Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Meeting of the Board of Governors
of
Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust ('the Trust')
on
Thursday 27 July 2017 at 6pm
in
Education Centre, Doncaster Royal Infirmary

AGENDA

No	Item	Action	Enclosures
1.	**Welcome and Apologies**	*Note*	(Verbal)
2.	**Declaration of Governors' Interests** Matthew Kane, Trust Board Secretary	*Note*	(Verbal)
3.	**Minutes of the meeting held on 27 April 2017**	*Approve*	Enclosure A
4.	**Action Notes from last meeting**	*Note*	Enclosure B
5.	**Feedback from members** All governors	*Note*	(Verbal)
6.	**Chair's Report** Suzy Brain England, Chair	*Note*	Enclosure C
EXECUTIVE REPORTS			
7.	**Chief Executive's Report** Richard Parker, Chief Executive	*Note*	Enclosure D
8.	**Board of Directors' minutes – April to June 2017** All Governors	*Note*	Enclosures E1-3
9.	**Strategic Direction** Marie Purdue, Acting Director of Strategy & Improvement	*Note*	Enclosure F
10.	**Finance Report** Jon Sargeant, Director of Finance	*Note*	Enclosure G
11.	**Business Intelligence Report** David Purdue, Chief Operating Officer *Directors for Nursing, Midwifery & Quality, People & OD and the Medical Director will be available to take questions.*	*Note*	Enclosure H

GOVERNANCE			
12.	**Doncaster Place Plan** Anthony Fitzgerald, Doncaster CCG	*Note*	Enclosure I
13.	**ACS and WTP Update** Richard Parker, Chief Executive	*Note*	Enclosure J
14.	**Well Led Governance Review** Suzy Brain England, Chair	*Note*	Enclosure K
15.	**Governor Effectiveness Survey** Matthew Kane, Trust Board Secretary	*Note*	Enclosure L (to follow)
16.	**Membership of Board of Governors Committees & Other Activities** Matthew Kane, Trust Board Secretary	*Note*	Enclosure M
SUB-COMMITTEES OF THE BOARD OF GOVERNORS			
17.	**Governor Sub-Committee minutes** Chairs of sub-committees	*Note*	Enclosures N1-5
18.	**Communications, Engagement and Membership Terms of Reference** David Cuckson, Chair of the Committee	*Note*	Enclosure O
MEMBERS' QUESTIONS			
19.	**Resolution:** *Members are invited to RESOLVE that the meeting of the Board of Governors be adjourned to take any informal questions relating to the business of the meeting.*	*Note*	(Verbal)
INFORMATION ITEMS			
20.	**Report from Governor Focus Conference** Brenda Maslen, Public Governor	*Note*	Enclosure P
21.	**Any Other Business (to be agreed with the Chair before the meeting)**	*Note*	(Verbal)
22.	**Date of Next Meeting:** Date: 26 October 2017 Time: 6pm Venue: Lecture Theatre, Doncaster Royal Infirmary	*Note*	(Verbal)

Suzy Brain England
Chair of the Board

21 July 2017

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Minutes of the meeting of the Board of Governors held on
Thursday 27 April 2017
In the Education Centre, DRI, Doncaster, DN2 5LT

	Present:	**Apologies:**
Chair	Suzy Brain England	
Public Governors	Mike Addenbrooke	Hazel Brand
	Phillip Beavers	Anwar Choudhry
	Shelley Brailsford	Bev Marshall
	David Cuckson	John Plant
	Dev Das	George Webb
	Eddie Dobbs	
	Nicola Hogarth	
	Peter Husselbee	
	Brenda Maslen	
	Susan Overend	
	Patricia Ricketts	
	Maureen Young	
Staff Governors	Vivek Desai	Shahida Khalele
	Lynn Goy	
	Lorraine Robinson	
	Roy Underwood	
Partner Governors	Ruth Allarton	Oliver Bandmann
	Lisa Bromley	
	Anthony Fitzgerald	
	Cllr Pat Knight	
	Ainsley MacDonnell	
	Cllr Susan Shaw	
	Dr Rupert Suckling	
	Clive Tattley	

In Attendance:	Alan Armstrong	Non-executive Director
	Karen Barnard	Director of People & Organisational Development
	Moira Hardy	Acting Director of Nursing, Midwifery and Quality
	Kirsty Edmondson-Jones	Director of Estates and Facilities
	Matthew Kane	Trust Board Secretary
	Simon Marsh	Chief Information Officer
	Martin McAreavey	Non-executive Director

	Linn Phipps	Non-executive Director
	Richard Parker	Chief Executive
	David Purdue	Chief Operating Officer
	Marie Purdue	Acting Director of Strategy & Improvement
	Emma Shaheen	Head of Communications and Engagement
	Sewa Singh	Medical Director
	Kate Sullivan	Corporate Secretariat Manger
Apologies:	John Parker	Non-executive Director
	Jon Sargeant	Director of Finance
	Philippe Serna	Non-executive Diretcor

Action

Welcome and apologies

G/27/04/0 The Chair welcomed those present to the meeting.

