equally, integration can result in a contracted market, limiting options for commissioners should performance be sub-optimal.
- How: Decisions will be required on: What services are competed and which ones are a co-designed and collaborative. For example, we may collaborate on the design and implementation of intermediate care services, part of this specification may be for the accountable care partnerships of providers to be responsible for commissioning homecare. This element of the service may still be subject to competition, but that competition may be run by the ACP. This approach will require engagement with all procurement functions to ensure legally compliant process are developed will be part of this. In addition, in a system where retendering services become less tenable due to a contracted market, agreements and contractual levers need to be developed and mutually agreed with providers to ensure commissioners have the ability to incentivise and sensibly penalise poor performance.

### Financial Strategy

Accountable Care has significant implications for activity and how it is costed and rewarded.

- Why: We need to understand how services will be funded, how savings will be realised, how benefits might be reinvested into prevention and demand management initiatives.

# Operating Framework

## Financial Strategy

- Why cont. We also need to understand how this is then disseminated across the system, between commissioning organisations, between providers and between both.  
Benefits for providers include the combined resources available to help manage the cost base more effectively and provide a more innovative and person centred response. It also means the incentive to invest in prevention, early identification and intervention and care delivery in alternative settings to reduce the demand on higher tier services.  
Benefits for commissioners include a risk sharing partnership with the provider. The integrated contract for aspects of care, with a base budget and outcome based incentives and penalties removes the perverse incentives currently created by the market

- How:

Cost modelling  
Detailed data on treatment costs which allow robust, clinically meaningful forecasts of how costs are impacted by demographic changes and new care models



Integrated financial plans  
Models which truly integrate the financial forecasts of organisations within a system

## Next steps

### Programme and accountable care system

- Develop joint governance arrangements for place shaping – HWWB, CEX group and Transformation Group to be reviewed
- Design system leadership development programme

### Areas of opportunity

- Develop working principles for commercial strategy
- Financial baseline validated for areas of opportunity
- Agree financial strategy, required savings, reinvestment proposals, monitoring approach
- Develop financial model for contracts
- Develop commercial strategy

### Broader financial strategy (medium term activity)

- Review opportunity to take group accounting approach follow scope definition for neighbourhoods and STP
- Agree approach to assessing provider impact and viability as scope of accountable care contracts increases

## 6. Workstreams

1. Executive  
Summary

2. Introduction  
& Context

3. Current  
State  
Assessment

4. Good  
Practice  
Examples

5. Programme  
Scope/Operati  
ng Framework

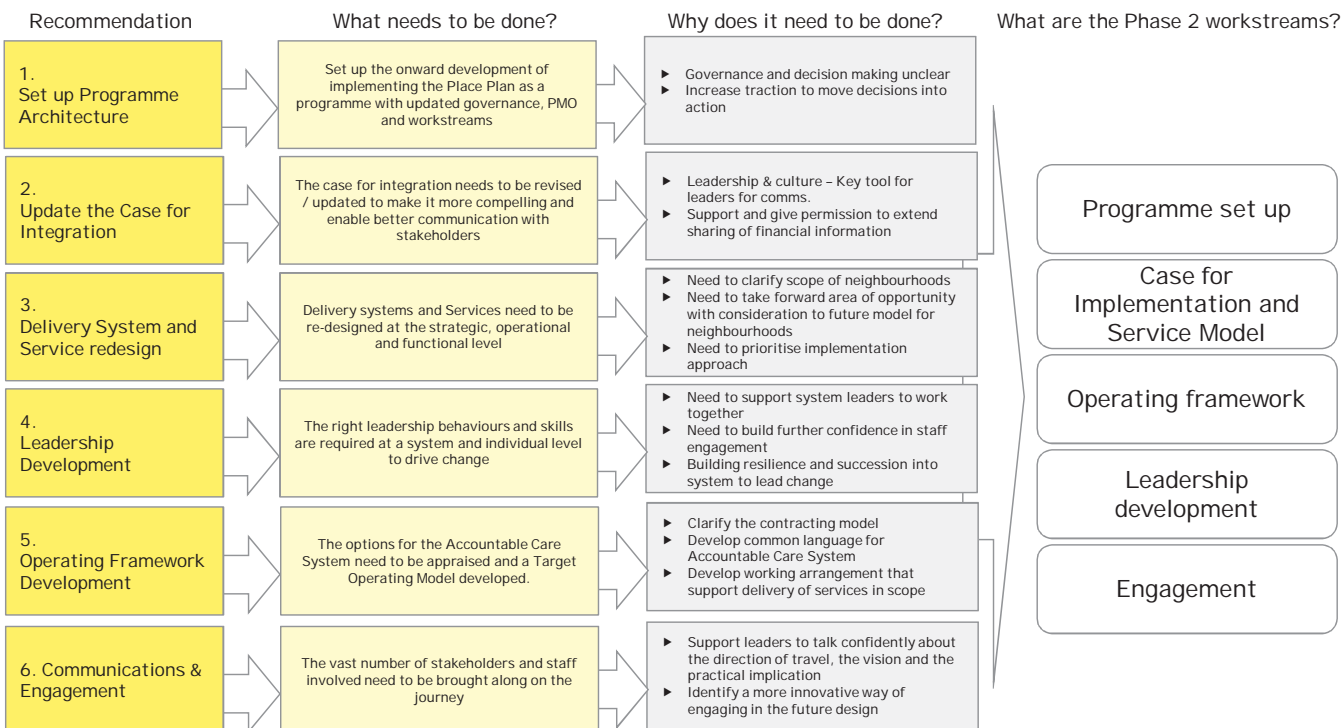
6.  
Workstreams

7.  
Implementatio  
n Planning

# Designing the Workstreams

This section describes the workstreams required for phase 2 of the Doncaster Place Plan. These workstreams are based on the findings from the Phase 1 maturity assessment and are designed to

help accelerated progress towards improved outcomes and financial sustainability through integrated pathways and an accountable care system:





# Workstream Definitions: Set Up Programme Architecture

## Purpose:

The purpose of the workstream is to design the programme architecture and programme management approach.

## What does good look like?

1. Clear programme structure and delivery framework
2. Reporting approach that assists key system leaders in decision making/ taking action at key gateways and on resources, risks and dependencies
3. Engage existing projects and work-streams to avoid duplication, manage dependencies align activity
4. Develop, implement and support the establishment and use of effective programme management to generate pace
5. Provide on-going assurance on successful delivery of the programme and benefits – making sure thing get done and get done right
6. Provides resources to the projects we say are important
7. Has clear governance that both within the programme and within the system (e.g what decisions can be taken where)

## How will this be done?

We will use the framework set out to the right to design the programme architecture, using existing tools etc where possible. This includes:

- ▶ Establishing a system sponsor
- ▶ Developing governance
- ▶ Ensuring an approach to risk management is set up
- ▶ Identifying the required programme team structure and allocating resources/ identifying gaps
- ▶ Establishing how the programme management approach will work



- ▶ Developing a PMO and reporting approach
- ▶ Developing a programme plan

## Not in scope for this workstream:

- ▶ Case for Implementation
- ▶ Communication

## Immediate next steps:

- ▶ Design and establish PMO
- ▶ Identify resources
- ▶ Review Governance

# Workstream Definitions: Case For Integration and Delivery System/Service Design

## Purpose:

This workstream will focus on refreshing the case for Implementation and the longer term design of the neighbourhood model/ commissioning organisation

## What does a good case for Implementation look like?

- ▶ What is the landscape within which Doncaster Health and Wellbeing is operating? Describes the events that have shaped the current environment (FYFV, Devo, STP, resident expectations)
- ▶ Why Change? What are we trying to achieve by this? What do we want to do better and why? What is not working well currently?
- ▶ Where do we want to achieve together?
  - ▶ For who? (What are the cohorts/ population)
  - ▶ Doing what? (What is the scope)
  - ▶ How? (How will we commission? How will we contract? How could providers respond?)
  - ▶ Why? (What is the evidence)
  - ▶ When? (Roadmap)
- ▶ What if we did nothing? What are the risks we need to manage if we do something?
- ▶ What are the potential benefits? Highlights the financial gap, describes the benefit themes and where they would be realised? Describe the necessity to identify a suitable mutual investment model (e.g. Capitation)
- ▶ How will we know it has worked? (Success measures from the perspectives of all our key stakeholders)

## How will we do this?

### Case for Implementation:

- ▶ Review the place plan and phase 1 material and develop an initial draft in line with the above
- ▶ Review and input into STP level commissioning proposals
- ▶ Utilise the task and finish group session to review and refresh
- ▶ Finalise drafts and approve draft with HSC transformation group



## System Delivery & Service redesign:

- ▶ Agree scope of services in neighbourhood hub
- ▶ Agree outcomes and ambition
- ▶ Service specifications
- ▶ Using customer led insight approach to evolve and evaluate
- ▶ Provider engagement to design service model
- ▶ Estates baselining

## Commissioning redesign:

- ▶ Baseline information
- ▶ Develop integration principles/ budgets in scope
- ▶ Transitional joint delegated governance established
- ▶ Design functions and agree hosting arrangements
- ▶ Transition plan

## Immediate activity:

- ▶ Refresh case for Implementation and approve with HSCTG
- ▶ Estates baselining (strategic estates group)
- ▶ Commissioning baseline, principles and governance

# Workstream definitions: Leadership Development

## Purpose:

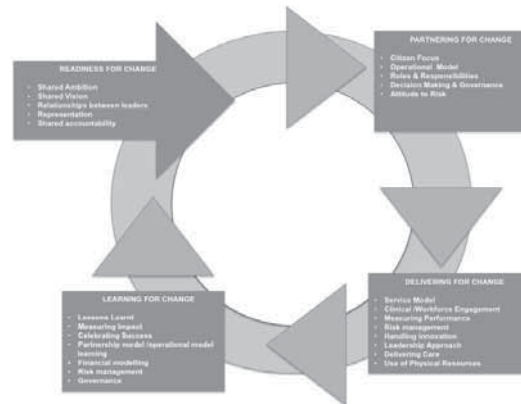
This work-stream will focus on the leadership that is in place across the health and social care system from two aspects – system leadership to drive the required change and individual leadership to provide personal coaching to drive confidence and the right behaviours to support the system change.

## What does good look like?

A jointly established, co-designed set of approaches, rules, behaviours and working practices at a system and individual level.

## How do we do it?

- ▶ Define the meaning of system leadership in Doncaster - Agreeing the system leadership 'operating rules and principles'. Finalising the system leadership programme & narrative. Testing the principles & framework
- ▶ System styles and ways of working: Developing the leadership framework -Understanding the similarities and differences across the System Leadership Group. Getting the best out of the System Group. Managing any potential shadow side of system working
- ▶ Testing the system: Working through the emergent operating model, via soft systems simulations, to test how the system leadership framework and ways of working react under points of pressure and opportunity. Refinement of the operating model and system leadership framework as a result
- ▶ Distributed leadership development: Ensuring that the system rules and leadership framework is effective at supporting a distributed model of leadership throughout the system. Developing effective system networks of planning & delivery



- ▶ Developing resilience: Developing system leadership resilience for the longer term; Resolving system challenges; Succession and 'social movement' planning for the longer term

## Immediate next steps

- ▶ Develop the detailed plan for this workstream in the context of the revised case for Implementation and results from the operating framework testing

# Workstream Definitions: Operating Framework

## Purpose:

This work stream will focus on the development of the operating model for integrated services

## What does good look like?

The key decisions have been set out in the scope section of this report. Working with all partners in the system, the operating framework will be established using an agile approach. This means developing and testing it using the areas of opportunity, whilst being cognisant of the broader neighbourhood model redesign in flight. The learning from these 'test' areas will be built used to evolve the approach at a system level

Three areas have been selected to accelerate over the next seven weeks, it is anticipated a second wave will the progress over the summer.

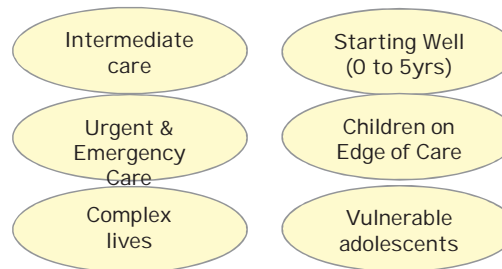
The project manager for this workstream will also support providers in the progression of work on some of the functional quick wins.

## How will we do this?

### For each area of opportunity

- ▶ Establish a specification, outcomes, activity etc.
- ▶ Establish budgets and contributors
- ▶ Develop service model with providers – design groups
- ▶ Develop cost and benefit model
- ▶ Develop draft contract
- ▶ Develop provider alliance agreements
- ▶ Agree monitoring approach
- ▶ Papers submitted to joint delegated governance arrangements

## Areas of opportunity for May/June focus



## Immediate next steps

### For the above areas:

- ▶ Develop/ Review specification
- ▶ Work with providers to establish service model and understand organisations involved
- ▶ Develop contracting principles
- ▶ Establish financial baseline and savings required

# Workstream Definitions: Communications & Engagement

## Purpose:

The purpose of this workstream is to coordinate communications in relation to the evolving case for Implementation. It should also develop the engagement approach for the neighbourhood system delivery and service redesign.

## What does good look like?

The Doncaster Place Plan is fundamentally about working together locally to achieve the best health and social care for Doncaster communities. Communicating and engaging with our local population is vital to delivering this vision. It is critical that all stakeholders are truly involved in this work. There has been lots of communication around the Doncaster Place Plan in various forms and mediums. However the Phase One current state assessment highlighted there still exists an inconsistency of understanding across stakeholders. It is essential that we deliver clear messages which staff and residents can easily understand. Greater Manchester have had significant success with their Taking Charge programme, a large scale engagement activity relating to population level health. It is proposed that this approach is reviewed and incorporated into the system delivery and service redesign approach to the neighbourhood model.

- ▶ Good broadcasting: Clear and consistent messages that are tailored to the audience
- ▶ Good engagement: Generating genuine insight and acting on it together to reshape services

## How do we do it?

- ▶ Stakeholder analysis
- ▶ Develop case for Implementation engagement pack in a number of different format to support broader consultation



with staff and users

- ▶ Develop proposal with Clever Together to establish approach to insight in neighbourhood model development
- ▶ Develop communication and engagement strategy in partnership with system leaders that is linked to the system delivery and service redesign activity
- ▶ Detailed communication plan

Immediate next steps

- ▶ Agree dissemination strategy for case for Implementation
- ▶ Clever together proposals

## 7. Implementation Planning

1. Executive  
Summary

2. Introduction  
& Context

3. Current  
State  
Assessment

4. Good  
Practice  
Examples

5. Programme  
Scope/Operati  
ng Framework

6.  
Workstreams

7.  
Implementatio  
n Planning

# Deliverable descriptions

## Introduction

This section sets out:

- ▶ Key deliverables from EY required in the next seven weeks (Phase 2a) to maintain pace in the progression of the place plan and to meet your deadline for the Chief Executives Meeting on the 16<sup>th</sup> June.
- ▶ Supporting activity and a timeline for the next seven weeks key deliverables that will be produced in the “immediate activity. A high-level description of each is outlined below. These will be prepared in advance of the Chief Executives Meeting.
- ▶ A high-level milestone plan for the next nine months to progress the place plan, aligned to the define programme workstream

Once the PMO is established and a programme manager assign, a detailed programme plan will be developed as part of the programme set up workstream.

Deliverables for Phase 2a:

## WORKSTREAM: PROGRAMME SET UP

PMO and programme management approach:

- ▶ Agree projects within remit of PMO
- ▶ Determine programme team required incl. PM/ PMO together with any additional resources required
- ▶ Identify project leads
- ▶ Determine reporting arrangements

## WORKSTREAM: CASE FOR INTEGRATION & SYSTEM REDESIGN

- ▶ Refreshed case for integration– in line with the deliverable structure set out in the workstream description
- ▶ Clear scope for strategic opportunities
- ▶ Proposals for joint delegated commissioning governance and a plan of activity for designing integrated commissioning

## WORKSTREAM: OPERATING FRAMEWORK

- ▶ Project charters for the agreed Operational Areas of Opportunity that shows timelines and activity required to go live
- ▶ Progress on delivery with agreed sign off points as set out in the Project Charters

## WORKSTREAM: LEADERSHIP DEVELOPMENT

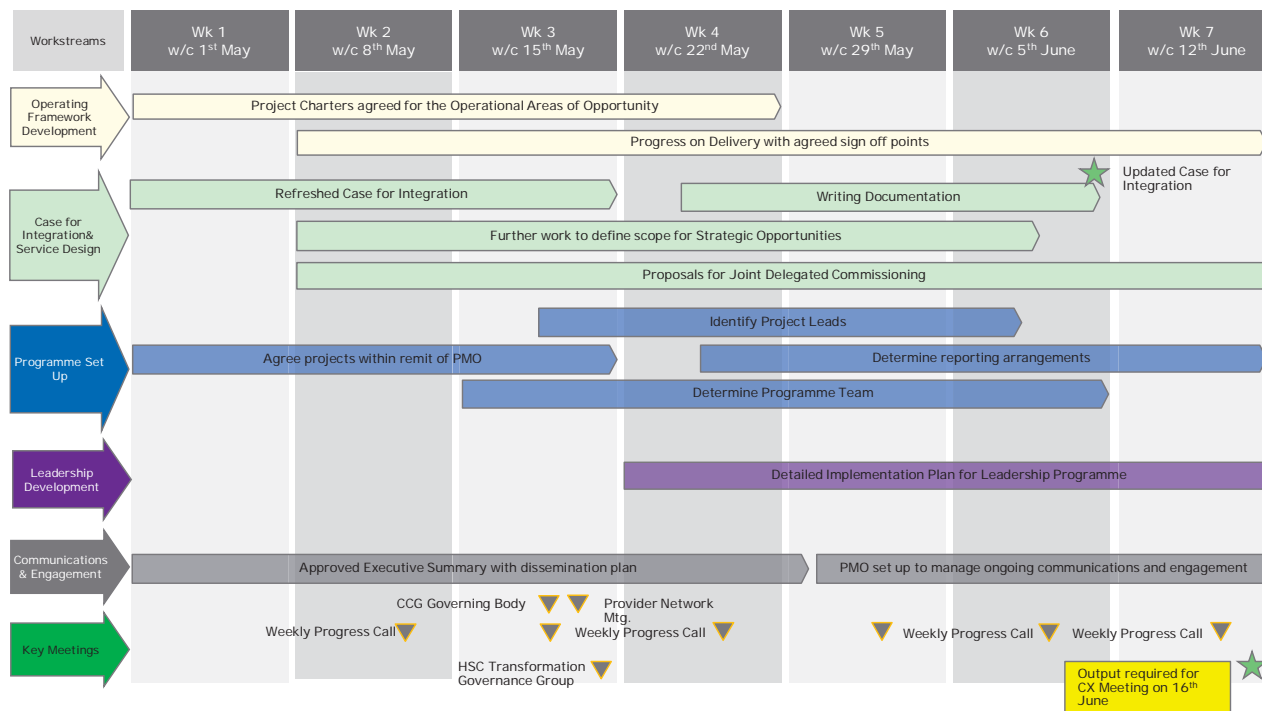
- ▶ Detailed implementation plan for the leadership programme

## WORKSTREAM: COMMUNICATION AND ENGAGEMENT

- ▶ Approved Executive Summary with dissemination plan
- ▶ PMO set up to manage ongoing communication and engagement

# Immediate activity plan

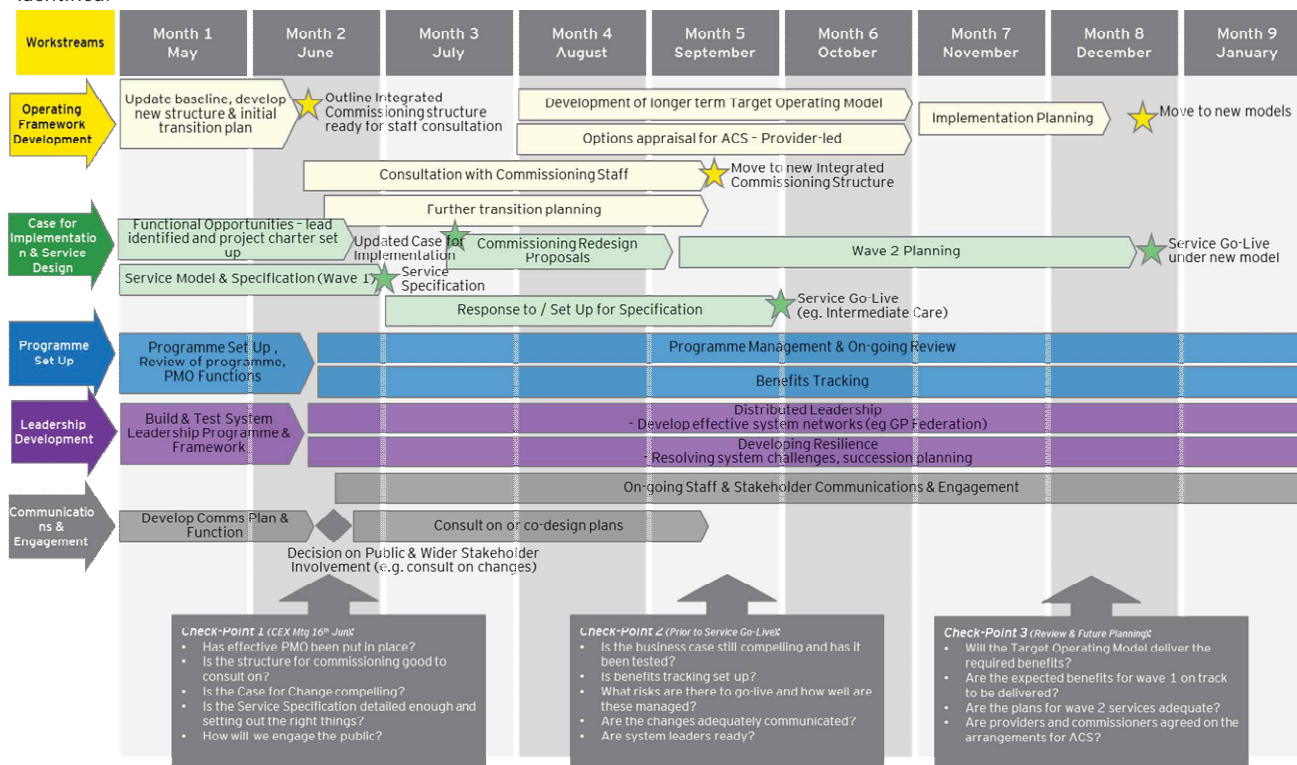
The agreed areas of focus for the next seven weeks of activity are on the creation of the infrastructure to support the five agreed workstreams – with the outputs required for the Chief Executives Meeting on the 16th June. A high level plan of activity is presented below, together with indicative milestone dates.





## Implementation planning

We have outlined below a milestone plan for the next 9 months – this is an indicative plan based on the key work-streams we have identified.



# Appendix



## Appendix I – Leadership Assessment



# Leadership

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## Objective

The Doncaster Place Plan and the requisite partnership arrangements that need to be in place to deliver it, require a very different approach to the planning and delivering of health and care services, than has previously been in place. As part of the diagnostic for Phase 1, we carried out a maturity assessment of the system leadership, to shape and design this new approach. This was for two purposes. The first was to inform the areas of system leadership inquiry. The second was to shape the support and framework for the next phase.

## Method

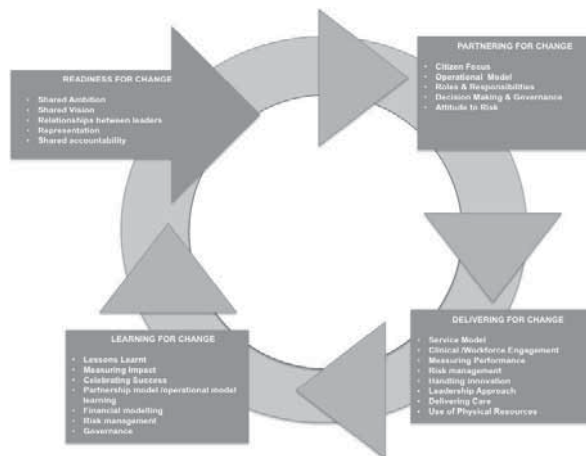
We carried out semi-structured interviews with the senior leaders (CEO/Chief Officer/Lead Director) across the main commissioning and provision organisations of Doncaster. We also observed the first sets of commissioner and provider only meetings.

## System Leadership Maturity Framework

The interviews and the observations were informed by a framework of partnership readiness shown right. This is based on the main stages of effective partnerships (preparing, partnering, delivering and learning) as well as integrating aspects of the 'Stepping up to the Place' assessment, developed by the Local Government Association and the NHS Confederation for joint collaborations around place based change.

## Early Assessment

Presented next are the early findings from the assessment process on the first two stages of the partnership readiness (preparing and partnering). This is provided in terms of the respective groups – commissioners and providers and then we present the next steps and issues for the integrated system going forward.



# Leadership

System Leadership Component 1: Preparing for Change	Commissioners	Providers
System Ambition/Vision/Values	There is a strong vision in place across the CCG and the Local Authority to guide the Doncaster Place Plan. Commissioners are very active in developing the focus and momentum across the Place. There are some subtle differences in culture, philosophy and ways of working across the Council and the CCG, which need more clarity and exploration to shape the strong joint commissioning partnership	There has been good sign up to the vision of the Doncaster Place Plan across Providers. Not all providers are in the same place, but this may be a facet of the 'cohort' focus – e.g. leading with intermediate care. Overall, providers are not as developed in their grasp of the changes in opportunity and role than perhaps they need to be and this is a focus for attention. There were some views that the DPP and its approach could also be bolder in its ambition. This was not to suggest it should be over-reaching, but that a bolder approach may support different levels of change across the system.
Relationship between Leaders	There are good working relationships across the senior commissioner leadership team. There is commitment to a stronger and joint way of working. This needs further development of what this practically means in terms of the leadership requirements and commitments to deliver joint working, alongside single commissioning responsibility.	There are more providers and therefore, by default, relationships are more complex. Some of the provider group have been involved from the inception of the DPP. As a result, they show good levels of commitment. Some provider leaders are newer to the initiative and need a bit more time. It is to be noted that there is not a dedicated provider forum across Doncaster. This may be something that would help the strengthening of the provider network going forward. The provider group also includes members of children's services provision, who feel it is important to shape the system leadership offer, but who, do not immediately see a requirement, in terms of the priority services which will be tested through the joint commissioning arrangements, which are adult services.
Representation	The commissioners have led a good degree of the preparatory work. There has been high levels of commitment from the senior team. Senior staff have been available to author and develop joint thinking and plans. There has been good consistency across the group.	The representation across the Provider group has been more mixed. Some of this is to do with the roles and order (i.e. the commissioning vision shaped different partnership models), some is to do with personnel changes in the group since the planning sessions. Finally, some of this is to do with better understanding of the prize of collaboration.
Shared Accountability	There appears to be very high levels of commitment to making the joint commissioning arrangements work. The Council is clear that it has to do things differently to make its financial savings, but also to deliver differently for the Doncaster citizen. Likewise, the CCG has shown strong commitment to sharing joint accountability. What this means in operational practice, needs now to be clearly mapped and tested, alongside the service models.	The Provider group are, perhaps understandably, in a slightly different place to their commissioning colleagues. There is a desire from the providers for a much clearer articulation of the strategic direction of the DPP and an understanding of the outcomes – i.e. what needs to be different. This also potentially includes a stronger and practical articulation of the provider model – i.e. there is an expectation of greater degrees of collaboration, innovation and system leadership across the provider group.

# Leadership

System Leadership Component 2: Partnering for Change	Commissioners	Providers
Citizen Focus	There is a strong and shared focus on the driver the Doncaster Place Plan being the Doncaster resident and locality groups. There are undoubtedly, as elsewhere in the country, differences in how health and Local Authority organisations view needs and solutions (the former rooted in medical model and the latter, rooted around a social/economic model of intervention). This provides a comprehensive approach to a system-wide and a systematic approach. It is important that both approaches are combined and that leaders (and organisation's) focus is around the cohort groups and not the organisations.	It was felt that this 'unit of currency' needs to be more strongly developed within the provider group. Not to suggest that providers do not consider the needs of Doncaster citizens and/or patients, but rather that the default currency hitherto has been the service model, contract threshold etc. For the system going forward, there needs to be stronger locality-based and person centred modelling and challenge, to shape services to needs and more upstream challenges, than fit residents to services, as is more the case at the moment. This will require development of more sophisticated locality intelligence systems.
Operational Model: - System Leadership - Service	<p>System Leadership: Although the vision and ambition across the joint commissioning group is strong, what this means in practical terms, still needs further focus and development. There are stretching principles in place, but these need rigorous testing in terms of what they may mean for different operational scenarios and how different 'system polarities' which might play out over the development of the partnership (discussed in the next section) and how these might be handled. This would help to confirm the 'rules of engagement', to cover leadership behaviours, as well as system actions.</p> <p>Service Model: It was reported that the interplay between the system leadership, or 'architecture' of the partnership and how the new commissioned services were tested against the model needed to be strongly and clearly connected, as both were largely interdependent. The system leadership model should and needs to create a strong partnership template for joint commissioning, across a range of services, beyond the immediate priorities.</p>	<p>System Leadership: It is fair to say the the provider network does not yet, as a collective, recognise itself as part of the Doncaster system leadership. As reported, there are pockets of good vision and commitment, but this is not yet matched with a clear understanding and commitment to a system leadership model with commissioning colleagues, or with other providers. Providers need to develop their system leadership framework as a group and then combine with the commissioners, where relevant. Having a practical focus should support this, but is not a replacement from understanding how the partnership model or network will practically work.</p> <p>Service Model: Providers wanted to have a much more practical approach to how joint working would be delivered in the future. There is a clear desire that commissioners set out their vision of the destination (i.e. what will be different as a result of the intervention) and the individual outcomes. Providers wanted to have freedom to innovate and collaborate. There was consensus that they did not want commissioners to micro manage them or service innovation. There was also recognition amongst providers that there is still not good enough understanding across the group of their respective service offers and strengths. This is a priority focus, as it prevents early and easy identification of where they might collaborate, or partner, or simply deliver as part of a commissioned service/pathway.</p>

# Leadership

System Leadership Component 2: Partnering for Change	Commissioners	Providers
Roles & Responsibilities	<p>The commissioners need to work through in a little more detail their levels of work and responsibility– i.e.</p> <ul style="list-style-type: none"> <li>A. What will continue to be done by health</li> <li>B. What will be done through the joint commissioning arrangement</li> <li>C. What will continue to be done by the LA</li> </ul> <p>There is a desire, over time, that more activity will be directed through the joint arrangements. Although both groups commission, there are still perhaps subtle and obvious differences in the approach. As greater strides are taken to a partnership approach, it is important to explore those similarities and differences.</p>	<p>What roles and responsibilities the providers will take (as per each commissioned service or areas) is at this point less clear. It was felt that with a clearer steer on the direction, providers would benefit from more time to work through delivery solutions, for each service, clarifying how roles and responsibilities would be managed.</p>
Attitude to Risk	<p>It is not yet clear what the risk tolerances are across the group. This is often different across partnerships (of any form) and is an important area to discuss and more clearly specify, as part of the operational model. Differences can be appropriately tolerated, if they are shared and transparent. Difficulties are introduced in new partnerships, where these factors are less visible and/or one partner assumes, for example, that the attitude to risk is the same across the partnership.</p> <p>Risk is referred to here in its broadest sense – role of the partnership, future direction, financial and organisational.</p>	<p>The same is true of the provider network, although their ability to discuss and set this out is more dependent upon having a practical service model and or example to work through. However, it is clear and understood that only if providers are willing to share risk, up to agreed tolerances, will different and required service solutions be developed for the people of Doncaster.</p>
Decision-Making & Governance	<p>It is recognised that although all Boards and decision making bodies of the respective commissioning groups have signed off the DPP in principle, more work needs to be done to take NEDs and Local Authority Members through the process, to ensure buy-in and importantly, to support the appropriate management of governance arrangements, which may not, in the first instance, be as flexible in supporting different and joint arrangements, as required.</p>	<p>This was mirrored by provider respondents. There is a recognition that organisational governance constraints and/or requirements could be used as a blocker of progress, if the system leadership and operational model are not correct, or are not fully owned by system leaders.</p>

# Leadership

Other Issues Raised as part of the Maturity Assessment	
A Programme Approach	<p>Many respondents identified that the strength of the partnership will grow on the basis of its ability to deliver real and measurable change. There is a fine balance to be struck across the system leadership group and their respective teams of setting out and refining the plan and the rules of engagement, with delivery and reflection. There was strong agreement that high level principles have been established and now adopting a disciplined programme approach to the initiative will strengthen it. This required a clear plan, with timescales and milestones, as well as regular review and learning points.</p> <p>Learning through the doing the DPP seemed to be a strong preference. This of course needs consistent understanding and management of how any of the system polarities, or issues, will be handled. There was also strong and similar views expressed that once the framework was established, that leaders needed to hold their nerve and not go back upon plans, behaviours, or agreements that had already been made. This is obviously not simply a matter of having a strong programme approach, but also of growing trust and commitment to the group, rather than to the individual institutions. This cannot be forced, but must grow. Undoubtedly, having clear parameters will support this nascent collaboration.</p> <p>Some respondents highlighted pace. This was more in terms of needing to keep momentum and managing chunks of delivery and action, with appropriate points of reflection. Because the arrangements will be appropriately tested through cohort and service groups, there is some apprehension that some provider partners attention will wane.</p>
Joining the Strategic Dots	<p>It was felt that as part of the further development of the DPP, there needed to be closer attention to how the programmes of work fitted within the wider regional and local context, particularly in terms of the South Yorkshire &amp; Bassetlaw Strategic Transformation Plan, but also local initiatives such as DN 21 and local transformation plans. It was recognised that the local issues are probably easier to handle.</p>
Developing the Compelling Narrative & Engagement	<p>There are good levels of engagement and representation from senior leaders across the health and care economy. This is vital at the planning and partnering stage. However, it was recognised that part of the test of the new relationships and ways of working will be its ability to engage and direct next tiers of commissioning and provider organisations. More attention needs to be given in this first phase, to develop a compelling and consistent narrative around the plan, to support understanding and wider engagement – to deliver the vision.</p>
Organisational Development	<p>Likewise, this may require, in time, support to both commissioning and provider organisations to change ways of planning, delivering and working to move to a different model of partnership across Doncaster. This will require attention to shaping joint culture, skills, competencies and mind-sets. Although this is not an immediate priority, it needs some consideration early in the process, so that partners organisations are ready, confident and capable to deliver changes</p>



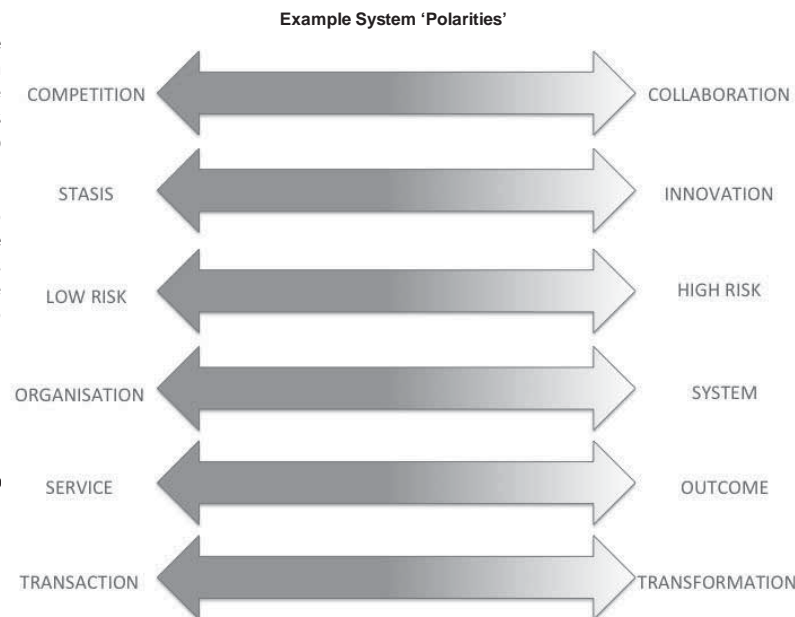
# Leadership

## Next Steps

As the work on the service model develops, there needs to be connected and parallel development on the specification of the operating model for the system leadership group – as commissioners, as providers and finally, as a connected system. To do this, it would be useful to work through a number of scenarios, and/or 'system polarities' attached to practical services to test and develop the system response. Some of these are represented below, from discussion so far. This will help set clear rules of engagement, which are practical, but which also shape a system leadership framework, or concordat.

## X Insert Next Workshop Views?

Play back the programme of sole commissioner – so provider and joint commissioner/provider workshops 1.

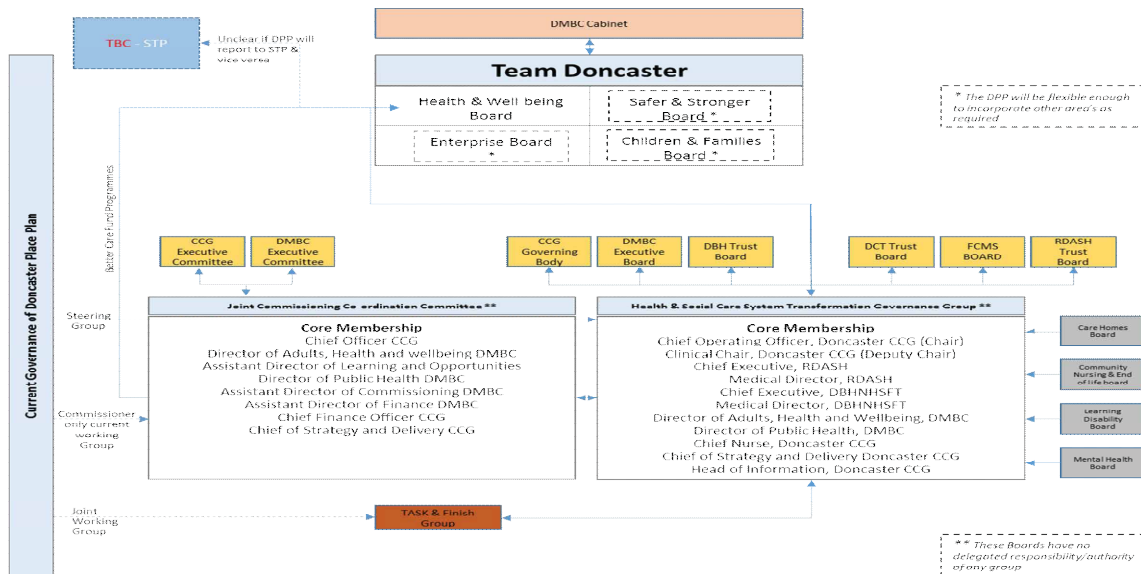


## Appendix II – Governance



# Governance

- The current governance of the Doncaster Place Plan was mapped through conversations with Stakeholders from the CCG and DMBC. The intention was to understand the current Steering and Working groups of the Doncaster Place Plan in addition to all governance in place for the programme i.e. Decision making forums, Escalation points, Roles and Responsibilities of Groups/ Boards, etc.
- The designated chains of governance illustrated from these conversations can be observed below:



# Governance

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## Observations:

The current governance of the Doncaster Place Plan is not fit for purpose this is due to the following factors:

- There is no formalised Steering Group – A steering group for a programme as large as this is essential to ultimately design the strategic vision of the programme and ensure risks & issues are discussed and resolved in a timely manner. Currently the Health & Social Care System Transformation Governance Group is the steering group however this group has no delegated responsibility or authority.
- There is no formalised Working Group – A working group is essential for a programme as large as this to formulate work products and drive the programme forward in addition to highlighting potential risks & issues for resolution/escalation. Currently the Task and Finish group is the working group however this is not a formal channel of governance in addition the group has no delegated responsibility or authority.
- There is no formalised Joint commissioning group with delegated authority to design the function of the Doncaster Place Plan – A joint forum to discuss the proposed function of commissioning is not in place which is a potential barrier for formalised plans being designed by an authorised authority.
- There is no formalised Joint provider group with delegated authority to design the form of the joint commissioned services – A joint forum for the proposed form of services is not in place this could be a potential barrier as no forum exists to discuss the method in which services will be delivered by providers who are in partnership. Proposed plans currently need to be signed off by multiple organisational boards which could lead to delays and challenges in decision making which could impact programme timelines and delivery.

## Recommendations

In order for the Doncaster Place Plan to have a robust governance process the following governance arrangements should be formalised:

- Steering group for the Doncaster Place Plan
  - Working group for the Doncaster Place Plan
  - Joint Commissioning group for the Doncaster Place Plan
  - Joint Provider group for the Doncaster Place Plan
  - Both statutory and local reporting also need to be considered in terms of who compiles which report and what governance arrangements review them.
-

## Appendix III – Workforce As Is



# Workforce

## Workforce Headcount

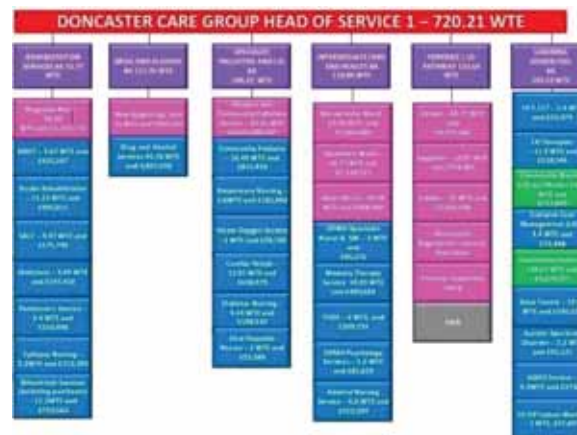
- ▶ This following information sets the scene for understanding the current workforce across all partners which will support the aims of the Place Plan.
- ▶ Most pay costs typically relate to direct pay costs and do not include 'on costs'. Typically an uplift of around 25% to 30% is used to include 'on-costs'. Where FTEs has been used this is clearly stated.
- ▶ It is important to note that the Place Plan looks at the future state whilst this looks as a snapshot of the current workforce figures.
- ▶ The services impacted by the Place Plan are not well defined so a mapping exercise needs to occur to allow us to understand which of the current workforce relates to the future Place Plan vision.

## Rotherham, Doncaster & South Humber NHS Foundation Trust

Rdash are now arranged over 4 Care Groupings:

- Doncaster
- Rotherham
- North Lincolnshire
- Children's

The Place Plan focusses only on the Doncaster Care Group and the Doncaster residents within the Children's Care Group. It has not been possible to identify the Doncaster element of Children's Care Group.



# Workforce

- ▶ Within the Doncaster Care Group there are 2 teams. Service 1 is involved in the delivery of services whilst Service 2 is involved in access and locality.



- ▶ Service 1 includes around 720.21 WTE staff the following service groupings:
  - Rehabilitation – 72.77 WTEs
  - Drug and Alcohol – 111.76 WTEs
  - Specialist Palliative – 106.15 WTEs
  - Intermediate Care & Frailty – 118.86 WTEs
  - Forensic – 123.64 WTEs
  - Learning Disability – 193.13 WTEs

- ▶ Service 2 includes around 773.32 WTEs and includes the following groupings:
  - Mental Health Rehabilitation – 72.53 WTEs
  - Acute All Age Mental Health – 130.51 WTEs
  - Access and Liaison – 118.10 WTEs
  - Rapid Response – 102 WTEs
  - North Locality – 82.17 WTEs
  - Central Locality – 110.37 WTEs
  - East Locality – 84.80 WTEs
  - South Locality – 74.41 WTEs
- ▶ In total the Doncaster Care Group has around 1,493.53 WTEs and has £58.5m Direct Pay Costs. Service 1 contributes £28.8m to this figure and Service 2 contributes £29.7m.
- ▶ The outstanding information is around the overheads for management costs and the Doncaster element of the Children's Care group.

# Workforce

## NHS Doncaster Clinical Commissioning Group

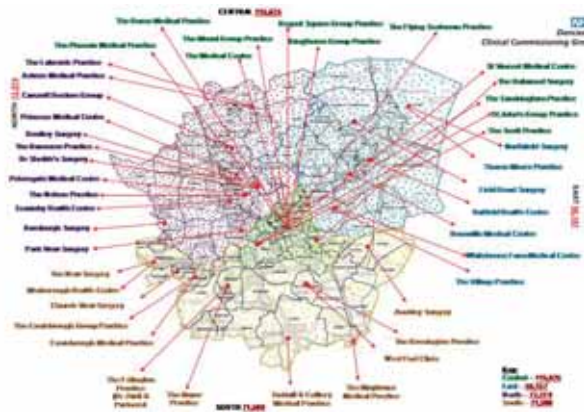
- ▶ The CCG employs 166.81 WTEs with a total direct pay cost of £6,258,482.
- ▶ These figures do not include a number of services which the CCG outsources. The outsourced services include:
  - Payroll
  - HR Shared Services
  - Occupational Health
  - Health and Safety
  - Legal Advice
- ▶ Costs for the services above are not included in the workforce figures.
- ▶ The CCG workforce is split by the following groupings:

Staff Grouping	WTEs	Total Direct Pay Costs
Corporate Services	15.24	£409,958
Finance and Contracting	19.97	£708,641
Governing Body	9.45	£878,224
Primary Care	3.79	£135,258
Quality and Patient Safety	89.45	£2,895,859
Senior Management Team	3.0	£251,752
Strategy and Delivery	25.91	£978,790

## Doncaster Local Medical Committee

There 43 GP Practices across Doncaster with approximately 140 GPs. The map bellows shows the distribution across the 4 localities.

The LMC currently represent the GP Practices within Doncaster. We do not have access to their workforce figures.





# Workforce

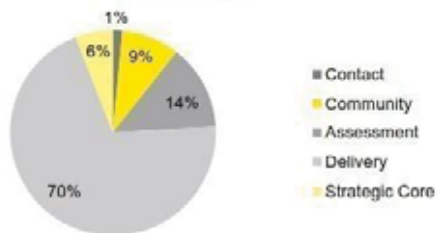
## Doncaster Metropolitan Borough Council

- ▶ The following data has been culled from EY's previous work with the Council 'Annex 1 – Baseline FINAL'
- ▶ Need to confirm if this includes all services covered by the Place Plan and to exclude any beyond the Place Plan and include any above the original EY work.
- ▶ Current services (excluding Public Health) are forecast to spend £133m per annum gross (£90.5mnet). Around 940 FTE are currently in post, with an additional 100+ vacancies.
- ▶ This information is based on 2016/7 budget (including recharges) and data from the HR system
- ▶ Services continue to predominantly focus on delivery - Two thirds of FTE effort is aligned to service delivery - key areas are specialist care (~240 FTE), Home Care (124 FTE), Community Safety (117 FTE) and Libraries and Culture (64 FTE)

This is the breakdown of services and WTEs

Assistant Director	Head of Service	Gross Cost	Net Cost	FTEs
<b>ADULTS SOCIAL CARE</b>				
	Team	39,394,344	17,461,046	375.93
	CARE MANAGEMENT	9,247,245	5,405,755	149.76
	COMMUNITY PROVISION	6,817,581	3,524,609	102.57
	REFUGEE SERVICES	5,188	5,188	0
	SPECIALIST MANAGEMENT	25,869	25,869	0
	SPECIALIST CARE	10,097,661	6,494,635	240.64
	<b>Total</b>	<b>14,771,684</b>	<b>6,425,488</b>	<b>147.89</b>
<b>COMMUNITIES</b>				
	COMMUNITIES	5,695,902	5,695,902	89.34
	COMMUNITY SAFETY	3,629,790	3,629,790	63.77
	LEISURE & CULTURE	0	0	0
	LIBRARIES & CULTURE	5,366,141	6,577,435	90.88
	TRANSLATION SERVICES	375,965	275	3.21
	TRANSLATION SERVICES	-22	-22	2.88
	<b>DIRECTOR OF ADULT SERVICES</b>	<b>147,054</b>	<b>147,054</b>	<b>0</b>
<b>RECREATION &amp; COMMISSIONS</b>				
	Team	81,307,493	62,846,969	86.65
	COMMISSIONING & CONTRACTS	88,488,085	60,173,625	88.67
	RECREATION & RECREATION	1,763,784	1,647,239	15.77
	RECREATION & RECREATION	1,763,784	1,647,239	15.77
	<b>PUBLIC HEALTH</b>	<b>20,276,784</b>	<b>176,444</b>	<b>17.83</b>
	COMMISSIONING	10,086,320	10,086,320	0
	PUBLIC HEALTH	1,005,891	10,086,320	0
	WELL PROGRAMME	9,175,573	9,175,573	0
<b>Other (Unallocated)</b>				
	<b>Grand Total</b>	<b>152,340,344</b>	<b>90,126,688</b>	<b>947.98</b>

## FTE allocated according to operating model area



# Workforce

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## Doncaster & Bassetlaw Teaching Hospitals NHS Foundation Trust

- ▶ We were not able to gather information but have found the following numbers from the Trust's website.
- ▶ Total staff employed as at 31 March 2015 (excl. bank and locum) are 6,638 (5,486.29 FTEs)

FTEs	Headcount	FTEs
Clinical Support	1,277	1,049
Other Healthcare professionals	726	643
Medical and Dental	503	480
Nursing and Midwifery	1,889	1,620
Non clinical (Administrative & Clinical and estates & ancillary	2,243	1,620
Total	6,638	5,486

## Doncaster Children's Services Trust

- ▶ No data received as yet but from Business Plan 2016-19, the following numbers have been sourced

Grouping (FTEs)	Doncaster Council	Department for Education	Total
Operational	428.4		428.4
Support	110.0	27.5	137.5
Total	538.4	27.5	565.9

- ▶ Total pay costs of £20,406,000 in 16/17


# Workforce

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## Fylde Coast Medical Services

- ▶ According to the figures provided by FCMS, the Doncaster services have an average of 99 staff.
- ▶ This figure includes around 45 substantive non clinical staff and 20 substantive clinical staff.
- ▶ In addition, the service typically uses 21 Agency GPs and 13 Agency Nurses/ECPs
- ▶ We do not have the total pay costs associated with these numbers.

## Next Steps

- ▶ Where gaps exist, it would be useful to complete the picture of total staff and pay costs across all providers and commissioners
  - ▶ In Phase 2, these figures will need to be broken down for the priority 'areas of opportunity'
  - ▶ As the future operating model and scope of services become clear, it will be necessary to assess the skills and capabilities across all groups and to evaluate these against future needs.
- 
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## Appendix IV – Shared Transformation Plans



# CCG & Council Shared Transformation Plans:

Adult Health and Well Being Project  
Complex Dependencies Project

Project	Cohort	Scope / vision	Capabilities / changes	Focus area	Stage of development	Timescale	Benefits
Adult Health & Wellbeing	C - delivered in localities	The Vision 'People are able to look after their own health and wellbeing, but know that support is always available from us and the community'.	Project 1: Customer Journey Project 2: Community Led Support Project 3: Transforming Commissioning Project 4: Digital and Technology Project 5: Performance Management and Continuous Improvement Project 6: Alternative Service Delivery Models Project 7: Health and Social Care Integration	Population: Adults Neighbourhood: all	There are current Immediate business improvement projects that are linked to this programme and delivering at this point in time. The Transformation Programme itself commences on 1st April 2017. It has a fully agreed business case and plan and is on track to deliver.	The Programme will be in place between 2017 and 2022. Key milestones are mainly financial at this stage though operational milestones are being developed within the process of producing individual project PIDs. Financial savings milestones are as follows - 2017/18 £4.3m 2018/19 £4.6m 2019/20 £3.2m 2020/21 £1.7m 2021/22 £900k. Total for the programme equals £14.6m.	More people on direct payments More people every month having meaningful conversations in their own communities 50% reduction in people accessing our front door Individual budgets are now our preferred model of choice Up to 30 community hubs 80% of people will use IAG or self serve Over 200 more older people given the support they need to live at home More than 60 adults of working age with a disability living independently Fewer staff Integrated commissioning with CCG Shared NHS and social care data Through ASDMs new companies formed – Domestic Abuse, Day Opportunities, Libraries Savings: 2017/18 £4.3M 2018/19 £4.6M 2019/20 £3.2M 2020/21 £1.7M 2021/22 £900K Total programme net savings £14.6M (all reflected in the MTFF)
Complex dependencies	A - delivered in localities	Engage directly and build trusting relationships with people with complex needs in a variety of settings Develop a multi-disciplinary team with a common theory of practice Development of asset-based approaches to build on individuals' existing relationships and skills and enabling them to take actions Improving outcomes for people with complex needs Reduce demand		Population: 53 identified individuals Neighbourhood: d:	Definition phase	Development of assertive outreach and engagement team - Jan - Mar 2016 Prototype in central locality - tbc Evaluation of prototype - tbc Roll out of new delivery model - tbc	

# CCG & Council Shared Transformation Plans:

Early Help Project  
Learning Disability (CCG)

Project	Cohort	Scope / vision	Capabilities / changes	Focus area	Stage of development	Timescale	Benefits
Early Help	A - delivered in localities	"To prevent and intervene early with children, young people and families experiencing problems in order to prevent escalation of problems. This will deal with root causes, providing support at an early age and an early stage of problems emerging. We will do this by taking a whole family approach and intervening in a co-ordinated way."	Reduction of Assets - Children's and Youth Centres Strategic Youth Alliance Development of Children's Voice and Advocacy Development of Early Help Strategic Partnership Starting Well Family Hubs Transfer of Family Support Workers to DCST - by 31.3.2017 Roll out of Outcomes Star - by 31.3.2017 and then BAU Data and systems	Population: 0-19 year olds Neighbourhood: all Doncaster	Delivering (current Early Help Strategy covers 2015-2018)	Current strategy runs from 2015-2018 - this is currently being reviewed by the Strategic EH Partnership Group Y1 2016/17 - Focus on Social Care pathway Y2 2017/18 - increase quality of Early Help Partnership support; align other public sector Early Help provision (e.g. Local Transformation Programme, Children and Young peoples plan); launch and embed the family hub integrated model; Improve Information, Advice and Guidance; generate contributions from partners through evidencing the value of Early Help; embed implementation of Outcomes Star Y3 2018/19 fully embed locality integrated working	All families supported through universal services at the earliest opportunity Resilience in families Reduction in referrals to specialist services Sustainable youth offer
Learning Disability (CCG)	C- Doncaster wide	Delivery of the core principles of Building the Right Support in Communities of People with a Learning Disability and / or ASD Deliver Transforming Care Partnership plans with local government partners, enhancing community provision for people with learning disabilities and /or autism Prevent people from going into crisis, support people to live as independently as possible in the community and prevention of the need for out of areas placements. Reduce cost pressures on spend for	Population- all ages with LD, full spectrum but transforming care around specific pathways. NB gap re autism and ADHD  Place Plan Cohort: Across all: Cohort A: Prevention & Early Help; Cohort B : Integrated Intermediate Health & Social Care; Cohort C: Enablement and Recovery  Neighbourhood or geographical area (includes footprints wider than Doncaster): Doncaster, Sheffield, N Lincs, Rotherham; LA work only Doncaster population		Live- early 2016	From April 2017 - Key Actions:  <ul style="list-style-type: none"> <li>• Reduce out of area placements – step down from locked rehabilitation</li> <li>• Development of Enhanced Community Team</li> <li>• Enhanced primary care support for people with a learning disability including annual health check</li> <li>• Implement intermediate care model – step down and step-up crisis management</li> <li>• Enhancement acute liaison services</li> </ul>	Reduce inpatient bed capacity by March 2019 to 10-15 CCG commissioned beds per million population, and 20-25 in NHS England commissioned beds per million population Improve access to healthcare for people with learning disability so that by 2020 75% of people on a GP register are receiving an annual health check. Reduce premature mortality by improving access to health services, education and training of staff, and by making necessary reasonable adjustments for people with a learning disability Remodelled provision of step down/up services supported by an enhanced community service focusing on patient case management and supporting individual need. This will deliver patient care within the local community and within the least intensive setting by ensuring timely intervention, identification of preventative care, avoidance of out of area care. Resourced through remodelling of existing commissioned

# CCG & Council Shared Transformation Plans:

## Mental Health Project

Cohort	Scope / vision	Capabilities / changes	Focus area	Stage of development	Timescale	Benefits
C-delivered locally	People with mental health problems will have sustained recovery, have access to information and peer support in order to maintain their wellbeing People with a mental health problems will enjoy good physical health and emotional wellbeing Primary Care and Secondary Care services will be responsive and supportive to those who experience mental ill health and they will have a positive experience and outcome		Population- all age MH although children's been developed a little separately; facing 4 neighbourhood areas  Place Plan Cohort: All cohorts: Cohort A: Prevention & Early Help; Cohort B : Integrated Intermediate Health & Social Care; Cohort C: Enablement and Recovery  Neighbourhood or geographical area (include footprints wider than Doncaster); 4 neighbourhoods	Live- commenced at different time but 15/16 for 5 year forward view; except MH liaison which not yet underway	From April 2017 - Key Actions:  <ul style="list-style-type: none"> <li>• Implementation of Single Point of Access for all age mental Health services;</li> <li>• Development of collaborative pathways to deliver physical health for people with severe and enduring mental health problems;</li> <li>• Development of community based model to improve perinatal mental health;</li> <li>• Modernise the adult mental health acute care and home treatment pathway</li> <li>• progress development of Early intervention in psychosis services</li> <li>• Deliver IAPT Plus and start the development of IAPT to include employment advisors improving access to employment opportunities</li> <li>• Develop the IAPT pathway to include joint care management of people with long term conditions</li> <li>• Core 24/ MH liaison development</li> <li>• Transferring stable patients back to primary care inc training at practice level by RDASH consultant and locally developed algorithm to support. Annual health check – will be further local tools developed to support</li> <li>• Comms both to staff/ primary care and out to general public</li> <li>• Bringing OOA patients back from locked rehabilitation and children also done (tripartite funding)</li> </ul>	<ul style="list-style-type: none"> <li>• Reduce suicide rates by 10%, against 16/17 baseline and understand significant events alongside suicides</li> <li>• Ensure delivery of MH access and quality standards incl 24/7 access to community crisis teams, home treatment teams , and MH liaison services in acute hospitals;</li> <li>• Reduction in A&amp;E attendances due to improved access to crisis prevention and crisis support services;</li> <li>• Reduction in A&amp;E attendances of people who are supported to better manage their Long Term Condition</li> <li>• 50% reduction in avoidable A&amp;E attendances by frequent flyers (£10,10)</li> <li>• Expand capacity so that 53% of people begin a NICE recommended package of care within two weeks of referral;</li> <li>• Additional psychological therapies, so that at least 19% with anxiety and depression access treatment through integration with Primary Care;</li> <li>• Increase access to individual placement support for people with severe mental illness in secondary care by 25% by April 2019, against 17/18 baseline.</li> <li>• Increase baseline spend on MH services to deliver MH Investment Standard;</li> <li>• Eliminate out of area placements for non-specialist acute care by 2020/21.</li> </ul>

# CCG & Council Shared Transformation Plans:

## Intermediate Care Project

Cohort	Scope / vision	Capabilities / changes	Focus area	Stage of development	Timescale	Benefits
B - Doncaster wide	Intermediate Care will be simpler and more responsive. There will be fewer teams and less hand offs along the intermediate care pathway. Intermediate Care will do more to maintain people at home and prevent admissions and A&E attendances as well as stepping people down from hospital as early as possible. Intermediate Care will be part of the local neighbourhood model to ensure continuity of care, maintenance of social networks and will build on existing community assets. The majority of Intermediate care services will be in the community, to support people in their own bed with less bed based intermediate care services. The Intermediate Care workforce will be able to respond to physical, mental health and social care needs in an integrated way.		<p>Population-all adults, not condition specific, no exclusions but tends to be older frail people and very old ie 85 plus</p> <p>Place Plan Cohort: Cohort A: Prevention &amp; Early Help; Cohort B : Integrated Intermediate Health &amp; Social Care; Cohort C: Enablement and Recovery</p> <p>Neighbourhood or geographical area (include footprints wider than Doncaster); whole of Doncaster; some elements could be delivered through neighbourhoods</p>		<p>November 2016- April 2017</p> <ol style="list-style-type: none"> <li>1. Test and refine delivery model by implementing and evaluating a series of discrete projects with providers</li> <li>2. Undertake skills audit and agree workforce development plan</li> <li>3. Further engagement with patients, carers and the public to develop the model</li> <li>4. Complete financial and activity modelling</li> <li>5. Continue to develop appropriate joint commissioning and provision model</li> <li>6. Identify any procurement processes required and plan accordingly. (Intention is to work with current providers to develop existing services)</li> <li>7. Develop a joint dashboard for intermediate care</li> </ol> <p>May 2017 onwards</p> <ol style="list-style-type: none"> <li>1. Sign off new service model following testing</li> <li>2. Ongoing public engagement and formal consultation, if required</li> <li>3. Jointly commission new service model and a phased implementation plan with existing providers 2017/18</li> <li>4. Or procure early 2017/18 and implement with successful bidder</li> <li>5. Or combination of 3 or 4</li> <li>6. Evaluate new model and implementation</li> </ol>	<p>Maintenance or improvement in reported patient experience of intermediate care services</p> <p>More service users are supported to maintain their independence, live at home and in the community as long as possible. A greater proportion of people feel supported to manage their long term condition(s). More service users will be enabled to reach their goals and maintain connections with their home and community environments. More responsive to step up referrals. Reduced A&amp;E attendances for people aged 75 and over (or limited growth). Reduced emergency admissions for people aged 75 and over (or limited growth). Proposal = Year 1 x% Year 2- x% TBC. Reduced ambulance conveyance to A&amp;E for people aged 75 and over</p> <p>Proposal 5% reduction initially - linked to YAS pathfinder target, increasing to x%. Reduced Delayed Transfers of Care. More people remaining at home following discharge from an acute bed. Fewer admissions to Intermediate Care beds, less intermediate care beds. Reduce bed base by 50% initially. Increase in community based intermediate care activity (linked to reduction in bed based activity) Reduce A&amp;E attendances by a cost of - not yet quantified</p> <p>Reduced emergency admission episodes by - not yet quantified. Reduction in excess bed days - not quantified. Reduced A&amp;E attendances - refer to Urgent &amp; Emergency Care Plan. Reduced conveyance to A&amp;E - refer to Urgent &amp; Emergency Care Plan. Implement new service model within or under existing financial envelope for intermediate care. Reduction in social care costs: Admissions into long term care are reduced. Reduction in level of on-going care needed as a result of reablement</p>



# CCG & Council Shared Transformation Plans:

## Primary Care Project

Cohort	Scope / vision	Capabilities / changes	Focus area	Stage of development	Timescale	Benefits
A - delivered in localities	<p>Patients of all ages will be able to access a range of primary care in different settings, dependent on clinical need</p> <p>Greater focus on health promotion, prevention, early diagnosis and interventions via the Keeping People Well pillar specification</p> <p>Timely access to the right skilled clinician</p> <p>Patients able to make informed decisions about their healthcare</p> <p>Patient independence is supported</p> <p>Patient care does not suffer as it moves between different services</p> <p>Access to primary care services will be timely</p> <p>Primary Care will become more stable with working at scale and the establishment of accountable care organisations</p> <p>Improved interoperability and integration between computer systems in primary care, the community and secondary care</p>		<p>Population- all age groups (responsive, extended) but 2 pillars focussed on complex frail 2% (the proactive pillar) keeping well pillar (18-40 that have multiple risk factors not already on a disease register)</p> <p>Place Plan Cohort: Cohort A: Prevention &amp; Early Help;</p> <p>Neighbourhood or geographical area (include footprints wider than Doncaster): 5 GP localities, ? federations but 1 overarching</p>	<p>Conceptual- responsive or</p> <p>Defined- keeping well and extended (PC committee and engagement group all received) or</p> <p>Live- proactive pillar</p>	<p>Quality</p> <p>Implementation of the Quality Assurance Framework and Primary Care Dashboard to support general practice delivering good quality care. Launch with general practice December 2016, initial intelligence gathering and dialogue to take place Jan-June 2017</p> <p>Investment</p> <p>National resilience, sustainability and transformation support programmes for GP Practices (Dec 2016 – March 2018).</p> <p>Investment in the Primary Care Strategy Model including the specifications for the Proactive Coordinated Primary Care Service, Extended Primary Care Service, Keeping People Well Service and Responsive Primary Care Service (from April 2017).</p> <p>Workforce</p> <p>Ring-fenced funding via CCG towards training for receptionists in active signposting and upskilling clerical staff to manage correspondence (Dec 2016 – March 2019).</p> <p>Practice Manager Development Programme.</p> <p>Second wave of the clinical pharmacist in practice scheme.</p> <p>Investment into the General Practice Nurse Development Strategy.</p> <p>Workload</p> <p>Releasing Time for Care programme Support practice EOIs by June 2017, &amp; implementation of the 10 high impact actions thereafter.</p> <p>Implement Productive General Practice programme in Doncaster April – June 2017.</p> <p>Support uptake of GP Improvement Leader Programme.</p> <p>Support update of Practice Manager Development Programme (national scheme).</p> <p>October 16 – April 18 Practice Infrastructure</p> <p>Capital investment in estates and technology infrastructure, Cohort 1 practice by March 2017, Cohort 2 by March 2019.</p> <p>Extra investment to support practices to adopt online consultation.</p> <p>Implementation of the national specification from April 2017.</p>	

# CCG & Council Shared Transformation Plans: :

Stronger Families Project  
Well North Project

Project	Cohort	Scope / vision	Capabilities / changes	Focus area	Stage of development	Timescale	Benefits
Stronger Families	A - Doncaster wide	To transform services to reduce dependence on high cost and often long term services, through the use of targeted and personal support to those families in greatest need, working with them in a whole family approach, bringing together the right services at the right time and as early as possible.		Population: agreed cohort of 2920 families Neighbourhood: all Doncaster	The national Troubled Families Programme, known locally as Stronger Families commenced in it's first phase in April 2012, following the success of that phase Doncaster became eligible for the expanded programme which commenced in April 2015 and has a 5 year lifespan. Assessment against the national programmes maturity model is that Doncaster is 'developing' we have a targeted number of families to engage and to support to achieve successful outcomes by the end of the 5 years.	Expenditure Programme (5 Years) commencing April 2015. Milestones can be defined in the profiled targets for the numbers of families that Doncaster intends to work with, and in respect of transformational changes against the National Maturity Model.	Doncaster has agreed to work with 2950 families (minimum) across the life of the programme, and achieving successful outcomes will be measured by either, moving a family member off out of work benefits and into work, or, the whole families has sustained and significant improvements across all of their identified issues. Transformational change is to reduce the long term demand and dependency on services and improve efficiency across the partnership. Through the development of enhanced ways of working, interventions have become much more evidence based, and we can show that interventions with families work. This has a number of benefits including more value for money, more effective outcomes for families, less duplication and greater efficiencies for services.
Well North	A- Local delivery	Address health inequalities to improve the health of the poorest fastest, Increase resilience at individual, household and community levels, reduce worklessness and increase enterprise	Well Doncaster is delivering a number of distinct action plans; environment and green space, community assets, community leadership, work and enterprise, arts & culture and invisible people. Research and evaluation cuts across these.	Neighbourhood: Denaby	Delivering	Start date April 2015. Budget profiled to 2020/21	Reducing demand on unplanned healthcare (number of A&E attendances and emergency admissions), reducing demand on adult social care (long term residential placements), reducing the number of people claiming out-of-work benefits (JSA, ESA, IB) and increasing self-employment.  Well Doncaster is a principle-based intervention working to a holistic model to create connected and healthy communities. Long term outcomes are to reduce demand on unplanned healthcare, reduce demand on long term social care and reduce out of work benefits. However the programme has not estimated or committed to specific measureable benefits.

## Appendix V – References



# Good practice examples for out of hospital services (1 of 4)

Service	Description	Qualitative Benefit	Evidence	Financial Benefit
Bed based intermediate care	<ul style="list-style-type: none"> <li>▶ Smoother access to intermediate care via access function</li> <li>▶ Aiming to reduce the length of stay by harnessing the role of home based intermediate care and the community treatment teams.</li> <li>▶ Clinical oversight provided by the integrated geriatricians service</li> </ul>	<ul style="list-style-type: none"> <li>▶ Supported, smoother transition from hospital</li> <li>▶ Additional step sideways capacity to support people to prevent a hospital admission</li> </ul>	<ul style="list-style-type: none"> <li>▶ NHS benchmarking – The first National Audit of Intermediate Care</li> </ul>	<ul style="list-style-type: none"> <li>▶ Avoiding admissions</li> <li>▶ Reduction in excess bed days</li> <li>▶ Reduction in attendance due to alternative settings</li> </ul>
Home based intermediate care	<ul style="list-style-type: none"> <li>▶ Consolidating reablement and CARA into a single service that supports hospital discharge and provides a longer term intervention where required from urgent response</li> </ul>	<ul style="list-style-type: none"> <li>▶ Supporting more people to remain at home with the right support</li> <li>▶ Prevention of residential care admissions</li> </ul>	<ul style="list-style-type: none"> <li>▶ Bristol PCT and Bristol County Council – net savings of £3.6m</li> </ul>	<ul style="list-style-type: none"> <li>▶ Joint impact of UT, UAR, HBIC and RAP</li> <li>▶ Admissions, attendances and bed days avoided</li> </ul>
Rapid Access Packages	<ul style="list-style-type: none"> <li>▶ As part of the intermediate care, short term domiciliary care packages would be available in urgent situations and when there is no immediate rehabilitation potential.</li> </ul>	<ul style="list-style-type: none"> <li>▶ Enabling timely access to short term domiciliary care provision to enable people to return/remain at home</li> </ul>	<ul style="list-style-type: none"> <li>▶ Barking, Havering and Redbridge</li> </ul>	<ul style="list-style-type: none"> <li>▶ Reduction in residential care admissions</li> <li>▶ Reduction in acute admission</li> <li>▶ Reduction in excess bed days</li> </ul>
Residential Healthcare Service	<ul style="list-style-type: none"> <li>▶ A GP led service supporting care homes.</li> <li>▶ Delivers more proactive care</li> <li>▶ Focus on ensuring palliative care arrangements in place.</li> <li>▶ Up-skilling care home staff to have better health input.</li> <li>▶ Supported by Pharmacy undertaking medicine usage review and prescription services.</li> <li>▶ Supported by integrated community treatment team where needed</li> <li>▶ Provides own out of hours service</li> <li>▶ Provides medical cover for short term residential beds</li> </ul>	<ul style="list-style-type: none"> <li>▶ Improved equality and access to health care for care home residents.</li> <li>▶ Reduction in medical needs requiring secondary care.</li> <li>▶ Improved end of life care.</li> <li>▶ Improved quality in care home provision</li> </ul>	<ul style="list-style-type: none"> <li>▶ Improving care in residential care homes: a literature review (JRF, 2008)</li> </ul>	<ul style="list-style-type: none"> <li>▶ Reduction in admissions</li> <li>▶ Potential to reshape continuing health care and commissioning of nursing placements</li> <li>▶ Supports hospital discharge</li> </ul>

# Good practice examples for out of hospital services (2 of 4)

Service	Description	Qualitative Benefit	Evidence	Financial Benefit
Hospital Transfer Team	<ul style="list-style-type: none"> <li>▶ Increasing the efficacy of the health and social care hospital discharge team.</li> <li>▶ Increase use of discharge planning tools across all ward staff.</li> <li>▶ Development of hub and spoke model to up-skill ward staff in discharge planning.</li> <li>▶ Critical friend role to clinical staff re appropriateness for discharge of clinically stable patients – risk management and enablement through better skilled staff</li> </ul>	<ul style="list-style-type: none"> <li>▶ Supporting people to get back to home or a home based setting in a safe, efficient way.</li> <li>▶ Better discharge planning</li> <li>▶ Better access to step down options</li> </ul>	<ul style="list-style-type: none"> <li>▶ NHS St Helens</li> <li>▶ Cambridge University Hospital foundation trust</li> <li>▶ NHS Camden – Reach Early Discharge Team</li> </ul>	<ul style="list-style-type: none"> <li>▶ Reduction in excess bed days</li> <li>▶ Reduction in readmissions</li> </ul>
Integrated locality teams	<ul style="list-style-type: none"> <li>▶ Integrated health and social care staff</li> <li>▶ Reablement and homecare attached to team for clients referred from community</li> <li>▶ Expectation that for existing clients who require reablement their home carer is up-skilled to deliver</li> <li>▶ Move to named carer model in homecare contracts</li> <li>▶ Key worker model which can be utilised in urgent scenarios to support decision making</li> </ul>	<ul style="list-style-type: none"> <li>▶ Co-ordinated health and social care support with the individual at the centre of the co-ordination of care</li> <li>▶ Proactive identification and management of risks to reduce escalation of needs</li> <li>▶ Efficiencies in working practice and better continuity of care</li> <li>▶ Better understanding of the person to be able to manage their conditions and support them to navigate the health and social care system</li> </ul>	<ul style="list-style-type: none"> <li>▶ North West London Integrated Care Pilot: 6.6% reduction in non-elective admissions</li> <li>▶ Cockermouth – prevention: £2.20 return for every £1</li> <li>▶ Community Budgets Health and Social Care expected 50% reduction in non contact time due to streamlined referral processes in Solihull</li> </ul>	<ul style="list-style-type: none"> <li>▶ Admissions, attendances and bed days avoided.</li> <li>▶ Reduction in need for unplanned care through better management of client holistic needs and quicker access to low level support to prevent escalation/exacerbation.</li> </ul>
Increasing the use of equipment	<ul style="list-style-type: none"> <li>▶ Further investment in more equipment to target falls and preventing admissions to residential care</li> <li>▶ Pharmacies provide non-complex items potentially reducing the cost of logistics as an additional benefit</li> </ul>	<ul style="list-style-type: none"> <li>▶ People are more independent and able to live in their own homes for longer</li> </ul>	<ul style="list-style-type: none"> <li>▶ 'Interventions for the prevention of falls ... meta-analysis " BMJ 2004</li> </ul>	<ul style="list-style-type: none"> <li>▶ Prevention of hospital admissions</li> <li>▶ Prevention of residential care admissions</li> <li>▶ Prevention of need for urgent response and intermediate care</li> </ul>

# Good practice examples for out of hospital services (3 of 4)

Service	Description	Qualitative Benefit	Evidence	Financial Benefit Description
Triage	<ul style="list-style-type: none"> <li>▶ Providing a single point of access to urgent community assessment and response.</li> <li>▶ Includes social care, nursing and specialist clinical support.</li> <li>▶ Acts as one of two access points to intermediate care.</li> </ul>	<ul style="list-style-type: none"> <li>▶ Alternative call for help at home.</li> <li>▶ Provide care and support in the home in urgent situations.</li> <li>▶ Rapid assessment and access to professionals,</li> <li>▶ Liaison with key worker for existing cases to ensure holistic management and right response.</li> </ul>	<ul style="list-style-type: none"> <li>▶ Bristol PCT and Bristol County Council – net savings of £3.6m</li> <li>▶ NHS Salford – Rapid Response Health and Social Care Crisis Team</li> <li>▶ South-east Essex Community Services</li> </ul>	<ul style="list-style-type: none"> <li>▶ Supports attendance and admission avoidance through providing a home base alternative.</li> <li>▶ Avoids admission to residential care due to additional community cover for more at risk clients.</li> </ul>
Assessment and Response	<ul style="list-style-type: none"> <li>▶ Assessment and provision in urgent circumstances to identify most appropriate pathway of care for individual</li> <li>▶ Where needed will provide 1-2 days care to eliminate need for acute care.</li> <li>▶ Part of 'access function' and can allocate intermediate care where longer term support may be needed</li> <li>▶ Initiate crisis MH beds or facilitate access back to CMHT where needed</li> </ul>	<ul style="list-style-type: none"> <li>▶ As above</li> <li>▶ Provide instant access medical and social cover in crisis situation to help person to remain at home where possible or identify a suitable solutions to support needs without escalating to acute</li> <li>▶ Support GPs to identify and deliver ambulatory care pathways as well as understand other service options for patient management</li> </ul>	<ul style="list-style-type: none"> <li>▶ Royal National Orthopaedic Hospital NHS Trust/King's College NHS FT Trust/Medihome – support for acute patients at home</li> <li>▶ King's College Hospital NHS FT – Older Person's Assessment Unit</li> </ul>	<ul style="list-style-type: none"> <li>▶ As above</li> </ul>
Use of Integrated Case Management in primary care	<ul style="list-style-type: none"> <li>▶ Proactive case finding of at risk clients including social risks such as isolation or depression</li> <li>▶ Supported by locality teams, with a coordination role of community matrons and the health improvement team</li> <li>▶ Locality teams members attached to GP practices to coordinate the relationship and increase visibility of support options</li> <li>▶ Bring resources together, identify cases and support case conferencing to plan</li> </ul>	<ul style="list-style-type: none"> <li>▶ Better communication</li> <li>▶ Co-ordinated case planning across primary care, health, and social care services.</li> <li>▶ Better management of conditions</li> <li>▶ Better continuity of care</li> <li>▶ Up-skilling of staff re different options available to support patients</li> </ul>	<ul style="list-style-type: none"> <li>▶ Cockermonth: £2.20 return on every £1 invested.</li> <li>▶ Barking and Dagenham</li> <li>▶ North West London care pilots 6.6% reduction in admissions</li> </ul>	<ul style="list-style-type: none"> <li>▶ Cost of locality teams has allocated resource to undertake coordination</li> <li>▶ The GP cost and benefit analysis is out of scope</li> </ul>

## Good practice examples for out of hospital services (4 of 4)

Service	Description	Qualitative Benefit	Evidence	Financial Benefit Description
Investment in Nursing Care/ Residential Care	<ul style="list-style-type: none"> <li>▶ Multi-Disciplinary Teams (MDTs)</li> <li>▶ Enhance nursing and therapies in care homes – especially for those with complex needs</li> <li>▶ Improvements in oral health, hydration, and nutrition</li> <li>▶ Improvement in end of life care</li> <li>▶ Promotion of mental health and wellbeing</li> </ul>	<ul style="list-style-type: none"> <li>▶ Improved health outcomes</li> <li>▶ Enhanced satisfaction for residents</li> <li>▶ More efficient use of resources</li> </ul>	<ul style="list-style-type: none"> <li>▶ Islington MDTs: 26% decrease in admission and 87 less bed days per month.</li> <li>▶ Worcestershire community nurse: 23.1% reduction in A&amp;E attendances</li> <li>▶ Peterborough review: 27% reduction in admissions</li> </ul>	<ul style="list-style-type: none"> <li>▶ Reduction in bed days</li> <li>▶ Reduction in admissions</li> </ul>

## Appendix VI - One Page Templates for the Areas of Opportunity





# Mental Health

## Context

- People with mental health problems will have sustained recovery, have access to information and peer support in order to maintain their wellbeing. People with a mental health problems will enjoy good physical health and emotional wellbeing
- Primary Care and Secondary Care services will be responsive and supportive to those who experience mental ill health and they will have a positive experience and outcome

## Scope

- Reduce suicide rates by 10%, against 16/17 baseline and understand significant events alongside suicides. Ensure delivery of MH access and quality standards incl 24/7 access to community crisis teams, home treatment teams, and MH liaison services in acute hospitals.
- Reduction in A&E attendances; by improved access to crisis prevention and crisis support services in addition to enhanced support to better manage Long Term Condition. 50% reduction in avoidable A&E attendances by frequent flyers (£10,10). Expand capacity so that 53% of people begin a NICE recommended package of care within two weeks of referral. Additional psychological therapies, so that at least 19% with anxiety and depression access treatment through integration with Primary Care. Increase access to individual placement support for people with severe mental illness in secondary care by 25% by April 2019, against 17/18 baseline. Increase baseline spend on MH services to deliver MH Investment Standard. Eliminate out of area placements for non-specialist acute care by 2020/21.

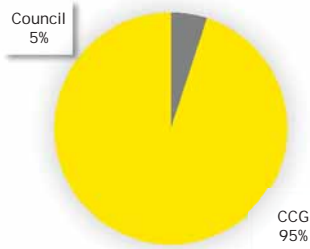
## Case for Implementation

- Parity of esteem – for mental health to have the same importance as physical
- Improve outcomes by improving community services
- Improve the experience of people using the services
- Improve the safety and effectiveness of services
- Develop preventative services to break the cycle of spending resources in reactive way.

## Finances and Activity

Area	Volume	Metric
RDASH Contract	1,354,777 / 8,077	MH Cluster days / contacts
Notts Healthcare Trust Contract	9,773	MH Cluster days
Sheffield Care Trust Contract	1,797 / 114	MH Cluster days / contacts
Specialist Packages	n/a	Individual Care Packages with Regular Review Periods
S117 Packages	n/a	Individual Care Packages with Regular Review Periods
Rethink Contract	4 beds	Occupied Bed Days
Alzheimer's		

- The services above equate to £43.1m of Council and CCG commissioning costs with the CCG making up 95% of the total



## Assumptions

- This area is commissioned by both the CCG and Council and is defined by the following services:
- Rdash contract, Notts Healthcare Trust Contract, Sheffield Care Trust Contract, Various Specialist Packages, Various S117 Packages, Rethink Contract, Alzheimer's Society, Adult Social Care (Council), Modernisation and Commissioning (Council), Public Health (Council)

## Approach / Next Steps

- Detailed Scoping to be done with Key stakeholders
- Develop and agree approach for the long term framework
- Detailed project plan to be developed
- Design and embed governance for the programme of work
- Validate end user and financial benefits
- Scope Risk/Issues and interdependences
- Assess key enablers (i.e. Estates rational and I.T)

# Learning Disabilities

## Context

- Population- all ages with LD, full spectrum but transforming care around specific pathways. NB gap re autism and ADHD
- Place Plan Cohort: Across all: Cohort A: Prevention & Early Help; Cohort B: Integrated Intermediate Health & Social Care; Cohort C: Enablement and Recovery
- Neighbourhoods – All Neighbourhoods are included in addition to specialist services in the surrounding

## Scope

- Delivery of the core principles of Building the Right Support in Communities of People with a Learning Disability and / or ASD.
- Deliver Transforming Care Partnership plans with local government partners, enhancing community provision for people with learning disabilities and /or autism.
- Prevent people from going into crisis, support people to live as independently as possible in the community and prevention of the need for out of areas placements.
- Reduce cost pressures on spend for out of area placements.

## Case for Implementation

- Reduce inpatient bed capacity by Mar 2019 to 10-15. CCG commissioned beds per million population, and 20-25 in NHSE commissioned beds per million population
- Improve access to healthcare for people with L&D so that by 2020 75% of people on a GP register are receiving an annual health check.
- Reduce premature mortality by improving access to health services, education and training of staff.

## Finances and Activity

Area	Volume	Metric
Rdash Contract	9,416 / 5 beds	Contacts / Occupied Beddays
Specialist Packages	n/a	Individual Care Packages with Regular Review Periods
S117 Packages	n/a	Individual Care Packages with Regular Review Periods

- The services above equate to £27.5m of CCG and Council commissioning costs.
- The Council contributes 66% of this total and the CCG contributes 34%.



## Assumptions

- This area is commissioned by both the CCG and Council and is defined by the following services:
- Rdash contract
- Various Specialist Packages
- Various S117 Packages
- Adult Social Care (Council)
- Modernisation and Commissioning (Council)

## Approach / Next Steps

- Detailed Scoping to be done with Key stakeholders
- Develop and agree approach for the long term framework
- Detailed project plan to be developed
- Design and embed governance for the programme of work
- Validate end user and financial benefits
- Scope Risk/Issues and interdependences
- Assess key enablers (i.e. Estates rational and I.T)

## Primary Care (Excluding GMS & PMS)

## Context

- Patients of all ages will be able to access a range of primary care in different settings, dependent on clinical need.
- Patients able to make informed decisions about their healthcare and their independence is supported.
- Patients identified for coordinated care will receive regular multidisciplinary reviews by a team involving health and care professionals with the necessary skills to address their needs.

## Scope

- Greater focus on health promotion, prevention, early diagnosis and interventions via the Keeping People Well pillar specification Timely access to the right skilled clinician.
- Patient care does not suffer as it moves between different services Access to primary care services will be timely. Primary Care will become more stable with working at scale and the establishment of accountable care organisations. Improved interoperability and integration between computer systems in primary care, the community and secondary care
- Identification of 2% most vulnerable and complex patients. Practice to proactively treat and coordinate care of this cohort of patients.
- Confirmation of named professional and their respective caseloads
- Patients on the proactive coordinated care register will have a single care plan that will be shared with all professionals involved in their care
- Patients will feel more empowered and motivated to take responsibility for their health and wellbeing

### Case for Implementation

- Slow development of general practice collaboration and working at scale
- Lack of focus and incentive on prevention and early detection
- Shortage in skill mix and workforce
- Variation of business models within practices
- Increased workload in primary care
- Increase in workload due to shift of services between secondary and primary care
- Lack of understanding regarding estates and infrastructure across Doncaster Practices

## Finances and Activity

Area	Volume	Metric

### Approach / Next Steps

- Implementation of the Quality Assurance Framework and Primary Care Dashboard to support general practice delivering good quality care. Launch with general practice December 2016, initial intelligence gathering and dialogue to take place Jan - June 2017.
- National resilience, sustainability and transformation support programmes for GP Practices (Dec 2016 - March 2018).
- Investment in the Primary Care Strategy Model including the specifications for the Proactive Coordinated Primary Care Service, Extended Primary Care Service, Keeping People Well Service and Responsive Primary Care Service (from April 2017).
- Releasing Time for Care programme Support practice EOLs by June 2017, & Implementation of the 10 high impact actions thereafter. Implement Productive General Practice programme in Doncaster April - June 2017.
- Support uptake of GP Improvement Leader Programme.
- Support update of Practice Manager Development Programme

# Urgent & Emergency Care

## Context

- A number of urgent care services were re-commissioned in Doncaster during 2015.
- These services are primarily those that are directly accessed by patients as their first step when seeking urgent care through choice and include: The Doncaster Same Day Health Centre; the Urgent Care Centre and the Front Door Assessment and Signposting Services at DRI.

## Scope

- These services are currently provided by 2 different providers
- It has been recognised by the local System Resilience Group that this may be an area to test out an Accountable Care Partnership approach due to the interdependencies between the services.
- This area is commissioned by the CCG only and is defined by the following services:
  - Accident and Emergency (A&E) across DBTH NHS FT
  - Front Door Assessment and Signposting Service (FDASS) at DBTH NHS FT
  - Urgent Care Centre (UCC) provided by FCMS
  - Same Day Health Centre (SDHC) provided by FCMS
  - Emergency Care Practitioner Service (ECPS) provided by FCMS

## Case for Implementation

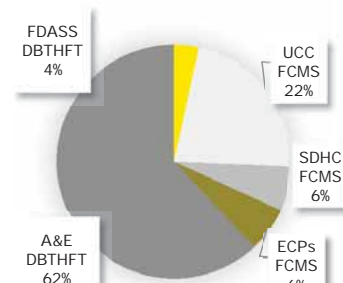
- Providing better support for people and their families to self-care.
- Helping people who need urgent care to get the right advice in the right place, first time.
- Ensuring that adults and children with more serious or life threatening emergency needs receive treatment in centres with the right facilities
- Connecting all urgent and emergency care services together so the overall physical and mental health and social care system becomes more than just the sum of its parts.

## Finances and Activity

Area	Volume	Metric
A&E	81,000	Attendances
FDASS	98,000	Attendances
UCC	70,350 / 34,650	Triage/ Contacts
SDHC	14,000	Contacts
ECPS	1,650 / 4,884	Consultations / Contacts

### Finance

- The services below equate to £15.2m of commissioning costs.



## Assumptions

- This area currently excludes non elective admissions to DBTH NHS FT

## Approach / Next Steps

- An Accountable Care Partnership type approach would support the inherent interdependencies between the services from both a service delivery and a performance perspective.
- Need to understand demand by locality to map demand to services
- Need to develop preventative measures

# Intermediate Care

## Context

- Intermediate Care will be simpler and more responsive.
- There will be fewer teams and less hand offs along the intermediate care pathway
- Intermediate Care will do more to maintain people at home and prevent admissions and A&E attendances as well as stepping people down from hospital as early as possible.

## Scope

- The majority of Intermediate care services will be in the community, to support people in their own bed with less bed based intermediate care services.
- This area is defined by the following services:
  - Mexborough Montagu Hospital - General Rehab at Doncaster and Bassetlaw (commissioned by the CCG)
  - Hawthorn and Hazel Wards at Rdash (commissioned by the CCG)
  - Unplanned nursing at Rdash (commissioned jointly)
  - Short Term Enablement Programmes (Steps) (commissioned by the Council)
  - Social Care Enablement Programme - Positive Steps (commissioned by the Council)
  - RAPT (Rapid Assessment Programme Team) (commissioned by the Council)
  - Integrated Discharge Teams (IDT) (commissioned by the Council)
  - Home from Hospital (commissioned by the Council)

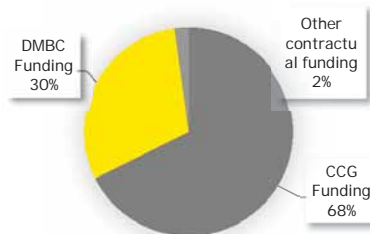
## Case for Implementation

- Maintenance or improvement in reported patient experience of intermediate care services.
- More service users are supported to maintain their independence, live at home and in the community as long as possible.
- Reduced A&E attendances for people aged 75 and over (or limited growth).
- Reduced Delayed Transfers of Care.
- More people remaining at home following discharge from an acute bed.
- Reduce bed base by 50% initially.

## Finances and Activity

Area	Volume	Metric
Assessment Teams	2 hospital based assessment teams	IDT RAPT
Bed Based Services	Four bed based units (approx 100 Intermediate care beds)	Hazel and Hawthorn Fred & Ann Green Rehab Positive Steps
Hospital Based Services	2 Community teams have a combined case-load of over 200.	CICT STEPs ECPs (Some elements commissioned as part of urgent care)

- The current Intermediate Care service costs around £17.6m



## Assumptions

- This project is developed and outputs need to be carefully measured

## Approach / Next Steps

- Move from focus on early discharge onto a focus on admission prevention
- Monitor KPIs to ensure that this project is delivering as expected
- Need to develop both admission avoidance schemes and preventative admission measures

# Starting Well (1001 Days)

Please Note: The Draft below focuses on Starting Well and the scope as agreed with stakeholders has shifted emphasis to Starting Well 1001 Days. Version 2 of this templates is now being produced in line with the agreed scope change.

Context	Scope	Case for Implementation
<ul style="list-style-type: none"> <li>This is about ensuring that all children across Doncaster have the opportunity to a good start in life.</li> <li>It is about developing support so that our children have the best possible opportunity to thrive</li> <li>It is about offering appropriate support to families and children at the right time.</li> </ul>	<ul style="list-style-type: none"> <li>To prevent and intervene early with children, young people and families experiencing problems in order to prevent escalation of problems.</li> <li>This will deal with root causes, providing support at an early age and an early stage of problems emerging.</li> <li>We will do this by taking a whole family approach and intervening in a co-ordinated way. This will mean look at areas such as:                             <ul style="list-style-type: none"> <li>Smoke free homes</li> <li>Breastfeeding</li> <li>Diet &amp; healthy start vitamins</li> <li>Safe sleeping</li> <li>Maternal mental health</li> <li>Stop smoking in pregnancy</li> <li>Immunisation uptake</li> <li>Illnesses</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>All families supported through universal services at the earliest opportunity.</li> <li>Resilience in families.</li> <li>Reduction in referrals to specialist services.</li> <li>Sustainable youth offer</li> <li>Healthier children who will develop into health adults</li> <li>Breaking the cycle of poor health and social outcomes by intervening early</li> </ul>

Finances and Activity			Assumptions
Area	Volume	Metric	<ul style="list-style-type: none"> <li>xxx.</li> <li>Limited to children aged 0 to 5 years old</li> <li>Focussed on those most at risk to break the cycle of life long dependency on health and social care services</li> </ul>
Approach / Next Steps			
			<ul style="list-style-type: none"> <li>Detailed Scoping to be done with Key stakeholders</li> <li>Develop and agree approach for the long term framework</li> <li>Detailed project plan to be developed</li> <li>Design and embed governance for the programme of work</li> <li>Validate end user and financial benefits</li> <li>Scope Risk/Issues and interdependences</li> </ul>

# Continuing Healthcare (CHC)

## Context

- Currently DCCG and DMBC hold separate budgets for CHC with decisions made over who pays for the individual care package
- In addition, care packages are procured separately so the overall market for CHC need and dependency is not managed collectively
- Both organisations face significant financial challenges and will review CHC spend to assess the opportunity to reduce spend

## Scope

- To improve and standardise systems and processes
- Ensure eligibility review checks and target review checks are met for all patients
- Integrated administration and clinicians to avoid delay and contact "hand-off"
- Develop and implement a caseload management framework together with a standard operating procedure
- Implement an escalation protocol to avoid cancellations of assessments
- Deliver a workforce development programme for all staff involved to ensure consistency of approach and shared understanding
- Communicated relentlessly with all staff
- Closely performance manage progress with revised, cleansed data

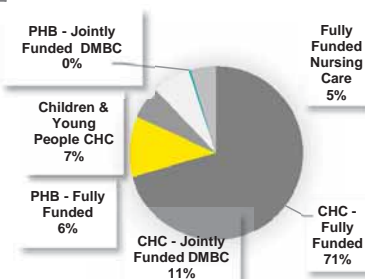
## Case for Implementation

- A co-ordinated approach to CHC will ensure that decisions are always made in the best interests of the individual and not related to budget ownership
- Co-ordinated market management will ensure that the most competitive price is procured each time
- Consistency of paperwork, reviews, process and decisions will reduce waste, lost time and duplication of effort

## Finances and Activity

Area	Volume	Metric
Various	n/a	Individual Care Packages with Regular Review Periods

- The CCG costs for CHC are £34.1m



## Assumptions

- This area is commissioned by both the Council and the CCG and is defined by the following services (Currently data is available for CCG only):
- Continuing Healthcare Fully Funded
- Continuing Healthcare - Jointly Funded DMBC
- Personal Health Budgets - Fully Funded
- Children & Young People Continuing Health Care
- Personal Health Budgets - Jointly Funded DMBC
- Fully Funded Nursing Care

## Approach / Next Steps

- Agree the financial position from DCCG and DMBC, crucially understanding the savings earmarked for this area and the level of risk this poses.
- Benchmark current performance with peers to understand how delivery could change
- Agree the new service delivery model to drive the required change

# Dermatology

## Context

- Dermatology services are currently provided in both primary and secondary care settings.
- It has been recognised in Doncaster that there is significant potential for a greater level of service to be provided within neighbourhoods, on a more equitable basis, by primary care.

## Scope

- The scope of this project will be around reducing the beds, outpatient attendances, outpatient procedures and excluded drugs from the acute setting and moving this activity to the community settings, where it is safe to do so.
- It will be about using Telederm more extensively to ensure that community settings can deliver dermatology services in a safe way

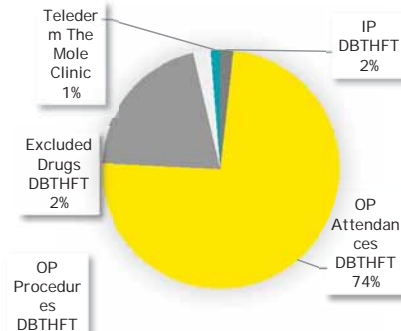
## Case for Implementation

- Patients will be able to access services more locally with less travel and less waiting time
- Referrals to secondary care would reduce, enabling secondary care to focus on the more specialist roles required.
- Acute costs would reduce

## Finances and Activity

Area	Volume	Metric
Inpatient	29 beds	PbR
Outpatient Attendances	18,900	PbR
Outpatient Procedures	3,700	PbR
Excluded Drugs	n/a	Quantity Dispensed
Telederm	No target	Assessments

- The current Dermatology service costs around £2.1m



## Assumptions

- This area is commissioned by CCG only and is defined by the following services:
  - Inpatients at DBTH NHS FT
  - Outpatient Attendances at DBTH NHS FT
  - Outpatient Procedures at DBTH NHS FT
  - Excluded Drugs at DBTH NHS FT
  - Telederm at the Mole Clinic
  - GP Minor Surgery?

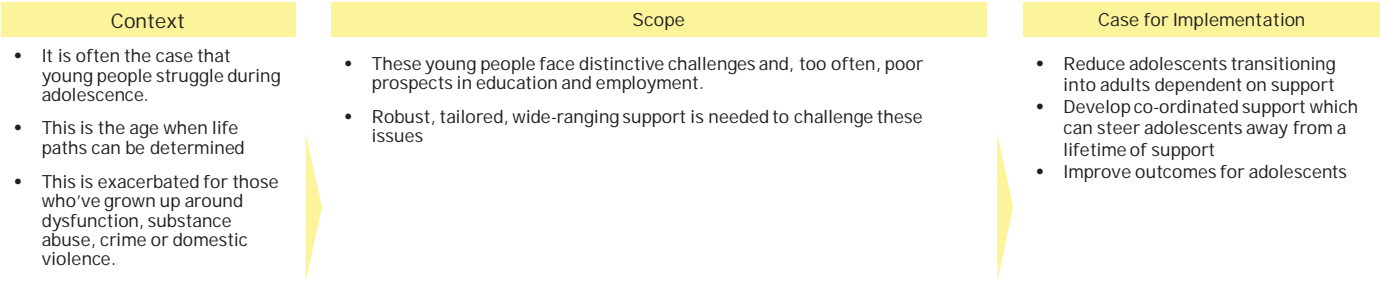
## Approach / Next Steps

- Detailed Scoping to be done with Key stakeholders
- Develop and agree approach for the long term framework
- Detailed project plan to be developed
- Design and embed governance for the programme of work
- Validate end user and financial benefits
- Scope Risk/Issues and interdependences



# Vulnerable Adolescents (Tier 4 Specialist Services)

Please Note: The Draft below focuses on Vulnerable Adolescents and the scope as agreed with stakeholders has shifted to Vulnerable Adolescents – Tier 4 Specialist Services. Version 2 of this templates is now being produced in line with the agreed scope change.



## Finances and Activity

Area	Volume	Metric

• xxx.

## Assumptions

• xxxx

## Approach / Next Steps

- Define exactly who is included within the project scope and develop a clear understanding on how we will deliver these principles
- Detailed Scoping to be done with Key stakeholders
- Develop and agree approach for the long term framework
- Detailed project plan to be developed
- Design and embed governance for the programme of work
- Validate end user and financial benefits

# Complex Lives

## Context

- This cohort includes some of the most vulnerable people living within Doncaster.
- The complex relationship and interdependencies between homelessness, drug and alcohol addiction, mental health problems, domestic abuse, violence, begging, offending behaviours requires integrated investment and delivery, with an increasing focus on prevention.
- This is one of two Team Doncaster prototypes for new delivery models (with town centre), and is one of the two pilot activities listed in the Place Plan (with intermediate care)

## Scope

- The scope and specifics of a new delivery model has been developed through a prototype phase since November 2016. The key components are:-
- Assertive outreach and engagement delivered in a multi agency approach
- Integrated case planning and delivery of accommodation with wrap around support with personalised pathways - supporting people over time to recover and stay well
- Key Workers for complex and less complex cases to provide the focal point for case coordination and ongoing support - the consistent point of contact for a person and their empowered champion in co-defining their outcomes
- 'Housing First' - the commissioning and development of housing support services to enable stability of accommodation with built in wrap around support
- An Outcomes Framework includes familiar Key Performance Indicators.
- One Shared System - A shared access and case management system enables pooling of intelligence and effective case management act from a person-centred perspective.

## Case for Implementation

- This is a low volume high cost cohort of people who experience very chaotic lifestyles, and have often experienced trauma in earlier life.
- The cohort also has a major impact on place, and in particular the town centre which is a major priority for Team Doncaster
- The response to the issue requires a highly integrated relationship between police, investment and practice from homelessness/supported housing, drug and alcohol and mental health services and the criminal justice system.
- Shared accountability for this cohort between organisations is crucial.

## Finances and Activity

Area	Volume	Metric
Homelessness/ supported housing		
Drugs/alcohol		
Mental health		
Offending behaviour		
Care leavers		

- A range of current commissioning activity currently focuses directly or in part on this cohort. This includes:-
- Homelessness commissioning managed by DMBC Adults and delivery by St Leger Homes
- Drugs and Alcohol commissioning by Public Health and delivered by RDaSH (via third parties in some cases)
- Mental health provision commissioned by the CCG and delivered by RDaSH.
- Social Care and mental health social work funded and delivered by DMBC
- Support for care leavers provided by DCST, commissioned by DMBC, with accountability lines to DFE
- Support for offenders commissioned by Home Office/Police and Crime Commissioner/Probation and delivered by the Community Rehabilitation Company

## Assumptions

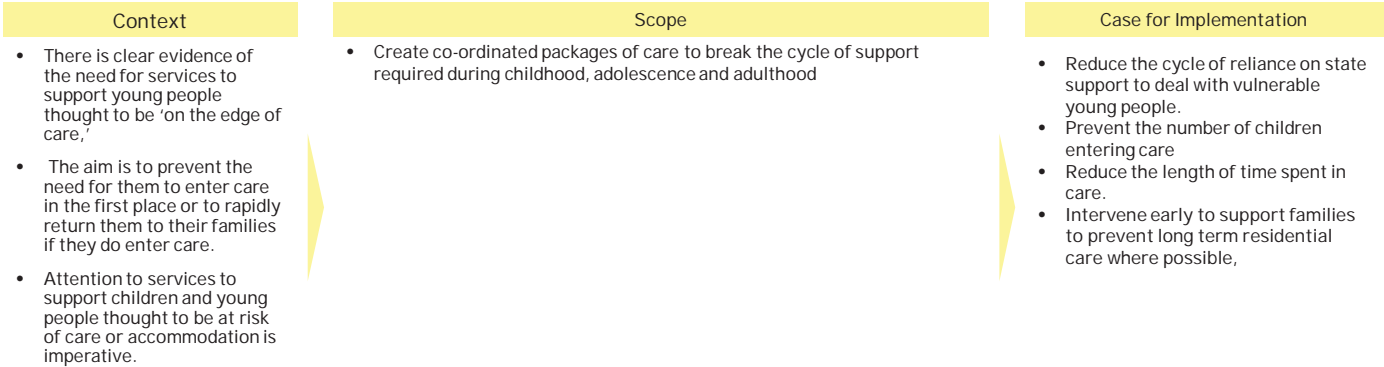
- There is a strong partnership commitment to produce a highly integrated response
- A new delivery model requires a joint strategic approach between commissioners across DMBC, Public Health and the CCG, with scope to extend to criminal justice commissioners
- It requires a collaborative delivery model between DMBC, St Leger, RDaSH, South Yorks Police, DCST, DBH & criminal justice agencies
- The development of an accountable care model will be managed in stages
- This is an area where community/peer led support is vital

## Approach / Next Steps

- Establish joint commissioning group for this area of opportunity asap
- Soft test of first stage joint commissioning and collaboration in delivery for intensive support workers and navigator case coordinators (as minimum between St Leger, RDaSH, DMBC)
- Soft joint commissioning of homelessness service reforms
- Develop and agree approach for the wider roll out/ long term framework
- Detailed project plan to be developed
- Design and embed governance for the programme of work

# Children on the Edge of Care

Please Note : This is currently a draft version that will be finalised with key stakeholders in the w/c 2<sup>nd</sup> May



Finances and Activity			Assumptions
Area	Volume	Metric	<ul style="list-style-type: none"><li>xxx.</li><li>Need to define age group this project will focus on</li></ul>
Approach / Next Steps			
			<ul style="list-style-type: none"><li>Define exactly who is included within the project scope and develop a clear understanding on how we will deliver these principles</li><li>Detailed Scoping to be done with Key stakeholders</li><li>Develop and agree approach for the long term framework</li><li>Detailed project plan to be developed</li><li>Design and embed governance for the programme of work</li><li>Validate end user and financial benefits</li></ul>

# Domestic Abuse

## Context

- The national agenda has moved from a risk led approach, to an approach which now also prioritises prevention and early intervention.
- It seeks to meet the needs of the whole family earlier and in so doing reduce the risk of escalation and serious harm in the longer term.

## Scope

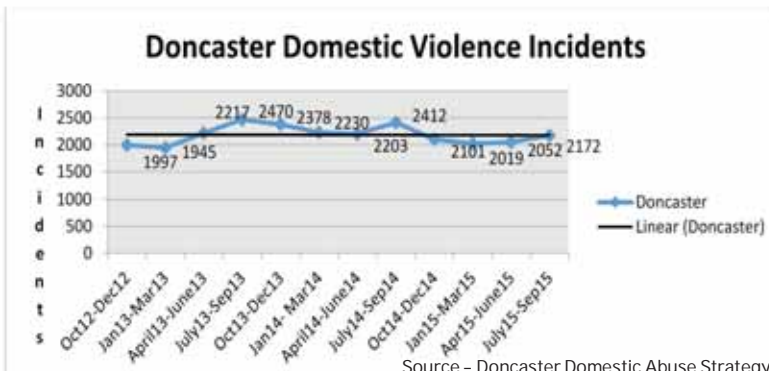
- The Vision for Domestic Violence in Doncaster is where domestic violence and abuse is recognised as unacceptable, and people live safe and happy lives free from abuse. Anyone experiencing domestic abuse, whether being abused, being the abuser, or witnessing abuse, has access to the support they need at the time they need it, to be safe and recover, or address their own behaviour
- Estimates for Doncaster show for high risk cases to MARAC the cost to services for adults is over £12m and will exceed this by the year 2020 if the rate continues or increases
- Earlier intervention could reduce High Risk case costs by £4m if services assess need earlier and intervene
- The overall wider public cost of domestic abuse in all cases for Doncaster is estimated to be over £110 million

## Case for Implementation

- Domestic and sexual abuse has been a key priority for the Safer Stronger Doncaster Partnership (SSDP) since 2010.
- The numbers of high risk cases referred are well above the average against both regional and national figures and SafeLives benchmark.
- The number of children affected has increased to over 800 in each of the last 2 years
- Although there has been a reduction of cases over the period the percentage of repeat cases remain higher than regional and national figures.

## Finances and Activity

## Approach / Next Steps



- To improve the use of the collective intelligence through:
  - effective use of data,
  - To continue to listen to staff working with families and in the community and also,
- To hear what victims (adults and children) and perpetrators tell us
- This will allow us to focus on achieving our key outcomes:
- The current strategy (2016 to 2020) identifies three key outcomes:
  - Outcome 1: Communities and families no longer accept or experience domestic abuse
  - Outcome 2: Families who are vulnerable to or experience domestic abuse are identified earlier and receive effective support to stay safe; reduce repeat victimisation and recover
  - Outcome 3: People who use abusive behaviour are challenged and provided with effective support to change

# Infection Control

## Context

- Multiple Infection control services across the organisational partners which have scope to be integrated, reduce cost and improve quality of service through best practice and knowledge sharing
- Infection Control is deemed to be an area which could integrate quickly in addition to a test area that could help produce 'lessons learnt' documentation
- Estimated 300,000 patients a year acquire healthcare associated infections

## Scope

- To aid in the reduction of infections rates across organisations which delay recovery and adversely affect quality of life for the Doncaster Population
- Enabler to; prevent people dying prematurely, positive experience of care and protection from avoidable harm
- Standardised quality of care across all care settings
- A more coordinated, person-centre approach which aims to deliver high quality care for all which prevents and or controls infection proactively
- Where possible leverage economies of scale to reduce costs
- Flex workforce to appropriate areas of need to ensure best practice is shared and embedded

## Case for Implementation

- To reduce and proactively control infection rates across partnership organisations with a robust strategy that has a focus on continuous improvement
- To better utilise multi-agency working and surveillance systems to enhance patient experience and reduce delayed recovery
- To standardise and embed best practice across partners to ensure we leverage knowledge sharing in addition to reducing cost

## Finances and Activity

Area	Volume	Metric

- xxx.

## Assumptions

- All partner organisations comply with NICE guidance
- All partner organisations have a similarly developed Infection Control service
- Infection Control Services are not outsourced

## Approach / Next Steps

- Rapid current state assessment of all Infection control services
- Baseline data to be validated and signed off
- SRO to be assigned
- Project team to be defined
- PID production
- Governance arrangement made and documented
- Project team mobilisation
- Project Management approach implemented for the programme

# Safeguarding

## Context

- Safeguarding is protecting vulnerable adults or children from abuse or neglect.
- It means making sure people are supported to get good access to health care and stay well.
- Across Doncaster, each partner needs to consider safeguarding and this issue is currently dealt with individually by each partner
- The aim is to remove this duplication and develop a shared safeguarding function

## Scope

- This project will be limited to the following partners:
  - Doncaster & Bassetlaw Teaching Hospitals NHS Foundation Trust
  - Doncaster Children's Services Trust
  - Doncaster LMC and Federations
  - Doncaster Metropolitan Borough Council
  - Fylde Coast Medical Services
  - NHS Doncaster Clinical Commissioning Group
  - Rotherham, Doncaster & South Humber NHS Foundation Trust

## Case for Implementation

- Remove duplicated services
- Provide a centralised service which promotes a consistent approach across the whole of Doncaster
- Reduce the overall cost of the current fragmented service
- Develop robust safeguarding measures will not only protect vulnerable adults and children but will also enhance the confidence of staff, volunteers, parents/carers and the general public

## Finances and Activity

Area	Volume	Metric

- xxx.

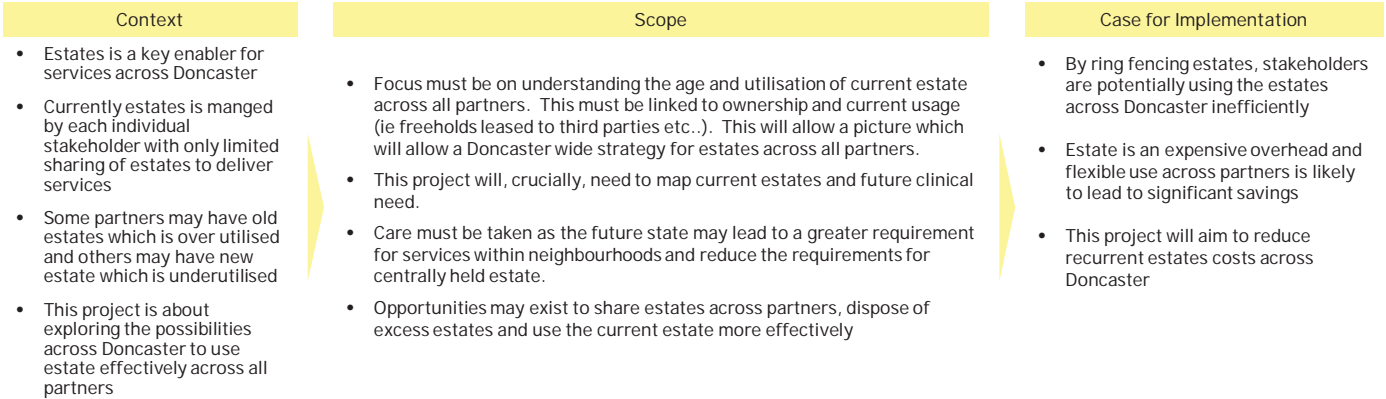
## Assumptions

- Benefits will be maximised if all partners participate in this project and agree to it's fundamental purpose

## Approach / Next Steps

- Understand the current cost, activity and workforce for each partner currently associated with safeguarding
- Develop and agree a future state
- Detailed Scoping to be done with Key stakeholders
- Develop and agree approach for the long term framework
- Detailed project plan to be developed
- Design and embed governance for the programme of work
- Validate end user and financial benefits

# Estates



Finances and Activity			Assumptions	
Area	Volume	Metric	<ul style="list-style-type: none"> <li>Arrangement will need to be discussed around sharing any proceeds for disposals of estates and/or investment in estates</li> <li>Arrangements will need to be agreed for the potential of sharing estate and splitting costs</li> <li>Partners will need to agree to share information on estates data</li> </ul>	
			Approach / Next Steps	
			<ul style="list-style-type: none"> <li>Detailed Scoping to be done with Key stakeholders</li> <li>Develop and agree approach for the long term framework</li> <li>Detailed project plan to be developed</li> <li>Design and embed governance for the programme of work</li> <li>Validate end user and financial benefits</li> <li>Scope Risk/Issues and interdependences</li> </ul>	

# Community Led Support

## Context

- Local people, community groups and local partners can all work together much more effectively with a common aim
- Health and social care professionals are integrated \joined up - at a community level
- The system / process works swiftly and responsively and is proportionate to people's needs and circumstances
- The focus is on getting upstream - early intervention and prevention

## Scope

- This project is aimed at keeping people within their own community and helping them to remain independent and in control of their own lives. It is about people accessing advice, information and lower level support to stop issues from escalating and building individual, community and family resilience and capacity. At its core is a re-ablement and enablement approach. It will, therefore, contribute significantly to the 5 BCF indicators:
  - Reducing Non-Elective Admissions
  - Reducing Delayed Transfers of Care
  - Reducing Residential Admissions (65 years + only)
  - Increasing the assistive technology installations aged 65+
  - Proportion of older people (65 years +) who were still at home 91 days after discharge from hospital into re-ablement / rehabilitation services

## Case for Implementation

- We cannot afford to do nothing, from both a financial perspective but also we are not yet achieving the best outcomes for people.
- For example, in Doncaster we admit more people per 1000 population into residential care than England and Yorkshire and Humber.
- We have a lower take up of Direct Payments, indicating both a lack of choice and control and an over reliance on statutory provision.

## Finances and Activity

Area	Volume	Metric

- xxx.

## Assumptions

- Health and Social Care staff have the appropriate support to work together at a community level

## Approach / Next Steps

- Develop Community assets and resilience will be developed in each locality
- Staff across agencies will have more flexibility and freedom to innovate leading to increased staff morale and motivation
- Expectations will be managed more effectively within the neighbourhoods
- Test out a more integrated service and community offer within localities to enhance the future models of care



# Single Point Of Access

## Context

- The current entry points to services are fragmented and difficult to navigate for service users
- Currently there are 29 different single points of access (SPA) available (23 community based, 3 bed based and 3 hospital based)
- 17 of the 29 are classed as gateways
- 86% of SPA's are for adults
- 38% offer a service at point of contact

## Scope

- Streamline the existing access to service through integration of current SPAs and/or creation of new gateways
- Ensure that all organisations have a consistent approach, which will help residents to navigate through the care systems
- Assess the benefits of having SPAs located in one hub or dispersed across Doncaster
- Effective service driven by a clear definition of the function of SPA, leading to increased user satisfaction
- Reduce the duplication of unnecessary services and gateways in order to lower costs

## Case for Implementation

- Services are over complicated, difficult to navigate and not efficient
- Currently not enough home based services exist to respond at times of crisis which could help people maintain independency
- Approximately 50% of over 75's admitted to hospital could potentially be support at home with different Intermediate care services
- Integration of Health and Social Care within SPA could support patients with independency and offered enhanced services which have both qualitative and financial benefits to patients and organisations

## Finances and Activity

Area	Volume	Metric

- xxx.

## Assumptions

- There could be a reduction in administration costs
- Reduction in inappropriate use of secondary care services
- Higher User satisfaction will be achieved

## Approach / Next Steps

- Detailed baseline and PID to be signed off by SRO
- Detailed population trends of service users aligned to neighbourhoods to be produced
- Governance Arrangements to be put in place
- Mobilisation of project team
- Pilots to be set up and ran in defined areas
- Programme to be managed with project management tools and techniques



**Doncaster and Bassetlaw  
Teaching Hospitals**  
NHS Foundation Trust

Title	Strategy & Improvement Update		
Report to	Board of Directors	Date	25 <sup>th</sup> July 2017
Author	Marie Purdue, Acting Director of Strategy & Improvement		
Purpose		Tick one as appropriate	
	Decision	✓	
	Assurance		
	Information		

Executive summary containing key messages and issues
<p>This paper seeks to provide:-</p> <ul style="list-style-type: none"> <li>a) Update on 17/18 Efficiency &amp; Effectiveness programme- paragraph 2</li> <li>b) Strategic Planning Process – paragraph 3</li> <li>c) Quality Improvement &amp; Innovation – paragraph 4</li> </ul>
Key questions posed by the report
<p>Is progress with the efficiency and effectiveness workstreams sufficient to address the efficiency requirement in the financial plan?</p> <p>Does the approach taken to developing the Strategic Direction and Quality Improvement &amp; Innovation Strategy assure Board that we will comply with best practice and our undertakings to NHSI?</p>
How this report contributes to the delivery of the strategic objectives
<p>Development of revised strategic vision</p> <p>Oversight of initial structures to support the implementation of the strategy</p>
How this report impacts on current risks or highlights new risks
<p>The main risk of not progressing existing workstreams and identifying new projects is that we will not have a credible and supported plan to deliver the savings necessary to reduce the financial deficit of the Trust. As a subset of this our key stakeholders and partners may lose faith in our ability to manage our own response to this issue and will take more direct ownership and control.</p>
Recommendation(s) and next steps
<p>The committee is asked to agree the Strategic Direction and note the progress made on implementation governance.</p>

## 1 Introduction

1.1. This paper seeks to provide:

- a) Progress on 17/18 Efficiency & Effectiveness workstreams - paragraph 2
- b) Strategic Planning Process – paragraph 3
- c) Quality Improvement & Innovation – paragraph 4

## 2 Progress on 17/18 Efficiency & Effectiveness workstreams

- The Efficiency & Effectiveness workstream update is now included in the Board report provided by the Director of Finance so the financial position can be seen in one report in its entirety.
- Overall responsibility for the Efficiency & Effectiveness Programme Management Office has been transferred to the Director of Finance portfolio, with the Acting Director of Strategy & Improvement retaining the strategy and Qii functions.
- Work is underway to ensure this is a seamless transition and that synergies continue to be supported where they exist, for example elective care.

## 3 Strategic Planning Process

3.1 Progress on strategic planning has continued including:

- Engagement on the draft strategic vision that has is now complete with over 600 responses from social media, electronic surveys, postcards and feedback from attendances at meetings within and outside the Trust.
- A governors' workshop on the strategy has taken place to follow up on work commenced in March to ensure the Strategic Direction was developed with regard to the views of the governors. The final version will also go to the Council of Governors at the end of July.
- Amendments have been made to the strategic vision in light of the feedback received from all of the engagement events with governors, the Board and other stakeholders.

3.2 The final version of the Strategic Direction is **attached** for Board to review and agree.

3.3 Following Board approval the final version will be submitted to NHSI as required as part of our undertakings.

3.4 Work on enabling strategies continues to enable further development of a three year plan to support the vision.

3.5 In May, Management Board focussed on the Clinical Services Strategy with input from all care groups and corporate departments, testing the strategic objectives and developing more detailed implementation plans. This was followed up at the June Management

Board to discuss and agree the priorities and associated responsibilities. Workstreams are being developed in the following areas:

- 3.5.1 Urgent & Elective Care (including Intermediate Care)
- 3.5.2 Elective Care (including Cancer Services)
- 3.5.3 Women's & Families

3.6 The workstreams will be clinically led and have support from the S&I team.

## **4 Quality Improvement & Innovation**

- 4.1 Development of the Quality Improvement & Innovation (Qii) strategy and its associated action plan is being completed and a final draft based on engagement with Care Groups and Corporate leads has been shared with them for comments.
- 4.2 One proposal in the strategy is to develop a 'Qii strategy huddle' that will include a wide range of staff from across the organisation to support translating the strategy into action. The group will informally review progress of the strategy, test out ideas for upcoming actions, gain feedback on impact, and help identify key successes and learning for reporting into formal meetings. Volunteers for involvement are being sought via Care Groups and Corporate leads, as well as from staffside.
- 4.3 An assessment has been undertaken of the Qii elements required to enhance the recent NHSI / CQC Well Led domain. This ensures that all the required Qii elements had been included in the proposed Trust strategy and action plan.
- 4.4 A development session on the Qii strategy is planned for the Board in July, and a date is being arranged for a similar session with Governors in August / September

## **5 Summary**

- 5.1 The Board is asked to review and agree the attached Strategic Direction.



## DRAFT Strategic Vision for 2017- 2022

Doncaster & Bassetlaw Teaching Hospitals NHS Foundation Trust

**PRIVATE & CONFIDENTIAL**



DRAFT

## Introduction: Foreword from Chair and Chief Executive

Add photos here to left side

Doncaster & Bassetlaw Teaching Hospitals NHS Foundation Trust (DBTH) is a busy and vibrant acute foundation trust, with one of the busiest emergency services in the country. Over the past eighteen months, we have gone through some substantial changes, some challenging, and others exciting, but all pointing towards a bright future for our patients, services and staff. As we move forward together, our new strategy describes what we want to achieve over the next five years and how we are going to get there.

As a Trust, we are extremely proud of the excellent improvements in the quality of care we continue to provide to our patients, an achievement we have sustained for the fourth year in a row. As part of this achievement, we have seen further reductions in severe avoidable pressure ulcers, falls and infections while our mortality rate has also reduced in comparison to last year and is well within the expected range. Maintaining quality of care is fundamental to our future plans and lies at the heart of all we do.

In January 2017, we were awarded teaching hospital status, becoming Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust (DBTH). We gained this accreditation due to our longstanding commitment to improving education and growing research, as well as ensuring that we are an integral partner in the sculpting of clinical and medical staff in the region. Becoming a teaching hospital will be of huge benefit to our patients and staff with further improvements to be made in innovative and quality health care, delivered by our professional team that is actively teaching and involved in research initiatives.

Following financial challenges which presented in Autumn 2015, we have also made great progress in our cost saving and efficiency efforts and these have to continue into the future. The progress we have made has been due to a number of factors, but can be mostly attributed to the 'can-do' attitude and enthusiasm of our staff, who have been working in different and innovative ways. Throughout this process it has been our goal to ensure that the patient remains our focus and we believe that, despite increased demands and challenges, we have achieved this.

Thanks to our identified savings and a one-off support payment from NHS Improvement for our strong performance against our financial plan, we start this planning period in a better position than expected. Like many other NHS organisations we will continue to face significant changes and challenges and we have therefore developed our strategic direction to anticipate these and to ensure we work effectively internally and with partners to develop solutions.

Over recent years we have strengthened our links with health and care partners in South Yorkshire and Bassetlaw, working as part of the Working Together Vanguard to develop new care models. We are also an integral partner of the South Yorkshire and Bassetlaw Sustainability and Transformation Plan (STP) which has now become a first wave Accountable Care System (ACS). This is thanks to established strong relationships with neighbouring Trusts and Clinical

Commissioning Groups and a proven history of working together to improve health and care for our population.

We have engaged with staff, external partners, patients and other stakeholders to ensure that our revised strategic direction continues to fit with the changing needs of the wider health community we serve, while working in tandem with national and regional directives.

We would like to take this opportunity to thank everyone who contributed to the development of our revised strategic direction 2017-2022. Your engagement and feedback has been invaluable and has helped to shape the direction of the Trust for the next five years.

The following document outlines our strategic direction and our plans for the future and we look forward to working with you to implement them to provide a high quality service for the population we serve.

Add signatures



## Who We Are and What We Do

Doncaster & Bassetlaw Teaching Hospitals NHS Foundation Trust (DBTH) is one of only five teaching hospitals in the Yorkshire region, and we have close working relationships with the University of Sheffield and Sheffield Hallam University. As a Trust we also maintain strong links with Health Education England and our local Clinical Commissioning Groups in both Doncaster and Bassetlaw.

We are fully licensed by Monitor and fully registered (without conditions) by the Care Quality Commission (CQC) to provide the following regulated activities and healthcare services:

- Treatment of disease, disorder or injury
- Nursing care
- Surgical procedures
- Maternity and midwifery services
- Diagnostic and screening procedures
- Family planning
- Termination of pregnancies
- Transport services, triage and medical advice provided remotely
- Assessment or medical treatment for persons detained under the Mental Health Act 1983

We provide the full range of district general hospital services and some specialist tertiary services, including vascular surgery. We also provide a number of community services including: sexual health services; therapies; Aortic Aneurysm Screening and audiology.

We serve a population of more than 420,000 across South Yorkshire, North Nottinghamshire and the surrounding areas and our three hospital sites are described below.