Apologies recorded above were noted.

Declaration of governors' interests

G/27/04/1 No changes were reported. No matters of conflict of interest were declared.

Minutes of the meeting held on 31 January 2017

G/27/04/2 The minutes of the meeting held on 31 January 2017 were APPROVED as a true record of the meeting.

Matters arising and action notes

G/27/04/3 The action log was reviewed and updates provided. No further matters arising were noted.

Feedback from members

G/27/04/4 In response to feedback about the car parking machines at Bassetlaw Hospital not accepting new £5 notes and new £1 coins, the Director of Facilities & Estates apologised for the inconvenience experienced. An order had been placed to reconfigure the machines but the Trust was on a waiting list for the necessary work to be undertaken as nationally all required reconfiguration.

G/27/04/5 General Offices at all sites were providing change to use in the machines and it was agreed to ensure that adequate signage was visible to advise patients and visitors of this until the necessary work had been undertaken. **KEJ**

Well Led Governance Review Findings

G/27/04/6 Danielle Sweeney of Deloitte LLP presented the findings of the Well-led Governance Review which had been undertaken during Q3 2016/17.

G/27/04/7 The review examined the Trust's approach towards the four domains of the Well Led framework: strategy and planning; capability and culture; process and structures and measurement. Evidence was gathered over an eight-week period from a variety of sources.

G/27/04/8 Core activities of the review had included one-to-one interviews with Board members and staff, observations of Board, committee, care group and operational meetings, focus groups, one to one interviews with external stakeholders and a desktop review of documentation.

G/27/04/9 An overview of findings of the four domains was provided, key points included:

Strategy & Planning

- There had been a very good achievement of strategic goals.

Capability & Culture

- The executive team were held in high regard across the organisation and there was an open culture among those staff spoken to.

Process & Structures

- Positive external stakeholder feedback
- Lots of effective examples of NED challenge
- Very good Governor engagement
- Board member attendance very good
- Care group governance structures were at varying levels of maturity and there were some recommendations around this.

Measurement

- There were a number areas of good practice including benchmarking of data.
- Good use of rolling data and trends.

In response to a query from Dev Das it was clarified that for those committees not observed as part of the review, feedback was obtained through focus groups with Governors and the desk top review.

G/27/04/10 David Cuckson commented that there had been a level of nervousness in the organisation in terms of the CEO and Chair changing at the same time. He went on to say that, amongst Governors, that anxiety had now dissipated, particularity since the appointment of Richard Parker as Chief Executive.

G/27/04/11 The Chair commented that a working group had been established to look at the findings of the review. She gave an overview of changes in the organisation and work undertaken since the time of the review and drew attention to the following;

- New Chair & CE Appointed
- Two new NEDS and new Governors appointed
- Work to address many of the recommendations and points mentioned were in train and included in action plans
- Risk documentation and the business assurance framework were all under review
- The Committee structure was being aligned to the Single Oversight Framework
- The Trust was working on a board development programme and looking at diversity across the organisation.

Evidence of work undertaken to address the recommendations would be brought to the next meeting. **MK**

G/27/04/12 The Well Led Governance Review findings were NOTED.

Chair's report and correspondence

G/27/04/13 The Board considered a report of the Chair which outlined her recent involvement in the following activities:

- Keep DBTH Tidy

- Members' Meeting – The meeting had been very beneficial. It was a great way for patients, the public and clinicians to talk about services and the Trust hoped to host more of these events in the future.

- WTP Update

- Lunchtime lectures

- Governor update – The Trust was working to enhance communication with Governors and a new Governor Briefing session had been introduced.

- Elections update - This year has seen a record number of candidates nominated for the 10 positions on the Board of Governors, with all of the roles either contested or otherwise filled. In light of the announcement of a General Election and the resulting period of Purdah, the Trust had taken advice on the governor elections and had agreed to proceed with elections and not to take any action to delay matters.

The Chair extended her thanks to Pat Ricketts, who was stepping down, for her long service.

G/27/04/14 The Chair's Report was NOTED.

Chief Executive's Report

G/27/04/15 The Board considered a report of the Chief Executive which outlined progress against the following:

- Next Steps in the 5 Year Forward View
- Fire Safety Compliance Update
- Putting an End to #PJParalysis
- Paediatrics at Bassetlaw Hospital
- Trust retains the Coveted Food Hygiene Rating of 5
- 1000 Days free of pressure ulcers on Mallard ward
- Meeting with Andrew Morgan, NHSI Regional Lead
- 2017 Budget
- Changes regarding non-EU Workers
- Single Oversight Framework
- CE Listening Events
- Helens Flu Fighter Champion
- Changes at Bassetlaw
- Changes within the Executive Team

Due to the General Election and Purdah, the pace of some items in the report would change as some decisions that may have been taken could now not be made until after the General Election. Primarily this included decisions about Children's Services & Hyper Acute Stroke Services.