**Add stats on workforce** – and community reflection i.e. scale of workforce as a percentage

**Insert infographic here**

## Providing Care within Our Community

### Doncaster Royal Infirmary (DRI)

DRI is a large acute hospital with over 500 beds, a 24-hour Emergency Department (ED), and trauma unit status. In addition to the full range of district general hospital care it also provides some specialist services including vascular surgery. It has inpatient, day case, diagnostic and outpatient facilities.

### Bassetlaw Hospital in Worksop

BDGH is an acute hospital with over 170 beds, a 24-hour Emergency Department (ED) and the full range of district general hospital services including a breast care unit and renal dialysis. It has inpatient, day case and outpatient facilities.

### Montagu Hospital in Mexborough

Montagu is a small non-acute hospital with over 50 inpatient beds for people who need further rehabilitation before they can be discharged. There is a nurse-led Minor Injuries Unit, open 9am-9pm. It also has a day surgery unit, renal dialysis, a chronic pain management unit and a wide range of outpatient clinics. Montagu is the site of our Rehabilitation Centre, Clinical Simulation Centre and the base for the Abdominal Aortic Aneurysm screening programme.

We are also registered to provide outpatient and other health services at **Retford Hospital**, including clinical therapies and medical imaging. Our site at the **Chequer Road Clinic** in Doncaster town centre offers audiology and breast screening services. We also provide some services in community settings across South Yorkshire and Bassetlaw. The rehabilitation beds we used to have at Tickhill Road Hospital in Doncaster transferred to Montagu Hospital in August 2012 however we still provide outpatient care of older people at this site.

In 2004, Doncaster and Bassetlaw Hospitals became one of the first 10 NHS trusts in the country to be awarded foundation trust status. This means we have more freedom to act than a traditional NHS trust, although we are still very closely regulated and must comply with the same strict quality measures as non-foundation trusts.

Add South Yorkshire place based map with sites and Doncaster, Bassetlaw and South Yorkshire

## **National Context**

A number of national documents are shaping our strategic vision. Core documents include The NHS Five Year Forward View (2015) (FYFV) and Place Plans developed by the two local Clinical Commissioning Groups (CCGs). The FYFV sets a clear and positive vision for the NHS, underpinned by strong collaboration across health and care systems and the necessity to develop new models of care. It placed integrated, person-centred support at the heart of health and care systems with an emphasis on public health, ill health prevention and empowering patients and their communities.

The recent Next Steps on the NHS Five year Forward View (2017) reviews progress since the launch of the Five Year Forward View and sets out a series of practical and realistic steps required for the NHS to deliver a better more joined up and responsive NHS in England. The plans and measures in this document are based on issues that matter most to the public and we have incorporated the requirements into our vision and plans for implementation.

## **Local Context - Our Place in the Community**

DBTH works closely with the two local CCGs in Doncaster and Bassetlaw and with the local authorities serving Doncaster and Bassetlaw. DBTH has a role within the health and social care community to respond to the priorities of the local and regional commissioners and meet the local population needs. The populations we serve have slightly different health related needs and challenges and the actions set out to address these are outlined in the respective CCG intentions and place plans.

### **Local Place Plans**

The local priorities in both areas have been incorporated into respective place plans. As an active partner in both Bassetlaw and Doncaster we have contributed to the development of local place based plans and have considered the priorities identified in these as part of the strategic vision development process. The health priorities and the actions to address them are identified in the local place plans are summarised below.

### **Doncaster**

Doncaster has a population of approximately 304,000, with a life expectancy 10.7 years lower for men and 7.1 years lower for women in the most deprived areas of Doncaster than in the least deprived areas. Life expectancy for both men and women is lower than the England average.

We have significant challenges to tackle in this area including:

- Health in Doncaster is improving, but not as fast as the rest of the country
- In general Doncaster has less healthy lifestyles than the rest of the country – this is true for children as well as adults

- Delayed transfers of care are impacted on by the fragmentation and complexity of health and social care services
- There is rising demand for health and social care services impacting negatively on emergency admissions
- There are workforce shortages across the local health and social care services, with some shortages in some specialities replicated regionally and nationally
- The cost of delivering health and care services is increasing

In Doncaster diseases such as cancer, cardiovascular disease, liver disease and respiratory diseases account for 80-90% of all preventable deaths. However local work to increase awareness of cancer symptoms, early identification and treatment over the past 2 years has resulted in some improvement.

There are increasing numbers of older people in the borough, many live alone and require help and support to maintain their independence.

### **Doncaster Place Plan**

**Key leaders from across health and social care in Doncaster have come together to articulate a shared vision and to develop a Plan for the whole of Doncaster. The Place Plan describes the joint focus over the next five years to 2021, building upon the existing body of work and plans already in place.**

Our joint vision is:

Care and support will be tailored to community strengths to help Doncaster residents maximise their independence, health and wellbeing. Doncaster residents will have access to excellent community and hospital based services when needed.

Care and support will be tailored to community strengths to help Doncaster residents maximise their independence, health and wellbeing. Doncaster residents will have access to excellent community and hospital based services when needed. The Plan has been developed across the three areas below:

**Cohort A – Prevention and Early Help:** This is focused on developing community assets and resilience; bringing together our response to the wider determinants of health and social care. It recognises the prevention step needed before all others, but also extends to early help and intervention to support children and families.

Cohort B – **Integrated Intermediate Health and Social Care:** Support independence in peoples own homes, test and push forward integration commissioning and provision, and avoid hospital admissions. The focus of this cohort is on managing the existing demand better. The offer will be focussed around the development of four types of response for intermediate care:

- Rapid response
- Short term response
- Medium term response
- Health and social care bed base for Doncaster

Cohort C – **Enablement and Recovery Services:** this is focused on shifting services out of hospital and into the community where appropriate, delivering care closer to home, through delivery of redesigned services.

Further information on the Doncaster Place Plan and CCG can be found here:

<http://www.doncasterccg.nhs.uk/wp-content/uploads/2016/10/Doncaster-Place-Plan.pdf>

### **Doncaster CCG Commissioning Plans**

In addition to the priorities identified in the place plan, the following health commissioning priorities have been identified by the CCG in Doncaster and each of these has a delivery plan.

Doncaster Place Priorities
Cancer
Community and End of Life
Intermediate Care
Medicines Management
Planned Care – Delivery Plan
Urgent Care
Children and Maternity
Dementia
Learning Disabilities
Mental Health
Primary Care

## **Bassetlaw**

Bassetlaw has a registered population of 114,389 (January 2016) and is projected to increase by just over 2% to 2021. Life expectancy at birth for both men (78.8 years) and women (82.2 years) living in Bassetlaw is lower than the England average (79.4 and 83.0 years respectively). Life expectancy is 5.7 years lower for men and 8.1 years lower for women in the most deprived areas of Bassetlaw than in the least deprived areas.

In the last 10 years, the all-cause mortality rate for men and women has fallen. Early deaths from heart disease, stroke and smoking have fallen and are now similar to the England rate.

Rates of road injuries and deaths and hospital stays for alcohol related harm are worse than the England average.

We have significant challenges to tackle in this area including:

- The number of people over 65 living with dementia is anticipated to increase by 20% between 2015 and 2021
- The number of patients with a long term limiting illness is projected to increase by 20.8% between 2015 and 2025
- Early deaths from cancer are significantly worse than the England average.
- Patients from deprived communities are more likely to be admitted as an emergency rather than a planned admission. In Bassetlaw emergency hospital admissions for CHD, MI, COPD, alcohol related harm and hip fracture in the over 65 are all significantly worse than the England average.

## **Bassetlaw Place Priorities 2017/2021**

Vision:

**To create a community of care and support**

The Bassetlaw Place has been working with its partners, including DBTH, on the concept of Accountable Care since 2015/16 following the successes of joint working through the Integrated Care Board to improve outcomes for local people and develop services to ensure the Bassetlaw place has a sustainable health and care system for the future. The transition from the Bassetlaw ICB to the Bassetlaw ACP took place in October 2016.

The Bassetlaw Place Plan represents the joint vision to improve outcomes for the local population through better prevention, high quality and sustainable services and a continued focus on efficiency value for money. The Bassetlaw Accountable Care Partnership (ACP) Board oversees the development and delivery of this plan.

## The Bassetlaw Accountable Care Partnership (ACP) Board

The ACP Board is an alliance partnership and does not require organisations to cede sovereignty of decision-making. The main purpose of the ACP Board will be to;

- Oversee the continued development and delivery of the Bassetlaw Place Plan.
- Develop, support and evaluate;
  - Provider innovation and new models of care,
  - Outcome led commissioning and provision
  - Integration of personal care and support that brings together professionals to work across traditional organisational and professional boundaries.
- Position the Bassetlaw health system to align with the SYB ACS to maintain sustainable services and anticipate and respond to national changes in policy.

It is anticipated that the delivery of these priorities will require and lead to five important benefits;

- New ways of caring for and supporting patients underpinned by holistic integrated care
- A more efficient health and social care system that seeks to maximise added value for the tax payer
- New ways of allocating financial resources with incentives aligned to improve care and patient outcomes
- New ways of transacting business i.e. contracts
- Health and social care professionals working across and outside their employing organisation

The following priorities are outlined in the Bassetlaw place plan with associated timeframes.

Bassetlaw Place Priorities
Care of the Frail and Elderly
Integration of General Practice
Long term Condition Management
End of Life Care
Intermediate Care
Urgent Care
Acute Planned Care
Cancer Care
Mental Health and Learning Disabilities
Maternity and Children Services

Further information on the Bassetlaw Place Plan and Bassetlaw CCG can be found here:

<http://www.bassetlawccg.nhs.uk/>



## Our Challenges and Opportunities

We have recently undertaken engagement events within the trust, including with our Board and Governors to identify our organisation's strengths, weaknesses, opportunities and threats.

In summary, the main areas identified in the analysis that impact on our plans are included below.

- We have recently achieved Teaching Hospital status providing many opportunities for further enhancing education, research and recruitment.
- Our CQC rating is good in caring and well-led and despite 74% of all areas being judged to be good, we were also judged as requires improvement in safe, effective and responsive therefore robust plans are in place to address these issues.
- We have made good progress relative to our peers in delivering care in line with national standards and have seen improvements in mortality statistics and other quality markers, despite considerable financial difficulties.
- We have award winning established professional teams and services with committed, efficient and resilient staff (e.g. Ward Staff, Leadership, dementia friendly hospital, Turnaround Team, R&D) and national recognition for ED and discharge with good trust membership and governor influence.
- We have had recent financial difficulties with a breach in our licence conditions but we have worked hard to address these with a 2016/17 year-end deficit significantly below our control total. We continue to have challenges with this given our significant underlying deficit, efficiency requirements and the challenges of increasing demand for our services.
- We have good local partnerships and are always looking for new and innovative ways to deliver care and achieve efficiencies at a local level and within the South Yorkshire & Bassetlaw area.
- South Yorkshire & Bassetlaw is one of the first wave Accountable Care Systems providing the opportunity to take on delegated powers, bringing the potential for new relationships between partners including health regulators and assurers to better achieve the ambitions set out.
- We provide a range of services and are uniquely placed in the north of the South Yorkshire & Bassetlaw area with good access routes to and from our hospital sites.
- Our multiple sites provide a number of benefits in terms of access and flexibility but can also create difficulties in providing staffing, especially given national and local shortages in appropriately qualified staff.
- Our estate is mixed and there are costs associated with older facilities and infrastructure, particularly at DRI and parking is also limited although a local Park & Ride is well used by staff and visitors.
- STP funding is likely to be available to support capital investment requirements associated with new models and changes to pathways.
- Changes to clinical pathways and increased demand put pressure on our diagnostic facilities that we are addressing but we are also constantly looking for ways to ensure these are used as efficiently as possible.



## South Yorkshire & Bassetlaw Accountable Care System (ACS)

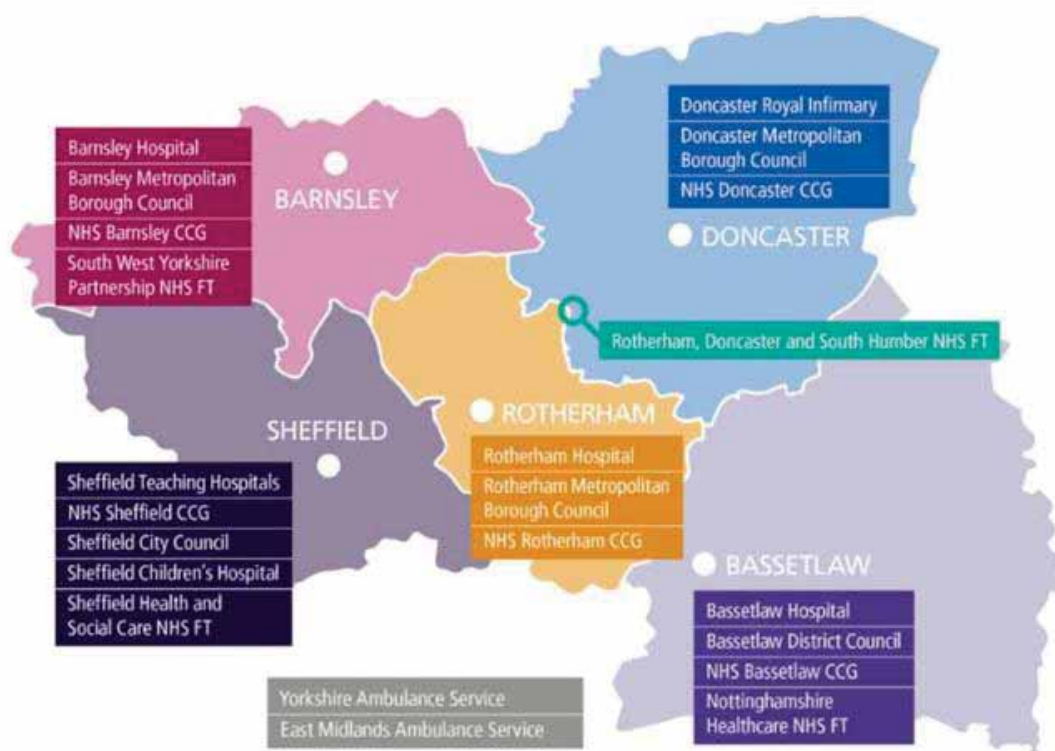
We are an integral partner of the South Yorkshire and Bassetlaw Sustainability and Transformation Plan (STP) which has now become a first wave Accountable Care System (ACS). As part of the ACS we work together with many health and social care partners across the South Yorkshire & Bassetlaw footprint as illustrated below. Being part of this wider system provides a number of benefits to DBTH and the population we serve.

Before the STPs, then the ACS, were established we already worked together as part of a “Working Together Programme” so we have good relationships, were already sharing services across sites and were providing services on behalf of other hospitals to ensure local provision, for example Chemotherapy.

As an active partner in the ACS, we continue to work together to share best practice in improving the services that are needed to provide health education and prevention and to enable improved access to high quality care in hospitals and specialist centres when this is required –so that no matter where people live they get the same standards, experience and outcomes for their care and treatment.

Working together we can also help the partners to achieve more efficiency when we buy services or goods together to provide better value for money.

The ACS footprint and main partner organisations are shown below.



As a partner in the ACS we have helped to shape the following ACS priorities and objectives that are displayed below. We have therefore also aligned our Strategic Vision and plan with these priorities and objectives.

Priorities	Objectives
<ul style="list-style-type: none"> <li>• Healthy lives, living well and prevention</li> <li>• Primary and community care</li> <li>• Mental health and learning disabilities</li> <li>• Urgent and emergency care</li> <li>• Elective and diagnostic services</li> <li>• Children's and maternity services</li> <li>• Cancer</li> <li>• Spreading best practice and collaborating on support services</li> </ul>	<ol style="list-style-type: none"> <li>1. We will reduce inequalities for all and help you live well and stay well for longer</li> <li>2. We will join up health and care services so they are responsive to your needs and accountable</li> <li>3. We will invest in and grow primary and community care, with general practice at the centre</li> <li>4. We will treat care for whole person, looking after their mental and physical health</li> <li>5. We will standardise acute hospital and specialised care – improving access for everyone, reducing inequalities and improving efficiencies</li> <li>6. We will simplify urgent and emergency care, making it easier for people to access the right services closer to home</li> <li>7. We will develop the right workforce, in the right place with the right skills – for now and in the future</li> <li>8. We will use the best technology to keep people well at home, to support them to manage their own care and to connect our people so they can provide joined up care</li> <li>9. We will create a financially sustainable health and care system</li> <li>10. And we will work with you to do this</li> </ol>

## Developing Our Plan

We wanted to make sure we worked with our staff, public and partners to develop our Strategic Direction and we have engaged with people using a variety of methods. We have had over 600 responses using the following ways of communicating.

- Social Media
- Postcards
- Posters and presentations
- Meetings with teams in the hospital
- Meetings and presentations with partners

Our Governors have played a vital role in shaping the strategy.

We changed a number of areas in the plan in line with feedback, including changes to our initial vision and objectives. People felt the values were still the right ones to have and we need to continue to work hard to ensure that they underpin everything that we do.

The following vision, values and objectives are in line with the views we have heard align to local and national priorities.

## Our Vision and Values

### Our Vision is:

**As an Acute Teaching Hospitals Trust, and a leading partner in health and social care across South Yorkshire and Bassetlaw, we will work with our patients, partners and the public to maintain and improve the delivery of high quality integrated care.**

Providing high quality care to the local population we serve will always be our main focus. We are proud of our record of continuing to maintain and improve standards of care, despite the financial difficulties of recent years.

Gaining teaching hospital status in 2016 was a huge achievement and creates a wonderful opportunity to develop our education and research portfolios to benefit patients and will help us to continue to attract and retain high calibre staff.

DBTH has been through a recent period of financial turnaround and are now moving into a period of transformation where we will look to see how we can deliver quality patient care in the most effective and efficient ways possible.

To achieve this transformation we recognise the need to be the best partner we can to work with other health and social care partners across Doncaster and Bassetlaw and South Yorkshire so our patients experience seamless and integrated care and we make best use of resources across the area.

### Our Values

To realise our vision we will remain true to our core values. Our values underpin all that we do and we expect that they will be evident in all that we say and do.



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

Our values are well received and this has been confirmed by an engagement process to confirm that our staff and patients feel that they remain central to our future.

What we will endeavour to do throughout the next strategic direction is to embed these values and ensure they are part of all that we do from how we behave to how we chose the people who join our teams and undertake appraisals.

## Values in Practice

The many little things in every day

Listening to patients and supporting their individual needs

Caring /compassionate and putting the patient first - I see shining examples daily - I am really proud of the team

Good feedback from family and patients

## Our Strategic Objectives

Our strategic objectives provide us with a means to achieve the vision identified above. The objectives help us to address the national and local challenges we face and to allow us to maximise the opportunities to develop the right services in the right way and in the right place. They are based on the local place plans and the South Yorkshire & Bassetlaw ACS Plans.

1. We will work with patients to continue to develop accessible, high quality and responsive services
2. As a Teaching Hospital we remain committed to continuously developing the skills, innovation and leadership of our staff to provide high quality, efficient and effective care
3. We will develop and enhance elective care facilities at BDGH and MMH and ensure the appropriate capacity for increasing specialist and emergency care at DRI
4. We will increase clinically led partnership working to benefit people and communities
5. Support the development of enhanced community based services, prevention and self-care.

### *1. We will work with patients to continue to develop accessible, high quality and responsive services*

Maintaining quality of care is fundamental to our future plans and is at the heart of all we do. Our CQC rating is good in caring and well-led. Despite 74% of all areas being judged to be good, we were also judged as requires improvement in safe, effective and responsive therefore robust plans are in place to address these issues and continue to improve.

We have made good progress relative to our peers in delivering care in line with national standards and have seen improvements in mortality statistics and other quality markers, despite considerable financial difficulties. We strive to maintain and improve this position in the future and are investing in improving access for all our staff to Quality Improvement & Innovation (Qii) tools to empower a culture of continuous improvement and innovation.

### *2. As a Teaching Hospital we remain committed to continuously developing the skills, innovation and leadership of our staff to provide high quality, efficient and effective care*

We have a vibrant and resilient workforce that has remained dedicated to maintaining high standards of care through a very difficult financial period and beyond. Our workforce has been engaged to shape the strategic vision and re-visit our values.

We recognise that to deliver our vision we need to invest in the people in the organisation at all levels to make sure we have the leadership and skills necessary for delivering care now, and into the future. Building on our recent Teaching Hospital status; we will continue to develop our education, research and leadership offer.

Making our organisation a good place to work improves recruitment and retention of existing staff. We offer flexible working within the context of service demands and are supporting the development of new roles to meet service needs and to address workforce challenges.

*3. We will develop and enhance elective care facilities at BDGH and MMH and ensure the appropriate capacity for increasing specialist and emergency care at DRI*

To be able to deliver high quality, efficient and effective care we need to make best use of the facilities on each of our sites.

We aim to improve pathways for patients who require planned care and we want to make sure that all of our expensive theatre, clinic and diagnostic resources are utilised to optimal levels.

We also need to respond to changes resulting from implementing national best practice that are likely to result in increased pressure on emergency capacity at the DRI site and make sure that front door emergency services on both BDGH and DRI sites are functioning as efficiently and effectively as possible to deliver the right care in the right place.

*4. Increase partnership working to benefit people and communities*

To achieve all of our objectives we need to be the best partner we can be to other health and social care providers, our local communities and most importantly our patients and service users. We will continue to work in a “place based way”, working in partnership to develop and implement appropriate models to provide care with the best outcomes in the right environment for patients and families.

We will effectively promote our organisational values and achievements, working with our stakeholders and staff to engage with the public we serve.

*5. Support the development of enhanced community based services, prevention and self-care.*

We provide a number of screening and community based services and intend to continue to do so.

In our services we will support and encourage self-care and reablement, as appropriate. We will also continue ongoing work to make sure that we maximise health promotion and wellbeing opportunities for our workforce, patients and visitors.

Further detail is provided on the diagram overleaf.



# Our strategic Objectives

## Patients

We have a vibrant and resilient workforce that has remained dedicated to maintaining high standards of care through a very difficult financial period and beyond. Our workforce has been engaged to shape the strategic vision and re-visit our values.

We recognise that to deliver our vision we need to invest in the people in the organisation at all levels to make sure we have the leadership and skills necessary for delivering care now, and into the future. Building on our recent Teaching Hospital status; we will continue to develop our education, research and leadership offer.

Making our organisation a good place to work improves recruitment and retention of existing staff. We offer flexible working within the context of service demands and are supporting the development of new roles to meet service needs and to address workforce challenges.

## People

We have a vibrant and resilient workforce that has remained dedicated to maintaining high standards of care through a very difficult financial period and beyond. Our workforce has been engaged to shape the strategic vision and re-visit our values.

We recognise that to deliver our vision we need to invest in the people in the organisation at all levels to make sure we have the leadership and skills necessary for delivering care now, and into the future. Building on our recent Teaching Hospital status; we will continue to develop our education, research and leadership offer.

Making our organisation a good place to work improves recruitment and retention of existing staff. We offer flexible working within the context of service demands and are supporting the development of new roles to meet service needs and to address workforce challenges.

## Partners

To achieve all of our objectives we need to be the best partner we can be to other health and social care providers, our local communities and most importantly our patients and service users.

We will continue to work in a "place based way" to provide the right services in the right place. We will effectively promote our organisational values and achievements, working with our stakeholders and staff to engage with the public we serve.

## Performance

To be able to deliver high quality, efficient and effective care we need to make best use of the facilities on each of our sites.

We aim to improve pathways for patients who require planned care and we want to make sure that all of our expensive theatre, clinic and diagnostic resources are utilised to optimal levels.

We also need to respond to changes resulting from implementing national best practice that are likely to result in increased pressure on emergency capacity at the DRI site and make sure that front door emergency services on both BDGH and DRI sites are functioning as efficiently and effectively as possible to deliver the right care in the right place.

## Prevention

We provide a number of screening and community based services and intend to continue to do so. We will work in partnership to develop and implement appropriate models to provide care with the best outcomes in the right environment for patients and families.

In our services we will support and encourage self-care and reablement, as appropriate.

We will also continue ongoing work to make sure that we maximise health promotion and wellbeing opportunities for our workforce, patients and visitors.



# Our strategic Objectives



## Patients

We will work with patients to continue to develop accessible, high quality and responsive services.

## People

As a Teaching Hospital we are committed to continuously developing the skills, innovation and leadership of our staff to provide high quality, efficient and effective care.

## Performance

We will develop and enhance elective care facilities at Bassetlaw Hospital and Montagu Hospital and ensure the appropriate capacity for increasing specialist and emergency care at Doncaster Royal Infirmary.

## Partners

We will increase partnership working to benefit people and communities.

## Prevention

We will support the development of enhanced community based services, prevention and self-care.

## **The Objectives in Action - Our Strategic Plan**

We have developed our three year strategic plan 2017- 2020 to identify the objectives for the way in which services will be developed and provided in a sustainable way.

The strategic objectives will be delivered across all of our services and the main plans will impact on services as described below. The categories are in line with the priorities identified in the South Yorkshire & Bassetlaw ACS.

### **Urgent and Emergency Care**

In line with our own and ACS objectives, we will continue to work with health and social care partners to make it easier for people to access the right services in the right place.

The Trust will continue to develop the Emergency Department (ED) at DRI which is the second largest in South Yorkshire. In addition to the further development of front door streaming and co-located urgent care facilities, the Trust plans to transfer minor injuries to a separate area to create additional space in the main department to expand the ED. Dependent on national funding, the expanded area will include a 9 bedded resuscitation room and a further 10 cubicles in the majors area to address the demand of the service as pathways to DRI increase with the proposed changes to the South Yorkshire and Bassetlaw stroke pathways and the potential impact from ACS developments. Part of this development will be the colocation of a CT scanner to improve patient pathways within emergency care.

At Bassetlaw Hospital we are committed to a 24/7 ED and will continue to work with the CCG to review streaming pathways and develop greater access to other urgent care services from ED. Funding has been agreed for improvements to the front door and streaming environment. In addition we will plan to develop our acute medical service increasing the provision of acute physicians and developing a dedicated facility which combines acute assessment, short stay beds and ambulatory care.

We constantly aim to provide care for the whole person and we continue to work in partnership with Rotherham, Doncaster and South Humber (RDASH) and Nottinghamshire Healthcare NHS Foundation Trusts to further enhance the mental health urgent care offer at both DRI and BDGH. We will also continue to develop services to respond specifically to the needs of frail older people, including access to specialist assessment skills and appropriate assessment areas.

We will continue to provide the well-used minor injuries service at MMH and look to enhance the nurse led model in this area.

### **Elective Care**

DBTH will continue to deliver a comprehensive portfolio of planned care which is complementary to the delivery of our core acute services. As part of our efficiency programme we will improve the utilisation and productivity of our out-patients and theatres.

We will transfer day cases to outpatient procedures and inpatient work to day-case in line with best practice to be top performing in all areas. As part of the care group review we plan to move appropriate services to Bassetlaw and Mexborough Montagu sites to ensure high quality estate

and theatre capacity is used effectively at the same time as developing urgent surgical and trauma capacity at DRI.

## Women's & Children's

As a Trust we are committed to providing both maternity and children's services on both DRI and BDGH sites. These services will be in line with "Better Births" and "Facing the Future" to ensure a sustainable service in line with proposed models in the South Yorkshire & ACs.

## Cancer

The delivery of effective cancer care remains a core service for the hospital. We will continue to work as part of a cancer network seeking to deliver as much care locally as possible.

## Intermediate Care and Rehabilitation

Across both place plans we are reviewing the requirements for intermediate care to ensure that alternatives to admission and appropriate non acute bed based pathways are effective.

**How does this affect all of our sites?**

Doncaster & Bassetlaw Teaching Hospitals NHS Trust				
Site	Doncaster Royal Infirmary	Bassetlaw District General Hospital	Mexborough Montagu	Other Community Sites
Services				
Urgent & Emergency Care	✓	✓	✓	
Elective Care	✓	✓	✓	✓
Maternity & Children's Services	✓	✓		Maternity & Children's community services
Cancer Services (including 2 week wait clinics)	✓	✓	✓	
Intermediate Care & Rehabilitation		✓	✓	

## Enabling Strategies

To implement our objectives we also need a number of “enabling” strategies and these are as follows:

### Clinical Service Strategy

In September 2016 we embarked on a detailed review of our clinical services at speciality level, led by the care group directors and supported by the senior clinical and managerial staff. This enabled detailed plans for each of the services to be developed in line with national best practice and local need. This helped us to form our vision and objectives.

The plans for each of our six Care Groups provide the basis of a framework for the Site Development Strategy, where each clinical service has been reviewed – taking account of feedback from a number of sources, engagement with clinical commissioners, other partners and the wider community. We are also working alongside clinical colleagues as a key partner in the ACS, to make best use of clinical collaboration and we already provide a number of services on behalf of partner organisations on our sites.

We are reviewing a range of options to address issues and opportunities in each service element within the care groups, such as development and expansion, partnership models of working or providing care in a different way. A key element of this has been to ensure our 3 main sites are utilised effectively and efficiently by the services.

### IT & Information

The creation of a full Electronic Patient Record across the Trust remains a strategic objective for 2020 in line with the Five Year Forward View requirement as published by NHS Digital. The Trust’s previous “best of breed” strategy for the purchase of replacement time-expired systems means that patient data now resides in multiple systems. An appropriate approach will be identified and designed to bring the data sources together, along with the digitisation of relevant historic paper based patient information, to create a single patient overview that can be used by clinical staff and the wider health community. While not a full and complete Electronic Patient Record (EPR), it will have the same outcomes and benefits.

This IM&T strategy has been developed to articulate a vision for both Information and Technology that supports the development of health services as identified in the overarching Trust strategy. The IT programmes, projects and activities described within it will fully support the achievement of the Trust strategic goals. Specifically the strategy addresses the following areas:

- Movement towards a digitally enabled healthcare environment within the Trust, within the Doncaster and Bassetlaw healthcare communities and within the ACS.
- Improving the patient experience
- Supporting Agile Working and care in the community
- Eliminating or considerably reducing the use of paper
- Reducing administrative overheads

## Estates & Facilities

The 5 year Estates & Facilities Strategy ensures that the Trust provides safe, secure, high quality healthcare accommodation to support current and future needs. The strategy identifies where we are now, where we want to be, and how we will get there. Identifying the current state is achieved by evaluating the condition of the existing estates through 6/7 facet condition and performance surveys, and identifying backlog costs linked to estates risks.

Our future state aligns with the clinical site development plans and reflects local and national drivers for change. Key estates aims will be derived from this work, which will form the basis of estates development plans detailing how we will get to our future state position taking account of key financial assumptions and risks to achievement. We intend to explore innovative partnerships with both the public and private sector to attract investment as appropriate. The Estates and Facilities strategy provides the physical framework with which the Trust will ensure sustainability into the future.

## Patient Experience & Person Centred Care

With the required components of 'quality' widely accepted as being the combination of safe, effective care and a positive experience for patients, the Patient Experience & Person Centred Care strategy sets out the Trust's intention to ensure the best possible experience of care for all patients.

The strategy describes how staff will understand their responsibility in ensuring each patient not only receives excellent clinical care, but that it is delivered in a manner that treats them as an individual, recognises their needs and cares for them with empathy and compassion.

The strategy outlines how this will be achieved, how progress will be monitored and within the implementation plan describes a structured approach to involving and engaging patients and working with stakeholders in the development and improvement of service delivery.

## Clinical Quality & Governance

The Trust has significantly improved patient safety and care quality for patients over the last three years. This is evidenced by sustained improvement across a range of patient outcomes and care quality metrics. We aim to:

- Sustain and consolidate the trajectory of improvement in care quality
- Deliver evidence based care
- Improve patient experience
- Embed a culture of transparency and openness

In order to deliver the above objectives, staff will be trained, empowered and supported to enable them to innovate and improve the care they are delivering. This will be underpinned by accurate care quality data available to all.



## Research & Development

The Trust's Research & Development Strategy 2013-18 identifies key strategic aims and objectives. As the strategy is in line with the revised Trust vision and strategic objectives and progress with associated delivery plan is extremely positive, the strategy will be reviewed towards the end of 2017/18, as planned.

The Research & Development strategy supports care quality improvement, innovation and service transformation. It will embed high quality research in all aspects of clinical care delivery so as to contribute to the evidence base that leads to improved patient outcomes. This will also enhance our ability to teach, train and develop staff. Key objectives will be:

- Consolidation and further development of the Trust as a research centre of excellence
- Increasing capacity and capability to undertake research
- Maximising research income

Achieving the above objectives will enhance our ability to recruit high quality clinical staff and enable the Trust to thrive as a Teaching Hospital.

## Quality Improvement & Innovation (Qii)

Providing the best possible care and outcomes for patients means continuous improvement and at DBTH we always want to do things better tomorrow than today. Building on the existing good practice within the organisation, our recently appointed Head of Quality Improvement & Innovation has worked with our staff and stakeholders to co-produce a strategy to increase capacity and capability in Qii to support delivery of our strategic vision.

The Quality Improvement & Innovation strategy outlines the processes for developing and embedding a Qii culture and is underpinned by an action plan for implementation across the organisation.

## People & Workforce Development

The current People and Organisational Development strategy has been refreshed to align with the Trust's revised strategic direction. The strategy takes account of national initiatives and strategies such as Developing People – Improving Care. Key areas of focus include workforce productivity, planning and development to ensure we have the right workforce to deliver our refreshed strategy. To this end, we continue to explore opportunities to innovate our recruitment strategy in addition to maximising local recruitment into nurse training programmes.

We recognise the importance of staff having a positive experience and feeling supported by their managers so we will refresh our leadership strategy and talent management plan to identify staff at all levels who have the potential to develop. Our refreshed strategy will also include more effective use of our workforce systems to free up managers' capacity.

## Finance & Commercial

Our financial strategy outlines the underlying planning assumptions used in the plan including inflation, national efficiency rates, income growth etc. Based on a recurrent run rate position it identifies any expected gap between income and expenditure over the planning period. This is

then adjusted for strategic changes outlined in the overall Trust plan. Finally efficiency and effectiveness plans are identified to close any further gap with hypothecated schemes suggested for later years of the plan.

The financial modelling then identifies cash flows and balance sheets to support the Trust. Where cash borrowing is required either to support revenue or to fund capital schemes included in the delivery of the Trust's strategic aims possible sources of funds will be identified.

### **Delivery and Monitoring of the Plan**

The strategies above will ensure that our organisation has the capacity and capability to be able to deliver our strategic objectives. Progress will be measured against a three year plan with headline milestones and clear measures to indicate what success looks like.

The plan will be further developed as ACS processes are

The plan implementation will be closely monitored by our Strategy & Improvement team to ensure that progress goes according to plan and any areas of concern are escalated to the Board.

The key milestones are included as a table in Appendix 1.

## Appendix 1 – Headline Plan

Strategic Workstream	Project	Summary of 3 Year Plans	Key Milestones
Urgent & Emergency Care	ED Development	<ul style="list-style-type: none"> <li>Streaming Developments with partners</li> <li>ED footprint expansion in line with ACS*</li> <li>Development of MIU</li> </ul>	<ul style="list-style-type: none"> <li>Implement actions following Bassetlaw FDASS Pilot in March 2017 – April 2017</li> <li>National requirement full FDASS by October 2017</li> <li>Development of ED footprint in line with ACS timescales yet to be determined</li> </ul>
	Hyper Acute Stroke	<ul style="list-style-type: none"> <li>Expansion of the service in line with ACS</li> </ul>	<ul style="list-style-type: none"> <li>Public Consultation ended February 2017</li> <li>Outcome of consultation awaited June 2017</li> <li>ACS Capital funding application made May 2017.</li> <li>Full implementation of HASU developments expected Spring 2018</li> </ul>
	CT Development	<ul style="list-style-type: none"> <li>Development of business case for increased activity* and co-location with ED</li> </ul>	<ul style="list-style-type: none"> <li>CIG approved operational and clinical aspects of the business case</li> <li>P21+ capital process final approval to be completed following confirmation of funding.</li> <li>ACS Capital funding application made May 2017.</li> <li>Summer 2018 estimated build completion if capital funding secured May 2017.</li> </ul>
Cancer Services	Chemotherapy Development	<ul style="list-style-type: none"> <li>Continue to develop services as key satellite unit</li> </ul>	<ul style="list-style-type: none"> <li>Continuous developments in partnership with STH</li> </ul>
Women's & Children's	Implementing Better Births	<ul style="list-style-type: none"> <li>Review and implementation of any actions</li> </ul>	<ul style="list-style-type: none"> <li>Timescales to be defined by ACS requirements.</li> <li>Estates plans be developed in 2017 in terms of Neonatal and Labour unit developments</li> </ul>
	Acutely Unwell Child	<ul style="list-style-type: none"> <li>Development in line with ACS</li> </ul>	<ul style="list-style-type: none"> <li>Timescales to be defined by ACS requirements</li> </ul>



Elective Care	Elective Development – Site review	<ul style="list-style-type: none"> <li>Determine appropriate site(s) for each service</li> </ul>	<ul style="list-style-type: none"> <li>Commenced January 2017, ongoing developments throughout 2017</li> </ul>
	Future provision of outsourcing of operations/  Private Provision review in line with lease expiry	<ul style="list-style-type: none"> <li>Develop plan for outsourcing</li> <li>Develop plan for future private delivery of care</li> </ul>	<ul style="list-style-type: none"> <li>Underway</li> <li>Contract negotiations and options appraisals in development to confirm timeline</li> </ul>
Intermediate Care	Doncaster	<ul style="list-style-type: none"> <li>Continue to be an active partner in review</li> <li>Work in partnership to review new models of care</li> </ul>	<ul style="list-style-type: none"> <li>Rapid response pilot January 2017- May 2017</li> <li>Timescales in line with</li> <li>Project Board meeting monthly work ongoing</li> </ul>
	Bassetlaw	<ul style="list-style-type: none"> <li>Development of Independence &amp; re-ablement unit</li> </ul>	<ul style="list-style-type: none"> <li>Confirm specification with Commissioners</li> <li>Mobilisation from Autumn 2017 – April 2018, subject to commissioning timelines</li> </ul>

DRAFT



**Doncaster and Bassetlaw  
Teaching Hospitals**  
NHS Foundation Trust

Title	Winter Planning		
Report to	Board of Directors	Date	25.07.2017
Author	David Purdue		
Purpose		Tick one as appropriate	
	Decision		
	<i>Assurance</i>		
	<i>Information</i>	X	

<b>Executive summary containing key messages and issues</b>
NHSi/NHSE have set out the criteria that health and social care systems need to have in place to support improvement in outcomes over the winter period. A&E Delivery Boards need to submit their plans in September 2017. This paper identifies the key elements of the plan which acute providers are responsible for and the steps the Trust has taken to ensure preparedness for winter.
<b>Key questions posed by the report</b>
Are the Board assured that the winter plan meets the requirements for the Trust to meet its targets and outcomes for patients.
<b>How this report contributes to the delivery of the strategic objectives</b>
The report identifies the actions being undertaken to support the Trusts objectives
<b>How this report impacts on current risks or highlights new risks</b>
The actions identified mitigate the risk of the impact of winter on patient quality and performance
<b>Recommendation(s) and next steps</b>
For the Board to be assured that the actions identified will improve patient outcomes.

Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust	
<b>Winter Planning 2017/18</b>	
<p>The Trust is expected to actively contribute to a system-wide Winter Plan to be published in September 2017. The elements of this plan have been set nationally by NHSi/NHSE to support the NHS through winter, with the aim of improving patient experience and the 4hr access target. The wider plan incorporates the use of 111 and ambulance systems and the extension of primary care hours.</p> <p>The Acute Trust requirements of the National Plan are identified in the following report.</p>	
<b>Demand and Capacity Planning</b>	<p>The Trust-wide bed plan has been reviewed and updated</p> <ul style="list-style-type: none"> <li>• Taking into consideration, reductions in length of stay over the past year specifically in acute medicine.</li> <li>• The need for focused work on length of stay in rehabilitation and trauma pathways.</li> <li>• Patient flows for elective care has been mapped to maximise the use of elective beds available on the Bassetlaw site and to free capacity on DRI.</li> <li>• Escalation beds to be utilised for surges in activity</li> <li>• Daily predictor tool to be used to ensure correct bed capacity</li> </ul>
	<p>Each elective speciality has reviewed the demand for elective work over winter to hit contracted levels.</p> <p>Elective capacity will be ring fenced to maintain patient pathways</p> <p>Elective work will stop for the first 10 days of January, with the exception of clinically urgent, cancer and day-case activity.</p>
	<p>To support staffing of additional beds</p> <p>A review of education and training over winter has been undertaken and a plan has been developed by the education team to enable staff to be released to work clinically</p> <p>Nurse specialist/ Out-patient nurses availability reviewed to allow additional support to wards.</p>
	<p>Non-medicine junior Drs are to review outliers on their base wards when reduced elective work, to ensure early discharge.</p>
	<p>Outlier plan for specialities agreed with medicine to support specific wards.</p>
<b>ED Streaming</b>	<p>Primary Care Streaming</p> <p>Service needs to be in place by October 2017 in both type 1 departments</p> <ul style="list-style-type: none"> <li>• DRI FDASS model reviewed with CCG, plans to increase percentage streamed to UCC. Staffing model to be agreed with CCG.</li> <li>• Plan to develop minor injuries area at DRI to stream patients away from ED.</li> <li>• Additional ambulatory pathways being proposed with on-site support from community services</li> <li>• BDGH model, national monies being used to develop a primary care hub on site.</li> <li>• Initial model will stream to primary care advanced practitioner and incorporate on site Out of Hours Service.</li> </ul>
<b>Workforce Plans</b>	<p>Acute medical support will be provided into ED daily to review medical</p>

	patients with the plan to increase admission avoidance pathways
	Surgical speciality specific plans developed to enable medical/ACP staffing to support workforce in ED each afternoon
	An Orthopaedic Registrar to be located in ED at Doncaster 10am-10pm
	Local ED improvement pathway work is being undertaken, with support from the Strategy and improvement team, to optimise flow and efficiency within the department
	The existing RAPT service will be reviewed in order to best use the resource available to meet the needs of patients in ED and CDU
	Ongoing support and involvement in the expansion of the Intermediate Care Rapid Response programme to avoid ED attendance and admission
<b>Patient Flow</b>	The effective use of EDD and criteria for discharge will be embedded across all wards
	Daily MDT board rounds to be undertaken within all specialties
	Teams are to monitor and manage internal delays in care through the wider implementation of Red and green days. Daily review of internal delays through the operational meeting at 12pm with plans in place to address delays
	TAPPS pilot project is underway within Frailty Units, supported by SY Leadership Academy. TAPPS to be extended to orthopaedics and rehabilitation prior to September.
	A predictor tool developed and tested for implementation in September
	A 'PyjamaParalysis' (NHSI) initiative is underway and the principles are to be shared more widely to prevent deconditioning
	The use of the Trust dashboard will be incorporated into the 3 times daily operational management processes to inform decision making
	Current weekly LOS meetings will be optimised to escalate delays and facilitate discharge. Dedicated Strategic meetings w, with key senior stakeholders will be held on both Doncaster and Bassetlaw sites.
	A review of transport arrangements is being undertaken for September 2017
<b>Delayed Transfers of Care</b>	<p>DTOC monitoring - a period of shadow monitoring will commence in August to ensure all delays are identified</p> <p>Transfer to assess model in place in both communities</p> <p>Trusted assessors trained in both Trusts</p> <p>DBTH has reviewed the plans for the spend of additional Social Care monies and agreed the areas of spend at the A&amp;E delivery Board.</p> <p>Trust agreed trajectory to reduce DTOCs</p> <p>Intermediate Care facilities being reviewed to ensure beds are utilised appropriately.</p>
<b>Ambulance Handover</b>	Dedicated ambulance liaison managers now identified to work with the Trust to support the departments at times of surge.
<b>Perfect Week - System Wide</b>	<p>System Perfect' to be held 5-12 September 2017</p> <p>All Health and Social Care partner organisations from both Doncaster and Bassetlaw communities are engaged to deliver a system wide event in September. This work is being supported by ECIP with the priority being to learn from the week to make sustainable change through Winter.</p>

<b>Escalation</b>	<p>Internal escalation triggers for both type 1 departments have been reviewed.</p> <p>Key triggers to be identified onto the ED dashboard, to escalate to the ops lead for the day.</p> <p>Operational lead for the day to be available on site until 8pm daily</p> <p>The Urgent care Network assessing the need for a South Yorkshire wide escalation tool.</p>
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**Doncaster and Bassetlaw  
Teaching Hospitals**  
NHS Foundation Trust

<b>Title</b>	Diversity & Inclusion Action Plans		
<b>Report to</b>	Board of Directors	<b>Date</b>	July 2017
<b>Author</b>	Karen Barnard, Director of People & OD John Scott, HR Manager		
<b>Purpose</b>		Tick one as appropriate	
	Decision	<input checked="" type="checkbox"/>	
	Assurance	<input type="checkbox"/>	
	Information	<input type="checkbox"/>	

<b>Executive summary containing key messages and issues</b>
<p>The purpose of this paper is to provide the Board of Directors with an update on the Trust's renewed focus on Diversity and Inclusion. A group of keen individuals have formed a Diversity and Inclusion forum and have run a number of drop in sessions with the aim of engaging with as many staff as possible. The group is keen to balance our statutory duties with a broader inclusion focus. As such the committees with Diversity and Inclusion contained within the terms of reference are the Workforce &amp; Education Committee and the Quality &amp; Effectiveness Committee. Feedback from the Diversity and Inclusion Forum will be provided to those committees on a regular basis and action plans will also be monitored through the WEC.</p> <p>The attached paper provides a general update and then highlights three particular areas of diversity – race, gender and disability with action plans detailed for 2017/18 as we move this agenda forward.</p> <p>The Board is asked to provide feedback on and approve the action plans contained within this paper.</p>
<b>Key questions posed by the report</b>
Does the Board feel that the priorities identified are appropriate at this stage of our journey?
<b>How this report contributes to the delivery of the strategic objectives</b>

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

**How this report impacts on current risks or highlights new risks**

By developing an inclusive workforce we aim for the Trust to be employer of choice.

**Recommendation(s) and next steps**

The Board is asked to approve the action plans contained within this report. The refreshed People & OD strategy will include reference to these action plans and monitoring will take place through WEC and QEC.

The Board is asked to publicly confirm its commitment as detailed within the report.

# **Diversity and Inclusion: Implications for the DBTH workforce**

## **Introduction**

1 The link between having a diverse and engaged workforce and improved patient experience is widely acknowledged across the NHS, prompted by the key reports by West and Kline. Investing in the DBTH workforce is critical to our future development and success. However, for an organisation to address the full spectrum of equality, diversity and inclusion is a major challenge. This paper therefore seeks to set a workable agenda for DBTH.

2 Our approach is one of inclusion and, at this stage, we will seek to draw parallels and common themes to provide fairness for all rather than target certain groups. The paper does, however, contain three category-specific annexes on disability, ethnicity and gender (Annexes 1, 2 and 3). These illustrate the current position, key issues and recommendations with focus and priorities to support this overarching Diversity and Inclusion Strategy.

3 The paper also draws on the experience of the recently formed Diversity and Inclusion Forum (DIF). This came partly from the experience of Willy Pillay, Deputy Medical Director and Karen Barnard, Director of People & OD on the Nye Bevan Development Programme at the NHS Leadership Academy which has a particular focus around diversity and inclusion. Many examples of positive change in other Trusts have resulted from the involvement of strong diversity and inclusion networks.

4 The DIF has based its initial work on the material produced by NHS Employers in support of creating 'a personal, fair and diverse NHS (described in annex 4). It has conducted a number of 'drop-ins' across the sites and held its first meeting in March. The current focus is on raising awareness and testing the appetite for a Trust-wide forum or fora. A summary of the feedback from those drop in's is at annex 5.

## **Summary**

5 There may be little compelling evidence to suggest that DBTH is failing to be an inclusive employer. But based on the analysis in this paper, both to assure ourselves and to offer the best possible work experience for all our staff, we recommend a two year workplan, summarised as:

- 1 2017-18 with a focus on understanding who we are and where we are; increasing awareness and building engagement; and ensuring we have the infrastructure in place;
- 2 2018-19 to focus on increasing skill levels amongst supervisors and managers; and in raising the profile of DBTH as an employer of choice



## Background

### The current workforce

6 An extract from our Equality Delivery System (EDS2) return from 31 December 2017 is attached at [annex 6](#) . The headline data includes:

- **Age**  
33% of our staff are aged 51 and above, only 18% under 30 which may well present a challenge over the next ten years. Our Apprenticeship programme should help address this issue.
- **Disability**  
3% of our staff have declared themselves as disabled, against a national figure of 6% in employment.
- **Ethnicity**  
8% of our staff are from a Black and Minority Ethnic (BME) group, almost double the local population. They are, however, most heavily represented amongst the medical staff with some 57% of our medical and dental staff being BME.
- **Gender**  
The workforce is 83% female, broadly in line with the NHS nationally which reports 77%. Women are reasonably well represented across the pay bands though, in common with many other NHS organisations, there is imbalance at Board level (members will recall reference to this in the Chair's report in June).
- **Lesbian, Gay, Bisexual and Transgender (LGBT)**  
We report only a small number of LGBT staff, which we know is understated, again reflecting the national position
- **Religion**  
The data is significantly incomplete with 65% undisclosed or unspecified, with 27% Christian, 3% other and 2% atheist.

### Data Quality

7 As a public sector organisation, we are required to report and publish our position, plans and progress each year using the EDS2 framework. The 2017 data is shown on our internet page, [Equality and Diversity 2017](#). This information covers patients and staff but, as illustrated above, there are significant gaps in our workforce data. This is similarly reflected in our returns under the Workforce Race Equality Standard (WRES) which, since 2015, have assessed our performance in terms of ethnicity (also published on our webpage).

8 Data quality for new starters is often distorted as candidates choose to withhold information at the application stage fearing it may prejudice their selection. Even where disclosure may advantage candidates, as with the guaranteed interview

positive action for disabled applicants, there are clear indications that data is withheld. Of our new starters in 2016, only 1.36% declared themselves as disabled alongside nearly 40% opting not to disclose. This is an area where we should do more to publicise our offer and seek to reassure applicants.

9 As that recruitment data automatically becomes our base management information, we need to address this challenge if we want our data to be considered robust. Turning to the staff profile for EDS2, we see that nearly 3% of our staff have declared themselves disabled and the missing data reduced to 23%. Yet, when it comes to completing the 2016 Staff Survey, the number stating that they have a long-standing illness, health problem or disability – the criteria for disability – has risen to 17% of all responses. The survey is, of course, anonymous which may suggest that trust is a key influencing factor.

10 A similar story applies to sexual orientation where 70% chose not to disclose during the selection process. That figure reduced to only 5% in response to the anonymised Staff Survey.

11 This 'choreography of disclosure' is a difficult area to address and reconcile. But we need to better understand the makeup of our workforce if we are to target help, and assess progress. One element will require us to construct a compelling narrative on the rationale and importance of achieving robust data, on which to base discussion and decisions. A second step will be to ensure our partner providers, including NHS SBS and Picker, understand fully the need to gather all monitoring data, not just those fields which impact on pay. Finally, two members of the DIF are keen to organise an LGBT group. We should support and nurture this, not least because it might give more colleagues the confidence to disclose.

### Awareness and Training

12 One section of the [SET training booklet](#) - Equality & Diversity - describes the legal framework and the broader expectations of staff. It also references our key policy document, '[Fair Treatment for All](#)'. There is a case study exercise on the Trust Welcome Programme which references diversity, and a session is included on the new Management Skills programme called 'Inclusive Leadership/Equality and diversity in context'. All training programmes will reference the issues of equality, diversity and inclusion as relevant to the subject matter (e.g. issues of dignity and religion during care sessions for HCAs). Further bespoke training has been delivered to specific groups on request (e.g. a programme of awareness sessions for all catering staff, prompted by a couple of cases in 2014-15).

13 This should represent good coverage across DBTH but, during the drop-ins, the DIF noted the lack of understanding of basic terminology and appreciation of the issues. That suggests that we do not currently have a sufficiently compelling narrative and/or have yet to embed the key messages and understanding across the Trust. Several articles in Buzz have also invited engagement with the conversation

but very few have contacted the dedicated mailbox. The DIF has recognised that we should continue these awareness sessions in the anticipation that this important message continues to grow across the Trust.

### Staff Survey results

14 Although Staff Survey results can only offer a partial picture, there are a number of worrying results in the 2016 results. These include disparities in the percentage of disabled staff who have received an appraisal (78% compared to 83%), and in the range of responses to the question 'I believe the organisation provides equal opportunities for career progression /promotion' which scored 86% and 85% for not disabled and white, but only 75% for disabled and 70% for BME staff. Similar disparities occur around feeling unwell due to work related stress and attending work despite feeling unwell.

15 Also of concern are the incidences of experiencing physical violence and harassment from patients and family members which are significantly higher for disabled staff. But perhaps the most worrying are the relative rates of those reporting harassment, bullying and abuse from colleagues which shows alarming differentials for disability (32% disabled compared to 22% non-disabled) and for our BME staff (33% BME compared to 23% White).

16 Although work has begun across DBTH on Staff Survey Action Plans, the low incidence of responses mean that these local plans are unlikely to pick up these areas. It is therefore been recognised that the Diversity and Inclusion Forum meet specifically to consider these results and develop a discrete Action Plan.

### Board level commitment

17 The previous Chief Executive regularly found the opportunity to voice his support for diversity and inclusion. He used messages around strategic direction, re-organisation, appraisal, the Staff Survey and even Turnaround to highlight fairness, inclusion and dignity. Recent communication and consultation around the Trust's values 'we care', with its focus on 'everyone counts' and 'valuing our diverse staff', suggest that staff buy in to those values. As a new Board we have an opportunity to reiterate our support in a public statement of commitment. The launch of the refreshed Strategic Direction and People & OD strategy are suitable vehicles in which to do this.

18 In terms of general messaging, there is extensive material available from NHS Employers and others. Our approach might simply be to echo the key points of the Personal, Fair and Diverse (PFD) campaign. This is attached at annex 4, alongside the NHS endorsed definitions for Equality, Diversity and Inclusion

## People/HR processes

19 Experience indicates that, to embed diversity into the organisation, we must ensure that our key people processes are fair and free from bias. Typically, that would suggest we conduct a regular equality audit of our policies and processes which influence:

- Recruitment and selection
- Appraisal
- Access to Development , Training and Education Opportunities
- Pay
- Promotion and progression, and
- Termination and exit

20 Again, our management information may be patchy in some of these areas. So we would propose to review critically the policies, processes and data quality this year, with a view to fully testing the management information in year 2.

## **Conclusion**

21 As indicated within Deloitte's well led review it is important that we refresh our attention on diversity and inclusion. Providing an evidence-based rationale for action will help support the case and the supporting narrative. With support from members of the Diversity and Inclusion Forum, we can begin to redress the balance whilst building our data quality and offer to staff.

## **Next steps and key tasks for 2017-18**

22 The Board is invited to discuss and comment on this paper and agree the following immediate actions for People & OD to coordinate:

1. Data cleanse of ESR – promote benefits of full disclosure as part of Manager and Employee Self Service
2. Audit recruitment arrangements to ensure positive action measures are in place
3. Review recruitment/outreach content on the Trust Internet
4. Refresh SET booklet
5. Review and update current training offer
6. Commitment statement/actions from Board/Executive Team
7. Further engagement from Diversity & Inclusion Forum and, specifically, the LGBT group
8. Complete and publicise WRES 2017

9. Develop discrete Action Plan to address concerns from 2016 Staff Survey
10. Report progress to Board in March 2018 (alongside Staff Survey initial findings) and confirm plans for 2018-19

## **People and OD**

**July 2017**

### **Key documents**

Kline, Roger. 2014. [The “snowy white peaks” of the NHS: a survey of discrimination in governance and leadership and the potential impact on patient care in London and England.](#)

West, M. Dawson, J. Admasachew, L and Topakas, A. (2012) [”NHS Staff Management and Health Service Quality Results from the NHS Staff Survey and Related Data”](#) Lancaster University Management School and The Work Foundation  
Aston Business School

### **Annexes**

- |                |   |
|----------------|---|
| <b>Annex 1</b> | <b>Diversity and Inclusion at DBTH – Disability</b>                 |
| <b>Annex 2</b> | <b>Diversity and Inclusion at DBTH – Ethnicity</b>                  |
| <b>Annex 3</b> | <b>Diversity and Inclusion at DBTH – Gender Equality</b>            |
| <b>Annex 4</b> | <b>What is a personal, fair and diverse NHS?</b>                    |
| <b>Annex 5</b> | <b>Feedback from the Diversity &amp; Inclusion Drop In Sessions</b> |
| <b>Annex 6</b> | <b>Our workforce – the current EDS2 report</b>                      |

## **Annex 1**

### **Diversity and Inclusion at DBTH – a focus on disability**

#### **Introduction**

1 To quote NHS Employers, ‘Over the last decade we have seen the NHS becoming more disability and diversity confident as well as disabled people becoming more comfortable about expressing their needs at work. For the NHS to become the employers of choice for talented disabled people, organisations need to demonstrate a good track record in accommodating the needs of disabled employees in more sophisticated ways.’

#### **The current position**

2 Key facts, figures and information include:

- There are over 11 million people with a limiting long term illness, impairment or disability and currently 1.3 million disabled people in the UK who are available for and want to work.
- At DBTH, we have some 200 disabled staff (2.9% of all staff, or 3.9% of those staff who responded). This illustrates the significant issue of under-reporting, or under-recording which must be addressed to get an accurate picture.
- The prevalence of disability rises with age. Around 6% of children are disabled, compared to 16% of working age adults and 45% of adults over State Pension age. Given the DBTH age profile, this could represent a double challenge with over 35% of our staff over 50.
- Although disabled people are now more likely to be employed than they were in 2002, disabled people remain significantly less likely to be in employment than non-disabled people
- Disabled people are significantly more likely to experience unfair treatment at work than non-disabled people. In 2008, 19% of disabled people experienced unfair treatment at work compared to 13% of non-disabled people –(Fair Treatment at Work Survey 2008).

#### **Drivers**

3 Four key factors align to make the coming year a significant time for DBTH in terms of disability:

- A Workforce Disability Equality Scheme for the NHS is in development which (assuming it mirrors the existing Workforce Race Equality Scheme) will use management information and staff survey results to assess the proportion of

disabled staff and their relative experience terms of recruitment, disciplinary action and experience of discrimination.

- DBTH needs to consider whether to consolidate its current position as a Level 2 Disability Confident Employer or strive to be a Level 3 Leader.
- The introduction of the Apprentice Levy and work experience frameworks and the opportunity this creates for greater engagement with disabled people and, in particular, disabled students at local colleges. Specifically, we want to explore the possibilities of engaging with people with learning disabilities as we think that offers a particular and unique perspective on the delivery of our services.
- Some worrying results in the 2016 Staff Survey which reported that disabled staff were two and half times more likely to experience discrimination and, perhaps consequently, were 11% less inclined to believe DBTH provided equal opportunities for career progression/promotion. Other notable negative variances were around suffering illness from work-related stress (56% against 36%) and attending work whilst feeling unwell (76% against 53%)

## **Analysis and conclusion**

4 This is not simply a moral issue. Extensive research argues that engaging with as wide a constituency as possible offers access to the broadest span of talent. To quote Herman Ouseley, 'you cannot achieve quality without equality'. There are immediate actions we can take to address gaps in our activities. But we also need a greater understanding of the scope of the challenge and the specific barriers. So an urgent action is to improve our management information at a corporate and local level. The challenges faced by disabled staff tend to be personal and unique so it is probably sufficient to continue with broad training based on diversity and inclusion rather than specific modules or events. However, a central resource should be created to support individuals and managers. Material is readily available on the intranet and NHS Employers has comprehensive resources and toolkits which we could supplement with local material.

## **Key recommendations for 2017-18**

5 The recommendations focus on improving the quality of our data so that we can better target action; raising awareness across DBTH; and encouraging greater engagement with the local community of disabled people:

### **A. Recruitment**

Initially review current arrangements with NHS Jobs in identifying people who might qualify for guaranteed interviews or places on shortlisting lists; and in drafting of adverts

### **B. Data quality**

Immediate action is needed to improve data held on ESR. This might include



a data cleanse or updating questionnaire. We also need to reinforce the importance of full data collection at recruitment/appointment.

C. Outreach and External Engagement

There is an immediate opportunity to work with Doncaster College in identifying a pilot placement opportunity for someone with learning disabilities. We would then seek to build on this to identify further placements, also considering partnership with The Prince's Trust

D. Engagement within DBTH

Our knowledge of disability amongst DBTH staff is poor. It was seldom mentioned during the diversity and inclusion drop-ins and we have no obvious case studies. We will need to raise the profile of disability through articles in Buzz but this could be a long process to build trust.

E. Help and support

Given the very personal issues around supporting staff with disabilities, we should look at a suite of support materials for managers and staff on the new intranet.

F. People & OD Strategy

It might be argued that it is implicit in the 2013-17 document, there is no specific mention of diversity, equality or inclusion which was flagged by the Well Led review conducted by Deloitte. This will be addressed in the revised strategy and, building on the data activity mentioned at B above, we should consider a KPI within the revised strategy on levels of self-declaration.

G. Workforce Disability Equality Standard 2018

Taken together, these actions would help position us to prepare for the completion of the WDES next year. Other considerations might include a review of the current estate in terms of access and availability of support.



## DETAILED WORK PLAN - DISABILITY

Item	Description	Start date	End date	Owner	Commentary
A.	<b>Recruitment</b>	June 2017	Sept 2017	JS/AJ	Review processes
B.	<b>Data quality on ESR</b>	June 2017	Dec 2017	MB/MI Team	Data cleanse or survey, or use of ESS/MSS
C.	<b>Outreach and External Engagement</b>	July 2017	tbc	JS/SD/KT	Work with Doncaster College in identifying a pilot placement. Also with Prince's Trust?
D.	<b>Engagement within DBTH</b>	July 2017	ongoing	JS/ES	Comms strategy and plan required
E.	<b>Help and support</b>	July 2017	Dec 2017	JS	Research, develop and publicise availability of support
F.	<b>People &amp; OD Strategy</b>	June 2017	Sep 2017	KB/JS	Ensure coverage across revised strategy
G.	<b>Workforce Disability Equality Standard 2018</b>	Sept 2017	March 2018	JS	Prepare for the completion of the WDES next year.