G/27/04/16 PJParalysis – To help promote this campaign, DBTH had asked Wards to create their own #EndPJParalysis board, with the best team awarded a teapot and patient activities. Dev Das asked why the Trust had not opted for an organisation wide approach and this was discussed. It was hoped that the ward based approach would engage staff in the campaign. A similar approach had been taken when the Trust had promoted John's Campaign and had worked really well. Richard Parker commented that the Trust was very proud to be supporting the #EndPJparalysis campaign which was already known to be beneficial to patients.

G/27/04/17 Improving Interactions - the Trust was holding a training session to help delegates think about how they can improve the interactions and outcomes they have with whomever they come into contact with. David Cuckson asked if Governors could observe the session. Richard Parker advised that Governors were welcome to observe all training within the Trust apart from specific to post training. A list of training dates would be provided to Governors so that they may attend should they wish to do so. **KB**

G/27/04/18 Paediatric Services at Bassetlaw Hospital -The Trust had moved to the Summer bed model of reduced paediatric beds, this was been done to give more annual leave opportunities to staff and to address illness patterns. This had led to concnern on a Facebook campaign group that the Trust had closed beds; this was not the case.

G/27/04/19 The Trust had been out to recruit for children's nurses and had offered posts to all of the 16 newly qualified candidates interviewed. Three of those had wished to take up positions at Bassetlaw Hospital but appointments could not be confirmed at this stage and the Trust was likely to face competition from surrounding organisations for their services.

G/27/04/20 The Trust would continue to make strenuous efforts to recruit staff and in August when students would begin to accept offers and sign contracts the Trust would have a clearer view on the position.

G/27/04/21 The Chief Executive emphasised that even if all three children's nurses were to come in to post at Bassetlaw Hospital there would still be only half of the staff required. If recruitment was unsuccessful the Trust would enter in to discussion with the community, parents, governors, and commissioners. An update would be provided at the next meeting. **RP**

G/27/04/22 In response to a query from Maureen Young about Paediatric Medical staffing, The Chief Executive advised that a number of posts had remained vacant for a long time and this reflected a significant national problem which was not exclusive to paediatric medical staff. This matter was a key point of discussion for the STP and involved discussion about advanced nurse practitioners and others. Currently the Trust covered most of the rota with locums, this was an issue not just at Bassetlaw Hospital but at DRI also.

G/27/04/23 The Chief Executive's report was NOTED.

Matters arising from the Board of Directors minutes

G/27/04/24 David Cuckson asked how Governors and members of the public had been considered in the proposed move to paperless Board of Governor meetings. It was reported that the first paperless meeting of the Board of Directors using iPads and laptops had gone well. Relevant support and training would be provided for Governors. The Trust was also considering use of video conferencing and was hoping to make progress with this throughout the course of the year.

Finance & Strategy & Improvement Report

G/27/04/25 The Board considered a report of the Director of Finance and the Acting Director of Strategy & Improvement that set out the Trust's financial position and CIP performance at month 9 2016/17.

G/27/04/26 The Chief Executive presented the report. Following the Board of Directors meeting but before the 2016/17 accounts had been closed the Trust had been told by NHSE that it would qualify for further Sustainability and Transformation funding for over performance against revised CIP targets. The year-end position would therefore close at £6.7m deficit.

G/27/04/27 The Chief Executive thanked all staff for maintaining focus on expenditure and CIP without compromising focus on quality.

G/27/04/28 The Trust had moved to a new procurement system and Mike Addenbrooke asked for assurance that suppliers and staff were aware of the processes to ensure that suppliers were paid by the Trust. Assurance was provided that significant work had been undertaken to ensure that suppliers and staff knew how to raise purchase orders that would ensure payment for goods and services.

G/27/04/29 In response to a query from Dev Das about the variance in the Control Total reported in the table on page 5 of the report it was agreed for that the Director of Finance would respond to the query outside of the meeting. **JS**

G/27/04/30 The Finance & Strategy & Improvement Report was NOTED.

Business Intelligence Report

G/27/04/31 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 9.

G/27/04/32 The Medical Director presented the report and drew attention to the following: It had been a winter of unprecedented demand for Trust services and yet the Trust had ended the year with 4hr Access Performance at 91.4%. This met the NHSI target for the Trust, was the best performance in South Yorkshire and was within the top 25% of acute hospitals nationally.

G/27/04/33 The trust was working hard to improve staffing and had recruited a number of UK trained emergency department medical staff.

G/27/04/34 Out of area activity - Peter Husselbee commented on the level of out of area patients attending the ED, more than 1 in 4 patients, and he asked how this affected the Trust and whether revenue for the activity was recovered. Assurance was provided by the Chief Operating Officer that all costs were recovered. The matter was discussed and the Chief Operating Officer explained that ambulance services took patients to the site with the shortest waiting times and this was why the Trust had experienced such a high level of out of area activity.

G/27/04/35 Other issues such as the impact of emergency admissions on elective work and delays in discharge for out of area patients were also discussed. The Trust was working with partners to reduce the level of out of area activity coming in to the Trust.

G/27/04/36 Mortality - At year end, performance for every month in the previous 12 months had been in the better than expected range for risk adjusted mortality.

G/27/04/37 Quality - CDiff for the year had ended 19% better than in the previous year. There had been a sustained improvement in hospital acquired pressure ulcers, serious falls and SIs.

G/27/04/38 The Medical Director expressed his sincere thanks to all staff for their hard work to during what had been a tough year.

G/27/04/39 Clive Tattley congratulated the Trust on improved quality metrics particularly the improvement in the number of SIs. In response to a question about future targets the Medical Director commented that the Trust had set out to be in the top 10% of the NHS and the current trajectory was taking the Trust in that direction. Work was underway to set slightly more challenging targets for next year and the Trust would continue with its commitment to the Sign up to Safety Campaign.

G/27/04/40 In response to a query from Mike Addenbrooke about learning from SIs, the Medical Director gave assurance that learning was taken through the Clinical Governance process and discussed at Clinical Governance meetings; there had been good progress cascading learning across the Trust over the previous year.

G/27/04/41 The Business Intelligence Report was NOTED.

STP & Working Together Partnership Update

G/27/04/42 The Chief Executive presented the report which updated Governors on the current developments within the Working Together Partnership Vanguard (WTP) and on the Sustainability and Transformation Plan (STP) for South Yorkshire and Bassetlaw.

G/27/04/43 At a recent WTP Timeout session Chief Executives had accepted the recommendation to pursue the option of becoming a first wave STP. South Yorkshire was one of the 10 areas selected to take this work forward. However the general election has impacted this process and some of areas where decisions were due to be made were likely to be delayed until after election period.

G/27/04/44 The STP & Working Together Partnership Update was NOTED

Agreement of NED Objectives

G/27/04/45 A key element of measuring the Board's effectiveness is the annual evaluation of Chair and NED performance, which at DBTH is led by the Appointments and Remuneration Committee of the Board of Governors.

G/27/04/46 The Committee had met on 9 March 2017 to consider the process by which the Chair and NEDs should be appraised. Due to the new Chair having only a short window in which to evaluate the performance of the non-executives (of whom two are new), the Committee agreed to split the objective setting and performance evaluation processes so that the

former was carried out in Spring and the latter in Autumn. A detailed report of NED objectives and the process was provided.

G/27/04/47 By show of hands the Board AGREED to the Chair & NED objectives set out in Appendix A and AGREED the process for the performance evaluation of the Chair and NEDs set out in Appendix B.

Review of Board of Governors' Effectiveness

G/27/04/48 At the meeting in January, it was agreed to undertake an effectiveness review of the Board of Governors and its sub committees.

The paper set out proposals for a review to comprise of 5 elements:

- Survey of governors and key stakeholders (including Execs, NEDs)
- Observations of Governor committees
- Consideration of intelligence and data from the Strategy and Improvement Directorate relating to the cost/benefit of each committee process.
- Feedback session at future Timeout
- Action plan to tackle the areas identified for improvement.

G/27/04/49 The Board of Governors ENDORSED the proposals for a review of Governor effectiveness, to start in May 2017.

Governor Sub-Committee minutes – for information

G/27/04/50 No matters were raised. The minutes were NOTED.

Any other business

G/27/04/51 None raised.

G/27/04/52 *Members RESOLVED that the meeting of the Board of Governors be adjourned to take any informal questions relating to the business of the meeting.*

Questions from members of public

G/27/04/53 In response to a question from a member about whether there had been or would be any public consultation with regard to SPTs the Chief Executive advised that where the business of the STP related to significant services that were likely to be of public interest the STPs had gone out to public consultation and the results of the consultations were on the STP website although it was clear that there were different levels of engagement in different areas. As the STP work continued it was very likely that a number of pieces of work would require significant public consultation and there had been learning from previous consultations that there needed to be a greater level of engagement.

G/27/04/54 Mr Sprakes raised concerns that he had not been able to get through on the telephone to the eye clinic at DRI on a Saturday and about access to the pharmacy for prescription medication during out of hours. The Chief Executive apologised for the problems Mr Sprakes had experienced and it was agreed to take the matter up outside of the meeting. Mr Sprakes was advised not to wait for a Board meeting to tell staff about any issues he was experiencing but to report this immediately.

Date and time of the next meeting:

G/27/04/55

Date:	27 July 2017
Time:	6pm
Location	Education Centre, DRI

Withdrawal of press and public

G/27/04/56 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.

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Action Notes

Meeting: Board of Governors

Date of meeting: 27 April 2017

Location: Education Centre

No.	Minute No	Action	Responsibility	Target Date	Update
1.	**G/16/06/47**	Presentation on P&OD to be scheduled for a future governor Timeout.	**KB**	**September 2017**	Item is being considered for upcoming Timeout. Timescale amended from June to September.
2.	**G/16/06/63**	An overview of the tendering process to be shared with governors.	**AS**	**June 2017**	Complete. Item on Procurement taken to Timeout in June 2017.
3.	**G/19/09/52**	Review process for Governor invitations to STAR Awards.	**ES**	**July 2017**	Action not yet due.
4.	**G/31/01/46 and 47**	DoF to provide feedback from capital event attended in February and to provide capital fund risk assessment presentation to governors at upcoming Timeout.	**JS**	**September 2017**	Item is being considered for upcoming Timeout. Timescale amended from June to September.