## **Annex 2**

### **Diversity and Inclusion at DBTH – a focus on ethnicity**

#### **Introduction**

1 The Five Year Forward View sets out a direction of travel for the NHS which depends on ensuring the NHS is innovative, engages and respects staff, and draws on the immense talent in our workforce.

2 To quote the guidance issued in 2017, 'The evidence of the link between the treatment of staff and patient care is particularly well evidenced for BME (Black and Minority Ethnic) staff in the NHS, so this is an issue for patient care, not just for staff. Yet it is strikingly clear that the NHS still has an immense amount to do to genuinely act on this insight. The lessons of previous efforts to tackle this challenge show that a focussed national and local effort will be essential if we are to make the progress we need.'

3 This places a particular focus on ethnicity for all NHS organisations both in terms of addressing imbalance, but also as a template for challenging other discrepancies across the protected characteristics. Since 2015, we have reported our position through the Workforce Race Equality Standard (WRES) and, in the last two years, have developed an action plan to address these results. Last year, the focus was on ensuring completeness and accuracy of the data but, from 2017, we will begin to address how to ensure our BME staff receive equitable treatment across DBTH.

#### **The current position**

4 Key facts, figures and information include:

- According to the 2011 census results, the local populations for Doncaster and Bassetlaw districts contain 3.8% and 2.7% BME people respectively
- Of our 6651 staff, 569 describe themselves as being in one of the Black and Minority Ethnic (BME) categories. That equates to approximately 8.5%. 220 have not disclosed their ethnicity
- However, the BME numbers are heavily skewed to clinical roles, with only 40 staff in the non-clinical workforce of 1900 or 2.1%. Only a handful of these are at Band 5 and above.
- The percentage of BME staff in the clinical workforce is broadly representative at 4.75% but with a similar concern above Band 5
- The figure leaps to 57% amongst the senior medical and dental staff groups.

## **Analysis and conclusion**

5 These figures raise particular concerns around how far we are engaging with the local population. In the last couple of years we have begun to target the local area for bulk Service Assistant, Healthcare Assistant and Nursing recruitment but this does not appear to be reflected in the numbers joining the organisation.

6 It also suggests that, whilst there are potential role models and mentors amongst the medical staff, there are fewer amongst the nursing workforce and less in the non-clinical workforce.

## **Key recommendations for 2017-18**

7 The recommendations focus on improving the quality of our data so that we can better target action; raising awareness across DBTH; and encouraging greater engagement with the local community.

### **A. Recruitment and shortlisting**

Initially review current arrangements with particular focus on comparative success rates through the recruitment process. Consider introducing a reporting regime, where recruiting managers submit short report on the process to Director of POD. This has proved influential in other Trusts in making recruiting managers 'think twice' and reflecting on any unconscious bias.

### **B. Data quality**

In common with other areas, immediate action is needed to improve data held on ESR. This might include a data cleanse or updating questionnaire. We also need to reinforce the importance of full data collection at recruitment/appointment.

### **C. Outreach and External Engagement**

Our overall ethnicity data masks the failure to reflect the local community amongst our lower pay bands. That is typically the level at which hospitals draw local people into the workforce. We should look carefully at the planning for the next rounds of cohort recruitment (for Service Assistants and Healthcare Assistants) and ensure we are targeting local ethnic minority groups.

### **D. Workforce Race Equality Standard 2017**

This plan can serve as the basis for our response to this year's WRES report, as it is drawn from the same data.

### **E. Further analysis**

Conduct benchmarking through the Yorkshire & Humberside Equality & Diversity Regional Network to further investigate disparity in success rates. Also review relative success rates for senior nursing vacancies.

## DETAILED WORK PLAN - ETHNICITY

Item	Description	Start date	End date	Owner	Commentary
A.	<b>Recruitment and shortlisting</b>	July 2017	Sept 2017	JS/RS	Review processes. Develop reporting regime
B.	<b>Data quality on ESR</b>	July 2017	Dec 2017	MB/MI Team	Data cleanse or survey, or use of ESS/MSS
C.	<b>Outreach and External Engagement</b>	July 2017	tbc	JS/RS	Research local groups. Align to cohort exercises
D.	<b>WRES 2017</b>	July 2017	Aug 2017	JS/KB	Data collected; report to be published by 1 August
E.	<b>Further analysis</b>	July 2017	Dec 2017	JS/KB/ HoN	Benchmark with colleagues on Y&H Network. Research feeder grades/success rates for senior nursing posts.

## **Annex 3**

### **Diversity and Inclusion at DBTH – a focus on gender**

#### **Introduction**

1 The NHS has always employed a large number of female staff and DBTH is no different. However, as Professor Sealey's recent [report](#) makes clear, the comparative lack of progression through organisations for women has resulted in a lack of representation at the top. This builds on the earlier work by Penny Newman in the report NHS Women In Leadership: Plan for Action. This strand uses those recommendations as its basis and is therefore concerned with raising aspiration and supporting development and progression.

#### **The current position**

2 Key facts, figures and information include:

- The working population of the UK is 47% female and, across the NHS, is 77%.
- At DBTH, we have 83% female staff. A table showing the dispersal by band is shown below.
- In the six Care Groups, two of our Care Group Directors are female; four of the 14 Assistant CGDs; and all our Heads of Nursing are female, as are the Matrons; and five of the six Care Group General Managers are female.
- Of the 13 voting Board Members, 4 are female (31%). Including non-voting members, that percentage rises to 37.5% (6 of 16).

#### **Analysis and conclusion**

4 There is currently a focus on Board representation, following on from the 2015 NHS Employers report on [Women in Leadership](#). This report cited six benefits of gender equality in the pipeline and at board level or equivalent:

- improving organisational performance and decision-making
- increasing productivity
- accessing the widest talent pool
- meeting patients' needs
- being an exemplar employer
- meeting global and national legislative requirements.

5 The report advocated the use of the UN's model of a multi-pronged approach as a template for the NHS. Most of the recommendations have face validity for DBTH and so a relevant selection forms the basis for our workplan.

## **Key recommendations for 2017-18**

5 The recommendations focus on improving the quality of our data so that we can better target action; raising awareness across DBTH; and encouraging greater engagement with the local community of females:

A. Goals

The NHS suggests an aspiration of 50:50 set at all levels, in all occupational groups. But check pipelines to assess whether this is realistic (e.g. numbers of males embarking on nursing qualifications)

B. Monitoring

Setting and monitoring annual targets at each level in the staffing structure to propel progress, shine the spotlight on gaps and success at each level and allow tracking of career advancement. We will link this to the requirement to publish Gender Pay Gap Reporting;

C. Shortlisting and Gender-based panels

To ensure full consideration of women and impartiality in assessments, focussing equally on potential and not solely on past records.

D. Flexible working arrangements

Review current arrangements to ensure they meet the demands and realities of child and elderly care.

E. Attracting female Non-Executives

The Chair has already confirmed that she will lead an initiative to attract local female talent to consider non-executive roles. This might include familiarisation, targeted induction and shadowing.

**Table showing gender spread across paybands at DBTH**

	Female	Male	Grand Total	% rate of Female
<b>Clinical</b>	<b>3770</b>	<b>712</b>	<b>4482</b>	<b>84.11%</b>
Apprentice	10	2	12	83.33%
Band 1	2	1	3	66.67%
Band 2	980	55	1035	94.69%
Band 3	199	35	234	85.04%
Band 4	81	12	93	87.10%
Band 5	1171	96	1267	92.42%
Band 6	741	82	823	90.04%
Band 7	333	46	379	87.86%
Band 8a	64	23	87	73.56%
Band 8b	8	6	14	57.14%
Band 8c	10	3	13	76.92%
Band 8d		1	1	0.00%
Band 9	2	2	4	50.00%
Medical & Dental Consultant	63	183	246	25.61%
Medical & Dental Non-Consultant Career Grade	32	59	91	35.16%
Medical & Dental Trainee Grades	73	106	179	40.78%
VSM	1		1	100.00%
<b>Non Clinical</b>	<b>1791</b>	<b>429</b>	<b>2220</b>	<b>80.68%</b>
Apprentice	5	1	6	83.33%
Band 1	516	178	694	74.35%
Band 2	589	64	653	90.20%
Band 3	415	42	457	90.81%
Band 4	116	54	170	68.24%
Band 5	37	12	49	75.51%
Band 6	25	24	49	51.02%
Band 7	40	21	61	65.57%
Band 8a	25	19	44	56.82%
Band 8b	6	2	8	75.00%
Band 8c	11	7	18	61.11%
Band 8d	2	1	3	66.67%
VSM	4	4	8	50.00%
<b>Grand Total</b>	<b>5561</b>	<b>1141</b>	<b>6702</b>	<b>82.98%</b>

## DETAILED WORK PLAN - GENDER

Item	Description	Start date	End date	Owner	Commentary
A.	<b>Goals</b>	July 2017	Sept 2017	JS/KB/	Review pipelines to assess realistic figures (e.g. numbers of males embarking on nursing qualifications) Publish targets
B.	<b>Monitoring</b>	June 2017	Apr 2018	JS/MI Team	Setting and monitoring annual targets at each level in the staffing structure. Publish Gender Pay Gap report
C.	<b>Shortlisting and Gender-based panels</b>	July 2017	ongoing	JS/SS/ Comms	Publish intention. Develop guidance. Monitor. Consider panel chairs reporting to Director
D.	<b>Flexible working arrangements</b> <b>Review current arrangements to ensure they meet the demands and realities of child and elderly care.</b>	July 2017	Sep 2017	JS/WEC	Review current arrangements to ensure they meet the demands and realities of child and elderly care.
E.	<b>Non-Executives</b>	July 2017	Sep 2017	Chair/MC	Target locals PLCs to identify potential involvement of female executives as Non-Execs



## Annex 4 NHS Employers Definitions

### What is a personal, fair and diverse NHS?

A personal, fair and diverse NHS is one where:

- everyone counts
- services are personal, designed to give patients what they want and need
- fairness is built in so that everyone has equal opportunities and treatment
- the skills and experiences of employees from all backgrounds are used and valued
- people can choose the services they want and have as much support as they need
- everyone is treated with dignity and respect, and when they complain - we listen and put things right
- talent flourishes and nothing stops people going as far as they want
- we are accountable and patients are informed and have more control
- care doesn't stop at the door, but helps people live healthier lives.

(Source: NHS Employers - [Creating a personal, fair & diverse NHS](#))

### Diversity and Inclusion

**Equality** is about creating a fairer society where everyone has the opportunity to fulfil their potential.

**Diversity** is about recognising and valuing difference in its broadest sense.

**Inclusion** is about an individual's experience within the workplace and in wider society and the extent to which they feel valued and included.

(Source: NHS Employers [Diversity and Inclusion](#))

## **Annex 5: Feedback from drop in sessions**

### **WHAT MAKES ME FEEL I BELONG AT DBTH?**

#### **What's good about working here?**

- Friendly faces
- Friendly
- Staff is friendly
- Overall a friendly place with hard working colleagues.
- Good communication
- An accessible senior management team
- Able to walk to work
- Inclusive!
- Having lunch together
- Feeling of belonging to the organisation
- Supportive colleagues
- Supportive managers and colleagues
- Positive feedback from colleagues and managers
- Appreciated by teams
- Good that we have a prayer room
- Working on Mallard Team to bring a better knowledge of dementia
- Felt comfortable and treated well
- Very inclusive. Most people are very friendly and welcoming and empathic
- It's nice to have a work 'family'
- Working in a friendly, busy department
- M2 family

## WHAT CAN I DO TO MAKE DBTH MORE INCLUSIVE?

### And what could others do to make it better?

- Christmas is celebrated every year – worth considering celebrating Diwali and Eid as lots of workforce in the Trust
- More information in Buzz about different religious festivals, etc.
- Muslim prayer room needs to be bigger than the little closet used presently
- Need better signage about prayer room, I was unaware of this
- Be more understanding/flexible of working parents
- A Social Club and a health club
- Car parking for all
- Senior Managers seen more regularly in a clinical environment
- Incentivise people to work harder i.e. what do people value?
- Allow all staff to be coached in work time to drive up productivity and value to the organisation
- Recognise the additional workload on staff potentially caused by changes /savings made to other teams and services and the effect on ability to perform role that this has
- Needs to be more family friendly
- Need to have a diversity forum
- Need a cultural diversity forum
- Need more information for disabled workers
- We should focus on diversity and especially focus on working together
- Communications is key!

## Workforce Equality Data

Workforce data provided below according to the protected characteristics currently recorded by the Trust.

This data was extracted as at 31 December 2016 when the Trust employed a total of 6642 employees comprising of permanent and fixed term contract employees. Please note this is a four page document.

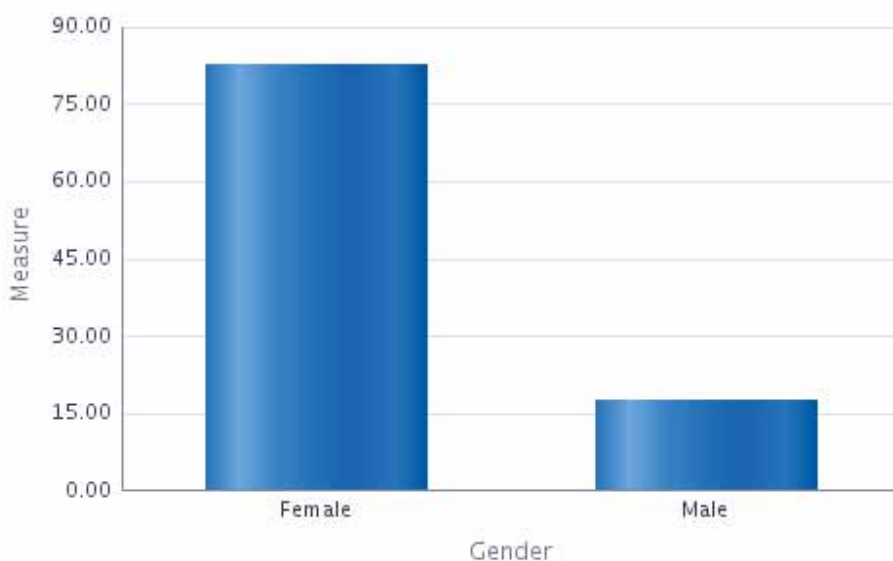
### Maternity

Protected Characteristic	Sub Group	Headcount	FTE	Headcount %
Pregnancy/Maternity	Maternity & Adoption	138	109.45	2.08%

### Gender

Protected Characteristic	Sub Group	Headcount	FTE	Headcount %
Gender	Female	5483	4413.74	82.6
	Male	1159	1032.41	17.4

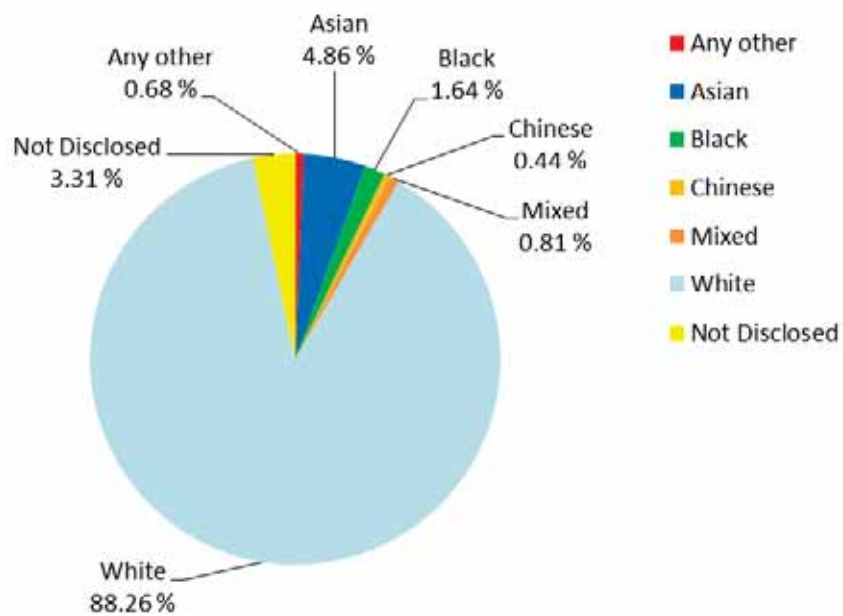
**Workforce Profile Data - Gender as at 31.12.2016**



### Ethnicity

Protected Characteristic	Sub Group	Headcount	FTE	Headcount %
Ethnicity	Any other	54	41.64	0.68%
	Asian	323	289.28	4.86%
	Black	109	94.06	1.64%
	Chinese	29	24.99	0.44%
	Mixed	54	45.34	0.81%
	White	5862	4776.73	88.26%
	Not Disclosed	220	174.11	3.31%

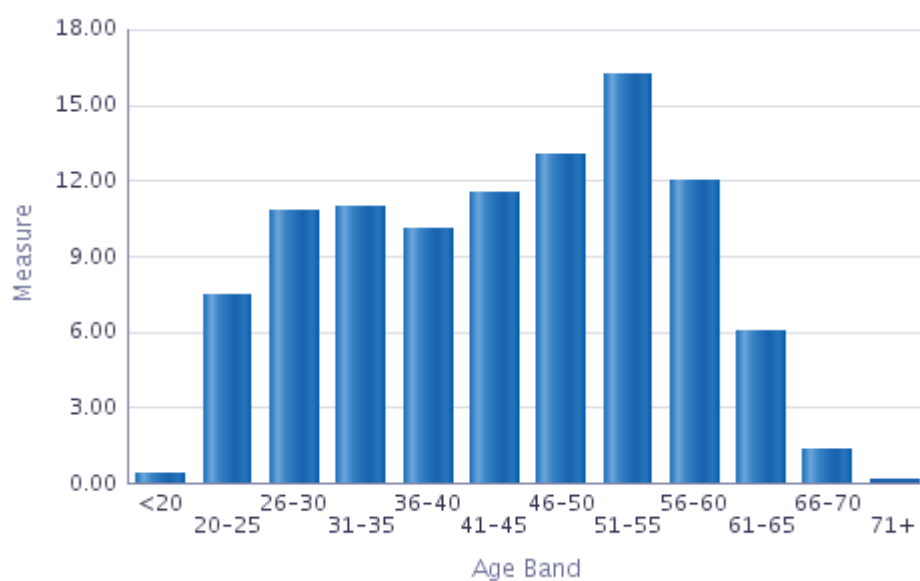
## Workforce Profile Data - Ethnicity as at 31.12.2016



## Age

Protected Characteristic	Sub Group	Headcount	FTE	Headcount %
Age	<20	27	22.30	0.41%
	20-25	495	455.16	7.45%
	26-30	717	611.88	10.79%
	31-35	727	591.03	10.95%
	36-40	670	547.41	10.09%
	41-45	766	638.28	11.53%
	46-50	863	730.93	12.99%
	51-55	1,077	891.99	16.21%
	56-60	797	608.21	12.00%
	61-65	400	287.56	6.02%
	66-70	91	54.73	1.37%
	71+	12	6.67	0.18%

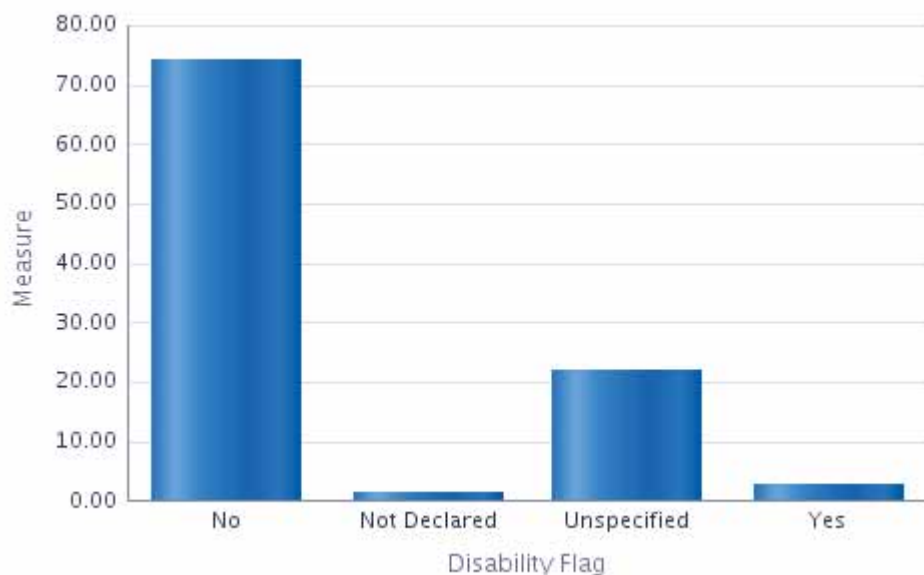
## Workforce Profile Data - Age as at 31.12.2016



## Disability

Protected Characteristic	Sub Group	Headcount	FTE	Headcount %
Disability	No	4,917	4056.38	74.0%
	Yes	191	153.11	2.9%
	Not Disclosed	87	69.80	1.3%
	Unspecified	1,447	1166.87	21.8%

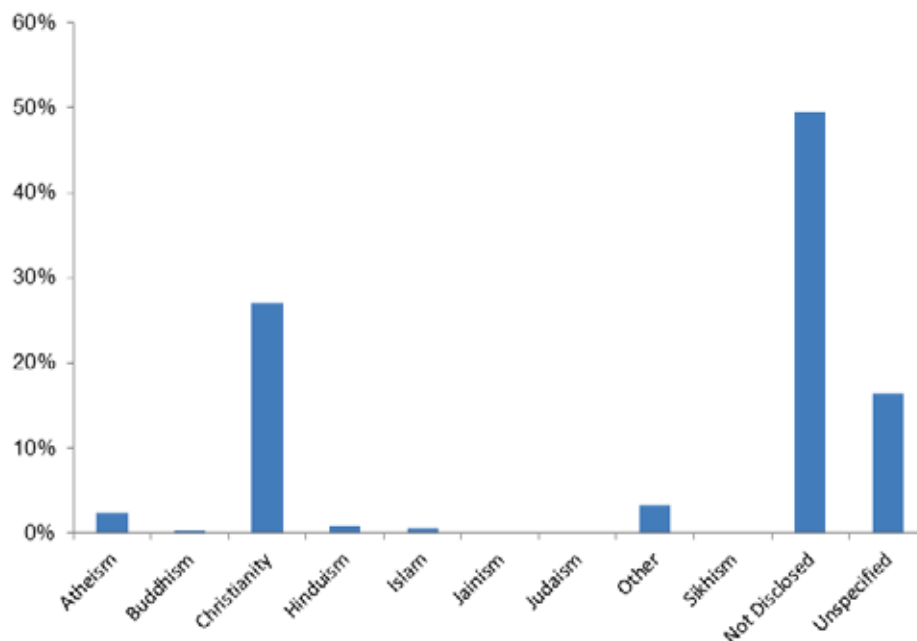
**Workforce Profile Data - Disability as at 31.12.2016**



## Religion / Belief

Protected Characteristic	Sub Group	Headcount	FTE	Headcount %
Religion / Belief	Atheism	156	131.68	2.35%
	Buddhism	12	11.25	0.18%
	Christianity	1788	1,462.65	26.92%
	Hinduism	50	49.06	0.75%
	Islam	34	32.46	0.51%
	Jainism	*	*	*
	Judaism	*	*	*
	Other	217	183.06	3.27%
	Sikhism	*	*	*
	Not Disclosed	3287	2,684.46	49.49%
	Unspecified	1090	883.65	16.41%

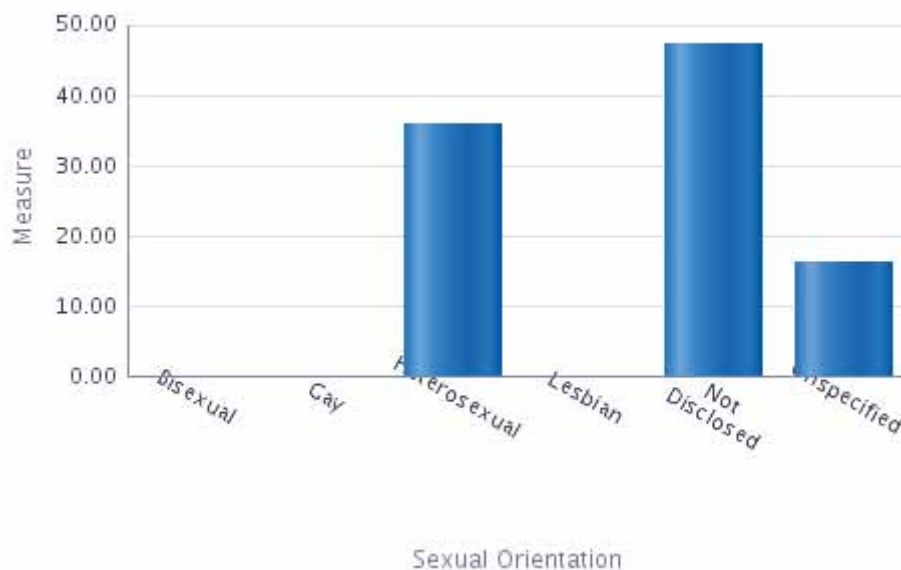
## Workforce Profile Data - Religion as at 31.12.2016



## Sexual Orientation

Protected Characteristic	Sub Group	Headcount	FTE	Headcount %
Sexual Orientation	Bisexual	*	*	*
	Gay	15	14.60	0.23
	Heterosexual	2,375	1971.87	35.76
	Lesbian	*	*	*
	Not Disclosed	3,142	2557.60	47.31
	Unspecified	1,091	884.65	16.43

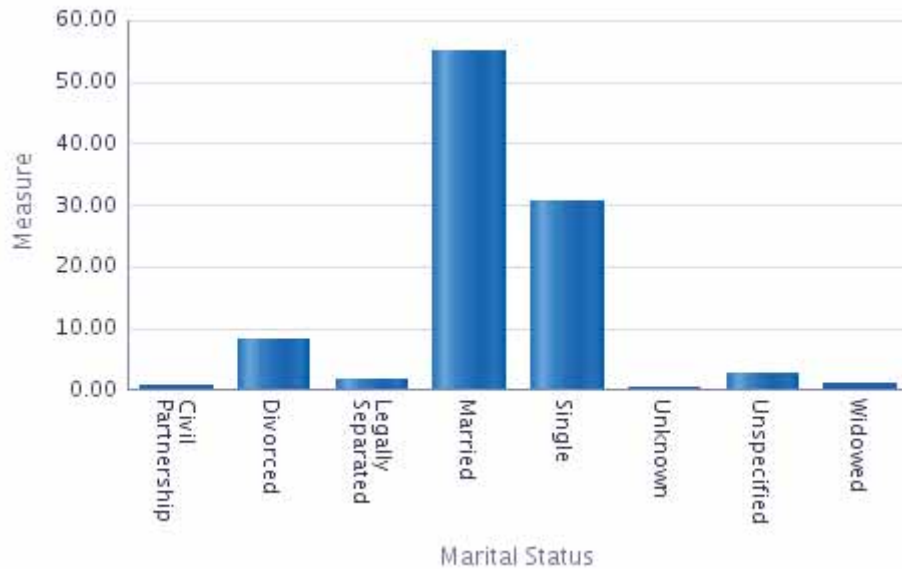
## Workforce Profile Data – Sexual Orientation as at 31.12.2016



## Marital Status

Protected Characteristic	Sub Group	Headcount	FTE	Headcount %
Marital Status	Civil Partnership	48	38.86	0.72%
	Divorced	539	440.50	8.12%
	Legally Separated	111	95.47	1.67%
	Married	3,638	2901.85	54.77%
	Single	2,040	1755.07	30.71%
	Widowed	70	52.54	1.05%
	Not Disclosed	22	17.25	0.33%
	Unspecified	174	144.61	2.62%

**Workforce Profile Data – Marital Status as at 31.12.2016**







**Doncaster and Bassetlaw  
Teaching Hospitals**  
NHS Foundation Trust

<b>Title</b>	<b>Chair's Log – Finance &amp; Performance</b>		
<b>Report to</b>	<b>Board of Directors</b>	<b>Date</b>	<b>25 July 2017</b>
<b>Author</b>	<b>Neil Rhodes, Chair of Finance &amp; Performance</b>		
<b>Purpose</b>		Tick one as appropriate	
	Decision		
	Assurance	x	
	Information		

**Executive summary containing key messages and issues**

This is a report of the Finance and Performance Committee that took place on 20 July 2017.

**General**

After a discussion about timeliness of papers and meeting structure I will be working through proposals with senior colleagues to improve the smooth running of future Finance and Performance meetings.

**Assurance area – Overall Financial Picture**

Jon Sargent reported a concerning slippage in Continuous Improvement Plans that needs to be brought to the attention of the Board. In essence, in our budgets and savings plans there are reserves and packets of savings that can be taken at choice throughout the year.

This flexibility, it was hoped, would enable a smoother run in at year end. Delivery shortfalls in CIPs over the past two months have meant that a substantial element of this flexibility has had to be used early to ensure targets were met and STF monies not lost this quarter.

The detail of this is contained within the Finance Paper before the Board but in broad terms CIP is 510k behind plan. This means there will have to be a real commitment and buy-in by all senior staff to step up the pace of CIP delivery if the picture is not to become very challenging indeed.

The Board needs to be apprised of and consider this issue.

The meeting was due to receive the detailed proposals in relation to the catering of outsourcing, ahead of presentation to the Board. This was not possible owing to slippage in timescales. It is intended that the August meeting will now receive the papers.

I stressed with Executive colleagues the need for proper NED scrutiny of the contract and warned that should not be prevented simply by the proximity of August F+P and the Board meeting meaning papers have to be prepared for the main board.

We were reassured to have confirmation by the Director of Finance that KPMG were quality assuring the work in hand.

### **Assurance area – Closing the Financial Gap**

Jon Sargeant reported changes to the line management of the Programme Management function, which moves from the Acting Director of Strategy and Improvement to the Director of Finance. Line management of the remaining Strategy and Improvement staff will be undertaken by the Chief Executive.

Jon outlined the revisions to the process employed to ensure Continuous Improvement Plans were framed, monitored and delivered, with the recreation of a monthly Programme Management Board to be chaired by the Chief Executive. The Committee were reassured by the evident intention to assert leadership and grip and look forward to this playing out in the shape of tangible plans for all of the funding gap efficiency requirement and an improvement in delivery.

We need to discuss at main Board how, with the functional responsibility changes, Strategy will be reported upon and monitored and where primacy will sit.

The Director of Finance stated that he had now received outline plans that gave confidence of our ability to bridge all but approx. £1m of the £14.5m funding gap. The Committee look forward to exploring this and the more detailed plans at the next meeting.

David Purdue, supported by project manager Pauline Antcliff, gave a workstream presentation in relation to Clinical Administration Redesign. A good understanding was gained of the activity being undertaken to identify and implement principally workforce efficiencies to deliver significant changes in this area. Resistance to change and problems being encountered were explored properly.

To improve the value of workstream presentations at future meetings I intend to ensure that they are given by the most senior budget holder below Board level – often a Care Group director – and that along with the slide set, the PID for the workstream is also shared ahead of the meeting, with the circulated papers.

### **Assurance area – Performance**

David Purdue presented an overview of the Trust's operational performance.

Overall, a reasonable picture with a four hour wait across the Trust of 92.46% which, whilst off target, represents top quartile performance. National performance remains below 90%. RTT stands at 90.9% with an improving picture noted across almost all of the specialities requiring improvement. National figure is 90.03%. Diagnostic waits is at 97.8% with improved performance to be seen in August. The Trust is compliant with the high impact intervention plan aimed to bring 62 day cancer target up and a detailed action plan is in place with the CCGs to address the performance shortfall against the 2 week wait target. Sickness absence has seen a slight rise but still much reduced on the figure seen in April and there has been a small rise in SET. Appraisal completion continues to hover around the 57-58% mark.

The Committee received a presentation in relation to the use of Agency/Locum staff from Director of People and OD, Karen Barnard. We sought assurance that all possible steps were being taken both in the short term, to address immediate issues and in the longer term to address structural issues. Owing to time pressures through lengthy discussion of financial issues a compressed presentation was received with limited time for questions.

Without rehearsing the presentation, we learned a 13% reduction in spend was targeted. The Finance section reported that medical agency spend was £610k higher in Month 3 than the run rate at the end of 16/17, but some assurance was gained in terms of positive recruitment against certain medical posts, a raft of management grip initiatives to ensure unplanned spend was always quality assured before authorisation and work with NHS Professionals to encourage staff to move from Agency to Bank. The benefits of being a teaching hospital were considered and international recruitment was discussed, together with how we might improve our attractiveness to middle grade doctors during their training programme.

The limited scrutiny given and the key nature of this area means we will return sooner rather than later to look again at this.

#### **Assurance area – Risk Management**

The Risk Register was deferred to be considered by ANCR in the meeting the same afternoon. Phillipe Serna (present at both meetings) to update - Thanks Philippe!

#### **Key questions posed by the report**

- Is the Board assured of the plans in place to tackle CIP slippage.

#### **How this report contributes to the delivery of the strategic objectives**

N/A

#### **How this report impacts on current risks or highlights new risks**

Whilst the trajectory in respect of CIP achievement is positive, delivery remains a risk and has been escalated to the Board.

Recommendation(s) and next steps
That Board receives the report for assurance.



**Doncaster and Bassetlaw  
Teaching Hospitals**  
NHS Foundation Trust

Title	Financial Performance – June 2017		
Report to	Board of Directors	Date	25 <sup>th</sup> July 2017
Author	Jon Sargeant - Director of Finance		
Purpose		Tick one as appropriate	
	Decision		
	Assurance		
	Information	X	

Executive summary containing key messages and issues
To update the Finance and Performance Committee on the financial position for the month of June 2017.
Key questions posed by the report
Action required to bring expenditure in line with planned levels.
How this report contributes to the delivery of the strategic objectives
Relevant strategic objectives; <ul style="list-style-type: none"><li>• Provide the safest, most effective care possible</li><li>• Control and reduce the cost of healthcare</li><li>• Focus on innovation for improvement</li><li>• Develop responsibly, delivering the right services with the right staff</li></ul>
How this report impacts on current risks or highlights new risks
Update on risk relating to delivery of 2017/18 financial plan.
Recommendation(s) and next steps
The Committee is asked to NOTE that the reported financial position is a deficit of £8.0m, which is £15k ahead of the year to date plan.



## FINANCIAL PERFORMANCE

P3 June 2017

25<sup>th</sup> July 2017

1. Income and Expenditure vs. Forecast							2. CIPs						
Performance Indicator	Monthly Performance		YTD Performance		Annual Plan	Forecast	Performance Indicator	Monthly Performance		YTD Performance		Annual Plan	Forecast
	Actual £'000	Variance £'000	Actual £'000	Variance £'000				Actual £'000	Variance £'000	Actual £'000	Variance £'000		
I&E Perf Exc Impairments	1,524	(361) F	7,993	(15) F	16,489	16,489	Employee Expenses	174	(378) A	562	(669) A	11,675	
Income	(31,124)	(588) F	(91,006)	(1,563) F	(361,298)	(361,298)	Drugs	0	0	0	0 A	65	
STF Incentive	(577)	0 F	(1,731)	0 F	(11,547)	(11,547)	Clinical Supplies	56	(32) A	72	(191) A	1,156	
Operating Expenditure	32,141	177 A	97,490	1,397 A	376,498	376,498	Non Clinical Supplies	0	0	0	0 A	10	
Pay	22,178	450 A	65,456	1,867 A	254,396	254,396	Non Pay Operating Expenses	17	(97) A	46	(136) A	1,224	
Non Pay	9,963	(273) F	32,034	(470) F	122,102	122,102	Income	28	(3) A	28	(65) A	369	
F = Favourable A = Adverse													
Financial Sustainability Risk Rating			Plan	Actual									
UOR			4	3									
CoSRR			1	2									
3. Statement of Financial Position							Total	274	(510) A	708	(1,061) A	14,500	
4. Other							5. Workforce						
All figures £m				Opening Balance 01.04.17	Current Balance 30.04.17	Movement in year	Performance Indicator	Monthly Performance		YTD Performance		Annual Plan	Forecast
								Plan £'000	Actual £'000	Plan £'000	Actual £'000	£'000	£'000
Non Current Assets				196,907	195,137	(1,770)	Cash Balance	1,900	2,180	1,900	2,180	1,900	1,900
Current Assets				33,612	64,737	31,125	Capital Expenditure	357	207	769	537	6,481	6,481
Current Liabilities				(31,967)	(73,005)	(41,038)							
Non Current liabilities				(79,348)	(75,655)	3,693							
Total Assets Employed				119,204	111,214	(7,990)		Funded WTE	Actual WTE	Bank WTE	Agency WTE	Total in Post WTE	Under / (over)
Total Tax Payers Equity				119,204	111,214	(7,990)							
							Current Month	6,031	5,577	170	284	6,031	0
							Previous Month	6,049	5,571	137	124	5,832	217
							Movement	18	(6) 0	(33)	(160) 0	(199)	(217)
Please note the previous month WTE have been restated due to an error in Oracle calculation.													

## 1. Context/Background

The month 3 position for 2017/18 is a deficit of £7,993k, which is £15k ahead of the planned year to date deficit of £8,009k. Income has overperformed against plan in June, but high agency expenditure has continued. The level of unidentified CIPs also continue to generate a significant overspend.

In order to hit the quarter end target the Trust has utilised non recurrent reserves of £600k as well as £875k of recurrent budget reserves, putting pressure on the reserves available for later in the year. The Trust cannot maintain this level of reserve utilisation throughout the year.

## 2. Executive Summary

Subjective Code	In Month Budget	In Month Actual	In Month Variance	YTD Budget	YTD Actual	YTD Variance	Previous YTD Budget	Previous YTD Actual	Previous YTD Variance	Annual Budget	Forecast
1. Income	-31,113	-31,701	-588	-91,175	-92,737	-1,563	-94,445	-94,855	-410	-372,761	-372,761
2. Costs	31,964	32,141	177	96,093	97,490	1,397	96,660	95,605	-1,054	376,414	376,414
3. Capital Charges	1,034	1,084	50	3,091	3,241	150	3,516	3,481	-35	12,836	12,836
<b>Total Position Before Impairments</b>	<b>1,885</b>	<b>1,524</b>	<b>-361</b>	<b>8,009</b>	<b>7,993</b>	<b>-15</b>	<b>5,730</b>	<b>4,230</b>	<b>-1,500</b>	<b>16,489</b>	<b>16,489</b>
4. Impairments	0	0	0	0	0	0	0	0	0	0	0
<b>Total Position After Impairments</b>	<b>1,885</b>	<b>1,524</b>	<b>-361</b>	<b>8,009</b>	<b>7,993</b>	<b>-15</b>	<b>5,730</b>	<b>4,230</b>	<b>-1,500</b>	<b>16,489</b>	<b>16,489</b>

I&E position	In Month Plan	In Month Actual	In Month Variance	2017/18 Plan
Position before STF	2,462	2,101	-361	28,036
STF funding	-577	-577	0	-11,547
<b>Reported position</b>	<b>1,885</b>	<b>1,524</b>	<b>-361</b>	<b>16,489</b>

During June, income has been £588k better than expected, largely driven by an over-performance on Non PBR Drugs. This also includes improvements in casemix following the completion of month 2 coding. During June, Care Group expenditure was £1.9m higher than budgeted levels. Within this figure there is an overspend of £330k relating to non PBR drugs, £450k of overspend on pay budgets (this includes £556k of prior month agency premium funding that is now included in Care Group positions, moved from reserves making the underlying overspend in month £1,056k) and £510k of unachieved CIP savings.

The cumulative income position at the end of Month 3 is £1,563k favourable.

Income Group	In Month Budget	In Month Actual	In Month Variance	YTD Budget	YTD Actual	YTD Variance	Annual Budget
Patient Income from CCGs	-25,728	-25,994	-266	-75,028	-75,974	-946	-302,225
Drugs	-1,748	-2,050	-302	-5,291	-6,042	-751	-22,601
STF	-577	-577	0	-1,731	-1,731	0	-11,547
Trading Income	-3,060	-3,080	-20	-9,124	-8,990	134	-36,471
<b>Grand Total</b>	<b>-31,114</b>	<b>-31,701</b>	<b>-588</b>	<b>-91,175</b>	<b>-92,737</b>	<b>-1,563</b>	<b>-372,845</b>

The expenditure position in June was £175k lower than budgeted levels, after an underspend of £1,764k within reserves. This reserves underspend includes the release of £875k of recurrent reserves, with the remainder relating to the additional sessions reserve where costs are being incurred in the Care Group positions.



Subjective Code	In Month Budget	In Month Actual	In Month Variance	YTD Budget	YTD Actual	YTD Variance	Previous YTD Budget	Previous YTD Actual	Previous YTD Variance	Annual Budget	Forecast
1. Pay	21,727	22,178	450	63,589	65,456	1,867	63,796	62,808	-988	251,339	251,339
2. Non-Pay	9,776	11,265	1,489	29,381	32,188	2,807	31,327	30,581	-696	110,931	110,931
3. Reserves	461	-1,304	-1,764	3,123	-157	-3,280	1,537	2,216	679	14,144	14,144
<b>Total Expenditure Position</b>	<b>31,964</b>	<b>32,139</b>	<b>175</b>	<b>96,093</b>	<b>97,488</b>	<b>1,395</b>	<b>96,660</b>	<b>95,605</b>	<b>-1,006</b>	<b>376,414</b>	<b>376,414</b>

### 3. Conclusion

High Medical Agency spend has continued in Month 3, leading to a year to date spend in this area £1.1m higher than expected levels. Unidentified efficiency is causing an overspend of £1.1m in the year to date position. Higher than planned income and a release of reserves has allowed the Trust to balance these pressures and come within the planned deficit. The identified pipeline schemes now need to be quickly implemented.

- Stronger controls and prospective reviews of Agency usage for both Medical and Nursing staff are being put in place with executive leadership of the review.
- A review of Elective and Outpatient performance is being undertaken to ensure that income under performance is minimised.
- Work continues to close the CIP plan with further pipeline opportunities now being identified.

### 4. Recommendations

The Board is asked to note the month 3 2017/18 financial position of £8.0million deficit, £15k ahead of plan after adjustment and note the underlying rate is a significant in month deficit. Remedial actions are being undertaken to address the CIP shortfall and issues around agency costs.



**Doncaster and Bassetlaw  
Teaching Hospitals**  
NHS Foundation Trust

# Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

## Board of Directors Meeting

### Performance - June 2017 - (Month 3)

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



Title	Business Intelligence Report		
Report to:	Board of Directors	Date:	25/07/2017
Author	Karen Barnard, Director of People and OD Moirra Hardy, Director of Nursing, Midwifery and Quality David Purdue, Chief Operating Officer Sewa Singh, Medical Director		
For:	Approval		
Purpose of Paper: Executive Summary containing key messages and issues			
<p>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</p> <ul style="list-style-type: none"><li>• Cancer, measured on average quarterly performance</li><li>• 4hr Access, measured on average quarterly performance</li><li>• 18 weeks including Diagnostic waits, measured quarterly but on monthly performance against active waiters, performance measured on the worst performing month in the quarter</li><li>• Infection control against CDiff annual trajectory</li></ul> <p>The quality report focuses on the key indicators of mortality and gives specific focus into best practice tariffs, complaints and serious incidents.</p> <p>The report is triangulated against staffing levels for the Trust with a focus on sickness/ absence and staff turnover.</p> <p>The report reviews the actions being taken to address for all performance and quality indicators.</p>			
Recommendation			
To note			
Delivering the Values - We Care (how the values are exemplified by the work in this paper)			
<p>We always put the patient first</p> <ul style="list-style-type: none"><li>• <i>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.</i></li></ul> <p>Everyone counts – we treat each other with courtesy, honesty, respect and dignity</p> <ul style="list-style-type: none"><li>• <i>By ensuring that all parties have contributed to the planning and delivery of services</i></li></ul> <p>Committed to quality and continuously improving patient experience</p> <ul style="list-style-type: none"><li>• <i>By delivering new ways of working across health and social care to ensure compliance with all quality indicators</i></li></ul> <p>Always caring and compassionate</p> <ul style="list-style-type: none"><li>• <i>By ensuring staff are committed to working with partners to improve services.</i></li></ul> <p>Responsible and accountable for our actions – taking pride in our work</p> <ul style="list-style-type: none"><li>• <i>By being accountable for delivery of the efficient and effective services</i></li></ul> <p>Encouraging and valuing our diverse staff and rewarding ability and innovation</p> <ul style="list-style-type: none"><li>• <i>Engaging with staff to encourage their ideas and working with them to change practice</i></li></ul>			
Related Strategic Objectives			
<ul style="list-style-type: none"><li>• Provide the safest, most effective care possible</li><li>• Control and reduce the cost of healthcare</li><li>• Focus on innovation for improvement</li><li>• Develop responsibly, delivering the right services with the right staff</li></ul>			
Analysis of Risk			
<ul style="list-style-type: none"><li>• Resource – Key financial issues related to additional funding streams to support planning for surge capacity.</li><li>• Governance – The Trust needs to maintain compliance framework with monitor</li><li>• Equality and Diversity – No known issues or risks.</li><li>• PR and Communications – Need for continued appropriate communication to ensure ongoing performance</li><li>• Patient, Public and Member Involvement – Public attendance at System Resilience Groups</li><li>• Risk Assessment – The risks to the Trust's performance are very high 2016/17, at this stage especially in relation to 4hr access</li><li>• NHS Constitution - Rights and Pledges – No known issues or risks.</li></ul>			
Board Assurance Framework			
1	Failure to achieve performance and compliance targets and processes	4 X 3 = 12	
2	Failure to match capacity with demand, particularly during winter	4 X 4 = 16	
3	Failure to maintain appropriate organisational corporate governance systems	5 X 4 = 20	



## Executive summary - Performance - June 2017

### Executive summary - Performance - June 2017

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

#### **Provide the safest, most effective care possible**

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

The business intelligence report also highlights key National and local targets which ensure care is being provided effectively and safely by the Trust.

#### **4hr Access**

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

#### **June Performance**

**Trust 92.46%**, Including GP attendances 93.7%

**Quarter 1 91.43%**, DBTH achieved the trajectory set by NHSi

Doncaster achieved **91.82%**. Total attendances 10248

836 patients failed to be treated within 4hrs, 208 less than May.

**13.01%** of patients were transferred to the urgent care centre. A review of the staffing at FDAS is being undertaken to increase the number of patients transferred.

Bassetlaw achieved **94.05%**. Total attendances 3947

234 patients failed to be treated within 4hrs, 42 more than in May.

The streaming plan for Bassetlaw is on time for the service to be launched at the beginning of September.

System wide perfect week planned for the 5<sup>th</sup> of September being supported by ECIP.

#### **Referral to Treatment**

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

**June 90.9%**

The focus of the data quality team is now on education within care groups to ensure the access policy is adhered to.

5 specialities remain non-compliant in June. The trajectory for improvement has been met by 4 of the specialities.

Further weekly reporting continues within the key specialities adversely affecting performance.

#### **Diagnostic performance 97.8%**

Key issue again relates to audiology capacity, locums are now in place but performance will not be on trajectory until August.

Medical imaging achieved 98.5% due to increased demand for non-obstetric ultrasound.

#### **Cancer Performance**

**May 62 day performance 86.2%**

**April 2 week wait 91.2%**

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

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

Additional monies have been agreed to invest in High Value pathways including urology.

#### **Stroke Performance**

46 patients were discharged in April with a stroke diagnosis. 26 were admitted within 4hrs. Of the 20 not admitted initial presentation and subsequent pathways accounted for 16 of the patient pathways.

The stroke pathway has been value stream mapped to identify the key elements to improve direct access.

At a Glance -June 2017 (Month 3)

Page	Monitor Compliance Framework	Indicator	Standard (Local, National Or Monitor)		Current Month	Month Actual	Data Quality RAG Rating
4-5		31 day wait for second or subsequent treatment: surgery	94.0%	M	May-17	100.0%	
		31 day wait for second or subsequent treatment: anti cancer drug treatments	98.0%	M		100.0%	
		31 day wait for second or subsequent treatment: radiotherapy	94.0%	M		100.0%	
		62 day wait for first treatment from urgent GP referral to treatment	85.0%	M		86.3%	
		62 day wait for first treatment from consultant screening service referral	90.0%	M		100.0%	
		31 day wait for diagnosis to first treatment- all cancers	96.0%	M		99.2%	
		Two week wait from referral to date first seen: all urgent cancer referrals (cancer suspected)	93.0%	M		91.2%	
		Two week wait from referral to date first seen: symptomatic breast patients (cancer not initially suspected)	93.0%	M		92.8%	
6-7		A&E: Maximum waiting time of four hours from arrival / admission / transfer / discharge (Trust)	95.0%	M	Jun-17	92.5%	
8-9	Maximum time of 18 weeks from point of referral to treatment- incomplete pathway	92.0%	M	Jun-17	90.9%		
	% of Patients waiting less than 6 weeks from referral for a diagnostics test	99.0%	N		97.8%		
	6-7	A&E Performance Indicators	Total time in A&E: 4 hours (95th percentile) HH:MM	04:00	N	Jun-17	05:01
A&E Admitted patients total time in A&E (95th percentile) HH:MM			04:00	N	07:40		
A&E Non-admitted patients total time in A&E (95th percentile) HH:MM			04:00	N	03:59		
A&E: Time to treatment decision (median) HH:MM			01:00	N	00:56:00		
A&E unplanned re-attendance rate %			5.0%	N	0.3%		
A&E: Left without being seen %			5.0%	N	2.9%		
Ambulance Handovers Breaches -Number waited over 15 & Under 30 Minutes				N	Jun-17	659	
Ambulance Handovers Breaches-Number waited over 30 & under 60 Minutes						69	
Ambulance Handovers Breaches -Number waited over 60 Minutes						13	
10-12	Stroke	Proportion of patients scanned within 1 hour of clock start (Trust)	48.0%	N	Apr-17	50.0%	
		Proportion of patients directly admitted to a stroke unit within 4 hours of clock start (Trust)	90.0%	N		56.5%	
		Percentage of eligible patients (according to the RCP guideline minimum threshold) given thrombolysis (Trust)	20.0%	N		4.3%	
		Percentage of patients treated by a stroke skilled Early Supported Discharge team (Trust)	40.0%	N		70.0%	
		Percentage of those patients who are discharged alive who are given a named person to contact after discharge (Trust)	95.0%	N		85.0%	
		Implementation of Stroke Strategy - TIA Patients Assessed and Treated within 24 Hours	60.0%	N	Jun-17	58.1%	
		13	Theatres & Outpatients	Cancelled Operations	0.8%	N	Jun-17
Cancelled Operations-28 Day Standard	0			N	1		
Out Patients: DNA Rate				L	9.3%		
Out Patients: Hospital Cancellation Rate				L	6.4%		
	Effective	Emergency Readmissions within 30 days (PbR Methodology)		L	May-17	5.8%	

Page	Fractured Neck of Femur	Indicator	Current Month	Month Actual (TRUST)	Month Actual (DRI)	Month Actual (BDGH)	Data Quality RAG Rating
17		% of patients achieving Best Practice Tariff Criteria	Jun-17	48.8%	37.5%	48.8%	
		Best Practice Criteria					
		36 hours to surgery Performance	Jun-17	53.3%	43.8%	76.9%	
		72 hours to geriatrician assessment Performance		93.3%	93.8%	92.3%	
		% of patients who underwent a falls assessment		100.0%	100.0%	100.0%	
		% of patients receiving a bone protection medication assessment		100.0%	100.0%	100.0%	
		Mortality-Deaths within 30 days of procedure		4.44%	6.30%	0.00%	
Page	Safe	Indicator	Standard (Local, National Or Monitor)		Current Month	Month Actual	Data Quality RAG Rating
19		Infection Control C.Diff	4 Per Month for Qtr 2 - 45 full year	M	Jun-17	1	
		Infection Control MRSA	0	L		0	
16		HSMR (rolling 12 Months)	100	N	Jun-17	No data available	
		Never Events	0	L	Jun-17	0	
		VTE	95.0%	N	May-17	95.0%	
19		Pressure Ulcers	12 Per Month 144 full Year	L	Jun-17	0	
		Falls that result in a serious Fracture	2 Per Month 23 full Year	L		0	
		Catheter UTI	Snap shot audit			0.39%	
Page	Complaints & Claims	Indicator	Current Month	Month Actual	Data Quality RAG Rating		
20		Complaints received (12 Month Rolling)	Jun-17	566			
		Concerns Received (12 Month Rolling)		807			
		Complaints Performance		43.0%			
		Liabilities to Third Parties Scheme (LTPS)		Data not available			
		Claims per 1000 occupied bed days		Data not available			
Page	Workforce	Indicator	Current Month	Month Actual	YTD (Cumulative)	Data Quality RAG Rating	
23		Sickness	Jun-17	3.5%	3.8%		
24		Appraisals			57.6%		
25		SET Training			70.6%		

# Monitor Compliance Framework: Cancer - May 2017 (Month 2)

## Context

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

## Reasons for Success/Failure

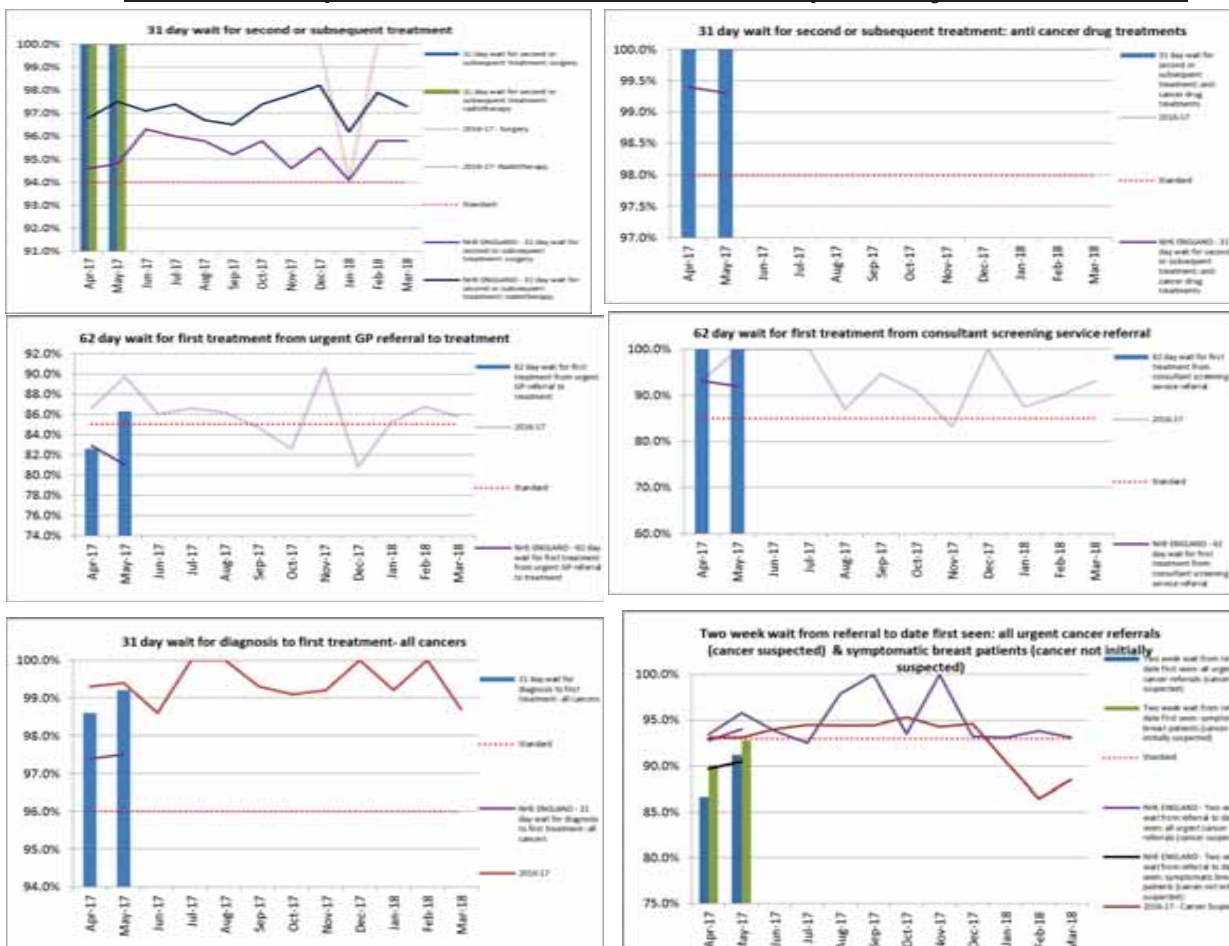
2 week wait failed to meet the target but with an improving position. Capacity issues are being addressed in dermatology and urology.  
62 day classic performance achieved at 86.2% as a result of improved pathway management from initial 2 week wait appointment.

## Actions being taken to address any issues

Action plan to improve 62 day performance completed  
The Trust reports weekly at the PTL all 62 day target performance  
External funding agreed to improve high value pathways including urology  
Individual breach reports are discussed with the MDTs to ensure learning is in place  
Improved access to diagnostics, KPIs set against a 7 day turnaround plan, new processes for flagging 62 day pathways being launched in Q1 2017/18  
Changes to referral systems being reviewed in line with E referral pathways which need to be embedded by April 2018  
Process mapping carried out on two week wait administration pathways.  
Key areas of work continue around capacity on sites.  
Patients being contacted when they delay their appointment outside of 14 days

Indicator		Standard	May-16	QTR 4 2016-17	Mar-17	Apr-17	May-17
31 day wait for second or subsequent treatment: surgery		94.0%	100.0%	97.7%	100.0%	100.0%	100.0%
31 day wait for second or subsequent treatment: anti cancer drug treatments		98.0%	100.0%	100.0%	100.0%	100.0%	100.0%
31 day wait for second or subsequent treatment: radiotherapy		94.0%	100.0%	100.0%	100.0%	100.0%	100.0%
62 day wait for first treatment from urgent GP referral to treatment	Tumour Type	85.0%					
	Breast			100.0%	100.0%	100.0%	94.6%
	Gynaecological			85.3%	37.5%	100.0%	100.0%
	Haematological			85.4%	80.0%	100.0%	80.0%
	Head & Neck			53.7%		0.0%	66.7%
	Lower Gastrointestinal			75.5%	90.9%	94.4%	85.7%
	Lung			73.8%	87.5%	100.0%	85.7%
	Other			95.2%		100.0%	
	Sarcoma			66.7%	0.0%	100.0%	
	Skin			97.4%	96.4%	90.5%	100.0%
	Upper Gastrointestinal			87.6%	80.0%	100.0%	77.8%
	Urological			74.2%	82.8%	52.9%	76.6%
	All Cancers			85.5%	85.8%	82.6%	86.3%
62 day wait for first treatment from consultant screening service referral	Tumour Type	90.0%					
	Breast			98.6%	100.0%	100.0%	100.0%
	Gynaecological			88.9%	100.0%		100.0%
	Haematological			100.0%	100.0%		
	Head & Neck						
	Lower Gastrointestinal			68.2%	0.0%	100.0%	
	Lung						
	Other						
	Sarcoma						
	Skin						
	Upper Gastrointestinal						
	Urological						
	All Cancers			94.3%	93.1%	100.0%	100.0%
31 day wait for diagnosis to first treatment- all cancers		96.0%	99.4%	99.3%	98.7%	98.6%	99.2%
Two week wait from referral to date first seen: all urgent cancer referrals (cancer suspected)		93.0%	93.1%	89.0%	88.5%	86.7%	91.2%
Two week wait from referral to date first seen: symptomatic breast patients (cancer not initially suspected)		93.0%	95.8%	93.3%	93.1%	90.1%	92.8%

## Monitor Compliance Framework: Cancer - Graphs -May 2017 (Month 2)



## Monitor Compliance Framework: A&E - June 2017 (Month 3)

### Context

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

### Reasons for Success/Failure

June Performance 92.46%  
 With GP urgent referrals 93.7%  
 Quarter 1 performance, 91.43% meeting the NHSi planned trajectory of 90%  
 Key issues related to internal ED doctor waits in both type 1 departments  
 Bed waits improved significantly in month

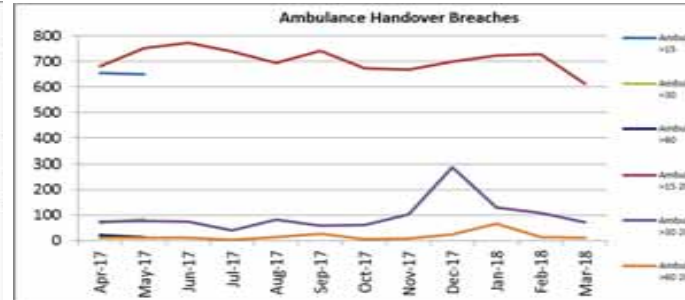
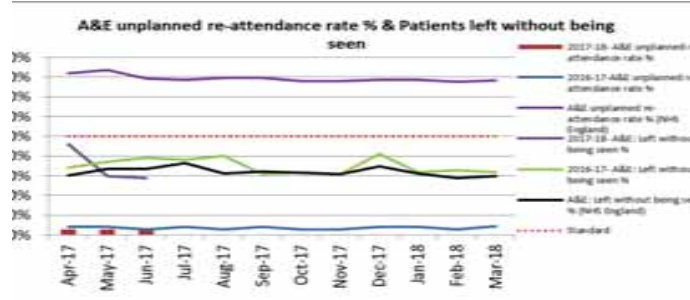
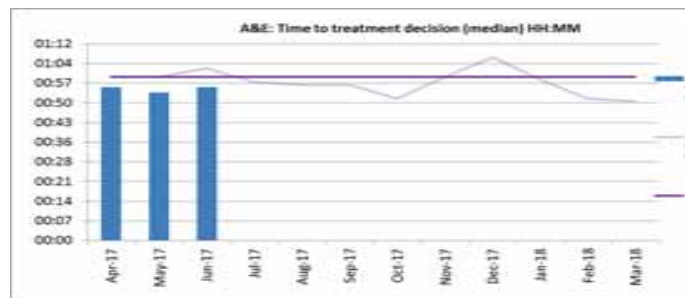
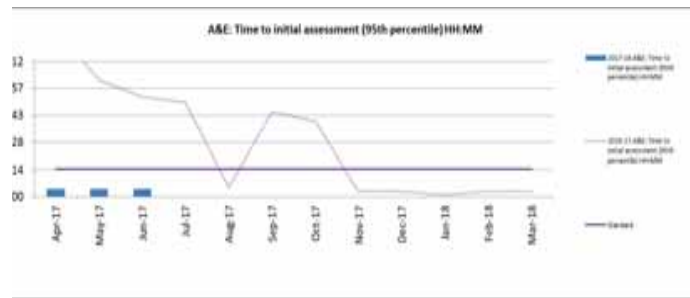
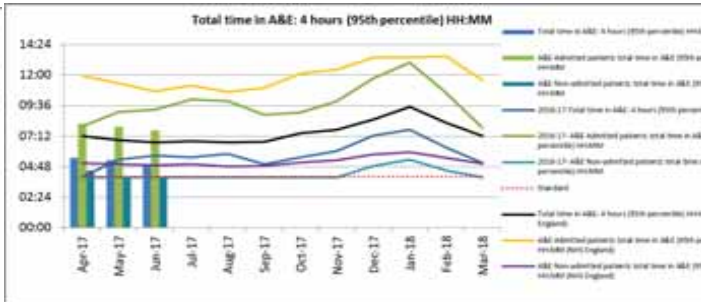
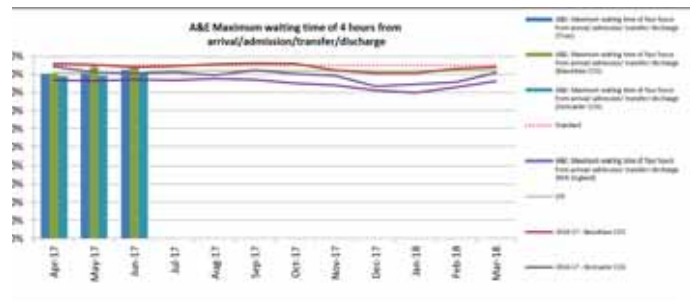
### Actions being taken to address any issues

Streaming bids successful for both type 1 sites, pathways being reviewed to maintain flow out of the ED. Currently 13% being streamed against the National best practice of 15%  
 Reviewing Urgent and Emergency Care as part of Bassetlaw Place Plan to assess the alternatives to ED  
 Workforce reviews being undertaking to assess the potential for alternative models of specialty support into the department  
 DTOC level trajectory below NHSi target, work continuing to support patient flow via Red to Green initiative  
 TAPPs pilot being extended to rehabilitation wards at MMH.  
 System wide " Perfect Week " planned for the 5th of September across both health and social care systems as the launch of the winter plan.

Indicator	Standard	Jun-16	Qtr 1 2017-18	Apr-17	May-17	Jun-17
A&E: Maximum waiting time of four hours from arrival/ admission/ transfer/ discharge ( <u>Trust</u> )	95.0%	92.3%	91.4%	90.4%	91.4%	92.5%
A&E: Maximum waiting time of four hours from arrival/ admission/ transfer/ discharge ( <u>Bassetlaw CCG</u> )		94.0%	92.8%	90.5%	94.2%	93.6%
A&E: Maximum waiting time of four hours from arrival/ admission/ transfer/ discharge ( <u>Doncaster CCG</u> )		90.6%	89.7%	88.9%	89.2%	91.0%
Total time in A&E: 4 hours (95th percentile) HH:MM	04:00	05:42	05:19	05:30	05:20	05:01
A&E Admitted patients total time in A&E (95th percentile) HH:MM	04:00	09:18	07:56	08:11	07:57	07:40
A&E Non-admitted patients total time in A&E (95th percentile) HH:MM	04:00	0:58	04:19	04:31	04:00	03:59
A&E: Time to treatment decision (median) MM	01:00	01:03	00:56	00:56	00:54	00:56
A&E unplanned re-attendance rate %	5.0%	0.3%	0.30%	0.3%	0.3%	0.3%
A&E: Left without being seen %	5.0%	3.9%	3.50%	4.6%	3.0%	2.9%
Indicator	Standard	Jun-16	Qtr 1 2017-18	Apr-17	May-17	Jun-17
Ambulance Handovers Breaches -Number waited over 15 & Under 30 Minutes		773	1961	654	648	659
Ambulance Handovers Breaches -Number waited over 30 & under 60 Minutes		75	222	69	84	69
Ambulance Handovers Breaches -Number waited over 60 Minutes		11	48	21	14	13



## Monitor Compliance Framework: A&E - Graphs - June (Month 3)



## Monitor Compliance Framework: 18 Weeks & Diagnostics -June 2017 (Month 3)

### Context

The Trust has changed the way the incomplete pathways snapshot is monitored.

- Late Entered Referrals are included
- The removal of any late entered clock stops prior to the end of September. Previously only those in the month or flagged on the DQ system would have been removed.
- Correction on weeks waiting calculation for incomplete pathways as the calculation previously reported one day extra on each pathway,
- Inclusion of ASIs.

### Reasons for Failure (if applicable)

Incomplete pathways for June ended at 90.9%.

There were 2: 52wk breaches reported in June both have been completed in July.

Specialties failed to meet 92% in June

- General Surgery
- Urology
- ENT
- Ophthalmology
- Trauma and Orthopaedics

Diagnostic performance for June:97.8%

Key issues: capacity issues in Audiology and non-obstetric ultrasound

### Actions being taken to address any issues

Weekly PTL meetings take place with Care Groups where Delivery Plans are discussed to bring performance levels back in line with commissioned activity and meeting RTT.

In response to the current RTT position Recovery Plans are regularly reviewed and challenged with each Care Group.

Main areas of concern: Ophthalmology, General Surgery, ENT and Urology

- Advanced Monitoring for RTT with Surgical Care Group. BI-weekly meetings chaired by COO.

- Outsourcing action plans agreed with care group for: Ophthalmology
- Internal action plans agreed with care group for: Pain Management, ENT and GI

Deep dive of waiting lists in GI and ENT currently being undertaken

- Collaboration with CCG on referral management and support in managing demand: Planned Care Programme Board and SDIP

- Paused validating below 15 weeks to focus on patient administration quality improvement.

- Working Group established focussed on patient administration - improving patient information through focussed training T&E plan

- Theatre Productivity Plans led by Theatre Work stream

Diagnostics

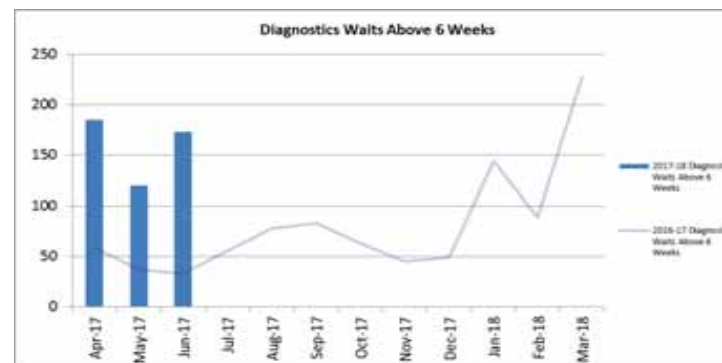
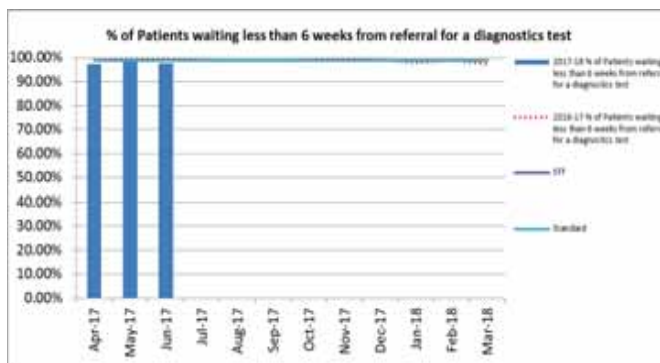
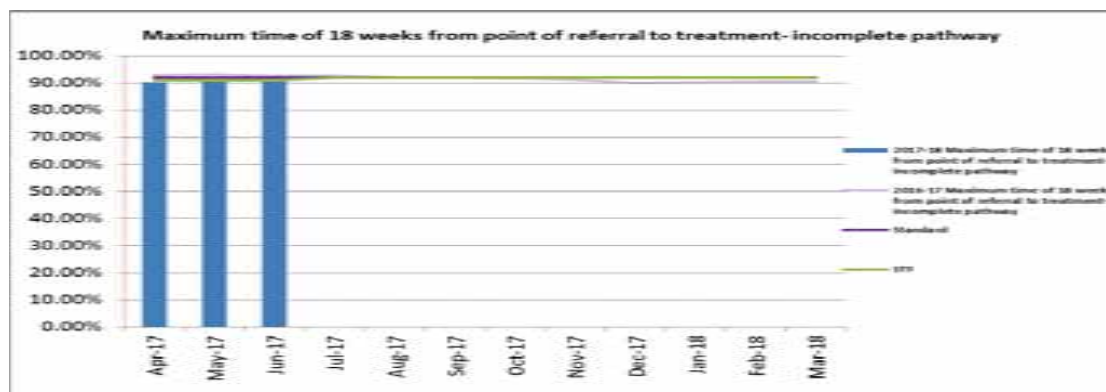
- Audiology, two locums commenced 10/04 and third Locum appointed early April.

- Endoscopy capacity secured through external supplier to mitigate patient breaches.

- Capacity reviews in non-obstetric ultrasound as a result of increases in obstetric ultrasound. Ongoing discussion with Obstetrics

Indicator	Standard	Jun-16	Ctr. 1 2017-18	Apr-17	May-17	Jun-17	Expected date to meet standard
Maximum time of 18 weeks from point of referral to treatment- incomplete pathway	92.0%			90.4%	90.6%	90.9%	
Indicator	Standard	Jun-16		Apr-17	May-17	Jun-17	Expected date to meet standard
% of Patients waiting less than 6 weeks from referral for a diagnostics test	99.0%	99.60%		97.54%	98.52%	97.76%	
Diagnostics Waits		33		185	120	173	

### Monitor Compliance Framework: 18 Weeks & Diagnostics - June (Month 3)



# Stroke -April 2017 (Month 1)

Context

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

Reasons for Failure (if applicable)

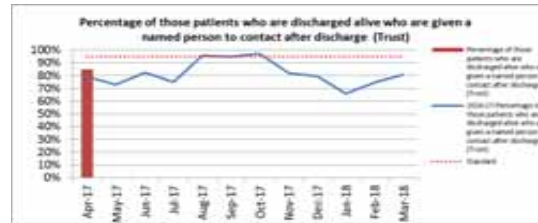
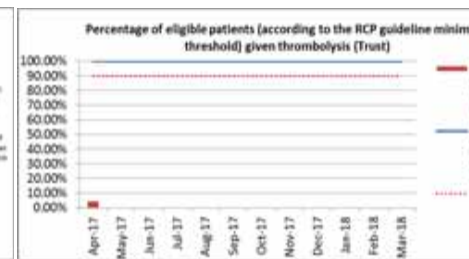
46 stroke discharges in April  
Key issues continue to relate to initial presentation. Of the 20 patients not going directly to the stroke unit, 16 were delayed due to their initial presentation and subsequent pathway.

Actions being taken to address any issues

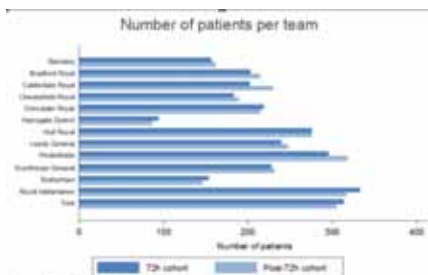
Key issues being addressed  
Presentation ED recognition and diagnosis  
Immediate management  
Inpatient strokes  
Access and Flow Demand – stroke and non-stroke  
Capacity – stroke and non-stroke  
Managing flow – acute site  
Flow into rehabilitation services – inpatient and community  
Early Supported Discharge  
Quality Stroke Team Assessment and Intervention  
Level of care

Indicator	Standard	Apr-16	Qtr 4 2016-17	Feb-17	Mar-17	Apr-17
Proportion of patients scanned within 1 hour of clock start (Trust)	48.0%	42.9%	44.9%	37.2%	43.8%	50.0%
Proportion of patients directly admitted to a stroke unit within 4 hours of clock start (Trust)	90.0%	69.6%	51.3%	51.2%	53.1%	56.5%
Percentage of eligible patients (according to the RCP guideline minimum threshold) given thrombolysis (Trust)	20.0%	N/A	N/A	N/A	N/A	4.3%
Percentage of patients treated by a stroke skilled Early Supported Discharge team (Trust)	40.0%	N/A	65.7%	69.2%	71.9%	70.0%
Percentage of those patients who are discharged alive who are given a named person to contact after discharge (Trust)	95.0%	N/A	74.5%	74.4%	80.7%	85.0%
	Standard	Jun-16	Qtr 1 2017-18	Apr-17	May-17	Jun-17

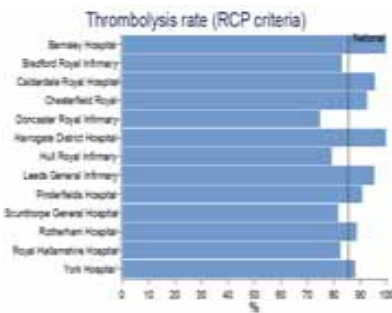
## Stroke - Graphs April 2017 (Month 1)



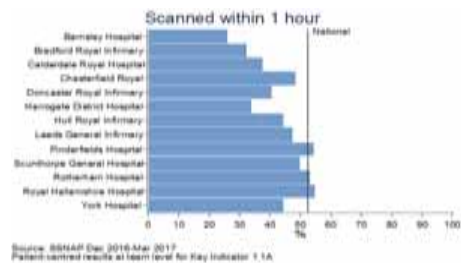
## Stroke - Graphs South Yorkshire December 2016- March 2017



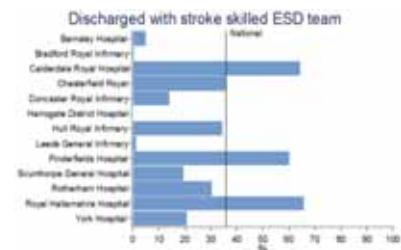
Source: SSNAP Dec 2016-Mar 2017  
Number of patients in both patient-cohorted cohorts - 33.2 and 38.2



Source: SSNAP Dec 2016-Mar 2017  
Patient-centred results at team level for Key Indicator 1.2A



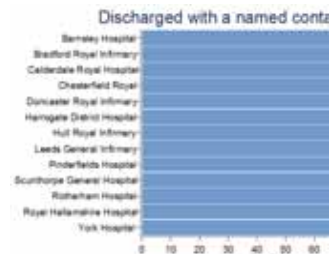
Source: SSNAP Dec 2016-Mar 2017  
Patient-centred results at team level for Key Indicator 1.1A



Source: SSNAP Dec 2016-Mar 2017  
Patient-centred results at team level for Key Indicator 10.3A



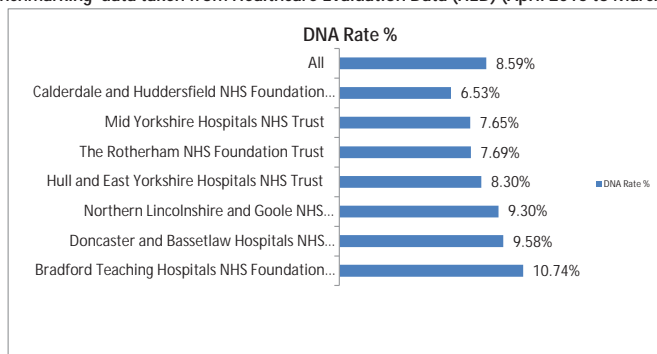
Source: SSNAP Dec 2016-Mar 2017  
Patient-centred results at team level for Key Indicator 2.1A



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

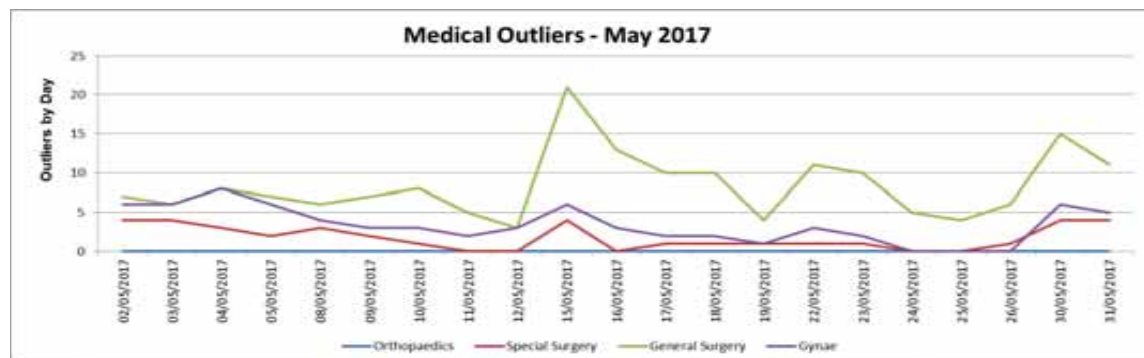
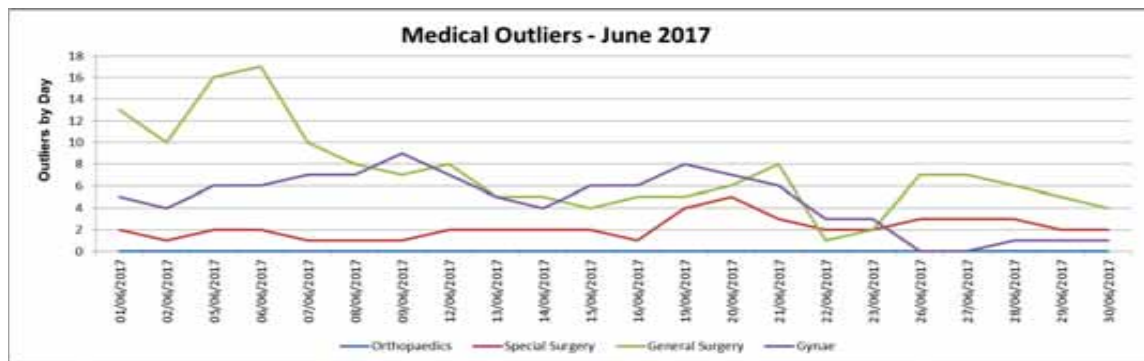
## Theatre & Outpatients -June 2017 (Month 3)

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



Indicator	Standard	Jun-16	Qtr 1 2017-18	Apr-17	May-17	Jun-17
Cancelled Operations (Total)	0.8%	1.4%	1.1%	1.1%	1.1%	1.0%
Cancelled Operations (Theatre)		0.9%	0.9%	0.7%	0.9%	1.0%
Cancelled Operations (Non Theatre)		0.6%	0.2%	0.3%	0.2%	0.1%
Cancelled Operations-28 Day Standard	0	2	5	0	4	1
Outpatients: DNA Rate Total (Refreshed Each Month)		10.27%	9.35%	9.12%	9.62%	9.27%
Outpatients: DNA Rate First (Refreshed Each Month)		10.08%	9.94%	9.51%	10.29%	9.96%
Outpatients: DNA Rate Follow Up (Refreshed Each Month)		10.36%	9.07%	8.94%	9.30%	8.95%
Outpatients: Hospital cancellation Rate (Refreshed Each Month)		6.77%	5.83%	6.10%	5.10%	6.35%
Outpatients: Patient cancellation Rate (Refreshed Each Month)		10.18%	10.19%	9.54%	10.27%	10.68%
Outpatients: Patient died cancellation Rate (Refreshed Each Month)		0.00%	0.00%	0.00%	0.00%	0.00%

Medical Outliers by Specialty - June 17 (Month 3)



	Daily average	Most Sleepers-out in June 2017	Least Sleepers-out in June 2017
Medicine to Ortho	0	0	0
Medicine to S12	2	5	1
Medicine to Surgery	7	17	1
Medicine to Gynae	5	9	0





## **Executive summary - Safety & Quality - June 2017 (Month 3)**

### **HSMR:**

Latest HSMR data available to end March 2017. Rolling 12 month HSMR is 92.6 and HSMR for the month of March was 81. The national dataset analysis has not been updated to include April as yet.

### **Fractured Neck of Femur:**

Mortality from Neck of Femur fracture has improved with overall Trust HSMR down to 90. The HSMR for BDGH has also improved to 105. Achievement of BPT has deteriorated to 50% due to insufficient theatre capacity. Trauma theatre capacity is due to be increased in September 2017.

### **Serious Incidents:**

For the month of June, there have been a total of 7 Sis comprising 5 Pressure Ulcers and 2 due to Care Issues. There have been no serious falls in month

### **Executive Lead:**

Mr S Singh

### **C.Diff:**

The rate of cases has reduced in June, returning to alignment with the target trajectory for the year. Interventions on Deep Cleaning, Antibiotic stewardship and monitoring hand washing compliance continue.

### **Fall resulting in significant harm:**

Good performance in Quarter 1

### **Hospital Acquired Pressure Ulcers:**

Expect to see a reduction to the current rate when demonstrated unavoidable through investigations.

### **Complaints and concerns:**

Normal variation is seen in the rate of complaints and concerns. Performance on reply times is slightly improved.

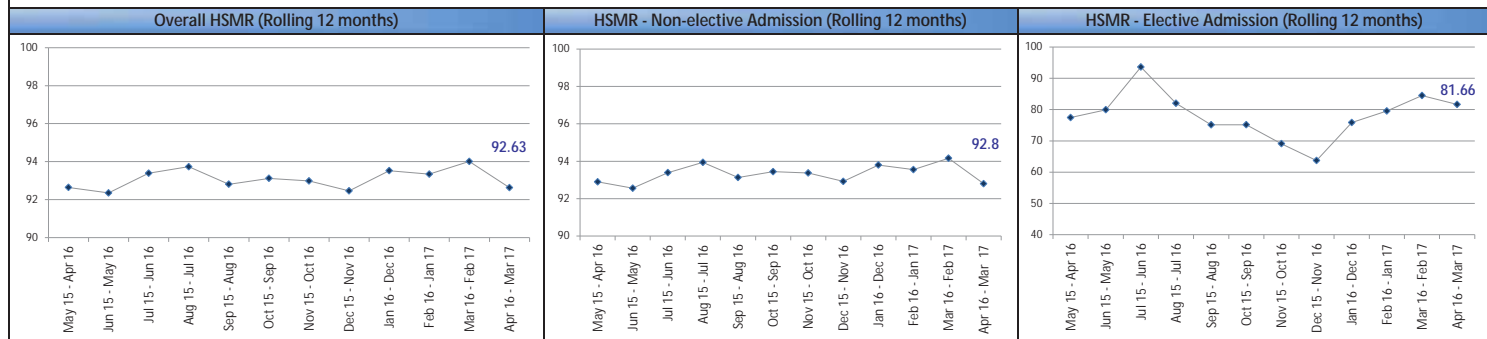
### **Friends & Family Test:**

Better than national recommended rates and for inpatient response rate, but worse on A&E response rate. Remains a challenge.

### **Executive Lead:**

Mrs M Hardy

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

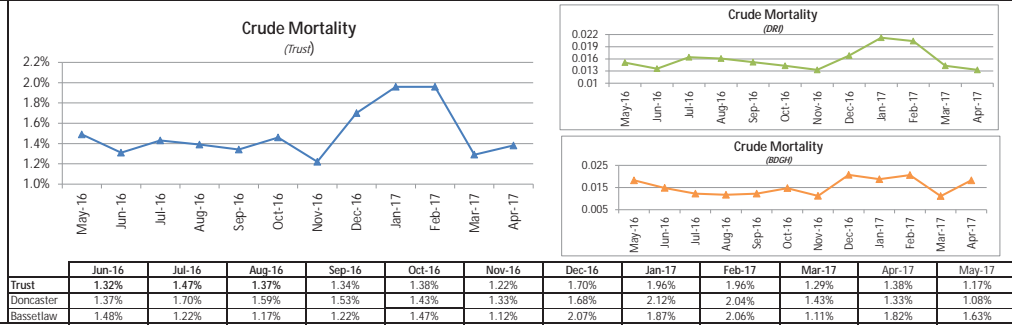


### HSMR Trend (monthly)

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

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

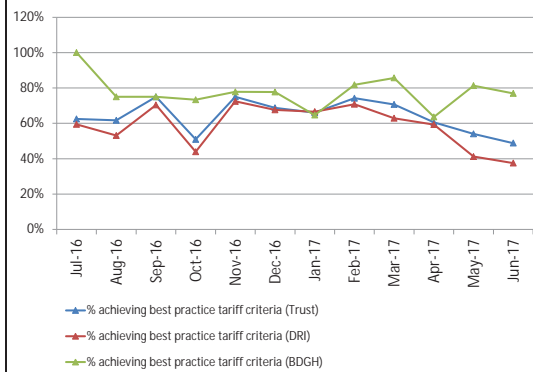
(number of deaths/number of patient discharged)



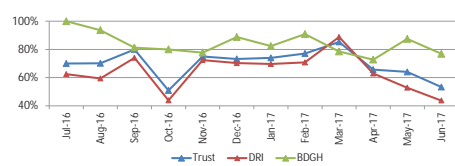
	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17
Trust	1.32%	1.47%	1.37%	1.34%	1.38%	1.22%	1.70%	1.96%	1.96%	1.29%	1.38%	1.17%
Doncaster	1.37%	1.70%	1.59%	1.53%	1.43%	1.33%	1.68%	2.12%	2.04%	1.43%	1.33%	1.08%
Bassetlaw	1.48%	1.22%	1.17%	1.22%	1.47%	1.12%	2.07%	1.87%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

## NHFD Best Practice Pathway Performance - June 2017 (Month 3)

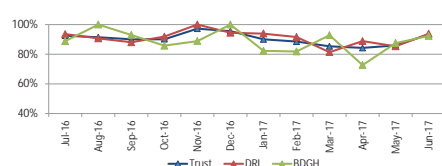
### Best Practice Criteria Performance



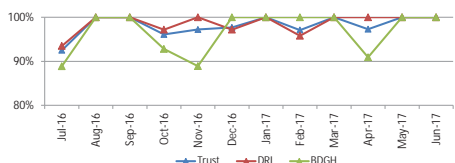
### 36 Hours to Surgery Performance



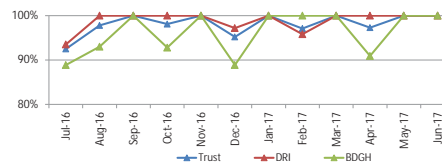
### 72 hours to Geriatrician Assessment Performance



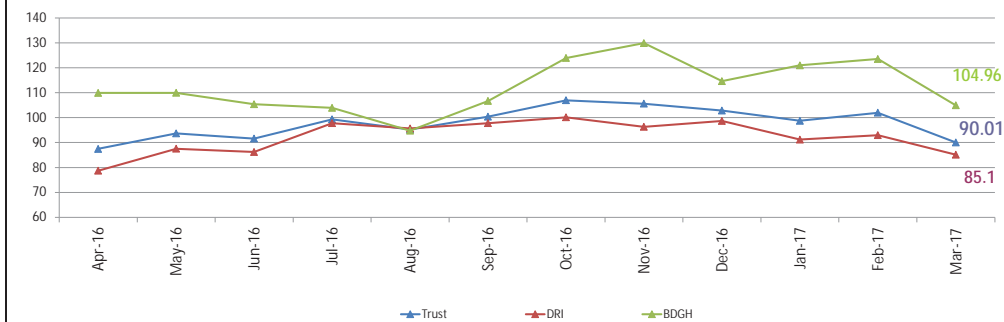
### Bone Protection Medication Assessment



### Falls Assessment Performance



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



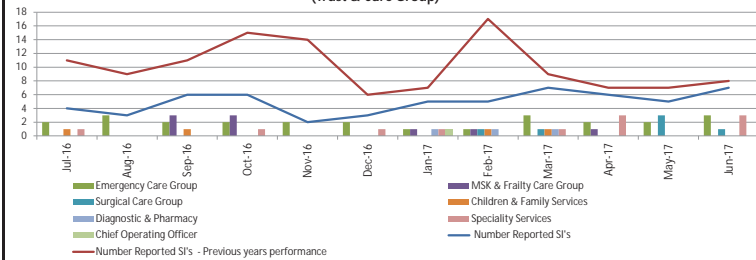
## Serious Incidents - June 2017 (Month 3)

(Data accurate as at 06/07/17)

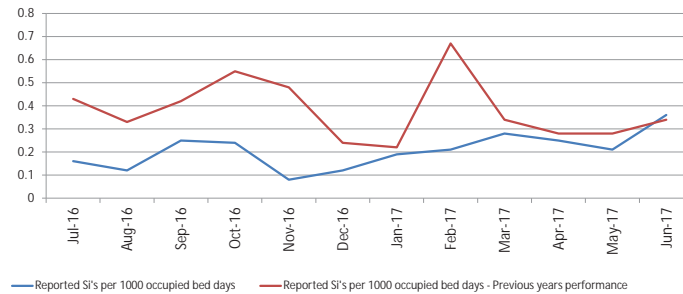
Please note: At the time of producing this report the number of serious incidents reported are prior to the RCA process being completed.

### Overall Serious Incidents

#### Number Serious Incidents Reported (Trust & Care Group)



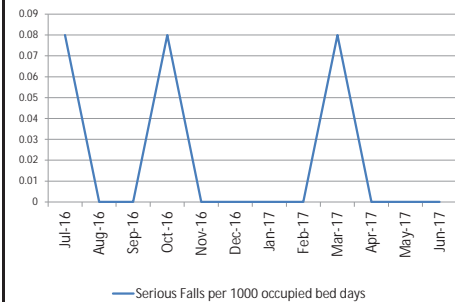
#### Serious Incidents per 1000 occupied bed days



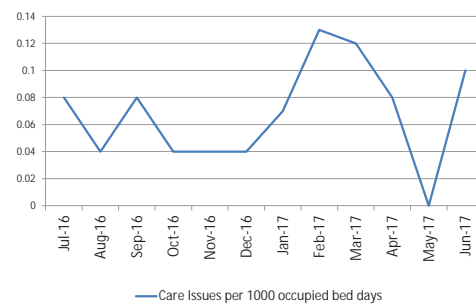
Current YTD reported SI's (Apr 17-Jun 17)	18	Number reported SI's (Apr 16-May 17)	22
Current YTD delogged SI's (Apr 17-Jun 17)	5	Number delogged SI's (Apr 16-May 17)	6

### Themes

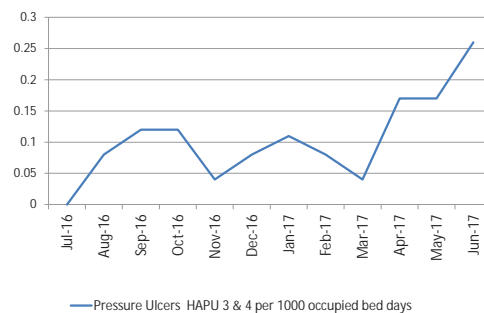
#### Serious Falls



#### Care Issues



#### Pressure Ulcers - Category 3 & 4 (HAPU)

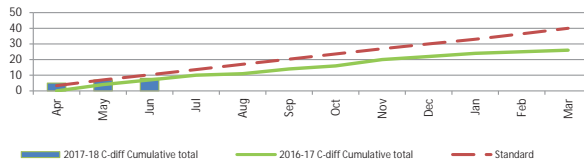


### Monitor Compliance Framework: Infection Control C.Diff - June 2017 (Month 3)

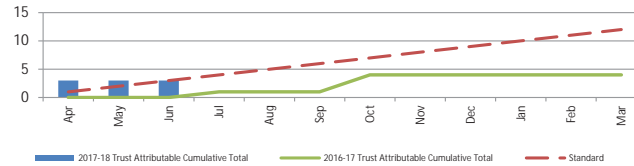
(Data accurate as at 12/07/2017)

	Standard	Apr	May	Jun	Q1	YTD
2017-18 Infection Control - C-diff	40 Full Year	5	2	1	8	8
2016-17 Infection Control - C-diff	40 Full Year	0	4	3	7	7
2017-18 Trust Attributable	12	3	0	0	3	3
2016-17 Trust Attributable	12	0	0	0	0	0

C-diff 2016-17



Trust Attributable C-diff 2016-17



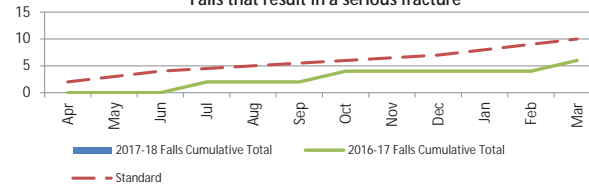
### Pressure Ulcers & Falls that result in a serious fracture - June 2017 (Month 3)

(Data accurate as at 06/07/2016)

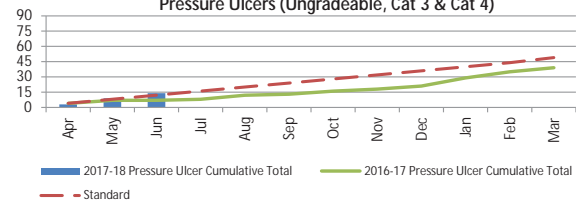
	Standard	Apr	May	Jun	Q1	YTD
2017-18 Serious Falls	10 Full Year	0	0	0	0	0
2016-17 Serious Falls	19 Full Year	0	0	0	0	0

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

Falls that result in a serious fracture



Pressure Ulcers (Ungradeable, Cat 3 & Cat 4)



	Standard	Apr	May	Jun	Q1	YTD
2017-18 Pressure Ulcers	34 Full Year	3	6	5	14	14
2016-17 Pressure Ulcers	60 Full Year	4	3	0	7	7

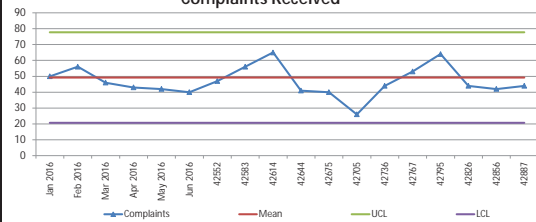
Please note: At the time of producing this report the number of pressure ulcers reported are prior to the RCA process being completed.

## Complaints & Claims - June 2017 (Month 3)

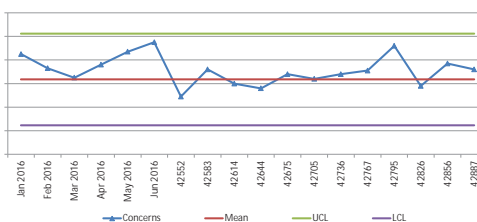
(Data accurate as at 06/07/2017)

### Complaints

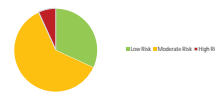
#### Complaints Received



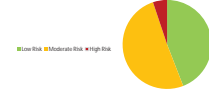
#### Concerns Received



#### June 2017 Complaints Received Risk Breakdown

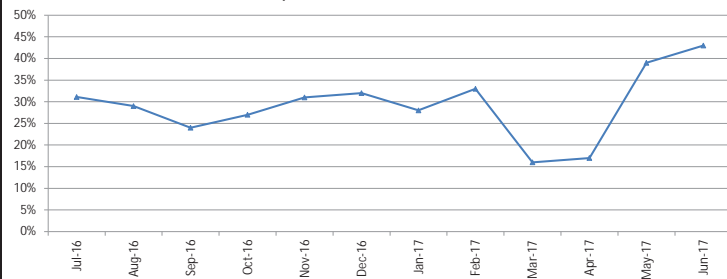


#### Year to Date Complaints Received Risk Breakdown



### Complaints - Resolution Performance (% 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 Ombudsman (PSHO)

Month	Number of cases referred for investigation	Number Currently Outstanding
June	0	9

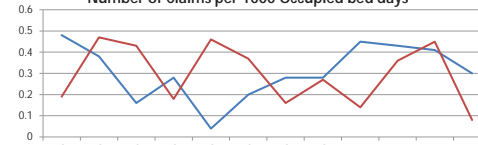
	Number referred for investigation YTD	Outcomes YTD	
2016/17	9	Fully / Partially Upheld	0
		Not Upheld	1
		No further Investigation	0
		Case Withdrawn	0
2017/18	1	Fully / Partially Upheld	
		Not Upheld	
		No further Investigation	
		Case Withdrawn	

### Claims

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

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

#### Number of Claims per 1000 Occupied bed days

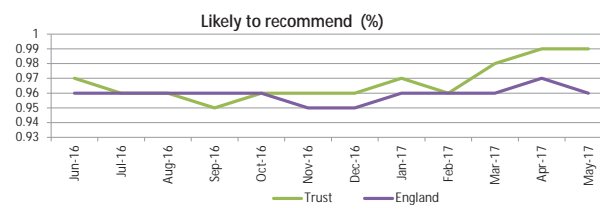
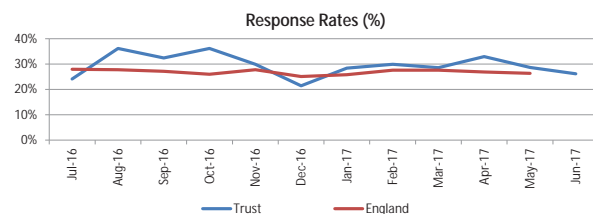


## Friends & Family - June 2017 (Month 3)

(Data accurate as at 11/07/2017)

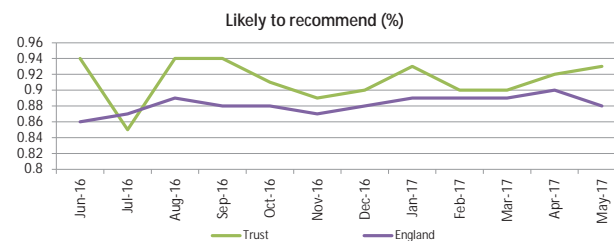
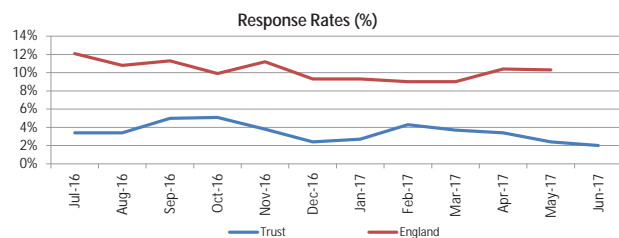
### Inpatients

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



### Accident & Emergency

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





## Executive summary - Workforce - June 2017 (Month 3)

### Sickness absence

Whilst the Trust saw a reduction in April to 4.01% and a further reduction again in May to 3.25% which is below the Trust target of 3.50%, we have seen a slight rise in June to 3.5% resulting in a cumulative figure of 3.83%. In June we have seen a significant reduction in the number of staff off sick between 1 and 6 months but unfortunately seen a small rise in those off sick for more than 6 months. These cases will be reviewed by the Deputy director of P&OD to ensure that the management of these cases are in line with plans. We continue to benchmark favourably across Yorkshire and Humber and the P&OD Team will continue to support managers across the Trust to maintain the performance in this area.

### Appraisals

The Trust's appraisal completion rate continues to hover around 57% with a small reduction from 58.51% to 57.59%. We continue to renewed focus as part of the revised accountability meetings with particular attention given to all senior managers having their appraisal as close to the start of the financial year as possible and other staff's appraisals being aligned to meet the peaks and troughs of operational demand. In order to enhance the quality of appraisals a review of the current paperwork has been undertaken and the paperwork updated (this will not detract from appraisals continuing in the meantime).

### SET

We have seen a small rise in compliance with Statutory and Essential Training in June to 70.57% compared to May's figure of 68.41% but generally across most areas the upwards trajectory continues.

### Staff in post

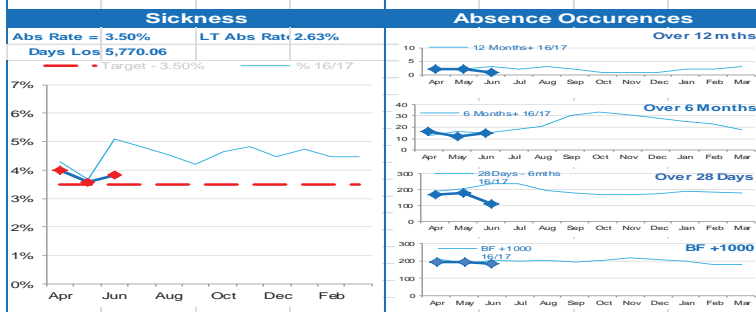
Please see attached tab covering staff in post by staff group



## Workforce: Sickness Absence - June (Month 3)

### CG & Directorate Sickness Absence - June 2017 (Q1)

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



	Jun-17		Cumulative	
	Days Lost	% Rate	Days Lost	% Rate
Doncaster & Bassetlaw Teaching Hospitals	5770.06	3.50%	19,155.72	3.83%
Chief Executive Directorate	0.00	0.00%	21.00	0.84%
Children & Family Care Group	738.05	4.38%	2,256.01	4.29%
Diagnostic & Pharmacy Care Group	427.74	2.39%	1,942.30	3.55%
Directorate Of Strategy & Improvement	1.80	0.42%	2.80	0.21%
Emergency Care Group	628.94	2.92%	2,705.16	4.13%
Estates & Facilities Directorate	1014.74	6.00%	2,995.75	5.83%
Recharge Medics	2.00	0.13%	3.00	0.06%
Finance & Healthcare Contracting Directorate	93.41	4.35%	185.56	2.82%
IT Information & Telecoms Directorate	51.73	1.58%	233.66	2.36%
MSK & Frailty Care Group	751.38	3.06%	2,469.78	3.35%
Medical Director Directorate	0.00	0.00%	4.24	0.60%
Nursing Services Directorate	36.20	2.22%	127.53	2.62%
People & Organisational Development Directorate	66.08	2.40%	168.45	2.01%
Performance Management Directorate	109.79	1.76%	407.47	2.16%
Speciality Services Care Group	693.14	3.91%	2,037.39	3.20%
Surgical Care Group	1155.05	3.97%	3,591.62	3.96%

Top 10 Absence Reasons			
Absence Reason	Days Lost	%	
S10 Anxiety/stress/depression/other psy	1,896.00	24.10	
S12 Other musculoskeletal problems	1,003.00	12.70	
S98 Other known causes - not elsewhere	722.00	9.20	
S25 Gastrointestinal problems	719.00	9.10	
S11 Back Problems	634.00	8.00	
S28 Injury, Fracture	439.00	5.60	
S26 Genitourinary & gynaecological disc	378.00	4.80	
S13 Cold, Cough, Flu - Influenza	269.00	3.40	
S15 Chest & respiratory problems	261.00	3.30	
S16 Headache / migraine	208.00	2.60	

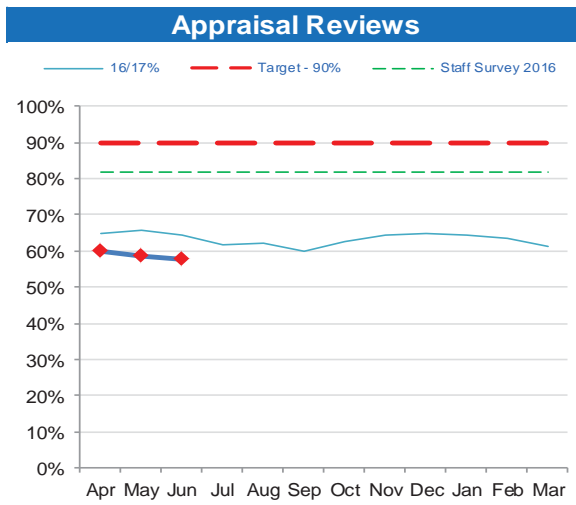
Benchmarking - Sickness Absence* April 2017			
Top Trust	Region	Absence Rate	
Doncaster and Bassetlaw Hospitals NHS Foundation Trust	Yorkshire and the Humber	3.83%	
Active Average			
All Trusts	Region	Absence Rate	
1 Doncaster and Bassetlaw Hospitals NHS Foundation Trust	Yorkshire and the Humber	3.83%	
2 Doncaster and Bassetlaw Hospitals NHS Foundation Trust	Yorkshire and the Humber	3.83%	
3 Doncaster and Bassetlaw Hospitals NHS Foundation Trust	Yorkshire and the Humber	3.83%	
4 Doncaster and Bassetlaw Hospitals NHS Foundation Trust	Yorkshire and the Humber	3.83%	
5 Doncaster and Bassetlaw Hospitals NHS Foundation Trust	Yorkshire and the Humber	3.83%	
6 Doncaster and Bassetlaw Hospitals NHS Foundation Trust	Yorkshire and the Humber	3.83%	
7 Doncaster and Bassetlaw Hospitals NHS Foundation Trust	Yorkshire and the Humber	3.83%	
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9 Doncaster and Bassetlaw Hospitals NHS Foundation Trust	Yorkshire and the Humber	3.83%	
10 Doncaster and Bassetlaw Hospitals NHS Foundation Trust	Yorkshire and the Humber	3.83%	
11 Doncaster and Bassetlaw Hospitals NHS Foundation Trust	Yorkshire and the Humber	3.83%	
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36 Doncaster and Bassetlaw Hospitals NHS Foundation Trust	Yorkshire and the Humber	3.83%	
37 Doncaster and Bassetlaw Hospitals NHS Foundation Trust	Yorkshire and the Humber	3.83%	
38 Doncaster and Bassetlaw Hospitals NHS Foundation Trust	Yorkshire and the Humber	3.83%	
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## Workforce: Appraisals - June (Month 3)

### Appraisal Reviews

#### CCG & Directorate Appraisals - June 2017 (Q1)

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



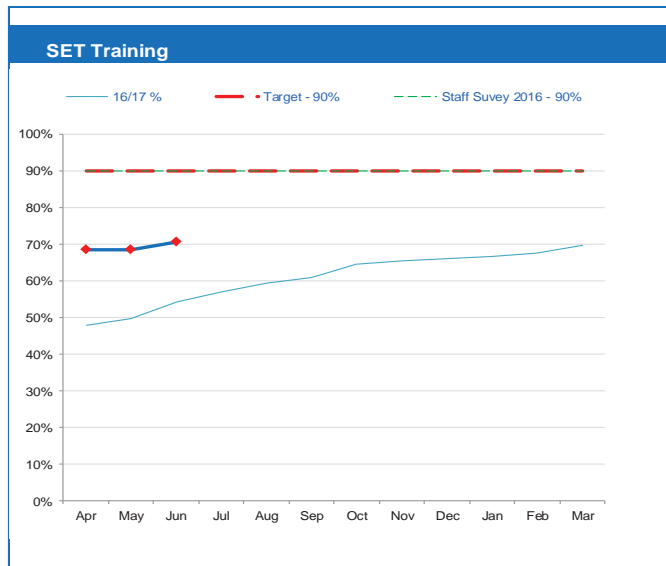
	% Completed
Doncaster & Bassetlaw Teaching Hospitals NHS FT	57.59
Chief Executive Directorate	29.63
Children & Family Care Group	70.41
Diagnostic & Pharmacy Care Group	51.41
Directorate Of Strategy & Improvement	71.43
Emergency Care Group	56.39
Estates & Facilities	20.98
Finance & Healthcare Contracting Directorate	6.76
IT Information & Telecoms Directorate	58.20
MSK & Frailty Care Group	78.67
Medical Director Directorate	57.14
Nursing Services Directorate	29.69
People & Organisational Directorate	83.67
Performance Directorate	82.17
Speciality Services Care Group	49.40
Surgical Care Group	64.52
Trust Funds	0.00

## Workforce: SET Training - June (Month 3)

### Appraisal Reviews

#### CG & Directorate SET Training - June 2017 (Q1)

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



	% Compliance
<b>Doncaster &amp; Bassetlaw Teaching Hospitals NHS FT</b>	<b>70.57%</b>
Chief Executive Directorate	71.81%
Children & Family Care Group	76.18%
Diagnostic & Pharmacy Care Group	76.01%
Directorate Of Strategy & Improvement	98.03%
Emergency Care Group	64.68%
Estates & Facilities	46.05%
Finance & Healthcare Contracting Directorate	74.57%
IT Information & Telecoms Directorate	86.42%
MSK & Frailty Care Group	80.37%
Medical Director Directorate	70.51%
Nursing Services Directorate	78.09%
People & Organisational Directorate	91.30%
Performance Directorate	58.93%
Speciality Services Care Group	70.00%
Surgical Care Group	74.10%

## Workforce: Staff in post - June (Month 3)

### Staff in Post

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

<b>Title</b>	<b>Nursing Workforce Information</b>		
<b>Report to</b>	<b>Board of Directors</b>	<b>Date</b>	<b>25 July 2017</b>
<b>Author</b>	<b>Moir Hardy, Acting Director of Nursing, Midwifery &amp; Quality</b> <b>Rick Dickinson, Acting Deputy Director of Nursing, Midwifery &amp; Quality</b>		
<b>Purpose</b>		Tick one as appropriate	
	Decision		
	Assurance	✓	
	Information		

#### Executive summary containing key messages and issues

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

- The workforce data submitted to UNIFY demonstrates the overall planned versus actual hours worked to be 100% for June 2017.
- 5 wards had a deficit of more than 10%, with DRI Central Delivery Suite, and Bassetlaw B6, ITU, A2 and Labour Ward. The maternity services were due to sickness and vacancies. B6 and ITU have had lower levels of activity and staff redeployed to manage services on occasions.
- Care Hours Per Patient Day (CHPPD) for June 2017 shows a slight increase from May from 7.6 to 7.5 overall in May, but a slight increase for registered staff and a slight reduction for non-registered staff. Data held within the Model Hospital portal has been updated this month and now shows data up to April 2017. This shows similar overall CHPPD, but with some variance on Registered and Non-registered staff.
- The Trust position regarding safe nurse staffing and efficiency (Agency Capping) from TDA, Monitor, NHSE, CQC and NICE remains within the 3% cap at 2.7% in June.
- Workforce information and Quality and Safety profile meeting requirements of NHS England (NHSE), including How to ensure the right people, with the right skills, are in the right place at the right time (2013) and Safe staffing for nursing in adult inpatient wards in acute hospitals (2014) relating to Hard Truths demonstrates that no wards were Red for Quality.

#### Key questions posed by the report

- Are the control measures for managing the nursing workforce provision achieving the desired outcome of adequate staffing levels, within the agency cap requirements?
- Are the systems to monitor quality providing an appropriate early warning sign for intervention?
- Are we complying to the relevant standards in reporting the staffing levels as part of Hard Truths, for both external and internal reporting requirements?

<ul style="list-style-type: none"> <li>Does the triangulation of staffing and quality data provide the assurance on the adequacy of resources balanced with quality improvement potential?</li> </ul>
<b>How this report contributes to the delivery of the strategic objectives</b>
<ul style="list-style-type: none"> <li>Provide the safest, most effective care possible</li> <li>Control and reduce the cost of healthcare</li> <li>Focus on innovation for improvement</li> <li>Develop responsibly, delivering the right services with the right staff</li> </ul>
<b>How this report impacts on current risks or highlights new risks</b>
<p>Risks associated to the inability to recruit to establishment and develop staff to provide harm free care, delivered with compassion and of appropriate quality.</p> <p>Risk associated with not meeting regulatory and commissioner requirement.</p> <p>The risks identified have been mitigated by the use of temporary staffing to provide planned versus actual hours worked at 100% in June. Despite the use of temporary staff to maintain safe staffing levels the Trust has remained within the 3% agency cap. The main risk in relation to staffing continues to be the recruitment to Registered nurse and midwifery vacancies and opportunities to recruit are actively being explored.</p>
<b>Recommendation(s) and next steps</b>
<p>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.</p> <p>Key issues and actions include:</p> <ul style="list-style-type: none"> <li>- the continuing work of the Non-Medical workforce utilisation programme as part of DBTH Strategy and Improvement programme</li> <li>- Exploring recruitment opportunities for nursing and midwifery</li> <li>- Complete AUKUH data collection from 01 July, ward nurse staffing requirements will be available to the Quality and Effectiveness Committee in September 2017.</li> <li>- Consider the NQB consultation on Midwifery Staffing levels.</li> </ul>

## 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 QEC on the implementation on Care Hours per Patient Day (CHPPD), which has been a required national return since 01 May 2016 and the data submitted to UNIFY.

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

## 2. BACKGROUND

This paper provides the DBHFT Quality and Effectiveness Committee 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 June 2017, which has been submitted to the UNIFY system, with additional information relating to the June 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 June 2017 by registered nurses and health care support workers compared to the planned hours. The Trusts overall planned versus actual hours worked was 100% in June 2017, the same as April and May. As part of the ongoing monitoring processes for staffing levels in wards and departments, the Trust is currently undertaking the Safer Nursing Care Tool assessments for inpatient wards, which is now undertaken twice a year. We are also undertaking assessments of acuity using EPanda in paediatrics, and the BEST tool in the coming weeks. We last undertook the Birthrate Plus assessment in Maternity 2 and half years ago and are considering the consultation document from NHS Improvement on "Safe, sustainable and productive staffing: An improvement resource for maternity services" published in June 2017.

[https://improvement.nhs.uk/uploads/documents/Safe\\_Staffing\\_Maternity\\_engagement.pdf](https://improvement.nhs.uk/uploads/documents/Safe_Staffing_Maternity_engagement.pdf)

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

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

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

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

- within 5% for 25 Wards (61%), the same as May
- between 5% – 10% for 7 Wards (17%) two less than May
- surpluses over 10% for 4 Wards (10%) the same as May
- deficits over 10% for 5 Wards (12%) two more than May

The wards where there were surpluses in excess of 10% of the planned hours are Gresley, Mallard, Rehab 2 and C1; each ward requiring additional staff to support patients requiring enhanced care.

The wards where there were deficits in excess of 10% of the planned hours are Central Delivery Suite (CDS) at DRI, and B6, ITU, Ward A2 and Labour Ward at Bassetlaw Hospital. The lower than planned staffing levels were due to:

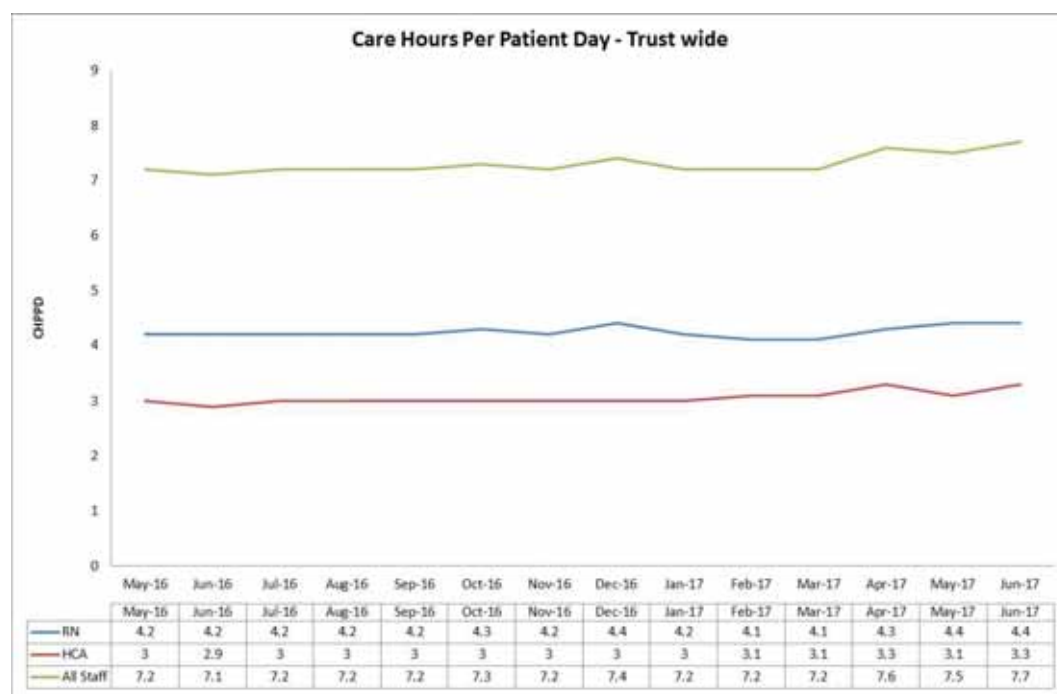
- Lower occupancy, acuity and dependency of patients on Ward B6 allowed staff to be safely moved to support other clinical areas.
- Labour Ward, CDS and A2 are due to staff sickness absence and vacancies. The service was optimised through the maternity service on call management and use of community staff to ensure safe services.
- Bassetlaw ITU had sufficient staff for the acuity of patients, with a shortfall of a HCA, due to a vacancy, impacting on the overall position.

### 3b. Care Hours Per Patient Day (CHPPD)

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

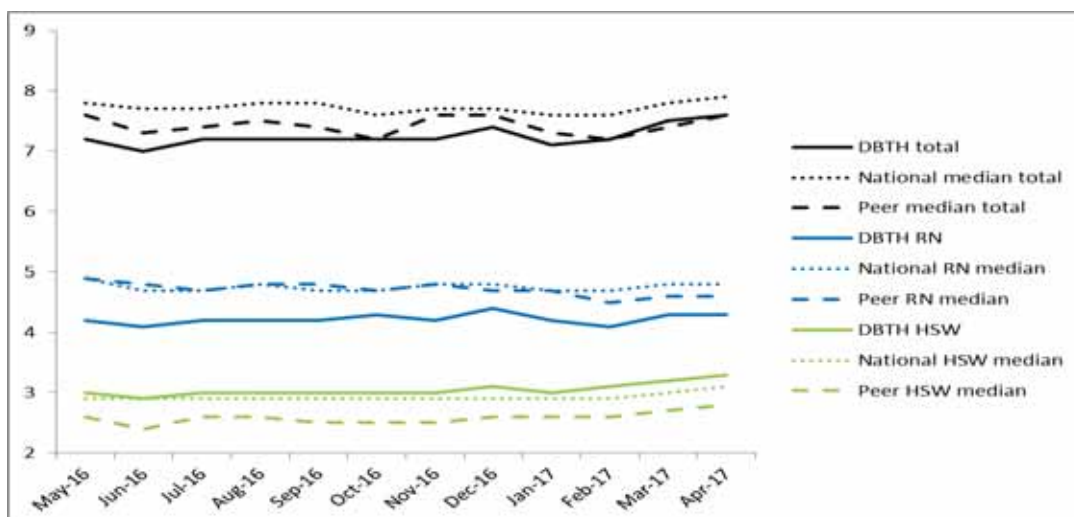
Care Hours Per Patient Day (CHPPD) – June 2017			
Site Name	Registered midwives/ nurses	Care Staff	Overall
BASSETLAW HOSPITAL	5.2	4.1	9.3
DONCASTER ROYAL INFIRMARY	4.4	3.2	7.6
MONTAGU HOSPITAL	2.1	2.5	4.7
TRUST	4.4	3.3	7.7

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



Data held within the Model Hospital portal has not been refreshed this month, with data up to April 2017. This illustrates that the overall CHPPD is similar to peers and national rates, with a slightly lower rate for Registered staff and HCA rates are slightly higher.





### 3c. Safe Staffing and Efficiency

A cap of agency expenditure for registered general and specialist nursing staff, midwives and health visitors has been in place since November 2015. The annual ceiling for DBHFT has been set at the lowest level of 3% which is a reflection of the relatively low level of bank and agency usage when compared to the national picture. The Registered Nurse rate for June is 2.7%, an increase from May at 1% and April at 2.2%, but within the 3% cap level.

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

### 3d. Nurse Manager Clinical Time

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

The Clinical and Supervisory Time in June 2017 was:

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

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

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

### **3e. Quality and Safety Profile**

The Quality Metrics (appendix 1) for adult wards include 19 indicators that cover each of the five CQC Key Assessment Criteria (safe, effective, caring and responsive, with the overall score illustrating well led). The review of the Metrics has increased to 19 measures in 2017/18, mainly comprised of data that is collected for other purposes. For metrics that have continued from previous years, there has been a resetting of the baseline to the outturn of 2016/17, revising trajectories for CDI, PU, falls with harm and multiple falls. New measures for this year include the complaint/concern rate, category 2 pressure ulcers, medicines storage, delayed/omitted medicines and the audit of appropriate fluid balance chart use linked with work to reduce the impact of acute kidney injury.

## **4. PLANNED ACTIONS AND KEY RISKS**

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

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

## **5. RECOMMENDATION**

The Quality and Effectiveness Committee is asked to NOTE the content of this paper and SUPPORT the identified actions.