Date of next Meeting: 27 July 2017
Action Notes prepared by: Matthew Kane
Circulation: Chair, Governors, NEDs, EDs

No.	Minute No	Action	Responsibility	Target Date	Update
5.	**G/27/04/05**	Pay & Display Machines - Ensure that adequate signage was visible to advise patients and visitors that the machines would not accept new £5 notes and £1 coins until the necessary work had been undertaken.	**KEJ**	**July 2017**	Update to be given at the meeting.
6.	**G/27/04/11**	Well Led Governance Review Findings – provide evidence of work undertaken to address recommendations.	**MK**	**July 2017**	Complete. Item on agenda.
7.	**G/27/04/17**	Improving Interactions Training- A list of training dates would be provided to Governors so that they may attend should they wish to do so.	**KB**	**May 2017**	Complete.
8.	**G/27/04/21**	Provide an update on recruitment for Paediatric Services at Bassetlaw Hospital.	**RP**	**July 2017**	Complete. Full update provided over-page.

Date of next Meeting: 27 July 2017
Action Notes prepared by: Matthew Kane
Circulation: Chair, Governors, NEDs, EDs

Doncaster and Bassetlaw Teaching Hospitals
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Update on paediatric recruitment – Bassetlaw

As part of a recruitment drive in March we advertised for trained and newly qualified Children's Nurses (qualifying in September 2017). From our initial advertisement we received five applications to our Paediatric nursing positions, four of whom were student nurses qualifying in September and one that was not paediatric trained.

In addition to this we ran a number of open days and attended recruitment events and as a result in April we offered interviews to 16 people for paediatric nursing and special care baby unit posts, most of whom are soon-to-qualify. 15 accepted and were allocated an interview slot, 6 of these withdrew on the day of the interview and 1 did not attend. Of the 8 interviewed we offered 6 staff posts. Five were student nurses who would not be available to commence work until October.

Despite our aim to ensure that we are an attractive prospect for potential team members, making Doncaster and Bassetlaw Teaching Hospitals their number one choice when choosing a future employer the competition is such that we have since received back word from a number of the newly qualified nurses who were offered positions with us, with only 2 still accepting positions on CAU.

We currently have an advert out for Children's Nursing vacancies on both sites, and this is being publicised through national nursing journals. We remain committed to try to recruit to a full establishment at Bassetlaw however this is looking increasingly unrealistic. News this week highlights that for the first time ever the number of nurses and midwives leaving the profession is higher than those joining, and like many other local and regional hospitals we are looking to recruit from a highly specialist pool of nurses, with paediatric nursing having the second highest vacancy rate across the country.

Doncaster and Bassetlaw Teaching Hospitals
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Title	**Chair's Report**		
Report to	**Board of Governors**	**Date**	**27 July 2017**
Author	**Suzy Brain England, Chair**		

Purpose		Tick one as appropriate
	Decision	
	Assurance	
	Information	x

Executive summary containing key messages and issues
The report covers the Chair's work May to July 2017 and includes updates on a number of activities: • Meeting teams • Strategy development • WTP Chairs & CEs Meeting • Governors • Changes to board committees • Members' Meeting • NHS Providers
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 – May - July 2017

Meeting teams

Following my corporate induction at the Trust, I have been keen to get out and about visiting a number teams and departments across our three sites. This enables colleagues to meet me, and enables me to find out what they are proud of as well as what they would like to change.

As teams have plans and budgets I encourage them to work together within their teams and care groups to adopt a problem-solving approach, seeking change for the better, looking to senior management for support when necessary.

My visits have included:

- Obs and Gynae (Women's and Children's) at Bassetlaw (continuing from last month's visit in Doncaster);
- Trauma and orthopaedics team meeting at DRI;
- MSK & Frailty at Montagu
- Walkabouts of Women's and Children's at DRI;
- Emergency Departments;
- Walkabout at Bassetlaw Hospital;
- Therapies and Orthotics at DRI;
- Stroke unit at DRI;

We have much to be proud of with committed colleagues and some excellent estate.

In line with our strategic intent to develop services further at Bassetlaw and Montagu the communications team is looking at how we shout about our excellence. Partnership working is a key part of our strategic future. Richard and I shared our support for greater integration with Doncaster CCG who are championing the Place Plan. Anthony will be speaking more about that at this meeting.

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.

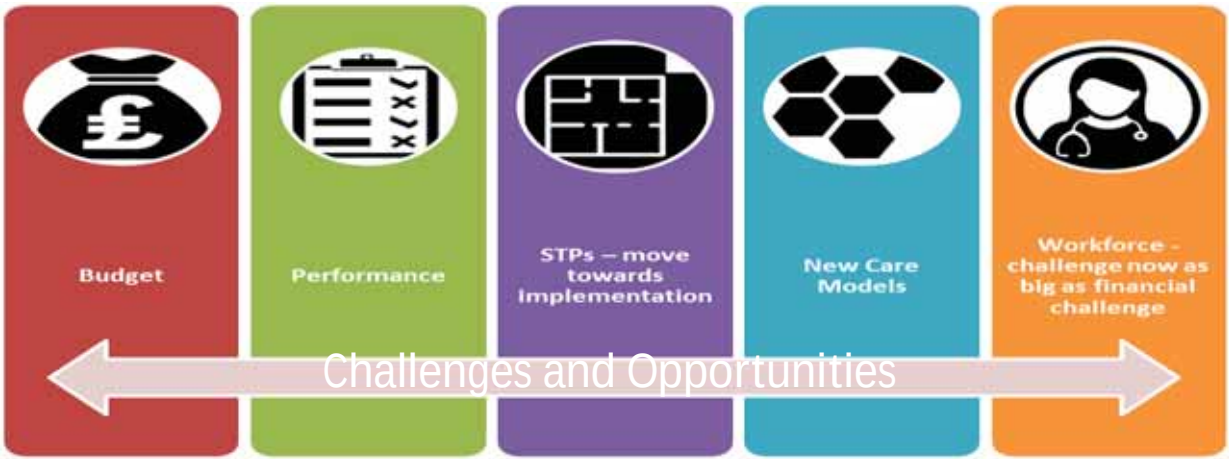
I continue to have catch ups with non-executives on a regular basis.

Strategy development

We have recently 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. You are all vital to the Trust's success.



WTP Chairs & CEs Meeting

In Tony Pedder's absence, I was invited to chair the Working Together Partnership of acute trusts' chairs and chief executives meeting on 3 July. I have 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.

Governors

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

- Mark Iain Bright and Lynne Logan in Doncaster
- Andrina Hardcastle, Peter Abell and Sharon Cook (who replaces Steven Marsh who decided not to take up his role for personal reasons) in Bassetlaw
- David Cuckson (returning) and Liz Staveley-Churton in Rest of England and Wales

- Lorraine Robinson (returning), Duncan Carratt and Karl Bower in the various staff constituencies.

We are also anticipating a new partner governor from Doncaster MBC to be announced shortly.

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

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.

At the meeting 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.

Changes to board committees

We have refined our board committee structure to align it with our emerging strategic direction and NHSI's new Single Oversight Framework.

The two oversight committees have been replaced by Finance and Performance and Quality and Effectiveness Committees which will be chaired by the new NEDs (Neil Rhodes and Linn Phipps respectively) and include executive representation. Audit and Non-clinical Risk Committee remains unchanged but the dates of all three committees have changed. Details have been sent to governors by email.

Members' Meeting

We held a well-attended members' event in the lecture theatre on 13th April concerning medical imaging and oncology.

It was great to meet so many people who have an interest in what their local hospital services are doing and my thanks to Dr Joe Joseph (pictured with me) and Dr Charles Merrill who both gave very engaging presentations on the present and future of cancer services and how medical imaging has grown and expanded over the decades.

There were a number of interesting questions asked and points raised that I have asked the Chief Executive to consider. Principally I would like to see more of these events and more corporate input into them. Thanks to those governors who attended.

NHS Providers

I have been very thankful for the congratulations I received following my appointment as a trustee for acute services chair on the NHS Providers Board. I attended my first meeting and induction on 5 July and would be pleased to speak further about it once I have my feet under the table.

I hope it will be extremely helpful and beneficial for the Trust and I hope we will all use this new national role to our full advantage. Participation will keep us at the forefront of issues affecting providers generally and the wider NHS in particular.

Chief Executive's Report
May - 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 to brief the new committee on developments.

NHS Cyber Attack

On Friday 12 May, a number of NHS organisations were affected by a ransomware attack, through a malware variant known as Wanna Decryptor.

The attack was not specifically targeted at the NHS and affected organisations across a range of sectors. Nevertheless, it is understood that the attack affected 48 NHS trusts, almost a quarter of the total, as well as 13 NHS organisations in Scotland.

At this stage there is no evidence that patient data was accessed. NHS Digital is working closely with the National Cyber Security Centre, the Department of Health and NHS England to support affected organisations and ensure patient safety is protected.

Doncaster and Bassetlaw Teaching Hospitals was not affected during the attack. This was because DBTH does not expose its internal service to the Internet. Our IT team isolates activity through something known as a DMZ (Demilitarised Zone) and this way we protect the Trust's network from untrusted external sources, such as the one involved in this particular attack.

Nevertheless, as news filtered through on Friday that a number of NHS organisations were affected, I took the decision, as a precaution, to temporarily stop inbound and outbound emails from outside sources (DBH and NHS mail was still operational). Full email access was restored a few hours later, on the Friday evening.

NHS Digital and CareCert have provided the Trust with a 'signature' of the infection which the IT Team have blocked, preventing it from affecting our systems, and we have also upgraded our systems. While the IT team continues to investigate we believe that we are protected against this type of attack. However, failure of services due to cyber-attack remains an extreme risk on our corporate risk register.

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.

TriHealth on the move

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

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

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.