APPENDIX 1: HARD TRUTHS July 2017 Paper

Workforce /Quality/Safety Profiles June 2017 Data				Workforce Information - Days				Workforce Information - Nights				Planned v Actual			Safe	Effective	Caring	Responsive	Well Led	Profile		WQAT 2015/16	WQAT 2016/17
Care Group	Matron	Ward	No of Funded Beds	Hours Total Planned Days reg nurse/mwf	Hours Total Actual reg nurse/mwf	Hours total planned support staff	Hours Actual Support Staff	Hours Total Planned Days reg nurse/mwf	Hours Total Actual reg nurse/mwf	Hours total planned support staff	Hours Actual Support Staff	Total Planned Hours	Total Actual Hours	Variance	Total score	Total score	Total score	Total score	OM total score	Work-force	Quality	Rating	Rating
Surgical	NS	B6	16	689.5	671.5	433	278	504	396	252	228	1878.5	1573.5	84%	1.0	1.0	0.0	1.5	3.5				
	NS	20	27	1674	1458	976.5	1033	713	713	713	966	4076.5	4170	102%	0.5	1.0	1.0	0.5	3.0				
	NS	21	27	1643	1459	945.5	1003.5	713	713	713	885.5	4014.5	4061	101%	0.5	1.0	1.0	2.0	4.5				
	LM	S12	20	1038.5	964	744	718	682	682	341	530	2805.5	2894	103%	2.5	0.0	1.0	2.5	6.0				
	RF	SAW	21	1561	1475.5	751.25	738.55	1072.75	1024	728.5	705	4113.5	3943.05	96%	0.5	1.0	3.5	3.0	8.0				
	LC	ITU DRI	20	5818	5711	384	384	5005	4961	0	0	11207	11056	99%	0.0	0.0	0.0	2.5	2.5				
	LC	ITU BDGH	6	1757	1649	372	176	1551	1430	0	0	3680	3255	88%	0.0	0.0	3.0	1.0	4.0				
												31776	30953	97%									
MSK and Frailty	SS	A4	24	1367.5	1197	1166	1204.5	744	744	744	813.5	4021.5	3959	98%	0.5	0.0	3.0	1.5	5.0				
	SS	B5	30.7	1764	1613.5	1764	1705	1116	1092	756	862	5400	5272.5	98%	0.5	1.0	0.0	2.5	4.0				
	AH	St Leger	35	1860	1693	1519	1392	1116	1051	1116	1320	5611	5456	97%	1.5	1.0	2.0	1.0	5.5				
	AH	1&3	23	1612	1457.5	1379.5	1569.5	744	744	1488	1906.5	5223.5	5677.5	109%	0.5	0.5	0.0	1.0	2.0				
	SS	Mallard	16	1116	1020	1116	1207	744	744	930	1374	3906	4345	111%	1.0	1.5	0.0	0.0	2.5				
	SS	Gresley	32	1488	1164	1488	2034.5	1116	1116	1116	1596	5208	5910.5	113%	0.5	1.0	0.0	1.0	2.5				
	SS	Stirling	16	1116	1048	1116	1140	744	744	744	936	3720	3868	104%	0.5	1.0	0.5	1.0	3.0				
	KM	Rehab 2	29	1147	1075	976.5	1161	744	744	744	1476	3611.5	4456	123%	1.5	0.0	3.0	1.0	5.5				
	KM	Rehab 1	29	1147	1139.5	976.5	1052.5	744	744	744	792	3611.5	3728	103%	1.0	0.0	1.0	1.5	3.5				
												40313	42673	106%									
Specialty Service	JP	18	12	1344	1091	96	318	720	720	360	384	2520	2513	100%	0.5	1.0	0.5	1.0	3.0				
	JP	18 CCU	12	1080	1006	360	395	720	720	360	372	2520	2493	99%	0.0	0.0	1.0	1.5	2.5				
	AW	32	18	1704	1494	720	614	720	720	588	696	3732	3524	94%	1.0	0.5	1.0	2.0	4.5				
	AW	16	24	1665	1372	1372	1377	1440	1392	1080	1188	5557	5329	96%	0.5	1.0	1.0	2.0	4.5				
	RM	17	24	1500	1129.5	1140	1328.5	1080	1080	1080	1224	4800	4762	99%	2.0	1.0	1.0	3.0	7.0				
	JP	CCU/C2	18	1080	1035	720	798	720	720	720	840	3240	3393	105%	0.5	0.0	1.0	2.0	3.5				
	RM	S10	20	1222	1093	975	823	720	720	360	372	3277	3008	92%	0.5	0.0	0.5	1.0	2.0				
	RM	S11	19	1125	1097	975	886.5	720	720	360	468	3180	3171.5	100%	1.0	0.0	0.0	1.0	2.0				
												28826	28194	98%									
Emergency	MH	ATC	21	2520	2352	2160	2088	1080	1032	1080	1044	6840	6516	95%	0.5	1.0	2.0	1.0	4.5				
	SS	AMU	40	2520	2196.5	2160	2531	2520	2302.5	2160	2688	9360	9718	104%	2.0	1.0	1.0	2.0	6.0				
	MH	A5	16	720	720	720	859	720	720	720	804	2880	3103	108%	1.0	1.0	0.0	3.5	5.5				
	MH	C1	16	945	969.5	720	954	720	732	720	1056	3105	3711.5	120%	0.0	2.5	1.0	2.0	5.5				
	SC	24	24	1080	1062	1440	1500	1080	1080	1440	1476	5040	5118	102%	1.0	1.5	2.0	1.0	5.5				
	SC	25	16	720	740	1080	1302	720	720	1080	1188	3600	3950	110%	2.0	1.5	0.0	1.5	5.0				
	SC	Respiratory unit	56	2775	2489	2160	2394	2520	2353	2160	2436	9615	9672	101%	2.5	3.0	1.0	2.0	8.5				
												40440	41789	103%									
Children and Families	AB	SCBU	8	784	763	0	21	660	660	0	0	1444	1444	100%	0.0	0.0	0.0	1.0	1.0				
	AB	NNU	18	2245	2171	119	119	1837	1749	165	165	4366	4204	96%	0.0	0.0	0.0	1.5	1.5				
	AB	CHW	18	1092	1092	587	587	990	968	330	330	2999	2977	99%	0.0	0.0	0.0	0.5	0.5				
	AB	COU/CSU	21	1230	1158	774	736	660	660	605	583	3269	3137	96%	0.5	0.0	0.0	0.0	0.5				
	SS	G5	24	1410	1179	720	836.5	984	923.5	360	479.5	3474	3418.5	98%	0.0	1.0	2.0	2.0	5.0				
	SS	M1	26	1420.25	1201	836.75	842.5	660	605	330	308	3247	2956.5	91%	0.0	3.0	0.5	1.0	4.5				
	SS	M2	18	771.04	662.79	317	281.25	330	330	319	297	1737.04	1571.04	90%	0.0	3.0	0.5	1.0	4.5				
	SS	CDS	14	2162	2121.5	754.15	710.4	2310	1789	660	592	5886.15	5212.9	89%	0.0	0.0	1.0	1.0	2.0				
	SS	A2	18	930	825	450	330	632	561	341	341	2353	2057	87%	0.0	2.0	0.0	2.0	4.0				
		A2L	6	1395	1066.1	464	346.55	1023	877.8	341	221.25	3223	2511.7	78%	0.0	0.0	0.5	1.5	2.0				
												31998.19	29489.64	92%									
		Trust Position										173353	173097	100%									

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



Title	Patient Experience and Complaints Quarterly Report – Q1 2017/18		
Report to:	Board of Directors	Date:	25 <sup>th</sup> July 2017
Author:	Moira Hardy, Acting Director of Nursing, Midwifery and Quality Lisette Caygill, Acting Deputy Director of Quality and Governance		
For:	Discussion		
Purpose of Paper: Executive Summary containing key messages and issues			
This report provides the Board of Directors with information relating to Quarter 1 performance using the information available from Datix and the learning points from the organisation.			
Recommendation(s)			
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 ( <i>how the values are exemplified by the work in this paper</i> )			
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 x4 =16	

## 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*. The data is produced directly from Datix. As Datix is a live system and is continually updated the report is accurate as per the report date and may not reflect the current status when viewed at the Board of Directors Meeting.

## 2. COMPLAINTS AND CONCERNS RECEIVED

The statistical process control (SPC) charts below show the trend in complaints and concerns in total and separately, from July 2015 to June 2017. These charts illustrate normal variation within expected limits.



## 2.1. COMPLAINTS & CONCERNS BY MANAGEMENT TEAM

The table below shows the Care Group rate of complaints and concerns for the last quarter.

	Concern	Complaint
Emergency Care Group	35	34
MSK and Frailty Care Group	26	28
Children and Families Care Group	13	25
Surgical Care Group	44	22
Specialty Service Care Group	23	15
Diagnostic and Pharmacy Care Group	18	5
Directorate of Estates and Facilities	19	4
Chief Operating Officer	23	3
Directorate of Nursing and Quality	2	1
Directorate of People and Organisational Development	2	0
<b>Total</b>	<b>205</b>	<b>137</b>

The charts below illustrate the trend for complaints within Care Groups and it is evident that there is normal variation over most Care Groups with the exception of Children and Families, who have had two statistically significant increases in complaints in September 2016 and March 2017. Upon further analysis whilst no specific cause or theme was identified, the increase in volume has had a large impact on complaints handling performance.



### 3. COMPLAINTS AND ENQUIRIES FROM MEMBERS OF PARLIAMENT

Members of parliament undertake representing their constituents and write to the Trust to obtain information and raise concerns and complaints. In Quarter 1 2017/18 there have been 19 occasions, which are demonstrated in the table below. The data is a subset of the overall complaint, concern and questions included in this report.

	Concern	Complaint	Advice, Comments and Questions	Total
Apr 2017	2	3	1	6
May 2017		2	2	4
Jun 2017	3	6		9
Total	5	11	3	19

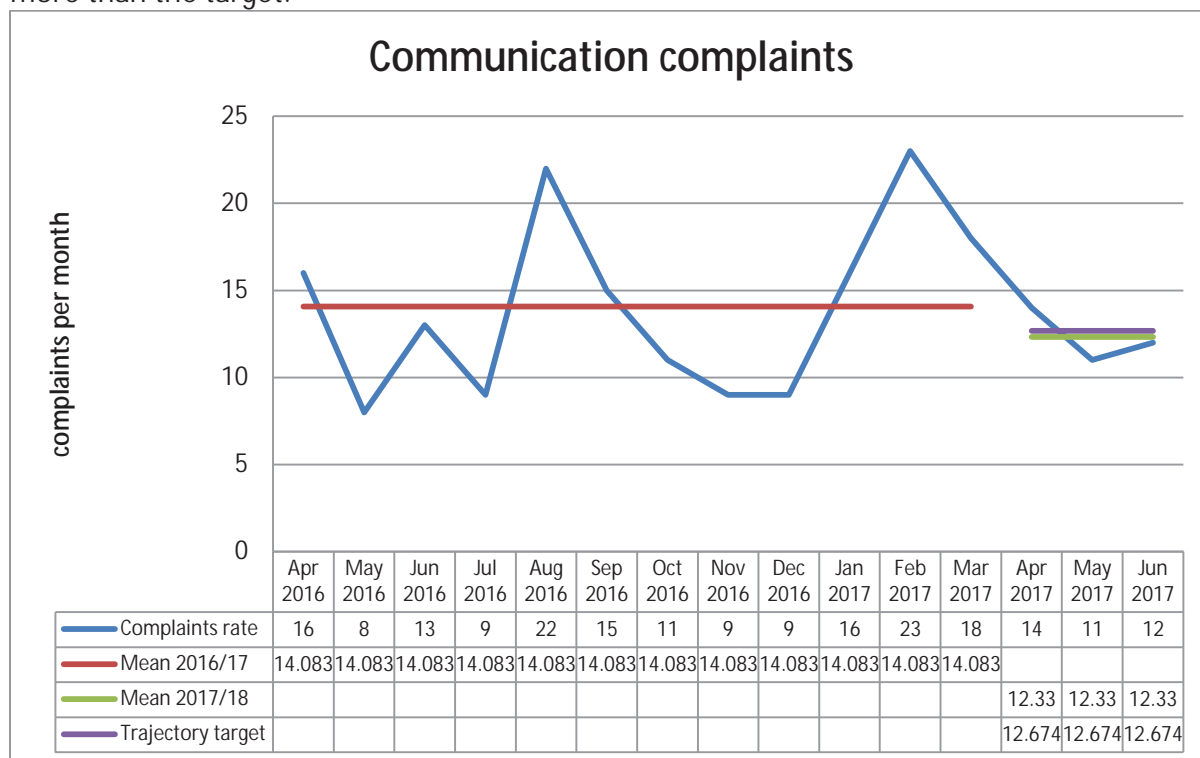
### 4. TOP 10 REASONS CITED IN A COMPLAINT

The following table lists the top 10 themes identified from complaints for the period from April– June 2017. 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.

	Communication and Staff Attitude and Behaviour	Families Care	Diagnosis and Diagnostic Tests	Pharmacy Care	Emergency Care	Emergency Care Group	MSK and Frailty	Care Group	Surgical Care	Group Specialty	Service Care	Chief Operating Officer	Directorate of Estates and Facilities	Education and Training	Nursing and Quality	Total
Communication ↔	2	1	20	18	6	5	3									55
Staff Attitude and Behaviour ↑	11	2	11	8	11	5		1	1							50
Admissions / transfers / discharge procedure / Sleeper out ↓	3		22	8	8	2										43
Treatment ↔	9		6	6	7	7										35
Competence ↑	5	1	5	7	8	4		1								31
Diagnosis ↓	7	3	11	5	5											31
Diagnostic Tests ↑			11	3	3	3										20
Medication ↔	3		5	4												12
Medical records ↑		1	5		1	1	1									9
Nursing – ADL ↓			2	5	1	1										9
Total	40	8	98	64	50	28	4	2	1							295

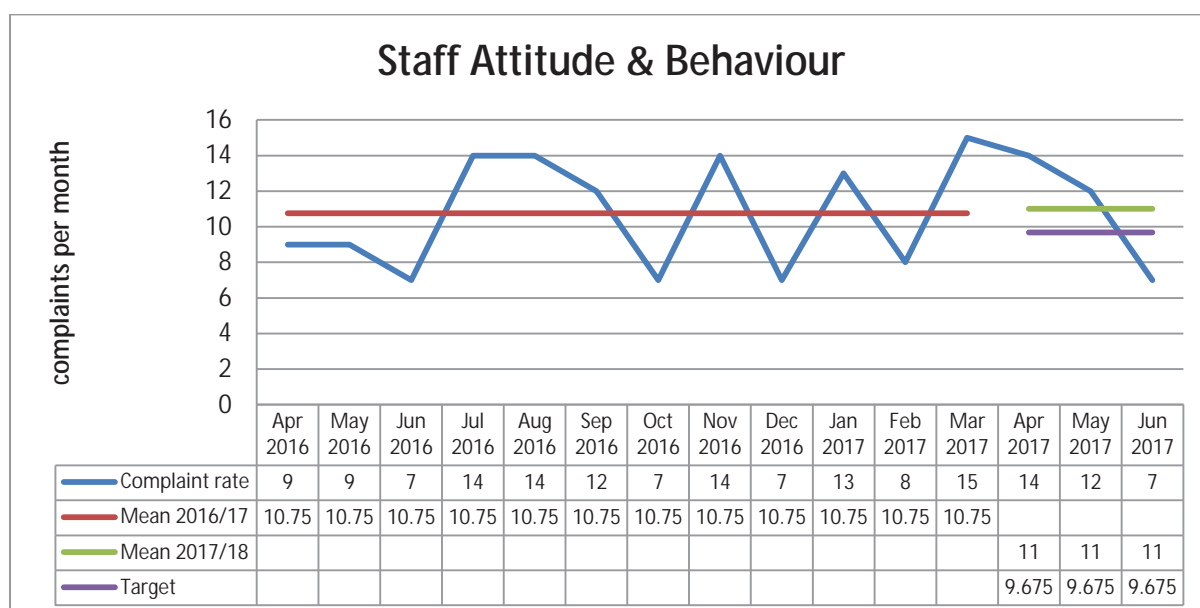
## 4.1. COMMUNICATION COMPLAINTS

One of the Quality account objectives set for 2017/18 has been to reduce Communication complaints, as a main theme for the majority of complaints. Q1 illustrates a reduction of more than the target.



## 4.2. STAFF ATTITUDE AND BEHAVIOUR

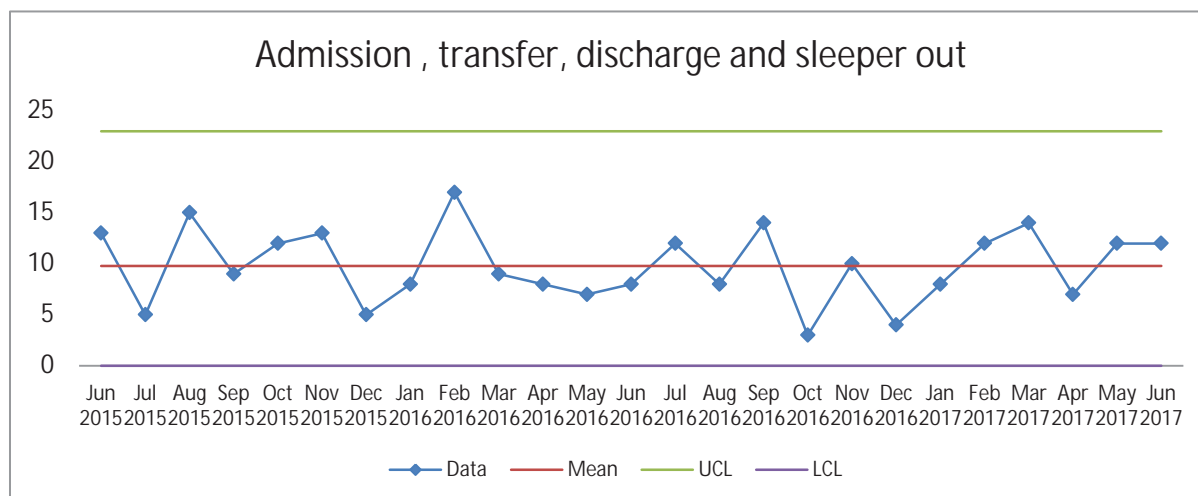
Another objective in the Quality account set for 2017/18 has been to reduce complaints in relation to staff attitude and behaviour. Q1 illustrates an average of two more reported cases per month than the target.





### 4.3. ADMISSION TRANSFER DISCHARGE & SLEEPER OUT

This demonstrates normal variation in the SPC chart below.



### 5. 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 targeted to be 20 days, Moderate risk is 40 days and High risk is 90 days.

	Low	Moderate	High	Total
Apr 2017	21	22	2	45
May 2017	25	20	2	47
Jun 2017	14	28	3	45
Total	60	70	7	137

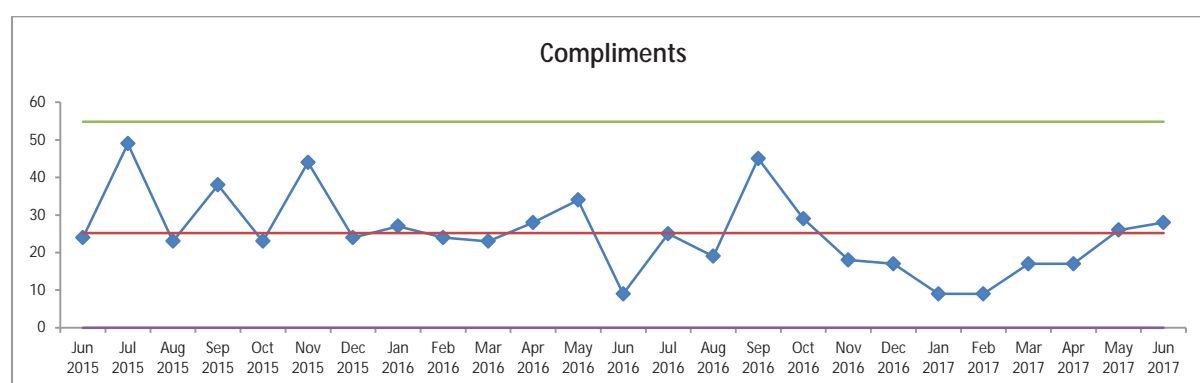
### 6. COMPLAINT REPLY PERFORMANCE

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. Weekly monitoring and performance reporting arrangements are provided to Care Group leads, so that they can ensure that they have effective systems in place. 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. The Patient Experience Team are currently reviewing the appropriateness of the time allocated with consideration of the complexity of the complaint and provide a monthly update to the

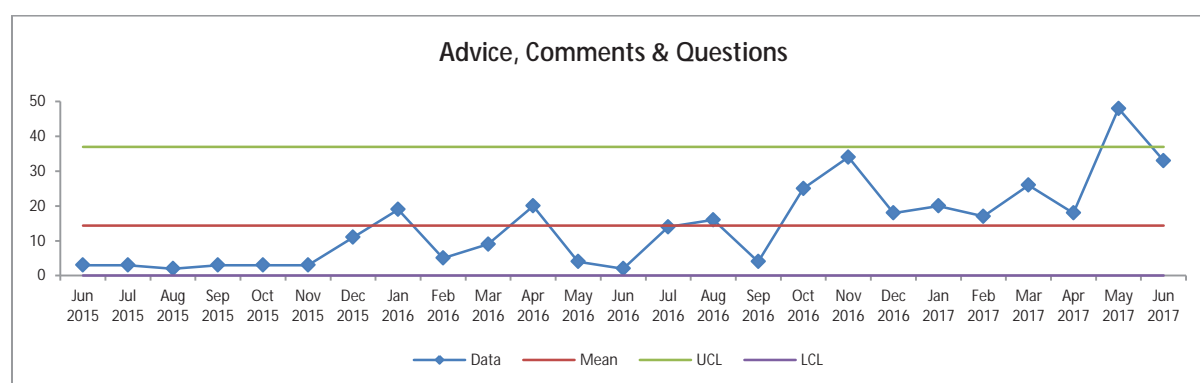
Patient Experience & Engagement Committee of actions taken to reduce outstanding complaints.

## 7. COMPLIMENTS / ADVICE, COMMENTS & QUESTIONS

The SPC chart below illustrates normal variation of the number of compliments reported on Datix either by the Patient Experience Team or added by wards and departments. Datix is currently being amended to create a simple reporting form for compliments for staff to log various kinds of thank you or compliment to make it easier to record on the system; this should go live by September 2017.



The advice, comments and questions raised with the Trust has risen and is an illustration of the enquiries raised that are not complaints or concerns about the quality of care, but obtaining more information or giving feedback.



## 8. PARLIAMENTARY & HEALTH SERVICE OMBUDSMAN (PHSO)

The latest available data from the PHSO Q1 and Q2 2016/17 was published in November 2016 and reported in the Q3 report. There is no additional data available from PHSO at the time of reporting.

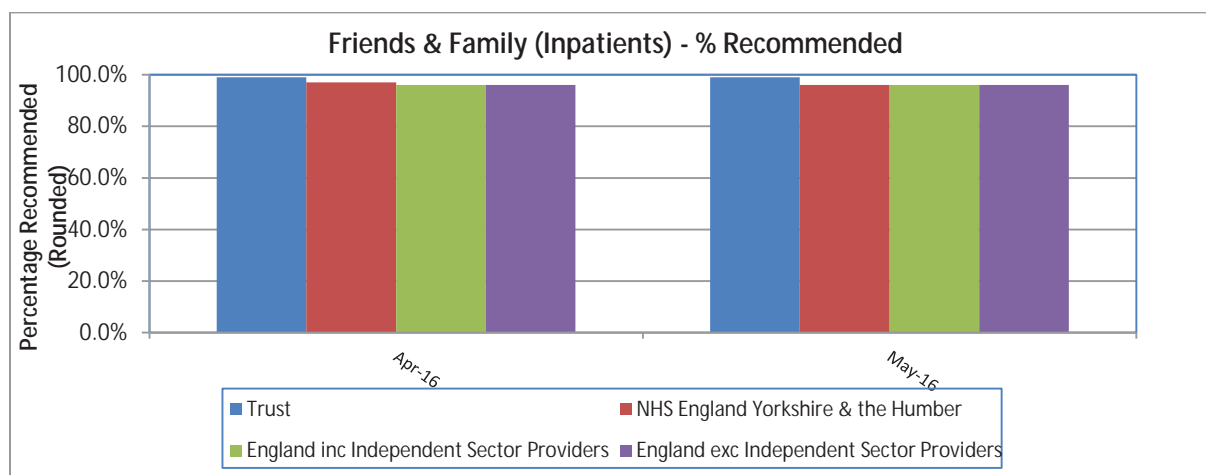
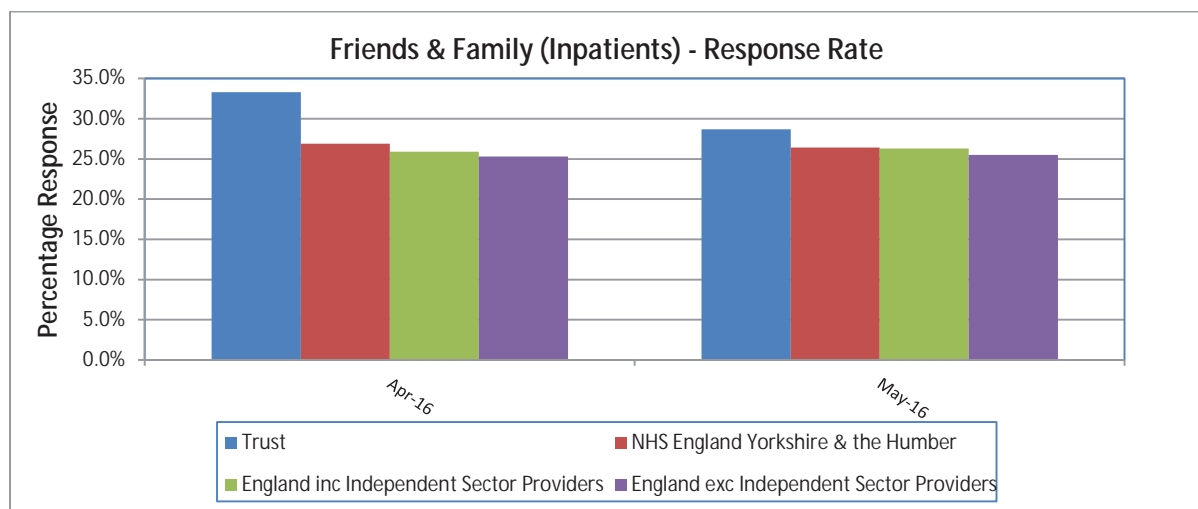
The table below illustrates the number of investigations started in Quarter 1 2017/18, shown with their original date received period, the oldest being from 2015 and outcomes of the investigation.

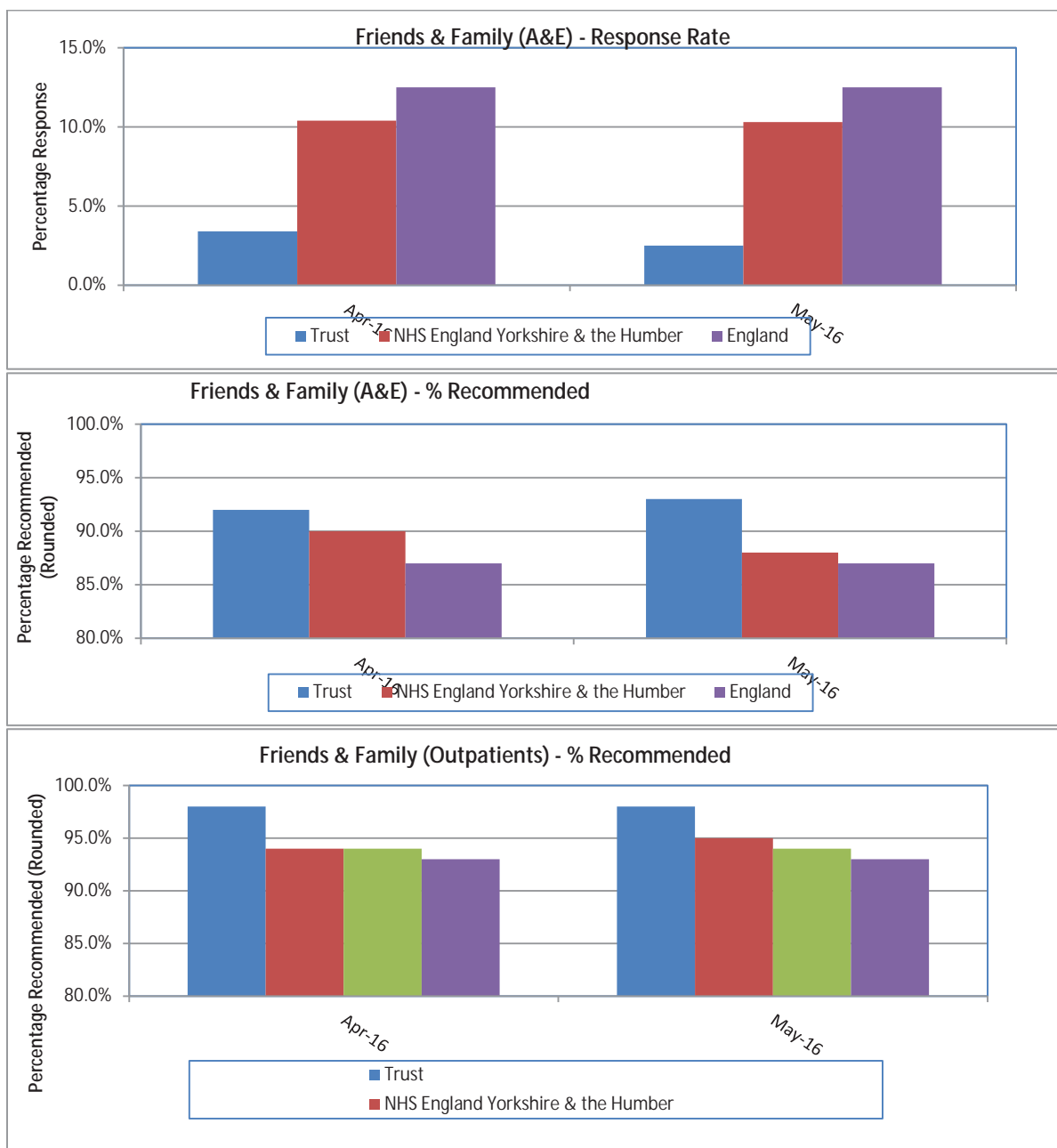
Q1 Investigation started by PHSO Original date of complaint received	14/15 Q4	15/16 Q2	16/17 Q2	16/17 Q4	Total
Children and Families Care Group	0	0	0	1	1
Emergency Care Group	1	1	1	0	3
Total	1	1	1	1	4

Q1 Outcomes of PHSO investigations	Not upheld	Upheld	Total
Children and Families Care Group	0	1	1
Specialty Service Care Group	1	0	1
Total	1	1	2

## 9. FRIENDS & FAMILY TEST (FFT)

The Charts below illustrate the Friends and Family test response rate for inpatients and A&E, with % recommended for the inpatients, A&E and outpatients. This demonstrates better than national and regional performance in all areas except for the response rate for A&E.





## 10. WARD PATIENT SURVEYS

There are monthly patient experience surveys completed in the inpatient wards and the cumulative outcomes are shown below. This is mainly positive, with nursing care specific questions being reported to be above 95%. There are strategies planned to improve on these results and these are listed in the last column.

QAT - Patient Experience Survey - Inpatient wards (1116 patients surveyed - Jan - April 2017)	Yes %	No %	Strategy to improve
Were you asked how you would like to be addressed e.g. by your first name, Mr, Mrs etc.	93.82	6.18	#Hello my name is....
Do staff introduce themselves to you when they meet you/provide care to you?	98.12	1.88	#Hello my name is....
Do staff ask your permission before they	98.3	1.7	Informal consent and

commence any procedure e.g. taking temperature/pulse etc.?			customer service skills
Do staff give you conflicting information?	15.5	84.5	Patient information and communication
Are you given the opportunity to wash your hands/use hand wipes as often as you wish?	96.68	3.32	Fundamental nursing care priorities
Do staff make sure you have everything you need within reach? e.g. drinks/call bell	97.85	2.15	Fundamental nursing care priorities
Do you get enough help from staff to eat your meals?	99.55	0.45	Fundamental nursing care priorities
Do you get enough help with drinks from staff?	99.19	0.81	Fundamental nursing care priorities
If you needed help from staff getting to the bathroom or toilet, did you get it within a timely manner?	97.63	2.37	Fundamental nursing care priorities
If you needed pain relief during your stay, was it provided quickly and without you having to ask twice?	93.7	6.3	Fundamental nursing care priorities
Are you kept informed about how your care/treatment is progressing? (e.g. test results)	93.82	6.18	Involving patients in their care and treatment
Are you given enough information about medicines you are given to take?	95.42	4.58	Patient information and communication
Are you given the opportunity to ask questions about anything you don't understand?	97.47	2.53	Patient information and communication
If your condition becomes worse at any time do you think anyone would notice?	96.86	3.14	Involving patients in their care and treatment
Do you know who you can talk to about your condition/treatment?	95.54	4.46	Involving patients in their care and treatment
Do you share a room or bay with anyone of the opposite sex?	5.82	94.18	Fundamental nursing care priorities
Overall, do you feel you are treated with care and compassion whilst in hospital?	98.66	1.34	Fundamental nursing care priorities

## 11. LEARNING FROM COMPLAINTS

### Patient Experience- Complaints Information for Patients, Families & Carers

It has been identified recently that a number of complainants are not aware of the twelve month cut off for submission of a complaint. We are improving our PET leaflet & information on the internet/intranet as part of the upgrade process to review the content and quality of information available to our patients, families & carers.

### Chief Operating Officer

Through review of the complaints/concerns received the main concern relates to cancellation of clinics or date changes. Whilst the team action and support requests from Care Groups, they also receive the complaint to manage. A change team has been put in place and any requests made outside the Standard Operating Procedure for booking/rescheduling are recorded and fed into the CEO. The team is exploring

opportunities to appoint an additional staff member to manage their complaints, and to work collaboratively with other Care Groups to assist in meeting deadlines and ensure swift resolution.

### **Duty of Candour**

This has featured in the first issue of Risky Business to highlight the key principles of our statutory duty. In addition, Datix has been updated to ease recording of the three touch points to demonstrate compliance and a weekly tracker has been developed to enable monitoring and appropriate action/support provided by the Patient Safety Team to the Care Group's.

## **12. PATIENT EXPERIENCE AND ENGAGEMENT COMMITTEE**

The Patient Experience & Engagement Committee has met on a monthly basis throughout Quarter 1 monitoring performance, quality of reply letters and learning from complaints, with contribution from Specialty, Surgical and Children & Families Care Groups, as well as the Chief Operating Officer. Reports from the annual Patient Led Assessments of the Care Environment (PLACE) along with the End of Life Relatives Survey for 2016/17 were received providing assurance of quality and identifying small areas for overall improvement. As a consequence of the PLACE feedback a Patient Environment Group is being established to devise an action plan based on the exception reports, monitor the works progress and report into PEEC. The national benchmark data is still awaited, but is usually released during August.

In addition PREM a new national annual survey led by the British Kidney Patient Association (BKPA) and the UK Renal Registry (UKRR) was also presented identifying DBTH as scoring amongst the highest in the country in all the domains (coming top in 4 of the 13 domains) and coming second nationally in the overall patient satisfaction measure.

## **13. RECOMMENDATION**

The Board of Directors is asked to NOTE the Quarter 1 Patient Experience and Complaints Quarterly Report.



**Doncaster and Bassetlaw  
Teaching Hospitals**  
NHS Foundation Trust

<b>Title</b>	NHSI Undertakings		
<b>Report to</b>	Board of Directors	<b>Date</b>	
<b>Author</b>	Matthew Kane,		
<b>Purpose</b>		Tick one as appropriate	
	Decision		
	Assurance	X	
	Information		

**Executive summary containing key messages and issues**

On 22 March 2016, it was reported to the Board that NHS Improvement had concluded that there had been a breach of licence and therefore enforcement action to remedy the breach was in order.

NHS improvement decided to accept undertakings from the Trust in relation to a number of areas, as well as adding an additional licence requirement requiring the Trust to ensure it has sufficient and effective board, management and clinical leadership capacity and capability as well as appropriate governance systems and process to enable it to address breaches of its licence and comply with the undertakings.

The attached tracker provides a breakdown of these undertakings, and a summary of progress against each one, providing the Board with oversight and highlighting any exceptions or concerns.

**Key questions posed by the report**

- Is the Board assured that the NHSI Undertakings are being complied with?

**How this report contributes to the delivery of the strategic objectives**

The undertakings are crucial to the Trust's long-term sustainability.

**How this report impacts on current risks or highlights new risks**

Further breach of the Trust's licence, or of any of the undertakings, may result in enforcement action by NHS Improvement.

**Recommendation(s) and next steps**

To review and note the attached.



## NHS Improvement Undertakings Tracker

RAG rating key:

<b>B</b>	Black - Complete
<b>G</b>	Green - On track to be achieved
<b>A</b>	Amber - Significant work to be done (i.e. not on track, not all milestones hit)
<b>R</b>	Red - Obstacles to achievement (i.e. likelihood that objective will not be achieved unless obstacles are addressed)

Ref	Undertaking	Management commentary	Lead	Timescale	Progress
<b>1</b>	<b>Sustainability</b>				
1.1	Take all reasonable steps to deliver the Trust's services on a clinically, operationally and financially sustainable basis, including but not limited to the actions in paragraphs 1.2. to 1.10 below. As part of this, the Licensee will take all reasonable steps to improve its financial position and minimise its external funding requirement, as measured by any extent or benchmark which may be specified by NHSI.	CIP plans and governance processes in development 11.9m delivered in 2016/17 and plans for £14.5m delivery in 2017/18 (approx. £13.5m identified). Involved in hospital review and Accountable Care System.	JS	Ongoing	<b>G</b>
1.2.1	Develop and submit to NHSI a Short Term Recovery Plan comprising: - a recovery plan for 2016/17 to be submitted to NHSI by 29 April 2016, or such other date as may be agreed with NHSI; and - a recovery plan for 2017/18 to be submitted to NHSI by July 2016, or such other date as may be agreed with NHSI.	2 year plan delivered in August. 3-5 year plan delivered in draft by April and in final by July 2017. Update provided to NHSI on 17 February. Final plan to be agreed at Board in July 2017.	JS	31-Jul-17	<b>G</b>
1.2.2	Develop and submit to NHSI a strategy for financial sustainability and an associated longer-term, five year financial plan ("the Strategic Plan"), to be submitted to NHSI by 30 September 2016, or such other date as may be agreed with NHSI.	3-5 year plan delivered in draft end April, and due to be agreed in final form by July 2017.	JS	31-Jul-17	<b>G</b>
1.3	Either deliver, or if NHSI so specifies, demonstrate to NHSI that it can deliver, each of the plans referred to in paragraph 1.2.	Ongoing	JS	Ongoing	<b>G</b>
1.4	In relation to the development of both the short term recovery plan and the strategic plan, consult with its commissioners and ensure that the plans reflect appropriately the views of its commissioners.	Several meetings including a QPIA panel already held. Both CCGs are on the panel and on the Programme Steering Group. A roundtable with the CCGs sponsored by NHSI has also taken place.	JS	31-Jul-17	<b>G</b>
1.5	Modify the plans if needed in response to any input from NHSI after NHSI has received and considered the plans, whether such input is provided before or after receipt of the assurance specified in paragraph 1.6.	Ongoing	JS	31-Jul-17	<b>G</b>
1.6	Obtain assurance that the plans and their delivery will enable the Trust to comply with paragraph 1.1. The source, scope and timing of that assurance will be agreed with NHSI, and the assurance will be provided to NHSI if NHSI so requests.	Factored into internal audit plan.	JS	Ongoing	<b>G</b>

Ref	Undertaking	Management commentary	Lead	Timescale	Progress
1.7	Develop and agree with NHSI Key Performance Indicators (“KPIs”) to assess the effective delivery and impact of the short term recovery plan and strategic plan, by such date as to be agreed with NHSI.	For future agreement	DJ / JS	tbc	N/a
1.8	Commission, at any point, the level of external support considered necessary by NHSI to assist the Licensee in the development and delivery of the plans, the scope and the identity of the provider of that support to be agreed with NHSI.	FIP phase 1 undertaken, other providers will be necessary for niche or specialist support.	RP	Ongoing	G
1.9	Ensure that the Trust has the necessary personnel, systems and processes to enable it to deliver the short term recovery plan and the strategic plan, including demonstrating that it has sufficient executive and senior management capacity and expertise to enable delivery.	Executive and deputy director structure established and embedded.	RP	Ongoing	G
1.9.1	Consult and agree with NHSI the appointment and scope of any key advisors in relation to the plans described above, in addition to external support referred to in paragraph 1.8 above.	Ongoing (see comments re: FIP)	RP/SBE	Ongoing	G
1.9.2	Consult and agree with NHSI executive capacity to support the delivery of the plans described above, including key executive appointments.	Ongoing as appropriate.	RP/SBE	Ongoing	G
1.9.3	Consult and agree with NHSI finance department capacity to support the delivery of the plans described above.	Proposals for changes to finance team approved August 2016. Reliance on interims reducing. Key appointments made to senior finance roles.	JS	Ongoing	G
1.1	Keep the short term recovery plan and the strategic plan, and their delivery, under review. Where matters are identified which materially affect the Licensee’s ability to deliver sustainable services, whether identified by the Licensee or another party, the Licensee will notify NHSI as soon as possible and update and resubmit the short term recovery plan and/or the strategic plan within a timeframe to be agreed with NHSI.	Ongoing, through reporting to NHSI.	RP / JS	Ongoing	G
<b>2 Financial Governance</b>					
2.1	Take all reasonable steps to address the weaknesses in its financial governance, including but not limited to the actions in paragraphs 2.2 to 2.5 below.	KPMG recommendations have been implemented in line with plan. Management response & action plan monitored at board committees. Internal audit undertaking regular audits on financial reporting processes, which has provided significant assurance.	JS	31-Dec-16	B
2.2	Develop an action plan to address the findings and recommendations arising from KPMG’s Financial Misreporting Investigation. This action plan will be agreed with NHSI. The Licensee will implement the action plan, unless otherwise agreed with NHSI.	Action plan agreed, implementation complete.	JS	31-Dec-16	

Ref	Undertaking	Management commentary	Lead	Timescale	Progress
2.3	Commission a wider governance review, the scope and timing of which is to be agreed with NHSI. If required by NHSI, develop an action plan to address any findings and recommendations arising from this review. This action plan will be agreed with NHSI. The Licensee will implement the action plan, unless otherwise agreed with NHSI.	Review completed by end of Q3 timescale. Working group established to scope recommendations. Majority of action plan implemented and reported to Board in June 2017.	RP	Ongoing	G
2.4	Following implementation of the action plans referred to in 2.2 and 2.3 above, if required by NHSI, commission a follow up review from a source and according to a scope and timing to be agreed with NHSI to test whether the actions are implemented. If such a review is commissioned, provide copies of the draft and final reports to NHSI within a week of receiving them.	To be undertaken by NHSI	RP	Tbc	N/a
2.5	If required by NHSI, commission an assurance review of the Trust's 2015/16 financial baseline position, with the scope and timing to be agreed with NHSI. Following this review, if required by NHSI, develop an action plan to address any findings and recommendations arising. This action plan will be agreed with NHSI. The Licensee will implement the action plan, unless otherwise agreed with NHSI.	To be undertaken by NHSI	RP/JS	Tbc	N/a
<b>3 Distressed Financing and Sustainability and Transformation Fund</b>					
3.1	Where interim support financing or planned term support financing is provided by the Secretary of State to the Licensee pursuant to section 40 of the NHS Act 2006, or the Licensee receives payments under the Sustainability and Transformation Fund, the Licensee will comply with any terms and conditions which attach to the financing or payments.	All terms and conditions will be complied with. Indeed compliance with such has been integrated into the Trust's financial, operational and other plans.	JS	Ongoing	G
3.2	Comply with any reporting requests made by NHSI in relation to any financing to be provided to the Licensee by the Secretary of State pursuant to section 40 or 42 of the NHS Act 2006 or payments made under the Sustainability and Transformation Fund.	All reporting requests will be complied with as required.	JS	Ongoing	G
3.3	Comply with any spending approvals that are deemed necessary by NHSI.	All requests will be complied with as and when required.	JS	Ongoing	G
<b>4 General</b>					
4.1	Implement sufficient programme management and governance arrangements to enable delivery of these undertakings.	Programme management arrangements established and recently refreshed in Q1 2017/18, reporting via Finance and Performance Committee.	JS	Q2 2017/18	B
4.2	Such programme management and governance arrangements must enable the Board to: - obtain clear oversight over the progress in delivering the undertakings; - obtain an understanding of the any risks to the successful achievement of the undertakings and ensure appropriate mitigation of any such risks; and - hold individuals to account for the delivery of the undertakings.	Turnaround programme reporting to Board via monthly Finance and Performance Committee. Workstream SROs are held to account by the Committee. Major risks may be escalated to Board.	JS	Q2 2017/18	

Ref	Undertaking	Management commentary	Lead	Timescale	Progress
4.3	Provide regular reports to NHSI on its progress in meeting the undertakings set out above, in a format to be agreed between the Licensee and NHSI, including reporting against the KPIs agreed pursuant to paragraph 1.7.	Weekly telephone meetings stood down. Regular reports and NHSI performance review meetings take place.	RP / JS	Ongoing	G
4.4	Attend meetings, or, if NHSI stipulates, conference calls, as required, to discuss its progress in meeting those undertakings. These meetings will take place once a month unless NHSI otherwise stipulates, at a time and place to be specified by NHSI and with attendees specified by NHSI.	As in 4.3.	RP / JS	Ongoing	G
4.5	Provide NHSI with the assurance relied on by its Board in relation to its progress in delivering these undertakings, upon request.	On request.	RP / SBE	On request	N/a
4.6	Provide to NHSI direct access to its advisors, the Licensee's board members, and any other members of the Licensee's staff considered necessary by NHSI, as needed in relation to the matters covered by these undertakings.	Regular NHSI contact with Chair & other board members. NHSI meetings with governors have taken place with next one planned for 15 September. NHSI has access to relevant advisors / consultants.	RP/SBE	Ongoing	G
4.7	Comply with any additional relevant reporting or information requests made by NHSI.	On request.	RP/SBE	On request	N/a



**Doncaster and Bassetlaw  
Teaching Hospitals**  
NHS Foundation Trust

Title	Corporate Risk Register and Board Assurance Framework – July 2017		
Report to	Board of Directors	Date	25 July 2017
Author	Matthew Kane, Trust Board Secretary		
Purpose		Tick one as appropriate	
	Decision		
	Assurance	X	
	Information		

**Executive summary containing key messages and issues**

The Corporate Risk Register and Board Assurance Framework have both been revised in line with guidance and first versions are attached to this report.

The new versions better reflect the intended purpose of the two documents:

- The BAF now reflects the key risks to the Trust's four strategic objectives, along with progress against corporate objectives so that performance, governance and risk are better aligned. It is intended to give a 'whole picture' of assurance to the Board and should be used to drive the Board agenda and the internal audit plan.
- The CRR details the Trust's extreme risks (i.e. those 15 to 25). This is in line with the Risk Identification, Management and Assessment Policy (also on agenda for consideration). The Committee may choose to redefine the boundaries of what is considered to be a corporate risk (e.g. all red and amber risks).

The BAF and CRR have been constructed following sessions with Finance and Performance and Quality and Effectiveness Committees and risks have been aligned to each committee accordingly. This exercise saw a number of changes to the CRR and BAF.

A number of risks (relating to finance, workforce, estates, service provision and IT) were mapped over. The following risks were amalgamated:

F&P2	Failure to deliver accurate financial reporting underpinned by effective financial governance <b>and</b> failure to deliver financial plan	L3 x I5 = 15
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The following risks were removed:

Old risk 10	Risk from board leadership transition including new Chair and Chief Executive, Director of Finance and non-executive directors	L2 x I4 = 8
Old risk 15	Failure to deliver accurate and timely performance information through CaMIS system	L3 x I4 = 12

The following new risks were added:

Q&E2	Lack of adequate CT scanning capacity at DRI	L3 x I3 = 9
Q&E3	Inability to sustain the Paediatrics service at Bassetlaw	L2 x I2 = 4
Q&E4	Failure to ensure adequate medical records system	L3 x I3 = 9
Q&E5	Failure to engage with patients around the quality of care and proposed service changes	L2 x I3 = 5
Q&E6	Failure to improve staff morale	L3 x I4 = 12
Q&E7	Failure to adequately prepare for CQC inspection	L2 x I3 = 6
F&P12	Failure to ensure that estates infrastructure is adequately maintained and upgraded in accordance with the Regulatory Reform (Fire Safety) Order 2005 and other current legislation standards and guidance	L3 x I5 = 15
F&P13	Inability to meet Trust's needs for capital investment	L4 x I4 = 16

All risks have been reviewed by nominated executive leads.

It is the Management Board that is responsible for approving changes to the Corporate Risk Register and the Board of Directors that is responsible for approving the Board Assurance Framework. The Management Board agreed the changes above at its meeting on 10 July.

Risks can move from the BAF to the CRR and vice-versa depending on the ratings.

To ensure Board and its committees are sighted on all risks it is intended to bring the BAF and CRR on a monthly basis to F&P and QEC and on a quarterly basis to Board and ANCR for review and proposed changes.

New risks can be identified in a number of ways:

- Through Board or its committees.
- Through departmental risk registers contained on the Datix system and subsequent discussion at care group clinical governance meetings.
- Through identification at Executive Team.
- Through a risk workshop – see committee effectiveness action plan.

The Trust Board Secretary and staff responsible for clinical governance meetings have already discussed how risk management at care group clinical governance level can be enhanced (i.e. by dealing with risk more formally rather than with a verbal item).

The following remains outstanding:

- Further work with executives on identifying gaps in controls and assurance needs to be carried out and added to the BAF and CRR.
- Training to be undertaken with staff on risk management. The Trust Board Secretary and Deputy Director of Governance and Quality have been in discussion on this.

#### **Key questions posed by the report**

- Does the risk register and board assurance framework cover the relevant risks?
- Are the controls, gaps, actions and ratings for the risks within the newly formatted risk register and board assurance framework adequate?
- How are we going to gain assurance on mitigation of organisational risks?

#### **How this report contributes to the delivery of the strategic objectives**

The Corporate Risk Register and Board Assurance Framework, taken together, allow the Board and its committees to maintain oversight on the key risks affecting the strategic and corporate objectives.

#### **How this report impacts on current risks or highlights new risks**

The report sets a new baseline for corporate risk reporting in the year and introduces some new risks.

#### **Recommendation(s) and next steps**

To note the report.

Doncaster & Bassetlaw Teaching Hospitals Corporate Risk Register																
No.	Description of Risk		Exec owner	Relevant committee	Original Risk Score 1:Low ...5:Extreme		Overall Original Risk Score	Controls	Current Risk Score 1:Low 5:Extreme		Overall Current Risk Score	Direction of travel	Target Risk Score 1:Low 5:Extreme		New and developing controls	Owner and target date
	Source (Lack of...Failure to ...)	Consequences (Results in ...Leads to ...)			Like- lihood	Impact			Like- lihood	Impact			Like- lihood	Impact		
F&P1	Failure to achieve compliance with financial performance and achieve financial plan	(i) Adverse impact on Trust's financial position (ii) Adverse impact on operational performance (iii) Impact on reputation (iv) Regulatory action	Director of Finance	Finance & Performance	3	5	15	(i) Business and budget planning processes. (ii) Financial governance policies and procedures. (iii) Monthly monitoring of financial performance. (iv) Data analysis of trends and action to address deterioration. (v) Continued liaison with budget holders to identify risks to delivery. (vi) Demand and capacity planning processes. (vii) Detailed monitoring by Finance and Performance Committee. (viii) Budgets set on recurrent outturn resulting in a more robust financial plan. (ix) Budgets signed off by care groups and corporate departments. (x) Monthly monitoring at Board and directorate level. (xi) Uncommitted general contingency reserve. (xii) Regular finance meetings with budget holders. (xiii) Performance review meetings with NHSI. (xiv) All directorates signed up to control total.	3	5	15	N/A	2	5	N/A	
F&P3	Failure to deliver Cost Improvement Plans in this financial year	(i) Negative impact on Turnaround (ii) Negative impact on Trust's financial position (iii) Loss of STF funding	Director of Finance	Finance & Performance	4	4	16	(i) Full Quality Risk Assessment and operational deliverability assessment of plans. (ii) Regular consideration of schemes by Management Board and Executive Team. (iii) Collaboration with other providers, to identify joint opportunities. (iv) CIP tracker developed to provide visibility of progress against plan. (v) Engagement in working together programme. (vi) PMO, with associated management processes, key deliverables, risk logs and reporting to Finance and Performance Committee. (vii) Implementation of innovation from external reviews. (viii) Regular meetings with NHSI to track progress.	4	4	16		1	4	None.	
F&P4	Failure to ensure that estates infrastructure is adequately maintained and upgraded in line with current legislation, standards and guidance. <b>Note:</b> A number of different distinct risks are contained within this overarching entry. For further details please consult the E&F risk register.	(i) Breaches of regulatory compliance and enforcement (ii) Claims brought against the Trust (iii) Inability to provide safe services (iv) Negative impact on reputation (v) Reduced levels of business resilience (vi) Inefficient energy use (increased cost) (vii) Increased breakdowns leading to operational disruption (viii) Restriction to site development	Director of Estates and Facilities	Finance & Performance	4	5	20	(i) Annual business plan supports identification of issues by Care Groups / Directorates (ii) Risk-based capital investment plans (iii) Maintenance and support service contracts (iv) Independent Authorising Engineers appointed for key services, providing annual audits and technical guidance (v) Revised business planning process for all capital investments (vi) Estate condition and backlog maintenance assessment undertaken via 6-7 facet survey (vii) Progress and monitoring of actions undertaken through compliance committees e.g. health and safety committee	4	5	20		2	5	(i) Estates and facilities strategy (ii) Review and develop business continuity and disaster recovery plans (iii) Comprehensive review of Estates and facilities risk register and risk escalation process (iv) Seek additional funding to rectify condition and backlog maintenance issues	
F&P6	Failure to achieve compliance with performance and delivery aspects of the Single Oversight Framework, CQC and other regulatory standards	(i) Regulatory action (ii) Impact on reputation	Chief Operating Officer	Finance & Performance (Impact on performance) Quality & Effectiveness (Impact on quality)	4	4	16	(i) Performance Management and Accountability Framework. (ii) Business planning processes (iii) Relevant policies and procedures. (iv) Daily, weekly & monthly monitoring of targets. (v) Regular monitoring of compliance. (vi) Data analysis of trends and action to address shortfalls. (vii) Continued liaison with leads to identify risks to delivery. (viii) CQC Compliance Governance and Assurance Process. (ix) External reviews policy. (x) Monitoring at monthly Care Group accountability meetings. (xi) A&E OAT process. (xii) Demand and capacity planning processes. (xiii) Weekly review of A&E Action plan in accountability meeting chaired by COO.	4	4	16		3	3	None.	
F&P8	Inability to recruit right staff and have staff with right skills	(i) Increase in temporary expenditure (ii) Inability to meet FYFV and Trust strategy (iii) Inability to provide viable services	Director of People & OD	Finance & Performance	4	4	16	(i) HR policies and procedures. (ii) Monitoring of use of agency staff through robust processes to stay within cap. (iii) Medical staff recruitment action plans. (iv) Care Group Business Plans – workforce plans. (v) E-Rostering processes. (vi) VCF processes. (vii) Consultant appointment approval processes. (viii) NHS Professionals processes & management information. (ix) Pilot of Assistant Practitioner role.	4	4	16		2	4	Exploring recruitment with other partners and through other methods.	Director of Nursing, Midwifery and Quality - ongoing.
F&P11	Failure to protect against cyber attack	(i) Trust becoming non-operational (ii) Inability to provide clinical services (iii) Negative impact on reputation	Chief Information Officer	Finance & Performance	3	5	15	(i) Penetration test of systems to identify gaps and risks; (ii) Firewalls, passwords, anti-virus equipment (iii) Policies and reinforcement through communication to staff; (iv) Staff awareness through Certified Security Professional course and other training; (v) Trigger alerts; (vi) Care Cert system at NHS Digital.	3	5	15		1	4	Dedicated resource to deal with information security	



F&P12	Failure to ensure that estates infrastructure is adequately maintained and upgraded in accordance with the Regulatory Reform (Fire Safety) Order 2005 and other current legislation standards and guidance. <b>Note:</b> a number of different distinct risks are contained within this overarching entry. For further details please consult the EF risk register.	(i) Breaches of regulatory compliance could result in Enforcement or Prohibition notices issued by the Fire and Rescue Services (ii) Claims brought against the Trust (iii) Inability to provide safe services (iv) Negative impact on reputation	Director of Estates and Facilities	Finance & Performance	4	5	20	(i) Regular external inspections from SVRS and Notts Fire Service (ii) Improved fire safety risk assessments and evacuation strategies (iii) Improved Fire Safety Training (iv) Programme upgrade of fire detection systems (v) Programme upgrade of structural fire precautions (compartments) (vi) External Audit Fire Authorised Engineer (vii) Fire safety training Trust Board and Exec Team (viii) Further Development of Fire Safety Response Team structure (ix) Risk based Capital Investment plans identified by estate condition and backlog maintenance assessments via 6 - 7 facet surveys (x) Progress and monitoring of acations undertaken through compliance committees eg health and safety committee	3	5	15		2	5	(i) Further review of Risk Based capital investment plans (ii) Comprehensive review of Estates and Facilities risk register and risk escalation process (iii) Seek additional funding to rectify condition and backlog maintenance issues	
F&P13	Inability to meet Trust's needs for capital investment	(i) Inability to sustain improveemnts in Trust's estate. (ii) Negative impact on patient safety. (iii) Negative impact on reputation.	Director of Finance	Finance & Performance	4	4	16	(i) Finance reports to Board and Finance and Performance Committee. (ii) Capital governance strcuture - Corporate Investment Group and Capital Monitoring Group. (iii) Guidance and templates for investment and disinvestment.	4	4	16		1	4	Clarity around process over STP capital projects.	

	PROBABILITY
1 RARE	Less than 5%
2 UNE LIKELY	5% to 20%
3 POSSIBLE	21% to 50%
4 LIKELY	51% to 80%
5 ALMOST CERTAIN	More than 80%

	BUSINESS OBJECTIVE	FINANCE	COMPLIANCE	SAFETY	REPUTATION	SERVICE DELIVERY
1 NEGLECTIBLE	Minor impact/delay/overspend/diffculty	Minor loss ≤ £1,000	Single, very short-term single non-compliance	Minor/heard injury (no intervention)	Low level public awareness/concern	Negligible impact/unnoticed by service users
2 MINOR	Small impact/delay/overspend/diffculty	Small loss £1,001-£10,000	Small, single, short-term non-compliance	Minor injury (local intervention)	Short-term local media coverage	Small impact/small inconvenience
3 MODERATE	Medium scale impact/delay/overspend/diffculty	Moderate loss £10,001-£100,000	Sustained single or a few short-term non-compliances	Moderate injury (professional intervention)	Longer term local media coverage	Medium level impact/moderate inconvenience
4 MAJOR	Significant impact/delay/overspend/diffculty	Significant loss £100,001-£1,000,000	Multiple sustained non-compliances	Major injury (hospital stay)	Short-term national media coverage	Significant impact/serious inconvenience
5 CATASTROPHIC	Substantial impact/delay/overspend/diffculty	Substantial loss ≥ £1,000,000	Multiple, long-term, significant non-compliances	Fatal injury	Longer-term national media coverage	Substantial/Complete service failure

Doncaster & Bassetlaw Teaching Hospitals Corporate Risk Register																
No.	Description of Risk		Exec owner	Relevant committee	Original Risk Score 1:Low...5:Extreme		Overall Original Risk Score	Controls	Current Risk Score 1:Low 5:Extreme		Overall Current Risk Score	Direction of travel	Target Risk Score 1:Low 4:Extreme		New and developing controls	Owner and target date
	Source (Lack of ...Failure to ...)	Consequences (Results in ...Leads to ...)			Like- lihood	Impact			Like- lihood	Impact			Like- lihood	Impact		
F&P7	Failure to achieve compliance with performance and delivery aspects of the Single Oversight Framework, COC and other regulatory standards	(i) Regulatory action (ii) Impact on reputation	Chief Operating Officer	Finance & Performance (Impact on performance) Quality & Effectiveness (Impact on quality)	4	4	16	(i) Performance Management and Accountability Framework. (ii) Business planning processes (iii) Relevant policies and procedures. (iv) Daily, weekly & monthly monitoring of targets. (v) Regular monitoring of compliance. (vi) Data analysis of trends and action to address shortfalls. (vii) Continued liaison with leads to identify risks to delivery. (viii) COC Compliance Governance and Assurance Process. (ix) External reviews policy. (x) Monitoring at monthly Care Group accountability meetings. (xi) A&E QAT process. (xii) Demand and capacity planning processes. (xiii) Weekly review of A&E Action plan in accountability meeting chaired by COO.	4	4	16	N/A	3	3	None.	

	PROBABILITY
1 BASE	Less than 5%
2 UNLIKELY	5% to 20%
3 POSSIBLE	21% to 50%
4 LIKELY	51% to 80%
5 ALMOST CERTAIN	More than 80%

	BUSINESS OBJECTIVE	FINANCE	COMPLIANCE	SAFETY	REPUTATION	SERVICE DELIVERY
1 NEGLECTIBLE	Negligible impact/delay/overspend/difficulty	Minor loss = £1,000	Trivial, very short-term single non-compliance	Insignificant injury (no intervention)	Low level public awareness/concern	Negligible impact/unnoticed by service users
2 MINOR	Small impact/delay/overspend/difficulty	Small loss £1,001 - £10,000	Small, single, short-term non-compliance	Minor injury (local intervention)	Short-term local media coverage	Small impact/ slight inconvenience
3 MODERATE	Medium scale impact/delay/overspend/difficulty	Moderate loss £10,001 - £100,000	Sustained single or a few short-term non-compliance	Moderate injury (professional intervention)	Longer-term local media coverage	Medium level impact/moderate inconvenience
4 MAJOR	Significant impact/delay/overspend/difficulty	Significant loss £100,001 - £1,000,000	Multiple sustained non-compliance	Major injury (hospital stay)	Short-term national media coverage	Significant impact/serious inconvenience
5 CATASTROPHIC	Substantial impact/delay/overspend/difficulty	Substantial loss = £1,000,000	Multiple, long-term, significant non-compliance	Fatal injury	Longer-term national media coverage	Substantial/Complete service failure

Doncaster & Bassetlaw Teaching Hospitals Corporate Risk Register																	
No.	Description of Risk		Exec owner	Relevant committee	Original Risk Score 1:Low...5:Extreme		Overall Original Risk Score	Controls		Current Risk Score 1:Low 5:Extreme		Overall Current Risk Score	Direction of travel	Target Risk Score 1:Low 4:Extreme		New and developing controls	Owner and target date
	Source (Lack of....Failure to ....)	Consequences (Results in ....Leads to ....)			Likelihood	Impact				Likelihood	Impact			Likelihood	Impact		

	PROBABILITY
1 RARE	Less than 5%
2 UNLIKELY	5% to 20%
3 POSSIBLE	21% to 50%
4 LIKELY	51% to 80%
5 ALMOST CERTAIN	More than 80%

	BUSINESS OBJECTIVE	FINANCE	COMPLIANCE	SAFETY	REPUTATION	SERVICE DELIVERY
1 NEGLECTIBLE	Negligible impact/delay/overspend/difficulty	Minor loss < £1,000	Trivial, very short-term single non-compliance	Insignificant injury (no intervention)	Low level public awareness/concern	Negligible impact/unnoticed by service users
2 MINOR	Small impact/delay/overspend/difficulty	Small loss £1,001-£10,000	Small, single, short-term non-compliance	Minor injury (local intervention)	Short-term local media coverage	Small impact/small inconvenience
3 MODERATE	Medium scale impact/delay/overspend/difficulty	Moderate loss £10,001 – £100,000	Sustained single or a few short-term non-compliances	Moderate injury (professional intervention)	Longer-term local media coverage	Medium level impact/moderate inconvenience
4 MAJOR	Significant impact/delay/overspend/difficulty	Significant loss £100,001 – £1,000,000	Multiple sustained non-compliances	Major injury (hospital stay)	Short-term national media coverage	Significant impact/serious inconvenience
5 CATAS-STROPHIC	Substantial impact/delay/overspend/difficulty	Substantial loss > £1,000,000	Multiple, long-term, significant non-compliances	Fatal injury	Longer-term national media coverage	Substantial/Complete service failure

Strategic Aim 1 - 1. Work with our patients to continue to develop accessible, high quality and responsive services, and with our staff to develop the skills, values, and leadership to provide high quality, efficient and effective care								
KEY STEPS	Ensure the delivery of the Trusts financial plan and the implementation of an agreed improvement and effectiveness plan with identified work streams and SROs. Delivering service change and savings through achieving agreed targets and milestones Co-ordinate the development of an innovative and sustainable workforce plan across the Trust. Developing and implementing plans to improve leadership, recruitment and retention initiatives Co-ordinate, develop and ensure the implementation, delivery and monitoring of the staff engagement action plan to ensure the delivery of the Trusts values and an improvement in the national staff survey results for 2017/ 18 Co-ordinate the production and delivery of Board and Executive Team Development Programmes To create a stable and motivated finance function, measured by staff turnover, implementation of restructures, staff survey Implement a Patient and Carer Experience and Engagement Strategy. Implementing national and international best practice in the use of feedback to improve services. Provide appropriate technology support to the Trust for the development of the Single Oversight Framework throughout 2017.							
PROGRESS	Direction  To be completed.							
RISKS	LINK TO CRR	EXEC	CURRENT RR	CONTROLS	ASSURANCE	GAPS IN ASSURANCE	ACTION TO ADDRESS GAPS	TARGET RR
Failure to sustain a viable specialist and non-specialist range of services  leading to  (i) Regulatory action (ii) Impact on reputation	F&P7	Chief Operating Officer	L2 x I2 = 4	(i) Participation in WTP (ii) Commissioner engagement (iii) Involvement/influence NHSE commissioning intentions (iv) R & D support for specialist services (v) Quarterly Executive discussions with STH (vi) Contribution to reconfiguration discussions	(i) Peer review programme outcome (9 June 2016) (ii) Patient outcome and service quality as published by National Registries (iii) Agreement with Sheffield over vascular services	(i) Strategic review of specialised services in Y&H currently in progress and due to report September 2017		L2 x I2 = 4
Inability to recruit right staff and have staff with right skills  leading to  (i) Increase in temporary expenditure (ii) Inability to meet FYFV and Trust strategy (iii) Inability to provide viable services	F&P8	Director of People & OD	L4 x I4 = 16	(i) HR policies and procedures. (ii) Monitoring of use of agency staff through robust processes to stay within cap. (iii) Medical staff recruitment action plans. (iv) Care Group Business Plans – workforce plans. (v) E-Rostering processes. (vi) VCF processes. (vii) Consultant appointment approval processes. (viii) NHS Professionals processes & management information. (ix) Pilot of Assistant Practitioner role.	(i) Increased fill-rate (ii) Recruitment report to Board, May 2017 (iii) Regular NHSI reporting which is reported to Exec Team (iv) Benchmarking work (v) WTP work	Workforce tracker		L2 x I4 = 8
Failure to protect against cyber attack  leading to  (i) Trust becoming non-operational (ii) Inability to provide clinical services (iii) Negative impact on reputation	F&P11	Chief Information Officer	L3 x I5 = 15	(i) Penetration test of systems to identify gaps and risks; (ii) Firewalls, passwords, anti-virus equipment. (iii) Policies and reinforcement through communication to staff; (iv) Staff awareness through Certified Security Professional course and other training; (v) Trigger alerts; (vi) Care Cert system at NHS Digital. (vii) All servers and systems patched to appropriate level (viii) Computers and network infrastructure get security patches automatically applied	(i) Trust unaffected by cyber attack in May 2017 (ii) Governors briefing June 2017	(i) Internal audit on cyber security		L1 x I4 = 4
Failure to engage and communicate with staff and representatives in relation to immediate challenges and strategic development  leading to  (i) Deterioration in management-staff relationships (ii) Negative impact on performance (iii) Negative impact on reputation	Q&E1	Director of People & OD	L3 x I4 = 12	(i) Staff survey action plan. (ii) Process to engage with LNC. (iii) Process to engage with JSCC. (iv) HR policies and procedures. (v) Staff engagement project strands.	(i) Casework reports to ANCR (ii) P&OD reports to Board (iii) Briefings regarding staff engagement during restructures (iv) Records of ongoing engagement via JSCC (v) Staff Survey results (vi) Grievance and employment tribunal rates (vii) Outcomes of negotiation & work with staff side. (ix) Delivery of engagement plan KPIs. (x) Listening events	Staff survey action plans (corporate & local). Care Group action plans being developed.		L2 x I4 = 8
Failure to ensure adequate medical records system  leading to  (i) Impact on safety (ii) Impact on reputation	Q&E4	Chief Operating Officer	L3 x I3 = 9	(i) Review of bays and action plans in place (ii) RFID business case agreed (iii) Plans to make DRI a closed library	(i) Storage bays reviewed	Action plan		L2 x I2 = 4
Failure to engage with patients around the quality of care and proposed service changes  leading to  (i) Negative patient and public reaction towards the Trust (ii) Impact on reputation	Q&E5	Acting Director of Nursing, Midwifery and Quality/ Medical Director	L2 x I3 = 6	(i) Consultations on major service changes (ii) CCC report to Board (iii) Friends and Family Test (iv) Monitoring through Patient Engagement Committee (v) Training on communication (vi) Work on learning from deaths (vii) Governor walkabouts	(i) Consultation on HASU and children's tiler 2 surgery (ii) Consultation on new strategic direction (iii) Bassetlaw Governors engagement work with the public	None.		L2 x I2 = 4

<p>Failure to improve staff morale leading to</p> <p>(i) Recruitment and retention issues</p> <p>(ii) Impact on reputation</p>	Q&E6	Director of People and OD	L3 x I4 = 12	<p>(i) Monitoring by staff experience group</p> <p>(ii) Revised appraisal process</p> <p>(iii) Chief Executive's listening exercises and 'you said, we did'</p> <p>(iv) Staff involved in strategy engagement</p> <p>(v) Management passport qualification developed</p> <p>(vi) Localised action plans</p> <p>(vii) Staff survey action plan monitored by Board and QEC</p> <p>(viii) Revamped staff brief</p> <p>(xi) 'Bugbears and bright ideas' approach</p> <p>(x) Agreed approach to staffside - management meetings</p>	<p>(i) Feedback from Friends and Family Q1</p> <p>(ii) Feedback from CEO's listening events</p> <p>(iii) Bugbears and bright ideas</p> <p>(iv) Report to QEC and Board, June 2017, on staff survey action plan</p> <p>(v) Place to work indicator in F&amp;F up 11% in Q1</p>	None.		L2 x I4 = 8
<p>Failure to adequately prepare for CQC inspection leading to</p> <p>(i) Sub-optimal performance in inspection</p> <p>(ii) Risk of regulatory involvement</p> <p>(iii) Impact on reputation</p>	O&E7	Acting Director of Nursing, Midwifery and Quality	L2 x I3 = 6	<p>(i) Self-assessment and mock inspection processes</p> <p>(ii) Engagement meetings with CQC</p> <p>(iii) Nottinghamshire Looked after Children and Safeguarding monitored by Trust Safeguarding People's Board</p>	<p>(i) Report to QEC and Board - June 2017</p> <p>(ii) CQC internal audit</p>	<p>(i) Positive assurance from CQC</p> <p>(ii) Good inspection and self-assessment outcomes</p>		L2 x I2 = 6

Strategic Aim 2 - 2. Develop and enhance elective care facilities at BDGH and MMH and ensure the appropriate capacity for increasing specialist and emergency care at DRI								
KEY STEPS	Development of a 5 year Estates Strategy, to include a Capital Development Programme linked to Condition Surveys and Corporate Risk Register. Produce a clinical service model for the delivery of safe and sustainable emergency, elective, diagnostic and support services across the Trust 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. Increase elective activity at BDGH and MMH to best utilise available resources and facilities Produce and implement a Quality Improvement & Innovation Strategy that is based on best practice and developed with staff, containing a plan to increase OII capacity and capability within DBTH (and potentially with partners) Maintain a robust and effective Programme Management Office ensuring robust systems and processes to drive, monitor and escalate effectiveness & efficiency, enabling and strategic clinical plans.							
PROGRESS	<div>Direction</div> <div>To be completed.</div>							
RISKS	LINK TO CRR	EXEC	CURRENT RR	CONTROLS	ASSURANCE	GAPS IN ASSURANCE	ACTION TO ADDRESS GAPS	TARGET RR
Failure to achieve compliance with financial performance and achieve financial plan  leading to  (i) Adverse impact on Trust's financial position (ii) Adverse impact on operational performance (iii) Impact on reputation (iv) Regulatory action	F&P1	Director of Finance	L3 x I5 = 15	(i) Business and budget planning processes. (ii) Financial governance policies and procedures. (iii) Monthly monitoring of financial performance. (iv) Data analysis of trends and action to address deterioration. (v) Continued liaison with budget holders to identify risks to delivery. (vi) Demand and capacity planning processes. (vii) Detailed monitoring by Finance and Performance Committee. (viii) Budgets set on recurrent outturn resulting in a more robust financial plan. (ix) Budgets signed off by care groups and corporate departments. (x) Monthly monitoring at Board and directorate level. (xi) Uncommitted general contingency reserve. (xii) Regular finance meetings with budget holders. (xiii) Performance review meetings with NHSI. (xiv) All directorates signed up to control total.	(i) Exceeded control total in 2016/17 (ii) Production of 2017/18 budget (iii) Unqualified opinion on 2016/17 accounts (vi) Accounts submitted to NHSI by deadline (v) Financial plans submitted to NHSI (vi) Board approval of budgets (vii) Budget setting approved by Finance and Performance Committee (viii) Minutes of accountability and NHSI meetings (ix) External Audit review of financial performance (within Annual Accounts work)			L2 x I5 = 10
Failure to deliver accurate financial reporting underpinned by effective financial governance  leading to  (i) Regulatory action (ii) Impact on reputation	F&P2	Director of Finance	L3 x I4 = 12	(i) Checklist of control accounts reviewed by the Finance and Performance Committee (ii) Board report reconciled to general ledger on a monthly basis (iii) All CIPs reported as actioned have been through budget retraction (iv) Governance structure for SBS system	(i) Unqualified opinion on 2016/17 accounts (ii) Consistency of reporting over sustained period (iii) Internal audit reports show significant assurance with only minor improvements in respect of financial reporting			L1 x I4 = 4
Failure to deliver Cost Improvement Plans in this financial year  leading to  (i) Negative impact on Turnaround (ii) Negative impact on Trust's financial position (iii) Loss of STF funding	F&P3	Director of Finance	L4 x I4 = 16	(i) Full Quality Risk Assessment and operational deliverability assessment of plans. (ii) Regular consideration of schemes by Management Board and Executive Team. (iii) Collaboration with other providers, to identify joint opportunities. (iv) CIP tracker developed to provide visibility of progress against plan. (v) Engagement in working together programme. (vi) PMO, with associated management processes, key deliverables, risk logs and reporting to Finance and Performance Committee. (vii) Implementation of innovation from external reviews. (viii) Regular meetings with NHSI to track progress.	(i) Performance against CIP for 16/17 of £11.9m (ii) Monthly CIP reports to Finance and Performance and Board (iii) Assurance provided to NHSI at quarterly meetings			L1 x I5 = 5
Failure to ensure that estates infrastructure is adequately maintained and upgraded in line with current legislation, standards and guidance. <b>Note:</b> A number of different distinct risks are contained within this overarching entry. For further details please consult the E&F risk register.  leading to  (i) Breaches of regulatory compliance and enforcement (ii) Claims brought against the Trust (iii) Inability to provide safe services (iv) Negative impact on reputation (v) Reduced levels of business resilience (vi) Inefficient energy use (increased cost) (vii) Increased breakdowns leading to operational disruption (viii) Restriction to site development	F&P4	Director of Estates and Facilities	L4 x I5 = 20	(i) Annual business plan supports identification of issues by Care Groups / Directorates (ii) Risk-based capital investment plans (iii) Maintenance and support service contracts (iv) Independent Authorising Engineers appointed for key services, providing annual audits and technical guidance (v) Revised business planning process for all capital investments (vi) Estate condition and backlog maintenance assessment undertaken via 6-7 facet survey (vi) Progress and monitoring of actions undertaken through compliance committees e.g. health and safety committee	(i) Compliance in fire safety at Montagu (ii) Presentations to Finance and Performance and Governors Briefings (iii) Catering contract agreed May 2017 (iv) New service assistants in post April 2017 (v) Completed 6/7 facet survey. (vi) Asbestos and window surveys complete. (vii) Asbestos management plan up to date. (viii) Window risk assessments complete. (ix) Water management protocols complete and progress commenced. (x) Electrical infrastructure surveys complete.	(i) Estates Strategy in development (ii) Full fire safety compliance at DRI		L2 x I5 = 10

<p>Failing to address the effects of the medical agency cap</p> <p>leading to</p> <p>(i) Negative patient and public reaction towards the Trust</p> <p>(ii) Impact on reputation</p>	F&P5	Director of People and OD/ Chief Operating Officer/Medical Director	L3 x I4 = 12	<p>(i) International recruitment programme.</p> <p>(ii) Teaching hospital status communicated through recruitment.</p> <p>(iii) Care Group to escalate recruitment difficulties to MD/COO.</p> <p>(iv) Use of Trust staff in first instance to address gaps wherever possible.</p> <p>(v) Signed memo of understanding between all Trusts in the WTP to abide by a standard set of principles.</p> <p>(vi) P&amp;OD / Workforce reports to BoD.</p> <p>(vii) Workforce and Education Committee.</p> <p>(viii) Agency spend and breaches going to Exec Team and Finance and Performance.</p> <p>(ix) Better system around rate-to-fill and fill rates.</p>	<p>(i) Recruitment report to Board May 2017</p> <p>(ii) Workforce and Education Committee</p> <p>(iii) Agency spend and breaches going to Exec Team and FinOC</p> <p>(iv) Improved rate-to-fill and fill rates</p>	<p>(i) Develop new service model to mitigate medical staff shortage</p> <p>(ii) Develop and progress workforce from using alternative workforce for service delivery</p> <p>(iii) Agree with Trust in WTP to minimise cap breaches</p> <p>(iv) Decrease local agency spend</p>		L3 x I2 = 6
<p>Failure to achieve compliance with performance and delivery aspects of the Single Oversight Framework, CQC and other regulatory standards</p> <p>leading to</p> <p>(i) Regulatory action</p> <p>(ii) Impact on reputation</p>	F&P6	Chief Operating Officer	L4 x I4 = 16	<p>(i) Performance Management and Accountability Framework.</p> <p>(ii) Business planning processes</p> <p>(iii) Relevant policies and procedures.</p> <p>(iv) Daily, weekly &amp; monthly monitoring of targets.</p> <p>(v) Regular monitoring of compliance.</p> <p>(vi) Data analysis of trends and action to address shortfalls.</p> <p>(vii) Continued liaison with leads to identify risks to delivery.</p> <p>(viii) CQC Compliance Governance and Assurance Process.</p> <p>(ix) External reviews policy.</p> <p>(x) Monitoring at monthly Care Group accountability meetings.</p> <p>(xi) A&amp;E OAT process.</p> <p>(xii) Demand and capacity planning processes.</p> <p>(xiii) Weekly review of A&amp;E Action plan in accountability meeting chaired by COO.</p>	<p>(i) Full and unconditional registration with CQC</p> <p>(ii) Business Intelligence Reports</p> <p>(iii) Annual Report &amp; Quality Account</p> <p>(iv) CE quarterly objectives report (BoD - quarterly)</p> <p>(v) Internal audit of CQC readiness</p> <p>(vi) CQC Intelligent Monitoring reports &amp; risk ratings (viii)</p> <p>(vii) In Group 2 on four hour waits</p> <p>(viii) A&amp;E Improvement Programme North - showcasing best practice</p>			L3 x I3 = 9
<p>Failure to ensure that estates infrastructure is adequately maintained and upgraded in accordance with the Regulatory Reform (Fire Safety) Order 2005 and other current legislation standards and guidance.</p> <p><b>Note:</b> a number of different distinct risks are contained within this overarching entry. For further details please consult the EF risk register.</p> <p>leading to</p> <p>(i) Breaches of regulatory compliance could result in Enforcement or Prohibition notices issued by the Fire and Rescue Services</p> <p>(ii) Claims brought against the Trust</p> <p>(iii) Inability to provide safe services</p> <p>(iv) Negative impact on reputation</p>	F&P12	Director of Estates and Facilities	L4 x I5 = 20	<p>(i) Regular external inspections from SVRS and Notts Fire Service</p> <p>(ii) Improved fire safety risk assessments and evacuation strategies</p> <p>(iii) Improved Fire Safety Training</p> <p>(iv) Programme upgrade of fire detection systems</p> <p>(v) Programme upgrade of structural fire precautions (compartments)</p> <p>(vi) External Audit Fire Authorised Engineer</p> <p>(vii) Fire safety training Trust Board and Exec Team</p> <p>(viii) Further Development of Fire Safety Response Team structure</p> <p>(ix) Risk based Capital Investment plans identified by estate condition and backlog maintenance assessments via 6 - 7 facet surveys</p> <p>(x) Progress and monitoring of acations undertaken through compliance committees eg health and safety committee</p>	<p>(i) Physical works to DRI and MMH</p> <p>(ii) Fire safety action plan</p> <p>(iii) Report to Board in June 2017</p> <p>(iv) Fire safety training for BoD scheduled July 2017</p> <p>(v) 96% of staff trained in fire safety - June 2017</p>	<p>(i) Full compliance with requirements of Fire Service</p>		L2 x I5 = 10
<p>Inability to meet Trust's needs for capital investment</p> <p>leading to</p> <p>(i) Inability to sustain improveemnts in Trust's estate.</p> <p>(ii) Negative impact on patient safety.</p> <p>(iii) Negative impact on reputation.</p>	F&P13	Director of Finance	L4 x I4 = 16	<p>(i) Finance reports to Board and Finance and Performance Committee.</p> <p>(ii) Capital governance strcuture - Corporate Investment Group and Capital Monitoring Group.</p> <p>(iii) Guidance and templates for investment and disinvestment.</p>	<p>(i) DBTH part of bidding process for STP funds</p>			L1 x I4 = 4
<p>Lack of adequate CT scanning capacity at DRI</p> <p>leading to</p> <p>(i) Negative impact on patient safety.</p> <p>(ii) Inability to safely manage the emergency and inpatient activity.</p>	O&E2	Chief Operating Officer	L3 x I3 = 9	<p>(i) Allocation within 2017/18 capital programme.</p> <p>(ii) Engagement with care group directors.</p>	N/a			L2 x I2 = 4
<p>Risk of fraud</p> <p>leading to</p> <p>(i) Impact on Trust's finance</p> <p>(ii) Negative impact on reputation</p>	ANCR1	Director of Finance	L2 x I4 = 8	<p>(i) Local Counter Fraud Specialist work plan and investigations</p> <p>(ii) Fraud awareness training.</p> <p>(iii) DH Counter-Fraud regime and oversight</p>	<p>(i) Quarterly and annual LCFS reports (i-iii)</p> <p>(ii) Achievement of satisfactory NHS Protect Quality Assessment outcome (i-iii)</p>			L1 x I4 = 4

Strategic Aim 3 - 3. Increasing partnership working to benefit people and communities								
KEY STEPS	Work with STP and Place based partners to ensure that the Trust maintains a sustainable future to deliver the needs of the local populations and the legal responsibilities required by NHSI and the CQC Ensure the completion of the Trusts Strategic Vision to reflect the aims and objectives for the Trust within the STP, Place and legal and regulatory requirements of NHSI and the CQC Work with external partners to review service delivery across the wider STP footprint to ensure services which support place based ambitions and the delivery of high quality and sustainable services Develop a specific programme of work to ensure that the future structure of the Medical Directors office reflects the future needs of the Trust, STP and Place and the composition of the medical workforce Deliver the appropriate integration and interoperability technology in support of the Doncaster Place based Intermediate Care Record and if appropriate the STP Evaluate the potential for Public/Private Partnerships, linked to the Trust strategic direction.							
PROGRESS	Direction  To be completed.							
RISKS	LINK TO CRR	EXEC	CURRENT RR	CONTROLS	ASSURANCE	GAPS IN ASSURANCE	ACTION TO ADDRESS GAPS	TARGET RR
Breakdown of relationship with key partners and stakeholders  leading to (i) Negative impact on strategic objectives (ii) Negative impact on reputation	F&P9	Chief Executive	L3 x I4 = 12	(i) Partnership working processes - Working Together, STP, Accountable Care Systems, HWB (ii) Engagement with commissioners & other local trusts (iii) Attendance at CCG governing body meetings (iv) CE meetings with NHS England (v) Regular briefings to Members of Parliament (vi) Partner Governor seats on the Board of Governors	(i) CE Reports (ii) Updates on HWB activity (iii) Updates regarding Working Together and STP programme via CE report (BoD) (ii) (iv) Committees in common and STP MoU (v) Support from commissioners (vi) Bassetlaw and Doncaster Place Plans endorsed. (vii) Well Led Governance Review reinforces the Trust's partnership arrangements.			L2 x I4 = 8
Failure to ensure business continuity / respond appropriately to major incidents  leading to (i) Negative impact on reputation (ii) Regulatory enforcement (iii) Negative impact on performance	F&P10	Chief Operating Officer	L2 x I4 = 8	(i) Business continuity plans (ii) Business Continuity Policy (iii) Statement of Compliance against National Core Standards for EPRR (iv) BRSG which monitors BC planning progress (v) Business Continuity Group linked to operational structures (vi) Major Incident Plan (vii) Training of A&E staff on CBRN incidents (viii) Emergency response plans in place (annually reviewed) - Evacuation of a hospital site - Mass Casualty Plan - Pandemic Influenza Plan - Severe Eeather Plan - Prison Plan - CBRNE plan (ix) Incident Control Room in line with EPRR Command and Control guidelines (x) Communications exercises undertaken twice yearly as required by statute (xi) Command & control training for BoD & senior managers on-call (xii) Revision of plans following test exercises.	(i) Power outage testing Summer 2017 (ii) Annual confirmation of compliance against National Core Standards for Emergency Preparedness, Resilience and Response (BoD, Nov 2016) (iii) Test exercises: Sickness, fuel (2016) (iv) Internal Audit follow-up review of business continuity arrangements (v) Risk assessment of major incident and business continuity plans with NHS England (2015) (vi) Y&H peer review of major incident plans 2016. (vii) External review of HAZMAT - compliant (September 2015) (viii) Hazardous Substances policy agreed by Board 29.11.2016 (ix) Tabletop exercises undertaken, SY risk assessment completed and two power cuts (x) Working with Care Groups to develop relevant desktop exercises. (xi) Trust unaffected by system-wide cyber attack, May 2017			L2 x I3 = 6



Strategic Aim 4 - Supporting the development of enhanced community based services, prevention and self-care.								
KEY STEPS	Work with partners to reduce demand on the acute services to ensure that demand equates to available resources							
PROGRESS	To be completed. <span>Direction</span>							
RISKS	LINK TO CRR	EXEC	CURRENT RR	CONTROLS	ASSURANCE	GAPS IN ASSURANCE	ACTION TO ADDRESS GAPS	TARGET RR
Inability to sustain the Paediatrics service at Bassetlaw  leading to  (i) Withdrawal of overnight service (ii) Negative impact on local community	Q&E3	Chief Operating Officer	L2 x I2 = 4	(i) Consultant led paediatric assessment unit in place. (ii) Arrangements for transferring overnight stays to DRL. (iii) Communication with CCG and HOSC. (iv) Arrangements with Sheffield Children's Hospital. (v) Ongoing paediatric nurse recruitment.	(i) Reports on transferrals (ii) Positive response to recruitment	(i) Firm acceptance of offers to new nurses		L2 x I2 = 4



**Doncaster and Bassetlaw  
Teaching Hospitals**  
NHS Foundation Trust

Title	Chair's and NEDs' Report		
Report to	Board of Directors	Date	25 July 2017
Author	Suzy Brain England, Chair		
Purpose		Tick one as appropriate	
	Decision		
	Assurance		
	Information	X	

Executive summary containing key messages and issues
<p>The report covers the Chair and NEDs' work in June/July 2017 and includes updates on a number of activities:</p> <ul style="list-style-type: none"><li>• Strategy development</li><li>• WTP Chairs' and CEOs' meetings</li><li>• South Yorkshire &amp; Bassetlaw ACS Oversight &amp; Assurance Group</li><li>• Walkabouts</li><li>• NHS Providers</li><li>• 121s</li><li>• Governors</li></ul>
Key questions posed by the report
N/A
How this report contributes to the delivery of the strategic objectives
The report relates to all of the strategic objectives.
How this report impacts on current risks or highlights new risks
N/A
Recommendation(s) and next steps
That the report be noted.

## Chair's Report – July 2017

### Strategy development

We have hosted two engaging and insightful sessions on the development of the Trust's strategic direction.

Members of the Board met on the morning of 28 June to round off a 1.5 day board session that also included a meeting, board development and team building session. Richard led a presentation on the political and economic background to the strategy then Marie guided us through the vision, strategic aims and objectives. A number of areas of the strategy have been refined accordingly.

This was followed by a 1.5 hour session with governors on Tuesday 11 July, which presented the progress so far following feedback from stakeholders, care groups and Board. There were a number of interesting points made both at the session and afterwards by email. We have had a great level of engagement from governors, old and new, and I look forward to working with them as we aim to deliver this strategy over the next five years. They are all vital to the Trust's success.



### WTP Chairs & CEs Meeting

In Tony Pedder's absence, I was invited to chair the WTP Chairs and Chief Executives meeting on 3 July.

We fed back the decisions from our Boards in respect of the committees in common report considered at Board on 27 June and received an update on the ophthalmology out of hours initiative. As discussed at a previous Board meeting, there are moves to align the dates of Board meetings across the patch and that item will be considered at this Board meeting in Part 2.

I also won support for separate area-wide conferences for Governors and NEDs on the Accountable Care System (ACS, was STP). I am meeting with Helen Stevens (along with Emma and Matthew) on 21 July to see how we can do this and whether Doncaster might be a good venue.

## South Yorkshire & Bassetlaw ACS Oversight & Assurance Group

I attended a meeting of the Accountable Care System's new oversight and assurance group on 12 July which is looking at governance and engagement issues across the ACS bearing in mind that it is unlikely any new legislation will be forthcoming. We must therefore find innovative ways to work within current structures to deliver change.

I gave an update on the governors' and NEDs' conferences and on the non-executives perspective of change as we move forwards. We also reviewed the terms of reference for the hospital services' review and the ACS memorandum of understanding which we will be ratifying today.

## Walkabouts

I continued my visits to hospital services on 17 July with a visit to Bassetlaw. Thanks to David Purdue for showing me around.

I had a very productive hour with Dean Fathers, Chair of Nottinghamshire Healthcare NHS Foundation Trust and John MacDonald, the new Chair of Sherwood Forest Hospitals. Both are leading ACSs and it was helpful to share progress on that as well as ensuring we do not miss anything that may have implications for Bassetlaw.

Also I have met with Sarah Jones, Chair of Sheffield Children's Hospital. She showed me round their new state-of-the-art outpatients and ward areas. We committed to enhanced partnership work to deliver the best paediatric care for Doncaster and Bassetlaw and the South Yorkshire and Bassetlaw ACS.

I continue to have catch ups with non-executives on a regular basis.

## NHS Providers

I attended my first meeting of NHS Providers Board on 5 July and received my induction. Items covered at the meeting included:

- Response to local authority public health cuts
- ACSs
- NHS Improvement / NHS England relationship



I am happy to share further details with people privately. Participation will keep us at the forefront of issues affecting providers generally and the wider NHS in particular.

## Governors

We will be meeting the new governors for their initial induction on Wednesday evening (26<sup>th</sup> July) and this will be followed by a formal meeting of the Board of Governors on 27 July.

At the meeting of the Board of Governors on 27 July, governors will receive a report on their recent governor effectiveness review and will be supported to consider whether they wish to revise the way they work and receive business intelligence.

Further to the elections last month one of the newly elected governors in Bassetlaw, Steven Marsh, decided for personal reasons not to take up the role.

The Constitution allows that where a vacancy arises within 6 months of an election then the candidate who secured the next highest number of votes for that constituency will be appointed. The fourth placed person in the Bassetlaw ballot was Sharon (Shaz) Cook. We have been in contact with Sharon and look forward to welcoming her on the 26<sup>th</sup>.

In other governor-related news, we held another successful Governor Briefing on 13 June where Simon and Kirsty came to speak and answer governors' questions on cyber security and estates including the new catering contract.

This was followed by a successful Governor Timeout session on 26 June featuring discussions facilitated by Jon Sargeant and John Parker on charities, Moira Hardy on Friends and Family Test, Rick Dickinson on Perfect Ward and Richard Somerset and Liz Tidswell on procurement. About two-thirds of the governors attended and there was some excellent engagement.



## Chief Executive's Report 25 July 2017



### Fire Compliance Issues

The Trust underwent an inspection by South Yorkshire Fire and Rescue of its compliance with fire safety notices on 30 June 2017.

As a result, Doncaster Royal Infirmary has had its site wide enforcement notice removed in its totality. Specific enforcement notices for Women's and Children's and East Ward Blocks were removed and replaced with new notices which will be addressed as part of the ongoing capital works programme.



Whilst on site at Montagu, the SYFR team identified some issues in the Rehab Wards at Montagu which are being addressed.

In another fire-related issue, Board will be aware that NHSI have undertaken testing of cladding panels across hospital sites in the UK. A small number of trusts including Sheffield Children's Hospital have been found to have estate that uses cladding that has not been able to withstand robust fire testing.

The only identified cladding panels for testing at DBTH were situated near Clinical Therapy at Bassetlaw Hospital. These have been tested and reviewed by Building Research Establishment and provisionally confirmed as not ACM (Aluminium Composite Material) which is thought to be the suspect material involved in the Grenfell incident.

### Paediatric Service at Bassetlaw

Due to an error information shared by the Trust on paediatric transfers from Bassetlaw Hospital to DRI for the period 15 May to 4 June was inconsistent with the information shared by Bassetlaw CCG. As soon as the error was spotted it was amended and the website and social media updated with the correct information.



Earlier in the month, rumours on social media circulated over possible weekend closure of the Children's Ward at Bassetlaw. We can confirm this is not the case and the Trust's position at this time remains unchanged.

The Trust's Chief Executive and Chief Operating Officer are due to attend a meeting of Notts County Council's Health Scrutiny Committee on the morning of 25 July (hence the Board moving to the afternoon) to brief the new committee on developments.

### **SYP ACS 'Outstanding'**

NHS England and NHS Improvement published the first ever ACS Progress Dashboard on 21 July and we will be among just a handful of areas in the country to be named as 'outstanding'.

The Dashboard is an initial assessment of our combined performance across health and care and while we know we have much work to do, our willingness to work together and our achievements as a collaborative partnership are already clear for all to see.

The Dashboard, driven by indicators in three broad areas; hospital performance, patient-focused changed and transformation, measures us against the following nine domains, resulting in a weighted score:

1. Emergency care – four hour standard
2. Elective care – 18 week standard
3. Safety – healthcare associated infections and special measures
4. General practice – improving access
5. Mental health – improving access
6. Cancer – improving access
7. Prevention – unnecessary hospital stays
8. System-wide leadership – partnership working
9. Finance – system control totals

We will receive an updated rating every year, and we can expect the methodology and metrics to evolve over time but equally as important will be our own scorecard which in addition to the national areas will reflect our wider local ambitions, such as improving educational attainment, aiding job creation, ensuring suitable housing and improving health outcomes for our whole population. A great advantage of being an ACS is that it will also help strengthen local partnerships in each of the five areas, as Accountable Care Partnerships, as we continue to build on the strong links between health organisations and local authorities to improve health and wellbeing services.

Our focus now is to build on the excellent foundations and rapidly progress our priority workstreams so that we are collectively taking the strain off our A&Es, making it easier for people to get GP appointments through our work in primary care and improving care and treatment in mental health and cancer.

## Changes to Children's Surgery and Anaesthesia

Following consultation, a decision to change the way some children's surgery and anaesthesia services are provided across South and Mid Yorkshire, Bassetlaw and North Derbyshire was made on Wednesday 28 June.

The decision, which was made by the joint committee of clinical commissioning groups, comes after three years of working together with clinical commissioning and hospital colleagues in Barnsley, Bassetlaw, Chesterfield, Doncaster, Rotherham, Sheffield and Wakefield to review and improve the care and experiences of all children needing an emergency operation.



It means that around one or two children per week needing an emergency operation at night or at a weekend, for very specific conditions, eg appendicitis, will no longer have their surgery in Barnsley, Chesterfield or Rotherham Hospitals. They will instead be treated at Doncaster Royal Infirmary, Sheffield Children's Hospital or Pinderfield's Hospital if they need their operation out of hours.

Doctors have helped to develop a 'managed clinical network' approach where, as a partnership, they will be able to provide a 24 hour, seven day a week emergency service for all children across South and Mid Yorkshire, Bassetlaw and North Derbyshire.

In Doncaster, there will be no change for our patients but it does mean that slightly more children will be treated at DRI every year. In Bassetlaw children needing an emergency operation out of hours are already taken to DRI.

Changes are due to start from January 2018.

## DBTH a hit with students

We have seen a big improvement in the feedback received by learners, leading the region in certain aspects of clinical and medical education according to the most recent survey results.



Each year the Trust takes part in the General Medical Council's (GMC) Training Survey, the results of which help the organisation to monitor the quality of medical education. In 2017, doctors in training, health professionals and mentors took part in the year's national and local training surveys, the results of which have shown big improvements at DBTH.



Most notably, the GMC survey reflects positive results for the Trust's Acute Internal Medicine, General Internal Medicine and General Surgery, all of which have scored as best in the region. In other areas, Endocrine, Diabetes and Gastroenterology were second best in South Yorkshire with notable improvements in Emergency Medicine, Obstetrics and Gynaecology and Paediatrics. Additionally, Core Medical Training and Geriatric medicine came in for particular praise, not only leading neighbouring organisations but placing joint fourth nationally.

These improvements are also reflected in the evaluations received from pre-registration student, for example nurses, midwives, allied health professionals, who are on placement with us. These students reported an overall satisfaction rate for learners of 98% (taken from the Practice Placement Quality Assurance), placing us amongst the best in the region, a significant endorsement for the Trust in its first year as a Teaching Hospital.

### **Mr Quraishi becomes President**

Following on from his recent royal commendation, Mr Muhammad Shahed Quraishi OBE has been elected as a section President of the Royal Society of Medicine (RSM), London.

Mr Quraishi, a Consultant Ear Nose and Throat (ENT) Surgeon at the Trust as well as an RSM council member of six years, will formally take up his Presidential role on 2 November 2018 to the Section for Laryngology (disorders of the vocals) and Rhinology (conditions of the nose).

RSM Presidents serve for a period of one year and Mr Quraishi has declared his Presidential year as the 'Year of Global Health' with a packed schedule of academic events and visits from eminent professors from across the world.

### **New role for Joe**

Dr Joe Joseph, Lead Cancer Clinician, has been appointed as clinical director of our cancer alliance that includes Sheffield, Rotherham, Chesterfield, Barnsley, Doncaster and Bassetlaw Trusts and Clinical Commissioning Groups.

Joe is currently Trust lead clinician for cancer and will be stepping down from this role on 31 August 2017.

### **Changes to PMO function**

With immediate effect, there will be a change to the executive structure with responsibility for the PMO transferring to the Director of Finance. Marie Purdue, Deputy Director of Strategy and Improvement, will continue to report to the Chief Executive with responsibility for Strategy and Improvement.



## Listening events

I will be hosting some more listening events in July and August and would like to meet with as many staff as I can to hear about their experience of working and caring at DBTH. More importantly, I would like to find out what we can do as a team to ensure we deliver safe, effective and quality services for the people of Doncaster, Bassetlaw and beyond.



At the last batch of sessions lots of staff attended to ask questions about their own areas. Lots of questions were answered and lots of rumours and myths were busted! More crucially, a lot of words have been put into action:

- In view of concerns about parking, a discounted car parking rate has been offered to part time and lower band staff.
- We engaged with large groups of clinical and frontline staff about the potential strategic direction through postcards, surveys and attending clinical governance meetings.
- We implemented a project to clean-up our Medical Record library.

## And finally ...

Sewa Singh, Medical Director, has completed his last on call duty with the cardiovascular team. Sewa will be stepping down from his on call duties so that he has more time to focus on his medical director role. His colleagues hosted a thank you lunch for Sewa for all of his support over the year.



## Financial Oversight Committee

### Draft Annual Report 2016/17

#### 1 Introduction

- 1.1 The purpose of this report is to provide the Board of Directors with a summary of the work of the Financial Oversight Committee (“the committee”) for the year 2016/17.

#### 2 Terms of reference

- 2.1 The Financial Oversight Committee was initially established as a temporary sub-committee of the Audit and Non-clinical Risk Committee in 2015, and its terms of reference were first approved by the Board of Directors on 19 October 2015.
- 2.2 Revised terms of reference were approved in February 2016, making the committee a permanent sub-committee of the Board of Directors. A work-plan was agreed by the committee in April 2016.

#### 2.3 Duties

The work of the committee has been predominantly focused on the following key areas:

- a) A detailed review of the causes of the 2015/16 misreporting of the financial position, including lessons learned, actions required, and monitoring of work undertaken and changes implemented to address the causes of the misreporting.
- b) Review of CIP and turnaround delivery in order to provide assurance to the Board. This included regular presentations from senior responsible officers leading on cost improvement plan work-streams.
- c) Monthly review of the Trust’s financial position.

#### 2.4 Meetings and membership

The committee met on 11 occasions during 2016/17 and the committee’s membership and attendance has been as follows:

	April 2016	May 2016	June 2016	July 2016	Aug 2016	Sept 2016	Nov 2016
<i>Committee members:</i>							
John Parker, Chair	X	X	X	X	A	X	X
David Crowe	A	X	X	X	X	X	X
Philippe Serna	X	A	X	X	X (c)	X	X
<i>Officers in attendance:</i>							
Jeremy Cook, Interim Director of Finance	X	X	X	A	A	X	X
Maria Dixon, Head of Corporate Affairs	X	X	A	n/a	n/a	n/a	n/a
Matthew Kane, Trust Board Secretary	n/a	n/a	n/a	X	X	X	X
Dawn Jarvis, Director of Strategy & Improvement	X	X	X	X	X	X	X
Andrew Thomas, Interim Associate Director Finance	X	X	X	X	X	X	X
<i>Governor observer:</i>							
Bev Marshall, Public Governor	X	X	X	X	X	A	A

	Dec 2016	Jan 2017	Feb 2017	Mar 2017
<i>Committee members:</i>				
John Parker, Chair	X	X	X	X
David Crowe	X	X	X	X
Philippe Serna	X	X	X	A
<i>Officers in attendance:</i>				
Jeremy Cook, Interim Director of Finance	n/a	n/a	n/a	n/a
Jon Sargeant, Director of Finance	X	A	X	X
Matthew Kane, Trust Board Secretary	X	X	X	X
Dawn Jarvis, Director of Strategy & Improvement	A	X	X	X
Andrew Thomas, Interim Associate Director Finance	X	X	X	X
<i>Governor observer:</i>				
Bev Marshall, Public Governor	X	X	X	A

## 2.5 Minutes

Minutes of each of the meetings were formally presented to a subsequent meeting of the Board of Directors, with the committee chair drawing any key issues to the attention of the Board.

## 2.6 Sub-committees

The committee had no sub-committees.

## 3 **Work plan**

- 3.1 The committee's work was largely dictated by its work-plan agreed in April 2016 as well as by the need to ensure timely scrutiny of the delivery of 2016/17 cost improvement plans.
- 3.2 Through this work, the committee contributed savings to the Trust of £11.9m, against an original target of £11m. The Trust finished the year with a substantially reduced deficit of £6.462m whilst still maintaining appropriate levels of quality.

## 4 **Committee effectiveness**

- 4.1 The committee has not conducted a committee effectiveness review but was subject to the Trust's external 'well led' governance review undertaken in Q3 2016/17.
- 4.2 The review made a number of recommendations in respect of the committee, namely that its focus was more geared towards CIP delivery than financial monitoring, much of the latter still continuing to take place within the Board sphere.
- 4.3 With the committee having done what it set out to do, the Board took a decision that with effect from June 2017 it would disestablish the Financial Oversight Committee and replace it with a committee focusing on finance and performance which would also retain a grip on the need to generate cost improvements. This will be the final report of the committee.

**John Parker**  
**Chair, Financial Oversight Committee**

**July 2017**

## Audit and Non-Clinical Risk Committee

### Draft Annual Report 2016/17

#### 1 Background

- 1.1 The purpose of this report is to provide the Board of Directors with a summary of the work of the Audit and Non-Clinical Risk Committee (“the committee”) for the year 2016/17 and, in doing so, comply with the committee’s Terms of Reference.

#### 2 Terms of reference

- 2.1 During the year, the committee has worked to Terms of Reference and workplan approved in June 2016.
- 2.2 A review of the workplan at the end of 2016/17 was deferred due to a number of other changes being made to the governance structure. This review will be factored into the next meeting of the committee.

#### 2.3 Meetings and membership

The committee met on five occasions during 2016/17 and the committee’s membership and attendance has been as follows:

*Committee members:* Philippe Serna, Chair  
David Crowe  
Martin McAreavey

*Officers in attendance:* Mark Bishop, Local Counter Fraud Specialist  
Maria Dixon, Head of Corporate Affairs  
Matthew Kane, Trust Board Secretary  
Jeremy Cook, Interim Director of Finance  
Jon Sargeant, Director of Finance  
Andrew Thomas, Associate Director - Finance

May '16	Jun '16	Sep '16	Dec '16	Mar '17
X	X	X	X	A
X	A	X	X	X
X	X	X	X	X
A	X	X	X	X
X	X	n/a	n/a	n/a
n/a	n/a	X	X	X
X	X	X	n/a	n/a
n/a	n/a	n/a	X	X
X	X	X	X	X

	Karen Barnard, Director of People & OD	X	X	A	A	X
	Kerry Williams, Local Security Management Specialist	A	X	A	X	n/a
	Sean Tyler, Head of Compliance	n/a	n/a	n/a	n/a	X
<i>Governor observers:</i>	Bev Marshall, Public Governor	X	A	X	X	X
	George Webb, Public Governor	X	A	X	X	X
<i>External audit representatives</i>		X	X	A	X	X
<i>Internal audit representatives</i>		X	X	X	X	X

2.4 The chair of the committee has met informally and in private with both internal and external auditors.

2.5 During these meetings and throughout the year, neither auditor has raised any issues of concern that has not also been covered in the full meetings of the committee. The committee has sought assurance that the necessary co-operation has been received from Trust managers and staff and that the auditors have been able to undertake their work without their independence being compromised. The committee is satisfied that there was sufficient and appropriate liaison and co-operation between internal and external auditors.

2.6 Minutes of each of the meetings have been formally presented to a subsequent meeting of the Board of Directors, with the committee Chair drawing any key issues to the attention of the Board. A report from the Chair of the committee is a standing item on the agenda of each Board meeting that follows a meeting of this committee.

## 2.7 Sub-committees

The committee has formally received the minutes of the Information Governance and Health and Safety Groups which report to it and approved the terms of reference of those committees where appropriate.

## 3 Work plan

3.1 The committee's agenda throughout the year was largely dictated by, but not limited to, the work plan. The committee achieved its work plan for 2016/17 and will in due course agree a work plan for 2017/18.

## 4 Internal audit

4.1 The Trust's internal audit services were provided by KPMG in 2016/17.



- 4.2 The internal audit plan for 2016/17 for 240 days was approved at the committee meeting on 24 June 2016 with revisions and additional days being agreed on 23 September 2016. The work conducted by internal audit during 2016/17 was as follows:

Review	Assurance rating	Recommendations (High)	Final report issued	Reported to Audit Cttee	Days
<b>Core Reviews</b>					
Core Financial Systems	<i>Partial assurance with improvements required</i>	6 (0)	Jan 2017	March 2017	15
Financial reporting month end checklist – Month 3	<i>Partial assurance with improvements required</i>	6 (0)	Aug 2017	Sept 2016	4
Financial reporting month end checklist – Month 5	<i>Significant assurance with minor improvement opportunities</i>	2 (0)	Dec 2016	Dec 2016	2
Financial reporting month end checklist – Month 9	<i>Significant assurance with minor improvement opportunities</i>	2 (0)	March 2017	March 2017	2
Financial reporting month end checklist – Month 11	<i>Significant assurance with minor improvement opportunities</i>	4 (0)	May 2017	May 2017	2
Information Governance Toolkit	<i>Significant assurance</i>	7 (0)	April 2017	May 2017	10
Data Quality – Performance Indicators	<i>Partial assurance with improvements required</i>	6 (1)	Dec 2016	March 2017	10
Data Quality – Reference Costs	<i>Significant assurance with minor improvement opportunities</i>	4 (0)	July 2016	Sept 2016	5
Independent Project Assurance - outsourcing of financial systems	<i>Significant assurance with minor improvement opportunities</i>	15 (0)	April 2017	May 2017	27
Corporate Governance & Risk Management	<i>Assurance rating not applicable</i>	n/a	n/a	n/a	5
Clinical and Quality Governance	<i>Assurance rating not applicable</i>	n/a	n/a	n/a	5
<b>Key Risk Reviews – financial management and business development</b>					
Payroll	<i>Significant assurance with minor improvement opportunities</i>	4 (0)	April 2017	May 2017	8
Finance Team Structure	<i>Significant assurance with minor improvement opportunities</i>	0 (0)	Sept 2016	Dec 2016	7



Review	Assurance rating	Recommendations (High)	Final report issued	Reported to Audit Cttee	Days
<b>Key Risk Reviews – financial management and business development (cont.)</b>					
Estates Strategy / Estates Infrastructure	<i>Assurance rating not applicable</i>	n/a	n/a	n/a	1
<b>Key Risk Reviews – IM&amp;T</b>					
IT Strategy / Capability	<i>Partial assurance with improvements required</i>	8 (3)	Jan 2017	March 2017	10
Booking Management	<i>Partial assurance with improvements required</i>	13 (0)	Dec 2016	March 2017	10
<b>Key Risk Reviews – Clinical Quality</b>					
CQC Compliance / Follow Up	<i>Partial assurance with improvements required</i>	9 (2)	March 2017	March 2017	10
Medicines Management	<i>Partial assurance with improvements required</i>	7 (1)	Oct 2016	Dec 2016	8
Patient Safety & Infection Control	<i>Significant assurance with minor improvement opportunities</i>	3 (0)	May 2017	May 2017	8
Incident Reporting, Investigation and Learning	<i>Partial assurance with improvements required</i>	9 (0)	May 2017	May 2017	8
Duty of Candour	<i>Partial assurance with improvements required</i>	6 (0)	May 2017	May 2017	5
Deprivation of Liberty and Mental Capacity Act 2005	TBC	TBC	TBC	TBC	5
<b>Key Risk Reviews – Workforce</b>					
Workforce – Recruitment Strategy	<i>Partial assurance with improvements required</i>	14 (0)	Feb 2017	March 2017	12
E-Rostering	<i>Partial assurance with improvements required</i>	11 (0)	Feb 2017	March 2017	8
<b>Internal Audit Management</b>					
Follow Up					8
Audit Planning					5
Contract Management					10
Attendance at ANCR and Healthcare Governance Committee					10
<b>Total</b>		<b>136 (7)</b>			<b>220</b>

- 4.3 At each meeting the committee reviewed the issues and recommendations from each completed audit, heard from the lead executive and reviewed the overall risk rating. The committee received regular reports and follow-ups.

4.4 Following concerns regarding executive oversight of audit reports, a new process has been initiated ensuring that Executive Team receives an update from internal audit two weeks prior to ANCR meetings.

4.5 An Internal Audit Plan for 2017/18 was agreed on 24 March 2017.

4.6 Head of Internal Audit Opinion 2016/17

The Head of Internal Audit's Opinion on the overall adequacy and effectiveness of the organisation's system of internal control was provided to the committee on 26 May 2017 as follows:

4.7 "The Head of Internal Audit Opinion is that **significant assurance with minor improvement opportunities** can be given as there is generally a sound system of internal control, which is designed to meet your objectives and that generally controls are being consistently applied in all the areas reviewed."

## 5 External audit

5.1 The Trust began 2016/17 with PricewaterhouseCoopers (PWC) as its external auditing firm. Following consideration of a report by the Board of Governors in June 2017, PWC were replaced as the Trust's external auditors.

5.2 A sub-committee made up of three Governors supported by the Chair of Audit and Non-clinical Risk Committee, the Interim Deputy Director of Finance, Head of Procurement and Trust Board Secretary conducted the tender exercise. EY LLP were appointed as the Trust's new external auditors by Governors in September 2016 for an initial term of three years.

5.3 The annual external audit review by EY, as stated in their ISA 260 report, provides an unqualified opinion on the Trust's financial statements. As the Trust has a breach of its licence conditions from the previous misreporting of the financial position the report identifies in the Value for Money assessment that the Trust has a significant underlying deficit to address in the medium to long term, and is currently reliant on ongoing liquidity support from NHS Improvement.

## 6 Annual Report & Accounts

6.1 The committee approved the Annual Governance Statement at its meeting 26 May 2016. The annual accounts were signed off on 31 May following a meeting on 30 May 2016, and following conclusion of the external audit.

## **7 Counter fraud and security**

- 7.1 The Trust has a nominated Local Counter Fraud Specialist who is fully accredited by NHS Protect. During the year the Trust completed the NHS Protect Quality Assurance process that is used to provide robust assurance to stakeholders, including the Department of Health, NHS England and contracting CCGs. As part of this process the NHS Provider Standards Self-Review Tool (SRT) was completed and a detailed Annual Report on counter fraud activities provided as evidence.
- 7.2 In March the Chair wrote to NHS Protect in connection with plans to phase out the support they afforded the Local Counter Fraud Officers that provide Fraud Prevention and Investigation services to NHS Trusts and offered to meet with them. It is the Chair of the Trust's audit committee to ensure that the Trust is adequately and effectively protected from fraud and has systems in place to ensure that fraud is detected where it has occurred and is prevented from occurring where it has not. A response has now been received from NHS Protect and this will be analysed over coming weeks.
- 7.3 The outcome of this process is assessed on a red, amber and green RAG level. The Trust SRT achieved an estimated level of 'green', indicating it has good counter fraud processes in place.
- 7.4 The Trust's Security Management Specialist attends every meeting to present a quarterly update on security matters, and this forms part of the committee's workplan.

## **8 Committee evaluation, effectiveness & training**

- 8.1 The committee undertook its annual effectiveness review in September 2016 and this resulted in some recommendations for enhancement.
- 8.2 The committee was also subject to the external review of the Trust's governance arrangements in Q3 2016/17. Whilst remarking that the ANCR terms of reference complied with most aspects of good practice, there were some proposals for enhancement:
  - 1. Update the committee work plan to reflect the revised terms of reference, incorporating the elements of good practice namely:
    - Responsibility for ensuring that robust systems and processes are in place to raise concerns throughout the Trust;
    - To oversee the effective implementation of internal and external audit recommendations (this does not currently feature in the cycle of business); and

–To review the operation of, and proposed changes to, the standing orders and standing financial instructions, the constitution, codes of conduct, the scheme of delegation and standards of business conduct. (These changes were incorporated into the ANCR TORs at Board June 2017; revised work-plan will be presented to September’s meeting)

2. Maintain the more concerted focus on follow-up of internal audit recommendations in line with the proposals made in September 2016; (Tracker now embedded and coming to each meeting)

3. Increase the level of focus and scrutiny on the effectiveness of risk management arrangements; and (New CRR and BAF coming to each board committee)

4. Review the reporting lines for the ANCRC sub-groups. (Initial work has been undertaken by KPMG; new terms of reference will be presented to ANCR in September)

## 9 Conclusion

9.1 The committee has received and reviewed much information and considered carefully the independent assurance work from the internal and external auditors. Overall the committee concludes that the Trust has a generally sound system of internal control. The basis for this judgment is outlined in more detail in the annual governance statement.

9.2 The committee thanks those who have attended meetings and/or provided information and support to it for their valuable help and assistance.

Philippe Serna  
Chair, Audit and Non-clinical Risk Committee

July 2017

**DONCASTER & BASSETLAW TEACHING HOSPITALS NHS FOUNDATION TRUST**

**Minutes of the Finance & Performance Committee  
held at 9:15 am on Friday 23 June 2017  
in the Boardroom, DRI**

**PRESENT :** Neil Rhodes, Non-executive Director (Chair)  
Martin McAreavey, Non-executive Director  
Philippe Serna, Non-executive Director  
Jon Sargeant, Director of Finance  
Karen Barnard, Director of People & OD  
David Purdue, Chief Operating Officer

**ALSO IN ATTENDANCE:** Marie Purdue, Acting Director of Strategy & Improvement  
Angie Lawson, Head of Transformation  
Matthew Kane, Trust Board Secretary  
Angela O'Mara, Exec Team PA

**WORKSTREAMS :** Sewa Singh, Medical Director  
Willy Pillay, Deputy Medical Director  
Richard Somerset, Deputy Procurement Director

**OBSERVER :** Linn Phipps, Non-executive Director  
Bev Marshall, Governor Observer

**Action**

**Apologies for Absence**

**17/6/1** None.

**Introductions**

**17/6/2** Linn Phipps, Non-executive Director and Chair of the Quality and Effectiveness Committee was welcomed to the meeting.

**Action Notes from Previous Meeting**

**17/6/3** 16/12/6 – Marie Purdue advised the committee of the ongoing quality impact assessment for all efficiency and effectiveness programmes. However, as the original action related to assurance to the Board it was agreed that this would be remitted to the Quality and Effectiveness Committee for consideration.

**MK**

**17/6/4** 17/5/10 – it was agreed that this would be removed as an action and progressed as part of the medical productivity workstream.

**17/6/5** 17/5/42 – as this action fell under the remit of the Workforce & Education Committee this would be considered by the Quality & Effectiveness Committee, including any gap in assurance relating to research activity.

**MK**

The action log was reviewed and updated.

## FINANCE

### Medical Productivity Workstream

- 17/6/6 Mr Pillay, vascular surgeon and Deputy Medical Director was introduced to the committee; following his appointment as deputy in January 2017 he had also taken on the role of Medical Productivity workstream lead.
- 17/6/7 In order that the committee understood the history behind the workstream the Medical Director provided a summary of activity relating back to the introduction of the new consultant contract in 2003. Fifteen clinical directorates were in place at the time of implementation and a variation in interpretation of the national terms and conditions was seen. Following Mr Singh's appointment as Medical Director in 2012 a decision was made to address this inconsistency and a job planning committee was formed. The committee consisted of an equal number of management and LNC members and the purpose of the group was to standardise practice to ensure delivery of a transparent process linked to demand and capacity. Despite extensive work, agreement with the LNC was not reached and a subsequent efficiency review of medical productivity commenced as part of the turnaround programme.
- 17/6/8 External consultants, Dearden and Kingsgate, were commissioned to undertake job planning and demand and capacity analysis, respectively. To date demand and capacity has been completed in 23 specialities, with just five remaining.
- 17/6/9 A summary of the financial assessment highlighted the largest efficiencies would be gained in the Women's & Family care group. Despite this being on hold due to the Royal College of Obstetricians and Gynaecologists visit and pending service redesign, a decision had now been made to progress this. A suggested completion date for Paediatrics was the end of Q2, followed by O&G by the end of Q3.
- 17/6/10 Following a review of the Clinical Excellence Award applications Martin McAreavey queried the high level of PAs seen amongst the consultant body and sought a view on how sustainable and effective this was. The Medical Director acknowledged this concern and gave some thought to the minimum and maximum activities range for remuneration. It should be noted that some activities may be remunerated by external parties outside of their clinical hours. The Working Together Programme was also considering consultant remuneration to ensure alignment across the patch.
- 17/6/11 Challenges and mitigating actions were summarised and support from the committee was sought around accurate data provision, a resource to work with the care groups to track progress and medical staffing support.
- 17/6/12 A business case for 3 medical staffing posts had been submitted to the Corporate Investment Group. The Director of People and OD supported the Medical Director's view that the additional resource would work actively within the care groups to progress job planning and workforce matters and that the initial staffing level may be subject to further review.



- 17/6/13 The Chair thanked Mr Singh for the clarity provided which allowed an improved understanding of the complexity of the task in hand and the journey to date.
- 17/6/14 In terms of securing an appropriate workforce skill mix, recent STP conversations had focused on links between the service model, workforce and infrastructure. It was recognised that solutions would differ across specialities and a significant piece of work was required to move this forward, including input from clinicians.
- 17/6/15 Philippe Serna identified the potential efficiency gain secured by moving the implementation date of O&G job planning forward to the end of Quarter 2. A wider discussion took place and it was agreed that following clarification of specific requirements Marie Purdue and Karen Barnard would determine a model of support. In view of the urgency of this matter Marie agreed that she would provide an update via email ahead of the next meeting.
- The Medical Productivity update was NOTED.
- Procurement Workstream**
- 17/6/16 Richard Somerset, Deputy Procurement Director presented to the committee an overview of the Procurement workstream. In 2016/17 savings of 2.26m were achieved, against a plan of 1.9m. An original target of 1.8m had been agreed for 2017/18, which had subsequently been reduced to 1.5m following the introduction of IR35. Savings of 1.38m had been identified to date and a summary of the key projects was provided; work continued to address the shortfall.
- 17/6/15 A discussion took place around the impact of IR35, the areas most affected being ED and Paediatrics. Whilst there was an agreement in place regarding upper payment limits there was evidence to confirm this was being breached and alternative remuneration to attract locums onto DBTH contracts had been considered.
- 17/6/16 The committee were briefed on the ways in which savings were identified. NHSI's Purchase Price Index and Benchmark (PPIB) tool provided comparative product prices at a national level and currently the Trust was in the top quartile, ranked 30 out of 180 trusts.
- 17/6/17 In response to a question from Bev Marshall, Richard Somerset confirmed that purchase versus lease was always considered as part of any procurement exercise with opportunities for additional savings being considered as part of any contract arrangements.
- The Procurement Workstream presentation was NOTED.
- Finance Report – Month 2 2017/18**
- 17/6/18 Jon Sargeant advised that contract discussions with Sodexo were ongoing, with the support of Capsticks. The Director of Finance and KPMG would quality assure the contract ahead of its presentation to Board for approval. The Chair requested this committee were provided with the opportunity to review this

MP/KB

JS

prior to its submission for approval.

- 17/6/19** The Director of Finance shared correspondence from NHSI notifying the Trust of an additional 419k payment from the Sustainability and Transformation Fund. As the additional sum had been received after the final accounts had been agreed an adjustment would be made by NHSI on the Trust's behalf, and the Trust would be required to record this as an uncorrected error in the 2017/18 accounts. Concerns regarding the potential for this to impact on closure of 2017/18 accounts had been highlighted to NHSI and a copy of the letter shared with EY, external auditors.
- 17/6/20** The Chair extended his gratitude to Anna Moulding, Andy Sidney, Gabriel Recalde and Keziah Matanga for their outstanding efforts dealing with year-end procedures.
- 17/6/21** The Director of Finance presented to the Committee a paper summarising performance in Month 2. The position was reported as a deficit of 6.46m, 346k behind the year to date plan. Income levels had recovered significantly from month 1 but high medical staffing spend along with a lower than planned CIP saving had impacted on achievement of May's plan.
- 17/6/22** A month end cash balance of 6.2m was noted against a 1.9m plan, this had been affected by the backlog of invoice processing, however, an improvement in total payment to suppliers had been seen when compared to last month.
- 17/6/23** Capital expenditure year to date was 0.3m against a plan of 0.4m; the agreed capital expenditure programme for this financial year being 6.5m. The executive team had indicated they would review the capital plan in early July following clarification on STP funding for HASU and the CT scanner. All orders for capital were currently being reviewed by the Director of Finance.

The Finance Report was NOTED.

#### **Strategy & Improvement Update**

- 17/6/24** The Strategy & Improvement update summarised progress on 2017/18 CIPs, development of new schemes in year and the strategic planning process.
- 17/6/25** Delivery in month 2 was 435k, against a plan of 985k. The underperformance related to procurement and the clinical admin and outpatients workstreams. Pipeline efficiency plans within the local workstream were being followed up but had not yet been implemented.
- 17/6/26** Members discussed the planned delivery and the back end loading which had been agreed due to the initial level of unidentified savings. It was agreed that once detailed EEPs were known this would be reviewed and reassessed for appropriateness.
- 17/6/27** Marie Purdue provided an update on the actions taken to date to ensure improved reporting and escalation processes for EEPs. Appropriate sign off from the SRO and senior care group teams had been secured and potential



pipeline schemes identified with workstream leads. A dedicated executive time out had included a review of the year end outturn forecast, pipeline schemes and further opportunities for each PID/workstream had been explored.