Changes to email

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

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

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

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.

Meeting with NHS Improvement

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

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

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

Sector cuts financial deficit

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

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

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

Parking Charges

Since becoming chief executive, one of the issues that has been raised again and again by staff, in the Staff Survey and in my listening exercises across the Trust, is car parking.

Whilst it is necessary to the Trust's financial plans for us to charge staff for parking, I felt that we need to find a better balance on this issue that has not only had a significant effect on staff morale but has also had an impact on nearby residents in Bassetlaw and Doncaster.

That is why in the 9th May edition of DBH Buzz, I announced a new tariff for staff parking that is cheaper than other trusts in the area and can be absorbed by our estates' income stream. This has been warmly received by staff. We will continue to monitor our rates via our car parking working group that includes staffside representation.

Assistant Nurse Practitioners

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

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

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

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

DBTH Stars

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

Other News

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

Minutes of the meeting of the Board of Directors
Held on Tuesday 25 April 2017
In the Boardroom, Doncaster Royal Infirmary

Present:	Suzy Brain England OBE	Chair of the Board
	Karen Barnard	Director of People and Organisational Development
	Moira Hardy	Acting Director of Nursing, Midwifery and Quality
	Martin McAreavey	Non-executive Director
	Richard Parker	Chief Executive
	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
In attendance:	Marie Purdue	Acting Director of Strategy and Improvement
	Simon Marsh	Chief Information Officer
	Kirsty Edmondson-Jones	Director of Estates and Facilities
	Matthew Kane	Trust Board Secretary
	Emma Shaheen	Head of Communications and Engagement

ACTION

Welcome and apologies for absence

17/04/1 Apologies for absence were received from Alan Armstrong and John Parker. The Board welcomed Neil Rhodes and Marie Purdue who were attending their first meetings in their official capacities.

Declarations of Interest

17/04/2 There were no interests declared in respect of the business of the meeting.

Minutes of the meeting held on 28 March 2017

17/04/3 The minutes of the meeting of the Board of Directors held on 28 March 2017 were APPROVED as a correct record with the following amendment:

17/03/47 - The Trust's rolling 12-month HSMR position at the end of December was 93 (not 87).

Actions from the previous minutes

17/04/4 The actions were noted and updated. The following updates were provided:

- 17/03/59 – The Board was advised that the tender for insurance had been let.

- 17/03/11 – All NEDs had been invited to the person centred care days and would be invited to future listening events.

Chair's report

17/04/5 The Board considered a report of the Chair which outlined her recent involvement in the following activities:

- Meetings across the Trust
- Members' Meeting
- NED Objective Setting
- Working Together Update
- Governor elections update
- Reports from the NEDs

17/04/6 The Chair commended her visit to the library, encouraging all NEDs to become members, as well as the Members' Meeting on 13 April that she felt was a good opportunity to find out what members thought about the Trust's services.

17/04/7 The Chair referred to advice issued in the previous week from NHS Providers as to whether elections to governor positions were affected by Purdah rules. Having taken a view from the Trust's elections specialists and other trusts it was agreed to proceed as planned. The Board backed this course of action.

17/04/8 Further to the reports from NEDs within the report, Neil Rhodes advised Board of discussions relating to the proposed redesign of Financial Oversight Committee into a new Finance and Performance Committee. Assurance would be fed back to the Board in the form of a Chair's Log and the Committee were supportive of working at pace in order to put in place a framework for the next Board in May.

17/04/9 Martin McAreavey fed back on the recent consultant interviews he had taken part in and the conference around duty, accountability and candour. In relation to a question relating to staff awareness of Datix statistics, the Chief Executive advised Board of plans for a new quarterly summary setting out the key complaints and risk issues to staff.

17/04/10 Linn Phipps fed back on her participation in the national "Learning from deaths in the NHS – new responsibilities for Board members" event in London, and placed particular emphasis on listening - how the Trust listens and responds to the views of patients, families and staff.

17/04/11 The Chair's report was NOTED.

Chief Executive's report

17/04/12 The Board considered a report of the Chief Executive which outlined progress against the following:

- Next steps in the Five Year Forward View
- Fire Safety Compliance Update
- Putting an end to #PJParalysis
- Government changes to Midwifery
- Consultations into hyper acute stroke and Tier 2 children's surgery and anaesthesia services
- Mandatory enhanced surveillance
- Changes to NHS Litigation Authority
- New training at DRI
- Acute Hospital Urgent & Emergency (UE) Mental Health Liaison Services (Adults and Older Adults) Transformation Fund
- IR35
- Strategic Hospital Review
- The Long Term Sustainability of the NHS and Adult Social Care
- Integrated Clinical Academic Programme Internships
- Improving interactions
- Changes within Executive Team

17/04/13 In drawing out some of the key headlines within the report, the Chief Executive advised that the calling of the General Election on 18 April may result in delays to moving forward some of partnership working as councils entered purdah. Board was also advised of changes to the management structure at Sheffield Teaching Hospitals.