17/6/28 A summary of the financial values for EEPs and pipeline opportunities were presented and the unidentified gap was reported at 4.3m. A number of efficiencies being worked on would not deliver savings until the next financial year e.g. introduction of Physician Associate and Advanced Care Practitioners. It was agreed that it would be helpful to see data relating to 2018/19 included in the EEP summary.

JS

17/6/29 The presentation and financial summary tabled by Marie Purdue at the meeting would be shared with the committee members.

17/6/30 In response to a question from Martin McAreavey, the Director of Finance reported a high level of confidence for delivery of 10.1m savings for 2017/18. In view of the remaining gap in identified savings the Chair considered it appropriate to escalate a strong concern to Board.

NR

The Strategy & Improvement Report was NOTED.

#### **Escalation items from workstreams**

17/6/31 No items were noted for escalation.

#### **PERFORMANCE**

##### **Business Intelligence Report**

17/6/32 David Purdue presented to the committee an update on the following elements of operational performance:

- 4 hour access
- 62 day cancer performance
- Referral to Treatment

17/6/33 Four hour access performance for the month of May was reported at 91.39%, with a quarter to date performance of 91.46%. The Trust's performance continued to be in the top 30% across the country. The month of May had been particularly challenging locally and nationally, especially around the first bank holiday weekend. The impact of IR35 continued to affect staffing within ED, further impacted this month by Ramadan.

17/6/34 A discussion took place around middle grade recruitment and David Purdue shared with the committee information related to the CESR programme. The Trust currently had seven colleagues working part time with the remainder of their time being devoted to education. At the end of the programme colleagues would have the opportunity to apply for a consultant position. Opportunities to host this programme or offer at a national level were being explored as part of the commercial workstream.

17/6/35 With regards to the balanced scorecard the Chair requested this provided a high level summary only, noting items for escalation rather than a detailed

operational view. This requirement was being progressed with some adjustments being made around the appearance of the report and work to resolve the link to the electronic staff record. It was expected that a draft balanced scorecard would be brought to the next meeting.

**17/6/36** The 62 day cancer target was reported quarterly as an average, the latest data available for April showed performance at 82.6%. The committee were advised that a national improvement plan was in place and the Trust were fully compliant with all aspects of this. The key areas impacting upon performance were urology and breast and a bid for funding for additional MRI capacity had recently been submitted to support this. The remainder of the high impact pathways were compliant.

**17/6/37** Martin McAreavey sought clarity around patient choice being the main reason for breach of the two week wait target and a discussion took place with regards to activity to improve this, including looking at the level of choice offered and liaising with GP practices to educate and prioritise patient attendance.

**17/6/38** In respect of stroke performance Martin McAreavey sought confirmation of actions to address the performance of patients directly admitted to a stroke unit within 4 hours. David Purdue advised of recent discussions within the CCG and plans to review and map the stroke pathway to identify improvements.

The Business Intelligence Report was NOTED.

#### **Referral to Treatment Deep Dive**

**17/6/39** David Purdue gave a presentation relating to referral to treatment performance. A summary was provided by speciality and Trust level and then benchmarked against a regional peer group. Performance was plotted against the NHSI STF target for RTT.

**17/6/40** The Committee were advised that the method in which patient administration was tracked changed in October 2016 to CaMIS. Prior to this work to clean up and validate waiting lists had been undertaken and performance was in line with the target of 92%. However, since then migration waiters had increased and performance had failed to meet the target. Work with the CCG to identify duplicate referrals had been carried out and a plan of action implemented.

**17/6/41** In January 2017 nine specialities failed to achieve the target, an improved position was noted in May, although it should be noted that four of the five areas below target accounted for the largest volume of waiting lists across the Trust.

**17/6/42** Benchmark data for April 2017 demonstrated a Trust performance of 90.4%, compared to 89.9% nationally. Rotherham and Sheffield Teaching Hospitals performed well within the peer group and reasons for this were considered.

**17/6/43** In response to a question from Bev Marshall, David Purdue advised that long waiters were assessed on a weekly basis. Whilst there were waiters between 20-40 weeks these were patients awaiting a diagnosis following multiple

investigations, rather than an initial assessment.

- 17/6/44** A discussion took place around the various issues impacting on performance including increased demand, workforce variances, seasonal cancellations and poor pathway administration. A number of initiatives to improve process were supported by the clinical admin and outpatients and theatre workstreams along with a planned programme of training and education. Improved performance data at consultant and speciality level ensured colleagues were held to account and targeted action plans were in place, included advanced monitoring for the surgical care group.

The Referral to Treatment presentation was NOTED.

## **RISK**

### **Risk Mapping**

- 17/6/45** The Trust Board secretary shared a first draft of the Corporate Risk Register (CRR) and Board Assurance Framework (BAF). Risks were currently being updated and new risks considered. In respect of a query raised by Philippe Serna, Matthew Kane confirmed press coverage had indicated hospitals as a potential risk for terrorist activity but no further details had been received.
- 17/6/46** The Chair sought a view of the format and content and clarified that the ratings would be provided by executives rather than agreed at this committee. In terms of management of the register, it was agreed that this would be by exception. Where joint risks were identified primacy would be taken by a designated committee.
- 17/6/47** The BAF had been updated to reflect the risks to strategic aims and the format was now more aligned to other NHS frameworks. Further development was required, especially around the 4th strategic aim and colleagues were encouraged to provide input to its development. Matthew Kane highlighted that there may be other lower scale risks that were not included within the CRR.
- 17/6/48** In response to a question from Philippe Serna the Trust Board Secretary clarified the meaning of the current risk score within the CRR, as opposed to the original risk score. In order to provide a more informative view the Chair suggested an additional column be added to indicate when the risk had last been reviewed. **MK**
- 17/6/49** Martin McAreavey asked how assurance offered to the committee would be incorporated into the BAF. A review immediately following the report was recognised as good practice, although assurance may also be received from external and independent sources.

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

### **Items for escalation to the Board of Directors**

- 17/6/50** 17/6/30 to be escalated as part of the Chair's log.

**Minutes of the meeting held on 22 May 2017**

**17/6/51** Minutes of the meeting held on 22 May 2017 were APPROVED as a true record.

**Time and date of next meeting:**

Date: 20 July 2017

Time: 9:15am

Venue: Boardroom, DRI

Signed:.....

Neil Rhodes

.....  
Date

DRAFT

Minutes of the Audit & Non-Clinical Risk Committee Meeting  
held at 9am on Friday 24 March 2017  
in the Boardroom, DRI

PRESENT : David Crowe, Non-executive Director (Chair)  
Martin McAreavey, Non-Executive Director

IN ATTENDANCE : Mark Bishop, Local Counter Fraud Specialist  
Steve Clark, External Audit (EY LLP)  
Mark Dalton, Internal Audit (KPMG)  
Karen Barnard, Director of People & OD  
Matthew Kane, Trust Board Secretary  
Simon Marsh, Chief Information Officer  
Clare Partridge, Internal Audit (KPMG)  
Linn Phipps, Non-Executive Director  
David Purdue, Chief Operating Officer  
Jon Sargeant, Director of Finance  
Leanne Shaw, Executive PA (Minutes)  
Andrew Thomas, Interim Associate Director of Finance  
Sean Tyler, Head of Compliance  
Roy Underwood, Head of Information Governance

GOVERNOR OBSERVERS: Bev Marshall, Public Governor  
George Webb, Public Governor

Action

**Apologies for absence**

17/1 Apologies were received from Philippe Serna.

**Minutes of the meeting held on 16 December 2016**

17/2 The minutes of the meeting held on 16 December 2016 were APPROVED as an accurate record.

**Matters arising and action notes**

17/3 The action notes of the meeting held on 16 December 2016 were reviewed and updated, and David Crowe asked for clear target dates to be provided. Matters arising were discussed as follows;

17/4 16/129 - The Committee was informed that a review of the quality of appraisals was currently being undertaken.

17/5 16/371 - In response to a query from David Crowe in relation to the Trust's level of vulnerability to cyber security, Simon Marsh reported that penetration testing had been carried out and once the recommendations outlined in the report had been reviewed, an action plan would be developed and presented at the next meeting.

SM

## Internal Audit Progress Report

- 17/6 Clare Partridge informed the Committee that good progress had been made against the internal audit plan and noted that Trust policies and procedures were in place and up to standard.
- 17/7 Mark Dalton provided the Committee with an update on progress, reporting that ten reports had been finalised and one report was awaiting management response. Four reviews were in progress, with a further three reviews due to commence in the remainder of quarter 4. The audit plan remained on track to be delivered within the planned number of days, with 187 out of 240 days delivered so far.
- 17/8 With regard to the potential delay with the Estates Strategy audit, the Committee was informed that a further piece of work around estates infrastructure would be carried out by external experts prior to the audit being carried out. Jon Sargeant was asked to provide a timescale for the work at the next meeting. JS
- 17/9 Mark Dalton reported that following the recent independent Well Led Governance review, management had requested that elements of the planned Risk Management and BAF, Corporate and Clinical Governance Arrangements and Whistleblowing reviews were delayed until early 2017/18. The Committee was asked to approve the changes to the plan.
- 17/10 The audit reports for the ten completed reviews were provided for information and Mark Dalton drew attention to the executive summaries and overall assurance rating for each review as follows;
- Booking Management - *partial assurance with improvements required*. Instances of non-compliance were found in relation to patient referrals and booking management. 13 recommendations had been made and agreed by management and David Purdue provided the following update;
- Standard Operating Procedure (SOPs) - in place for setting up new or ad-hoc clinics, and clinic change forms instigated for six week notice period
  - E-referrals - referrals to be graded by Dermatology as part of the new system. New to follow-up ratios to be reviewed by Consultants
  - Meeting to take place with primary and secondary care and LMC to discuss new contract requirements and access policies.
- 17/11 David Purdue agreed to share the latest outpatient dashboard with the Committee. DP
- 17/12 In response to a query from David Crowe in relation to management's expected assurance rating and the actual assurance rating for the Booking Management review, David Purdue commented that although the correct policies and procedures were in place, they had not been fully adhered to and colleagues would receive further training.
- 17/13 Concerns in relation to the difference in the expected levels of assurance between internal audit and management was echoed by Martin McAreavey, and Mark Dalton commented that general issues across all reports included compliance with policies and procedures, and staff capacity.

- 17/14 In response to a query from Linn Phipps, Clare Partridge commented that patient experience would form a separate audit review in the future. However, Linn would be keen to see patient experience illustrated in all reviews.
- 17/15 Information Governance Toolkit Review (phase 1) - *significant assurance with minor improvement opportunities.*
- 17/16 IT Capability Review - *partial assurance with improvements required.* Eight recommendations had been made with improvements in all of the four IT capability areas. Simon Marsh reported that the business case to recruit into the senior posts within the IT structure would be submitted to the Board for approval, and the development of the IT Strategy was currently in progress.
- 17/17 In response to a query from David Crowe in relation to providing assurance that actions were being undertaken from the recommendations, Simon Marsh agreed to provide clear deadline dates at the next meeting. SM
- 17/18 E-rostering - *partial assurance with improvements required.* The rating was in line with management's expectations. 11 recommendations had been made and Karen Barnard provided the following update;
- Wards had been subject to Grip and Control meetings as part of turnaround with weekly updates to the Executive Team
  - E-rostering Steering Group had been established to ensure actions were taken forward and robust controls over the process were in place
  - Interface with NHSP - business case cost neutral
  - Administrative staff instead of Ward Manager to populate rotas.
- 17/19 David Purdue agreed to meet with Karen Barnard and KPMG outside of the meeting to discuss some of the recommendations further. DP/KB/  
KPMG
- 17/20 Workforce - Recruitment Strategy - *partial assurance with improvements required.* There had been some non-compliance with the recruitment policy. 14 recommendations had been made and agreed with management.
- 17/21 Core Financial Systems - *partial assurance with improvements required.* Although continued improvements had been recognised, further areas had been identified within the review and six recommendations had been made. Jon Sargeant commented that the turnover of staff in Finance had been an issue. Clare Partridge was happy with the general day to day working within the department.
- 17/22 Independent Programme Assurance over the Outsourcing of Financial Systems - phase 2 - assurance rating not provided at this stage as this was part of a 3-phase review.
- 17/23 Data Quality - Performance Indicators - *partial assurance with improvements required.* Six recommendations had been made. The Trust had been made aware of opportunities for improvement in relation to the underlying data used to compile the RTT indicator. The Trust's Performance Improvement Action Plan had been discussed and agreed with Commissioners.



- 17/24 Financial Reporting Month End Checklist (Month 9) - *significant assurance with minor improvement opportunities.*
- 17/25 CQC Action Plan - *partial assurance with improvements required.* Implementation of the Trust's action plan to address the CQC's findings from its last inspection in April 2015 had not been progressing as well as Internal Audit would have expected. 18 recommendations had been made, namely around medicines management, mandatory training and lack of standardisation in assessment and streaming of patients in the Emergency Departments at Doncaster and Bassetlaw.
- 17/26 Significant concerns were raised by David Crowe and Martin McAreavey in relation to the slow progression of the CQC action plan, in particular around completeness and embeddedness of actions previously reported as completed. David Purdue agreed to discuss key findings with the Acting Director of Nursing, Midwifery and Quality and Acting Deputy Director of Nursing, Midwifery and Quality outside of the meeting. DP
- 17/27 Bev Marshall asked for consistency in all reports in relation to including whether the assurance rating had been in line with management's expectations. KPMG
- 17/28 The Committee:
- (1) NOTED the Progress Report.
  - (2) APPROVED the changes to the Internal Audit Plan identified in minute 17/9.
- Internal Audit Plan 2017/18**
- 17/29 Mark Dalton presented the report and explained that minor changes had been discussed and agreed with the Executive Team. The proposed timetable and outline scope of the key risk based reviews to be carried out in 2017/18 had been provided.
- 17/30 Martin McAreavey queried how additional audits could be added to the plan. Clare Partridge explained that these could be added following consultation with the executive team and after an appraisal of the benefits and value added.
- 17/31 Linn Phipps queried why the review of CIPs had been scheduled to be carried out in 2018/19 when it had been high risk and Mark Dalton explained that CIPs had previously been subject to significant external scrutiny and assurance had subsequently been provided to the Trust.
- The Internal Audit Plan 2017/18 was NOTED.
- Internal Audit Technical Update**
- 17/32 The Internal Audit Technical Update was provided for information and NOTED.
- Recommendation Tracker**
- 17/33 Mark Dalton provided an update on the positive progress the Trust had made against outstanding internal audit recommendations.



- 17/34 In response to a query from David Crowe in relation to ensuring that there would be no slippage on progress in future years, Mark Dalton commented that specific reviews would be revisited on an annual or cyclical basis.

The Action Tracker was NOTED.

#### **External Audit Plan for 2016/17**

- 17/35 Michael Green presented the audit plan for 2016/17, summarising the initial assessment of the key risks facing the Trust and gave an overview of how the following risks would be addressed through their audit strategy;

- Going concern
- Authorisation of cash payments
- Risk of management override
- Risk of fraud in revenue recognition
- Risk of misstatement in valuation of property, plant and equipment

- 17/36 In response to a query from David Crowe in relation to the control weakness in the authorisation of cash payments, Jon Sargeant commented that controls had been implemented and payment runs would be checked by senior finance personnel.

- 17/37 Steve Clark explained that procedures would be in place for testing journals throughout the year and checking for any inappropriate movement of such journals.

- 17/38 Steve Clark outlined two significant VFM (value for money) risks that had been identified; sustainable resource development - financial resilience, and informed decision making - financial governance. Steve commented that two further risks would be added in relation to data quality and CQC inspection.

- 17/39 In response to a query from Bev Marshall, Jon Sargeant explained how the Trust's underlying deficit had been calculated. A paper would be presented to the Financial Oversight Committee outlining the recurrent deficit and the reasons for the deficit.

JS

- 17/40 David Crowe suggested Jon Sargeant met with Bev Marshall outside of the meeting to provide an uncomplicated explanation of the Trust's financial position.

JS/BM

The External Audit Plan for 2016/17 was NOTED.

#### **Q1 Health Sector Update**

- 17/41 The Q1 Health Sector update was provided for information and NOTED.

#### **Progress Update Report**

- 17/42 Michael Green gave a verbal update on the work that had been undertaken since the last meeting, reporting that audit planning had been completed. An interim audit had commenced in February to test transactions to month 9 in order to identify any issues as early as possible and would be completed early the following week.

The verbal Progress Update Report was NOTED.

## **Local Counter Fraud Progress Report Q4 2016/17**

**17/43** Mark Bishop summarised the key points of the report as follows;

- Philippe Serna had written to NHS Protect on behalf of the Trust in relation to the review of their functions and services, and a response was awaited. Security management would not be supported from 1 April 2017
- The self-review tool for counter fraud activity had been submitted on time and the overall assessment outcome of 'green' had been as expected
- Estates & Facilities and Performance remained outliers in relation to SET training compliance for fraud awareness
- The National Fraud Initiative (NFI) had identified 133 matches for checking, 28 of which remained outstanding

**17/44** It was noted that there had been 13 new investigation referrals, nine cases had closed, two were pending sanction action and 12 remained open for further development.

**17/45** In response to Martin McAreavey, Mark Bishop commented that there were no concerns within the Estates and Facilities directorate in relation to fraud risks. In relation to fraud awareness training levels within the directorate, Mark explained that this had possibly been due to limited computer access and shift working patterns, however SET training sessions would be facilitated in large groups to improve the take up.

The LCFS Progress Report for Q3 was NOTED.

## **Local Counter Fraud Operational Plan 2017/18**

**17/46** Mark Bishop presented the plan that set out the counter fraud activity for the period 1 April 2017 to 31 March 2018.

**17/47** In response to a query from Linn Phipps, Mark Bishop confirmed that demonstrable outcomes would be provided in the quarterly report.

**17/48** The LCFS Operational Plan for 2017/18 was provided for information and NOTED.

## **Security Management Annual Report**

**17/49** The item was deferred to the next meeting.

## **Security Update**

**17/50** Sean Tyler provided an update on the Trust's security arrangements and drew attention to key points within the report as follows;

- Self-review tool - overall 'amber' rating achieved
- Security and car parking tender due to be advertised at the end of March 2017
- LSMS had become a member of two National Professional Advisory Groups (NPAG) for security and car parking, to enable networking with colleagues by sharing best practice to promote continuous improvement

- 17/51 Sean Tyler commented that he would be reworking the format of the report to make it fit for purpose going forward. David Crowe asked to liaise with Jon Sargeant and Matthew Kane outside of the meeting to discuss.

ST

JS/MK

The Security Update was NOTED.

### **Suspensions and Exclusions Report**

- 17/52 Karen Barnard provided a summary on the cases that were currently listed. Three cases had been closed, two cases were undergoing disciplinary procedures and there had been one new case that was pending feedback from the police.

The Suspensions and Exclusion Report was NOTED.

### **Revision to the Scheme of Delegation**

- 17/53 Jon Sargeant presented the report, noting that an early review of the Trust's Scheme of Delegation, SFIs and SOs had been undertaken as a result of the new finance and procurement system going live on 1 April 2017, and it had been proposed to increase the authorisation limits for purchase orders. The annual review would take place as planned in July 2017.

- 17/54 In response to a query from George Webb, a minor amendment to the charitable funds authorisation was recommended and agreed.

JS

The Revision to the Scheme of Delegation was recommended to Board for approval.

### **Board Assurance Framework and Corporate Risk Register**

- 17/55 Matthew Kane presented the report outlining the quarter 4 position. Risks in relation to the Trust's financial position had reduced, and an overview of where the risks had started and finished in the year had been provided.

- 17/56 The Board Assurance Framework and Corporate Risk Register for 2017/18 would be reviewed with the Executive Team prior to being shared with this Committee.

- 17/57 David Crowe commented that in order to meet best practice, the report format and content would change moving forward. The updated Board Assurance Framework would be presented at the next meeting.

- 17/58 In response to a query from George Webb in relation to the early departure of the substantive Director of Strategy and Improvement, it was reported that contingency plans had been put in place and an acting up role had been filled internally. The Nominations and Remuneration Committee would be responsible for reviewing the voting arrangements.

The BAF and Corporate Risk Register was REVIEWED and NOTED.

### **Procurement Policy**

- 17/59 The Procurement Policy had been developed to bring various guidance documents

into one document, and set out the framework for all procurement activity to be undertaken.

The Procurement Policy was NOTED and RECOMMENDED for Board approval.

### **Annual Information Governance Report**

**17/60** Roy Underwood presented the annual report for 2016/17. The Committee noted that the Information Governance Toolkit (IGT) standards had been reviewed by internal audit and all actions had been completed. The overall IG Toolkit compliance score was satisfactory at 75% with an aspirational target of 79% for 2017/18.

**17/61** In response to a query from Martin McAreavey in relation to the sharing of patient identifiable data with third party organisations, Roy Underwood explained that there was a policy in place, IG Toolkit scores would be checked and site visits would be carried out if required.

The Annual Information Governance Report was NOTED.

### **Assurances Regarding the Overall Arrangements for Compliance with IG Standards**

**17/62** The Committee NOTED the report that set out the responsibilities of the groups within the Information Governance Assurance Framework.

### **Losses and Compensation Payments**

**17/63** The Losses and Compensation Payments report for the period December 2016 to February 2017 was NOTED.

### **Waiving of Standing Orders**

**17/64** Jon Sargeant presented the quarterly report, noting that a more detailed explanation for the use of tender waivers had been included.

The Waiving of Standing Orders quarterly report was NOTED.

### **Month End Checklist**

**17/65** Jon Sargeant presented the checklist that summarised and recorded the tasks required as part of each month end close down.

The Month End Checklist report was NOTED.

### **Committee Effectiveness Self-assessment Action Plan**

**17/66** Matthew Kane presented the action plan that set out current progress against each of the recommendations, noting that the majority of the actions had been implemented.

**17/67** The Committee Effectiveness Self-assessment Action Plan was NOTED.

### **Issues escalated from sub-committees**

**17/68** None.

### Issues for escalation to Board of Directors

17/69 It was agreed to escalate the CQC Internal Audit review.

### Minutes of the Health and Safety Committee meeting

17/70 The minutes of the Health and Safety Committee meeting held on 1 December 2016 were NOTED.

17/71 In response to a query from Martin McAreavey in relation to the decline in Datix reporting, Sean Tyler was asked to investigate. ST

17/72 In response to a query from Martin McAreavey in relation to legal expenses for sharps injury claims, Jon Sargeant agreed to investigate and provide an explanation. JS

### Any Other Business

17/73 As this was his last meeting before standing down as a director, Martin McAreavey passed on the Committee's thanks to David Crowe.

### Time and date of next meeting:

17/74 Date: 26 May 2017  
Time: 9am  
Venue: Boardroom, DRI

Signed:

.....  
Philippe Serna  
Chair

.....  
Date

**Minutes of the Audit & Non-Clinical Risk Committee Meetings  
held at 9am on Friday 26 May 2017  
in the Boardroom, DRI**

PRESENT : Philippe Serna, Non-executive Director (Chair)  
Martin McAreavey, Non-Executive Director

IN ATTENDANCE : Steve Clark, External Audit (EY LLP)  
Mark Dalton, Internal Audit (KPMG)  
Michael Green, External Audit (EY LLP)  
Matthew Kane, Trust Board Secretary  
Richard Parker, Chief Executive  
Clare Partridge, Internal Audit (KPMG)  
Jon Sargeant, Director of Finance  
Kate Sullivan, Corporate Secretariat Manager (Minutes)  
Andrew Thomas, Interim Associate Director of Finance

GOVERNOR OBSERVERS: Bev Marshall, Public Governor  
George Webb, Public Governor

OBSERVERS PUBLIC: Karen Widdowson

**Action**

**Apologies for absence**

17/75 Apologies were received from Linn Phipps.

**Draft ISA 260 Report**

17/76 The report was not available at the time of the meeting. Steve Clark provided a verbal update and drew attention to the following key points:

17/77 There was still work to do; a key issue had been historical issues relating to working papers for brought forward balances. This had been addressed for the current year following the move to a new ledger system from 1<sup>st</sup> April 2017. However, the issues relating to the previous years' working papers and the significant level of manual adjustments had driven larger sample sizes and had resulted in the audit work for 2016/17 being very time consuming.

17/78 A significant area of work remaining was journal testing; the Trust had processed a significant number of journal lines in 2016/17 and there were a significant number of reversing journals to test. The deadline for the submission of the Annual Accounts and Financial Statements was Wednesday 31 May 2017. Auditors had previously identified this as a risk but this risk was reducing daily as work progressed. The Trusts finance team, including the Director of Finance and senior members of the team, and EY would be working over the weekend to achieve the deadline.

17/79 In response to concerns raised by Philippe Serna, Steve Clark gave assurance that at

the current time there were no material or non-material adjustments to the financial accounts.

- 17/80** Philippe Serna was committed to ensuring that all Executive and Non-Executive Directors had sight of the Financial Accounts before submission and how this would be achieved was discussed. It had been agreed to hold a further meeting of the ANCR on Tuesday 30 May 2017 to approve the final accounts and these would be circulated to the Board later the same day.
- 17/81** George Webb expressed his disappointment that the final financial accounts were not available and asked if anything could have been done to ensure they had been available and why Governors had not been pre-warned of the issues. Bev Marshall echoed this and furthermore expressed concern about reputational risk to the Trust should the deadline not be met and this was discussed. Jon Sergeant had been in regular contact with Philippe Serna but he offered his apologies for not keeping the Governor observers informed about progress and he undertook to ensure this was considered in the future. One of the key issues had been there were a significant number of new staff within the finance team and only a limited number with the critical knowledge to provide working papers.
- 17/82** Steve Clark updated the committee on reporting issues. The audit of the financial statements has been challenging. The Trust experienced difficulties in providing a full set of working papers to support the entries in the financial statements. This was exacerbated by the loss of corporate memory experienced within the finance team, the limitations of the Agresso ledger system and the implementation of SBS from April 2017. EY acknowledged that the Trust had experienced significant upheaval within the finance department during the year and that significant improvement has been made in the operation of financial controls and processes.
- 17/83** Jon Sergeant gave assurance that there was sufficient capacity within the finance team to complete the work required to achieve the deadline and EY echoed this.
- 17/84** The key factor in the difficulties experienced by both the finance team and the audit team were linked to the limitations of the financial ledger, issues with poor coding within the ledger and the excessive use of journals. The Trust had now implemented the SBS ledger and many of the issues should be resolved, subject to further work around source coding. EY were committed to working with the Trust during 2017-18 to ensure the financial reporting and audit process was improved. This included early engagement with the finance team to identify improvement areas and completion of a hard close at month 6 with early substantive testing.
- 17/85** There was further discussion and Steve Clark advised EY expected to issue an unqualified opinion on the Trust's financial statements, However, until they had completed their outstanding procedures, it was possible that further matters requiring amendment may arise. In respect of going concern, EY noted the Trust's ongoing reliance on liquidity funding from NHSI and the underlying deficit of the Trust of £28m. This would be included as a matter of emphasis relating to the going concern in the audit report which was unqualified.

The Draft ISA 260 Report Update was NOTED, the final ISA 260 Report would be provided at the meeting on 30 May 2017.



## Quality Report 2016/17 – External Assurance

- 17/86 The report was not available at the time of the meeting. Steve Clark advised that the work was complete and had gone well and no qualifications had been issued. The final Quality Report would be provided at the next meeting on 30 May 2017.

The Quality Report 2016/17 – External Assurance Update was NOTED.

## Annual Report and Head of Internal Audit Opinion

- 17/87 Mark Dalton presented the report which set out the key findings in relation to reviews completed for 2016/17, all of which were completed following agreement of terms of reference with management. Final reports had been presented to the Audit and Non-clinical Risk (ANCR) Committee following their agreement with relevant officers.
- 17/88 Since the last meeting 7 reviews had been completed. Assurance opinions would be issued as follows; 1 with significant assurance, 4 with significant assurance with minor improvement opportunities and 2 with partial assurance. The full reports would be presented at the July meeting of the ANCR. MD
- 17/89 The annual report summarised:
- Findings in relation to the planned internal audit coverage and output;
  - Internal audit performance as measured against the agreed suite of performance targets; and
  - Head of Internal Audit Opinion to Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust.
- 17/90 **Overall Opinion** - For the period 1 April 2016 to 31 March 2017 internal audit opinion was that *Significant assurance with minor improvement opportunities* could be given on the overall adequacy and effectiveness of the organisation's framework of governance, risk management and control.
- 17/91 Mark Dalton drew attention to pages 5 & 6 which provided an overview of Internal Audit coverage and outputs with RAG rated assurance ratings. The core reviews were rated green/amber. Those reviews rated amber/red related to risk based reviews and were less positive however this had been expected as these were areas identified by the Trust as areas of risk.
- 17/92 Philippe Serna thanked internal audit for the report. Bev Marshall commented that it was well presented, very easy to understand and one of the best reports he had seen. This was echoed by the Committee. Philippe Serna commented that report reflected the progress made by the Trust and he commended the Trust on this.
- 17/93 The working relationship between internal audit and the Trust had been very positive; Jon Sergeant commented that KPMG had been flexible and helpful. Internal audit reports were now being taken through the Executive Team meetings prior to going to ANCR and this had been very helpful.
- 17/94 In response to a query from George Webb about whether a review of the new financial systems would be undertaken, it was clarified that the Trust and EY would



carry out a review later in the year. A mini year end at month 6 would be undertaken to identify any potential issues.

17/95 The Annual Report and Head of Internal Audit Opinion was NOTED.

#### **2016/17 Annual Governance Statement**

17/96 Richard Parker presented the Draft Annual Governance Statement which formed the Trust's statement of internal controls. The report set out how the Trust had ensured that it had implemented processes appropriate to its circumstances under the following headings:

- Scope of responsibility
- The governance framework of the organisation
- Risk assessment
- The risk and control framework
- Review of the effectiveness of risk management and internal control
- Significant issues

17/97 In light of the late receipt of the ISA 260 Report the Annual Governance Statement was incomplete; a final statement would be provided following the meeting due to be held on 30 May 2017. RP/MK

17/98 Matthew Kane had received comments from external audit and would incorporate those in to the statement. MK

The Draft 2016/17 Annual Governance Statement was NOTED.

#### **Draft 2016/17 Annual Accounts & Financial Statements**

17/99 Jon Sergeant presented the unaudited accounts for the financial year end dated 31 March 2017, as submitted to NHSI and EY on 26 April 2017.

17/100 The audit was currently taking place and as of the time of the meeting there were no known changes that would impact upon the bottom line, identified changes being presentational in nature. The deadline for submission of the accounts, with a final opinion, was 31st May 2017. The final 2016/17 Annual Accounts & Financial Statements would be circulated to the Committee as soon as they were available. JS

17/101 Jon Sergeant provided an overview of the paper. The accounts had been hard to produce due to the systems used in year and there would be further notes to the final report about changes that needed to take place. Both the Trust Finance Team and the EY Team had worked very hard, the audit had been challenging and he thanked everyone for their work to produce the accounts and audit.

17/102 In response to a query Jon Sergeant clarified that the underlying in year deficit for 2016/17 was £28m.

The unaudited Draft 2016/17 Annual Accounts & Financial Statements were NOTED.

## WTP Committees in Common

- 17/103 Matthew Kane presented the report outlining the Working Together Acute Trusts proposals for a governance structure which would enable them to work together to implement change. Each Trust had agreed, in principal, to establish a committee which would work in common with the other Working Together Partnership Committees in Common. The Committee considered the draft terms of reference, delegation scheme (decision rights) document and joint working agreement concerning the proposed Committees in Common governance arrangements.
- 17/104 Key areas discussed included:
- ToRs
  - Proposed delegated authority of £1m to the Committees in Common to enable them to make decisions. This would require a change to the Trusts Scheme of Delegation
  - Joint Working Arrangements
  - Independent oversight arrangements
  - Reporting lines from the WTP Committees in Common meetings
  - Membership and deputation arrangements
  - Quoracy
- 17/105 In response to a query from Bev Marshall about why the membership was not consistent with the STP area, Richard Parker advised that the STP and WTP were two distinct groups and this was discussed. It was agreed to clarify the membership of the WTP Committees in Common. MK
- 17/106 Martin McAreavey and Bev Marshall raised queries about independent oversight of the WTP Committees in Common and how it would be held to account and this was discussed. Matthew Kane undertook to take this away and feedback outside of the meeting. MK
- 17/107 In response to a query from Martin Mcareavey about data security, Richard Parker gave assurance that data protection laws would be considered as part of the process.
- 17/108 The ANCR understood the desirability for Committees in Common as being within the spirit of partnership and collaborative working although it was understood that discussions to align Board meetings on a particular week of the month may negate the need for the new arrangements.
- 17/109 In response to a query from Philippe Serna, Matthew Kane clarified that delegations were to the committee not to individuals therefore individual delegation thresholds did not apply.
- 17/110 The meeting was to be attended by the Chief Executive and Chair of each Trust and concern was raised about decisions being made when they were not in attendance and this was discussed. Similar concern had been raised by other member Trusts and was part of ongoing discussions. While there was no strong objection to the proposed £1m financial threshold, the ANCR supported the approach suggested by Sheffield Teaching Hospitals and other trusts that the Board of Directors, as the

sovereign body within each trust, must be sighted on proposals for service redesign.

17/111 In relation to the question regarding Governor involvement and Capsticks' view of whether the agenda and minutes would need to be sent to Governors, it was understood that the provisions set out in Section 18D to Schedule 7 of the National Health Service Act 2006 meant that discussion at Board on matters relating to the CIC would be available to governors in any case even if the actual CIC agenda and minutes were not. Governor observers present at ANCR were comfortable with this approach.

17/112 In respect of specific comments on the documents provided Matthew Kane would feedback the following:

- Terms of reference & Joint Working Agreement, paras. 1.1 – Amend the title of our trust to Doncaster & Bassetlaw Teaching Hospitals NHS Foundation Trust and add 'Sheffield Teaching Hospitals NHS Foundation Trust'
- TOR, Para. 6 – Correct numbering of sub-paragraphs
- TOR, Para. 13.2 – How will AOB be dealt with? Will this require authorisation from the Meeting Lead?
- Joint Working Arrangement – Will some service changes require public consultation? How will this be undertaken?
- JWA – What are the possible financial consequences for a trust who exits the Partnership? What are the compensation arrangements for trusts who may be penalised by the exit from an arrangement of another trust?
- JWA – What are the duties and responsibilities relating to intra-trust data sharing? Does this need to be captured or is it covered within existing agreements/legislation?
- Sign off at end of JWA – Amend the title of our trust to Doncaster & Bassetlaw Teaching Hospitals NHS Foundation Trust.

17/113 The WTP Committees in Common report was NOTED and further comments would be fed back to Matthew Kane outside of the meeting; Matthew undertook to forward the ANCRs comments to the WTP.

MK

#### **Any Other Business**

17/114 **ANCR Composition & ANCR Terms of Reference** - The papers had been circulated outside of the meeting. Matthew Kane presented the report. The Committee noted the reasoning to amend a recommendation previously made by the ANCR to the Board of Directors to include the Executive Director of Finance as a member of the ANCR.

17/115 The Committee **SUPPORTED** the recommendation for the ANCR to recommend to the Board an amendment to resolution (2) from the item 'Review of Board Committees', substituting the words:

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

With the words:

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

**17/116** A notice bearing the above proposed resolution, to be signed by five directors, would be presented to the Board of Directors. **MK**

**17/117** Governor Observers would be included in the circulation of the ISA 260 and Quality Reports once they became available. **MK**

**Time and date of next meeting:**

**17/118** **Date:** 20 July 2017  
**Time:** 2pm  
**Venue:** Boardroom, DRI

**Signed:**

.....  
**Philippe Serna**  
**Chair**

.....  
**Date**

Meeting held at 9am on Tuesday 30 May 2017  
in the Chief Executive's Office, DRI

Action

PRESENT : Philippe Serna, Non-executive Director (Chair) *by phone*  
Martin McAreavey, Non-Executive Director *by phone*

IN ATTENDANCE : Steve Clark, External Audit (EY LLP) *by phone*  
Michael Green, External Audit (EY LLP)  
Matthew Kane, Trust Board Secretary  
Richard Parker, Chief Executive  
Jon Sargeant, Director of Finance  
Kate Sullivan, Corporate Secretariat Manager (Minutes)  
Andy Sidney, Head of Financial Control

**Apologies for absence**

17/119 Apologies were received from Linn Phipps, George Webb and Bev Marshall.

**ISA 260 Report**

17/120 Steve Clark thanked the Trust and external audit teams for their hard work over the weekend. Michael Green advised that all outstanding issues had been addressed.

17/121 Opinion - External audit had issued an unqualified opinion on the Trust's financial statements with uncertainty relating to the Trust's ability to continue as a going concern. This uncertainty related to the Trust's ongoing reliance on liquidity funding from NHSI and the underlying deficit of the Trust of £28m and this would be included as an emphasis of matter relating to going concern the audit report.

17/122 Audit differences – there had been one unadjusted difference in the draft financial statements of the Trust and one within the consolidated financial statements which management had chosen not to adjust. The aggregated impact of unadjusted audit differences in the Foundation Trust was £281k and in the consolidated financial statements, £515k. The bulk of these related to the prior year and did not materially impact on the accounts.

17/123 Steve Clark drew attention to Page 8 & 9 - Areas of Audit Focus – Significant Risks. A potential classification issue had been identified relating to disclosure of income and expenditure in notes 4, 5 and 6. The most significant of these related to CCG income being understated by £20m. This did not affect the total income recognised by the Trust. Jon Sergeant provided an explanation of this and commented that he was happy for this to be changed.

17/124 Philippe Serna had provided comments relating to some of the wording of the report outside of the meeting, this was discussed and it was agreed all comments would be reflected in the report.

17/125 Michael Green drew attention to Page 11 – Audit Issues and Approach – Significant Risks – Going Concern: In respect of going concern, EY noted the Trust's ongoing reliance

SC

on liquidity funding from NHSI and the underlying deficit of the Trust of £28m. This would be included as a matter of emphasis relating to the going concern in the audit report which was unqualified.

**17/126** Michael Green drew attention to Page 12 – Areas of Focus – Authorisation of Cash Payments: No indication of fraud had been identified but one instance of a cash payment being authorised by a junior member of staff within the accounts payable team had been identified. The Trust had taken action to address this and had implemented increased control over cash payments and their authorisation. EY had reviewed the controls and confirmed that they were working as designed. Several instances where staff had been paid as suppliers had also been identified, these had been investigated. The cases related to consultant staff being paid for separate services; no fraud had been identified.

**17/127** Michael Green drew attention to Pages 14/15 – Audit Issues and Approach – Other findings where he provided an overview of the following areas which were NOTED:

- Inventory Finding
- Prior year adjustments finding
- Asset Register finding
- Employee Remuneration finding
- Management override

**17/128** In response to several questions from Martin McAreavey, Michael Green gave assurance that no mismatched balances would be reported; all balances were supportable and that Trust had accounted for everything appropriately.

**17/129** Management Overrides – significant work had focussed on journals due to the volume of journals processed. Following the introduction of new systems in April 2017 the number of journals processed was expected to have significantly decreased.

**17/130** Inventory Finding – It had been noted that the Trust did not complete a stock take on a quarterly basis. This was discussed and Jon Sergeant gave assurance that work would be taken forward to ensure more regular stock takes were carried out.

**17/131** Audit Differences – The summary of audit differences was reviewed and NOTED.

**17/132** Other reporting issues – Group Audits: The Trust experienced difficulties in providing a reconciliation and consolidation schedule demonstrating how the group financial statements had been produced. This was partly attributable to the fact that the charitable funds operated in an unsupported financial ledger that did not allow the Trust to provide timely and accurate information. Steve Clark recommended that the charitable funds be deconsolidated; Jon Sergeant undertook to bring a proposal paper to the Finance and Performance Committee.

JS

**17/133** Yearend close plan - the wording of this section of the report was discussed; Jon Sergeant requested that the report be amended to reflect pressures on resourcing and issues with the SBS system, Michael Green undertook to reflect the comments in the final report.

MG

- 17/134 Feedback from the meeting would be reflected in the report which would be finalised the same day, circulated to the wider Board and submitted on 31 May 2017, the deadline date. EY/MK

The ISA 260 Report was APPROVED.

#### **Draft 2016/17 Annual Accounts & Financial Statements**

- 17/135 The report had been circulated outside of the meeting.
- 17/136 The 2016/17 Annual Accounts & Financial Statements were APPROVED subject to the agreed changes to the EY report.

#### **Quality Report 2016/17 – External Assurance**

- 17/137 Michael Green presented the report. As a result of the work EY had performed an unmodified limited assurance report would be issued to the Trust.
- 17/138 The Quality Report 2016/17 – External Assurance Update was APPROVED.

#### **Time and date of next meeting:**

- 17/139 **Date:** 20 July 2017  
**Time:** 2pm  
**Venue:** Boardroom, DRI

**Signed:**

.....  
**Philippe Serna**  
Chair

.....  
**Date**

## Board of Directors Agenda Calendar

STANDING ITEMS			OTHER / AD HOC ITEMS
MONTHLY	QUARTERLY	BIANNUAL / ANNUAL	
AUGUST 2017			
CE Report	QEC minutes	Proposed AMM arrangements	Annual Revalidation update(medical)
Business Intelligence Report	ANCR Minutes	Annual Security Report	Health and Wellbeing
Nursing Workforce		Infection Control Annual Report	
MB Minutes			
Finance & Performance Minutes			
Finance Report			
Chairs' Assurance Logs			
SEPTEMBER 2017			
CE Report		Risk Policy	
Business Intelligence Report		Fred & Ann Green Legacy minutes	
Nursing Workforce			
MB Minutes			
Finance & Performance Minutes			
Finance Report			
Chairs' Assurance Logs			
OCTOBER 2017			
CE Report	ANCR minutes	Charitable Funds minutes	
Business Intelligence Report	Chief Executive's Objectives		
Nursing Workforce	Complaints, Compliments, Concerns and Comments Report		
MB Minutes	R&D Strategy metrics (in BIR)		
Finance & Performance Minutes	Safeguarding & maternity metrics (in BIR)		
Finance Report	P&OD Quarterly report		
Chairs' Assurance Logs			
NOVEMBER 2017			
CE Report	QEC minutes	Annual Compliance against the National Core	



		Standards for Emergency Preparedness, Resilience and Response (EPRR)	
Business Intelligence Report	Board Assurance Framework & corporate risk register Q2		
Nursing Workforce			
MB Minutes			
Finance & Performance Minutes			
Finance Report			
Chairs' Assurance Logs			
<b>DECEMBER 2017</b>			
CE Report	Report from the Chair of the ANCR committee (Verbal)		
Business Intelligence Report			
Nursing Workforce			
MB Minutes			
Finance & Performance Minutes			
Finance Report			
Chairs' Assurance Logs			
<b>JANUARY 2018</b>			
CE Report	ANCR minutes (16.12.16)	Budget Setting / Business Planning / Annual Plan	
Business Intelligence Report	Chief Executive's Objectives	SOs, SFI, Scheme of Delegation	
Nursing Workforce	Complaints, Compliments, Concerns and Comments Report		
MB Minutes	R&D Strategy metrics (in BIR)		
Finance & Performance Minutes	Safeguarding & maternity metrics (in BIR)		
Finance Report	P&OD Quarterly report		
Chairs' Assurance Logs			
<b>FEBRUARY 2018</b>			
CE Report	QEC Minutes	Budget Setting / Business Planning / Annual Plan	
Business Intelligence Report	Monitor Quarterly Declaration Q3		

Nursing Workforce	Board Assurance Framework & corporate risk register Q3		
MB Minutes			
HWB Decision Summary			
Finance & Performance Minutes			
Finance Report			
Chairs' Assurance Logs			
<b>MARCH 2018</b>			
CE Report	Report from the Chair of the ANCR committee (Verbal)	Budget Setting / Business Planning / Draft Annual Plan	
Business Intelligence Report	Monitor Q3 Results Notification	Staff Survey	
Nursing Workforce		Fred & Ann Green Legacy minutes	
MB Minutes			
HWB Decision Summary			
Finance & Performance Minutes			
Finance Report			
Chairs' Assurance Logs			
<b>APRIL 2018</b>			
CE Report	ANCR minutes	Draft Annual Report	Mandatory training update
Business Intelligence Report	Chief Executive's Objectives	Draft Quality Account	
Nursing Workforce	Complaints, Compliments, Concerns and Comments Report	Budget Setting / Business Planning / Final Annual Plan	
MB Minutes	R&D Strategy metrics (in BIR)		
HWB Decision Summary	Safeguarding & maternity metrics (in BIR)		
Finance & Performance Minutes	P&OD Quarterly report		
Finance Report			
Chairs' Assurance Logs			
<b>MAY 2018</b>			
CE Report	Monitor Quarterly Declaration Q4	Annual Report	
Business Intelligence Report	QEC Minutes	Quality Account	
Nursing Workforce	Report from the Chair of the ANCR committee (Verbal)	Annual accounts	

MB Minutes	Board Assurance Framework & corporate risk register Q4 (inc. annual assurance summary)	ISA260 and quality account assurance	
HWB Decision Summary		Charitable Funds minutes	
Finance & Performance Minutes			
Finance Report			
Chairs' Assurance Logs			
<b>JUNE 2018</b>			
CE Report	Board Assurance Framework	MB Annual Report	
Business Intelligence Report	Report from the Chair of the ANCR committee (Verbal)	SOs, SFI, Scheme of Delegation	
Nursing Workforce	Monitor Q4 Results Notification	ANCR Annual Report	
Bed Plan			
MB Minutes			
Finance & Performance Minutes			
Finance Report			
Chairs' Assurance Logs			
<b>JULY 2018</b>			
CE Report	Chief Executive's Objectives		Reference Costs
Business Intelligence Report	Complaints, Compliments, Concerns and Comments Report		Diversity and Inclusion
Nursing Workforce	R&D Strategy metrics (in BIR, to include R&D annual summary)		
MB Minutes	Safeguarding & maternity metrics (in BIR)		
Finance & Performance Minutes	ANCR Minutes		
Finance Report	P&OD Quarterly report		
Chairs' Assurance Logs			
<b>OTHER ITEMS</b>			
Review the appointment of Peter Brindley (Executor of Fred and Ann Green Will)			3 yearly (May 2018)
Constitution review			3 yearly (Jan 2018)

**Minutes of the meeting of the Board of Directors**  
**Held on Tuesday 27 June 2017**  
**In the Boardroom, Doncaster Royal Infirmary**

<b>Present:</b>	Suzy Brain England OBE	Chair of the Board
	Alan Armstrong	Non-executive Director
	Karen Barnard	Director of People and Organisational Development
	Moirra Hardy	Acting Director of Nursing, Midwifery and Quality
	Martin McAreavey	Non-executive Director
	Richard Parker	Chief Executive
	John Parker	Non-executive Director
	Linn Phipps	Non-executive Director
	David Purdue	Chief Operating Officer
	Neil Rhodes	Non-executive Director
	Jon Sargeant	Director of Finance
	Philippe Serna	Non-executive Director
	Sewa Singh	Medical Director
<b>In attendance:</b>	Marie Purdue	Acting Director of Strategy and Improvement
	Simon Marsh	Chief Information Officer
	Matthew Kane	Trust Board Secretary
	Emma Shaheen	Head of Communications and Engagement
	Emma Challans	Deputy Chief Operating Officer
	Nick Mawer	Ophthalmology Consultant (part)
	Gerard Jayamanne	Ophthalmology Consultant (part)

**ACTION**

**Welcome and apologies for absence**

- 17/06/1** All members of the Board were present. It was noted that Kirsty Edmondson-Jones, Director of Estates and Facilities, would be attending Part 2.

**Declarations of Interest**

- 17/06/2** Board were advised of updates to the registers of interest for Suzy Brain England OBE and Linn Phipps.

**Actions from the previous minutes**

- 17/06/3** 17/03/07 - The actions were noted and updated. Board was advised that a response from NHS Protect in respect of the future of support to NHS local counter fraud specialists had not yet been received but would be chased. **JS**
- 17/06/4** 17/04/54 – Non-executives had yet to be invited to a quality summit. The only one that had taken place clashed with another meeting in which non-executives were involved. As soon as one was arranged, non-executives would be invited.

### **Red Eye, Red Flags**

- 17/06/5 The Board received a presentation from Mr Gerard Jayamanne, Ophthalmology Consultant, on the mobile phone app he had developed called *Red Eye, Red Flags*.
- 17/06/6 The app was designed to be used by clinicians working to aid decision making when looking after patients with ophthalmic presentations. Red Flags were alert signs and symptoms that indicated a more serious underlying pathology.
- 17/06/7 The *Red Eye, Red Flags* app had six videos that helped primary care providers identify which patients might benefit from immediate referral to an ophthalmologist. From the app, users could also download a number of helpful e-books.
- 17/06/8 In response to a question from Martin McAreavey, Dr Jayamanne commended the support he had received from senior management to develop the technology. The Trust was seeking to recruit some student programmers to develop additional apps. It was agreed to provide Board with details of applications the Trust had developed. SM
- 17/06/9 The presentation was NOTED.

### **Corporate Objectives**

- 17/06/10 The Board considered a report of the Chief Executives that set out draft objectives for 2017/18.
- 17/06/11 The report also set out the actions that would be required to achieve the objectives alongside a number of other considerations. Key enablers to the achievement of the corporate objectives were the following milestones:
- Clinical and operational performance and plans
  - Financial stability and improvement
  - CQC assessment of Good
  - NHSI segment 2 with removal of licence breach
  - Completion and delivery of the revised Strategic direction
  - Reduction of the key quality, financial, operational and strategic risks
- 17/06/12 The corporate objectives would be further reviewed and updated following the Board of Directors' strategy session on 28 June and the outcome of consultation and feedback from patients, governors, staff and partners.

- 17/06/13 Further to a question from Neil Rhodes, the Board was advised that a medium term financial plan would be presented to Finance and Performance Committee in due course.
- 17/06/14 Board APPROVED the corporate objectives for 2017/18 and actions attached as an appendix to this report.

### **Charitable Funds Policy**

- 17/06/15 The Board considered a report of the Director of Finance that sought approval for a new Charitable Funds Policy.
- 17/06/16 The Policy specifically centred around the Board's role as corporate trustee and other roles and responsibilities in relation to charitable funds, audit and accounting practices, the Charitable Funds' operations and fundraising. The appendices included a revised reserves and investment policy and template form for the donation of funds.
- 17/06/17 Also included in the Policy was a revised corporate governance framework for charitable funds that would see the disbanding of the Fred and Ann Green Committee and a refreshed Charitable Funds Committee that would include all non-executive directors. The executor for the Fred and Ann Green estate and a Trust governor would be observers.
- 17/06/18 The Board:
- (1) APPROVED the Charitable Funds Policy.
  - (2) APPROVED that John Parker would act as Chair of the new Charitable Funds Committee.
  - (3) APPOINTED the Medical Director to the Charitable Funds Committee in addition to the members already identified in the Policy.

### **Estates Return Information Collection (ERIC) 2016/17**

- 17/06/19 The Board considered a report of the Director of Estates and Facilities that sought approval of the 2016/17 ERIC submission.
- 17/06/20 Estates Return Information Collection (ERIC) formed the central collection of estates and facilities data from all NHS organisations in England providing NHS funded secondary care during the fiscal year ending 31st March 2017. ERIC data provided the Government with essential information relating to the safety, quality, running costs and activity related to the NHS estates and supported work to improve efficiency.
- 17/06/21 The Board APPROVED the information enclosed on the ERIC 2016/17 submission which would be committed through EFM Information, HSCIC (NHS DIGITAL) on 30/06/2017 and released publicly in October 2017.

### **Review of Committee Structure - update**

- 17/06/22** The Board considered a report of the Trust Board Secretary that sought approval of an amendment to the terms of reference for Audit and Non-clinical Risk Committee.
- 17/06/23** The notice to rescind and replace the decision was signed by five directors in accordance with Standing Orders.
- 17/06/24** Board APPROVED an amendment to resolution (2) from the item 'Review of Board Committees' considered at Board of Directors on 25 May 2017, substituting the words:

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

With the words:

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

### **Ophthalmology Post Implementation Review**

- 17/06/25** The Board considered a report of the Ophthalmology Consultant that presented a post implementation review for the new Eye Centre at DRI. The paper studied the main objectives for the investment in the Fred and Ann Green Ophthalmology Unit and explored if these had been achieved.
- 17/06/26** Board was advised that the new Centre had brought a number of benefits including additional sessions and a new logging system that more efficiently enabled the service to track patients. Board was advised that patient flow and the patient experience generally had improved. New staff had been recruited to roles within the Centre although there was still more to do in terms of recruiting consultant staff.
- 17/06/27** Board raised issues with the quality of the review and felt that it was underdeveloped in a number of areas. It was agreed that in future all post implementation reviews would go through the Corporate Investment Group for quality assurance before coming to the Board.
- 17/06/28** With those caveats, the Board NOTED that the actions identified in the PIR would improve the outcomes for compliance and patient outcomes.

## Strategy & Improvement Update

- 17/06/29** The Board considered a report of the Acting Director of Strategy and Improvement that included updates on CIP progress, the 2017/18 CIP programme, the strategic planning process and the move from turnaround to transformation.
- 17/06/30** The planned delivery for the Improvement Programme for FY17/18 was £14.5m, with a reported actual delivery at M2 of £435k against a forecast delivery of £985k. This was behind plan by £550k as a result of underperformance in the procurement, clinical administration and outpatients and local work streams and a lower than anticipated level of budget slippage.
- 17/06/31** Work-stream presentations to the Finance & performance Committee on progress, issues and risks had been timetabled based on perceived level of risk. Care Group and corporate departmental meetings had taken place with the PMO and Finance to sign off implementation of identified schemes and discuss any new ideas. New ideas generated had been added to the pipeline and were being scoped to determine feasibility.
- 17/06/32** In respect of effectiveness and efficiency plans, further benchmarking and analysis had been undertaken with the Executive Team to hypothesise further potential efficiency savings. The gap had reduced to £4.3m, of which £3.2m related to recurrent savings.
- 17/06/33** Engagement on the draft strategic vision continued with electronic surveys, postcards and attendances at meetings within and outside the Trust. The final version was on track to be completed by July 2017 as agreed with NHSI. The draft would be shared at a Board timeout in June with circulation of a final version prior to Board agreement for submission at the July meeting.
- 17/06/34** Neil Rhodes reminded Board that next month the Trust would be four months into the year and questioned whether all areas charged with delivering savings were fully engaged in the process. The Board felt there may be some merit in the Board meeting with care groups directors to understand some of the challenges and emphasised that slippage was not an option.
- 17/06/35** The Board RECEIVED the Strategy and Improvement Report for assurance.

MK

*The meeting adjourned at 10.10am and reconvened at 10.15am.*

## Finance Report as at 31 May 2017

- 17/06/36** The Board considered a report of the Director of Finance that set out the Trust's financial position at month 2, 2017/18.



- 17/06/37** The month two position for the 2017/18 financial year was £346k worse than plan due to high medical staffing spend in a number of specialities, along with lower than planned delivery of planned EEP savings. The cumulative income position at the end of Month 2 was £974k favourable. The cash position was good.
- 17/06/38** Neil Rhodes fed back on the meeting of the Finance and Performance Committee held on 23 June. The meeting had received work-stream updates on medical productivity and procurement and carried out a deep dive of Referral to Treatment. Issues around vacancies would be explored further at July's Committee. The Trust performed within the top quartile of trusts in respect of procurement.
- 17/06/39** The Board NOTED the reported financial position was a deficit of £6.5m, which was £346k behind the year to date plan.

#### **Business Intelligence Report as at 31 May 2017**

- 17/06/40** The Board considered a report of the Chief Operating Officer, Medical Director, Acting Director of Nursing, Midwifery and Quality and Director of People and Organisational Development that set out clinical and workforce performance in month 2, 2017/18.

- 17/06/41** Performance against key metrics included:

4 hour access – In May the Trust achieved 91.39% (92.48% including GP attendances) against the 95% standard. This put the Trust within the top quartile of trusts for performance.

RTT – In May, the Trust performed below the standard of 92% achieving 90.6%, with five specialities failing to achieve standard for the month.

Cancer targets – In April, two week waits were 86.7% against a 93% standard. The key issues continued to be related to patient choice and capacity in Dermatology and Urology departments. A full action plan had been developed to improve two week wait performance. The 62-day performance achieved 82.6% against the 85% standard, again mainly due to capacity issues within Urology.

HSMR – The Trust's rolling 12-month position remained better than the expected level of 100, currently at 92.6.

C.Diff – The number of cases in May was lower than in comparison to the same period in the previous year, however the Trust remained above trajectory. A robust infection prevention plan of action had been put in place and was being monitored.

Falls – There were no cases of serious falls in May.

Pressure ulcers - Twice as many pressure ulcers had been reported this month compared to the same time last year. All pressure ulcers were currently being reviewed through an RCA process and therefore this position may change during June.

Appraisal rate – The appraisal rate at June was 58.5%, a slight increase from last month.

SET training – There had been no change since last month for compliance with Statutory and Essential Training (SET) and at the end of June the rate was 68.4%.

Sickness absence – The cumulative sickness rate for June was 3.6%, which compared favourably to Trusts across Yorkshire and Humber.

17/06/42 Further to questions from Martin McAreavey, the Chief Operating Officer referred to concerns regarding stroke performance and undertook to share discharge performance with Finance and Performance Committee. DP

17/06/43 The Business Intelligence report was NOTED.

#### **Nursing Workforce Report**

17/06/44 The Board considered a report of the Acting Director of Nursing, Midwifery and Quality which provided detailed information relating to the nursing workforce, highlighting issues that could impact on the Trust's ability to sustain appropriate staffing levels and skill mixes.

17/06/45 The overall planned versus actual hours worked in May 2017 was 100%, same as April. Care Hours Per Patient Day (CHPPD) stood at 7.5 across the Trust. Details of the quality and safety profile were provided in the report. One ward (Ward 17) triggered as red and would be subject to a future quality summit. Agency spend remained within the 3% cap.

17/06/46 Linn Phipps fed back from the meeting of the Quality and Effectiveness Committee held the previous week. Much of the report was around process and ways of working as the Committee established itself and it was agreed that Linn's approach be shared more formally with Board in September. LP

17/06/47 The report in respect of Nursing Workforce was NOTED and the actions identified to ensure that the risks associated with inappropriate nurse staffing levels were appropriately managed was SUPPORTED.

#### **Well Led Governance Review Action Plan**

17/06/48 The Board considered a report of the Trust Board Secretary which presented the action plan in response to the Well Led Governance Review undertaken in Q3 2016/17.

- 17/06/49** The review made 18 recommendations that were approved at Board on 31 January. A working group comprising the Chair, Chief Executive, two NEDs and the Trust Board Secretary had been established to scope the actions that would address each of the recommendations.
- 17/06/50** In response to a question from Martin McAreavey, Board was advised that independent assurance in relation to the actions would be provided through an internal audit of corporate governance arrangements in Q2 2017/18. The action plan would also be assessed during the CQC inspection.
- 17/06/51** Board NOTED progress in respect of the Well Led Governance Review Action Plan.

#### **CQC Inspection update**

- 17/06/52** The Board considered a report of the Acting Director of Nursing, Midwifery and Quality that provided an update on the Trust's readiness for CQC.
- 17/06/53** A new monitoring framework had been outlined called CQC Insights which included an annual Provider Information Request (PIR) covering the Trust's Well Led arrangements and core services in an acute hospital context. Core service inspections (unannounced), accompanied by a Well Led inspection (announced) would be the norm, targeting a proportional inspection frequency to overall and service ratings. There would be the potential for a ratings review where core services were reviewed along with a Well Led Trust level inspection.
- 17/06/54** Engagement meetings with the CQC continued on a quarterly basis, with occasional issues being raised with the Trust by the CQC, in a similar frequency to the previous months and year. Self-assessment and mock inspection activities were being refreshed across the Trust, by Care Groups, with independent checks from the Acting Director's team.
- 17/06/55** There were some services that required interventions to improve their quality of services in order to achieve a good rating. It was likely that the Trust would receive a PIR and have an unannounced inspection in the coming months, focusing on 'requires improvement' core services and would be followed with an announced Well Led inspection.
- 17/06/56** The matter had been considered in depth at the Quality and Effectiveness Committee and there was a discussion around adding a more specific risk to the corporate risk register. Following discussions at Executive Team a column had been added to the CQC action plan around the extent to which recommendations had been embedded.

**MK**

**17/06/57** Board agreed that it was necessary to profile its key initiatives such as WQAT, John's Story and PJ Paralysis and asked to be kept updated with self-assessments.

**17/06/58** Board NOTED that:

- (1) The Trust continued engagement meetings with the CQC hospital inspection team.
- (2) Mock inspections and self-assessment processes were undertaken across all services to highlight issues that could impact on the objective of achieving a good or better core service and well led inspection ratings.

### **Reports for Information**

**17/06/59** The following items were NOTED:

- Chair and NEDS' report
- Chief Executive's report
- Clinical Governance Annual Report
- Financial Oversight Committee minutes, 22 May 2017
- Clinical Governance and Oversight Committee minutes, 18 April 2017
- Board of Directors' Calendar

**17/06/60** There was a brief discussion regarding the item in the Chair's report on the national requirement to have a 50:50 gender split on boards. Four of the Board's six non-executives would have terms ending in 2018 and there would be a paper to governors shortly on a proposal for open recruitment to fill those roles.

**17/06/61** Appointments would be staggered throughout the year to avoid any loss to corporate memory.

### **Items escalated from Sub-Committees**

**17/06/62** None.

### **Minutes**

**17/06/63** The minutes of the meeting of the Board of Directors on 23 May 2017 were APPROVED as a correct record.

### **Any other business**

**17/06/64** The Chair consented to the following item of other business being taken in the public session of the meeting:

### Annual accounts

Philippe Serna passed on his thanks to key members of the Finance Team for their work in preparing and submitting the 2016/17 annual accounts.

### **Governors questions regarding business of the meeting**

**17/06/65** There were no governors present at the meeting.

### **Date and time of next meeting**

**17/06/66** 9.00am on Tuesday 25 July 2017 in the Boardroom, Doncaster Royal Infirmary.

### **Exclusion of Press and Public**

**17/06/67** It was AGREED that representatives of the press and other members of the public be excluded from the remainder of the meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest.

Suzy Brain England  
Chair of the Board

**Date**