17/04/14 In respect of IR35 rules, the Chief Executive advised that plans had been put in place over the Easter Bank Holiday period to mitigate against spikes in A&E activity but that the period had gone without major incident. IR35 rules had resulted in some shift cancellations, It was confirmed that these should be subject to a four week notice period otherwise the Trust had a duty to consider informing the General Medical Council. The Chair reiterated the Trust's commitment to finding a long-term solution to temporary staffing issues.

17/04/15 The Board commended the Trust's work on ending PJ paralysis as a means of reducing patient dependency and institutionalism. It was agreed to write to the team expressing thanks for the work being undertaken. **MK**

17/04/16 The Chief Executive's report was NOTED.

Carol's Story

17/04/17 The Board watched a short film and received a presentation from Dr Lee Cutler, Consultant Nurse – Critical Care, on an item relating to a patient experience at two hospitals in the Trust. The film had been produced in association with Metro Films who had previously produced Gina's Story.

17/04/18 Having watched the film, the Board reflected on its key messages around culture, the power to choose and staff empowerment. The Chair reminded Board that its new committee structure would see an added emphasis on patient experience through the new Quality and Effectiveness Committee.

17/04/19 Carol's Story was NOTED.

Use of Trust Seal

17/04/20 The Board APPROVED the use of the Trust Seal in respect of the lease of land at 28-50 Ryton Street, Worksop, Notts.

2016 Staff Survey Results and Action Plan

17/04/21 The Board considered a report of the Director of People and Organisational Development that set out the Trust's staff survey results and action plan.

17/04/22 Between October and November 2016, 47% (2,938) of DBTH staff completed the NHS staff survey. This was the third year using an online survey of all staff and showed a continuing improvement on previous years' completion rates of 44%.

17/04/23 The survey highlighted a deteriorating picture for the Trust overall. Compared to all acute Trusts, of the 32 key findings this year:-

- 1 issue was in the best 20
- 3 issues were better than average
- 4 issues were at the average
- 5 issues were worse than average
- 19 issues were in the worst 20%

17/04/24 Compared with the Trust's 2015 results, one issue had improved, 17 stayed the same and 14 issues deteriorated. Upon the new Chief Executive coming into post a number of actions had taken place to address the issues raised and an action plan had been formulated around:

- How the Trust communicated with and listened to staff
- How the Trust involved staff
- Supporting managers to engage effectively with their staff

- Staff experience

17/04/25 Following consideration of the report further work on the action plan was required around highlighting measures of success and ensuring objectives were smart. Details of individual care group responses would also be forwarded to non-executives. **KB**

17/04/26 Linn Phipps raised a question discussed at the recent NHS Providers Network meeting which she had attended, around how the Trust measured how staff felt outside the staff survey, as well as how the Trust were enabling managers to support their staff.

17/04/27 The Board NOTED the outcomes from the 2016 staff survey and APPROVED the actions set out in the action plan, subject to the improvements highlighted above.

Annual Accounts - Going Concern Basis

17/04/28 The Board considered a report of the Director of Finance that sought authority for the Trust to prepare its financial statements on a going concern basis and to make the necessary declarations as part of its annual report and annual accounts.

17/04/29 In accordance with International Accounting Standard 1 the Trust, as part of its annual accounts preparation, was required to consider its ability to continue as a going concern. The report provided a summary in support of this. Board were satisfied with the assessment contained within the paper.

17/04/30 Board APPROVED that:

1. The Trust should be considered a going concern for accounts preparation purposes.
2. The Trust should prepare its annual accounts for the year 2016/17 and balance sheet as at 31st March 2017 on that basis.
3. The annual report should clearly state this assessment whilst also outlining the risks facing the trust.
4. Power be delegated to ANCR to sign off the accounts at a special meeting of the Committee on 26 May 2017.

Strategy & Improvement Update

17/04/31 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.

17/04/32 The report highlighted that savings at M12 were £11.893m, a decrease since M1 of £522k and a decrease since M11 of £69k. Delivery in M12 was £1.833m, ahead of plan in month by £516k and ahead of stretch by £433k in month.

17/04/33 The CIP for 2017/18 is £14.5m, of which £6.248m has been identified in developed delivery plans. Further CIP ideas were at varying stages of scoping and development with the relevant scheme SROs.

17/04/34 In response to a question from Linn Phipps on how assured the Trust was on delivering CIPs, the Board was advised that it would be important to consider not just internal savings but place based and partnership initiatives too. The need for a six month review of CIPS was emphasised. **MP**

17/04/35 The Board RECEIVED the Strategy and Improvement Report for assurance.

Finance Report as at 31 March 2017

17/04/36 The Board considered a report of the Director of Finance that set out the Trust's financial position at month 12 2016/17.

17/04/37 The Board was advised that the year-end position was a £17m deficit, in line with the financial forecast. In response to the strong performance against the original financial plan, the Trust had received one-off support from the NHS Improvement in the form of a bonus payment which reduced the deficit to £6.7m.

17/04/38 Key points from the report included:

- Income was £1.6m higher than expected in month, £1.1m of which related to STF funding.

- Capital expenditure year to date was £10.1m of which £2.1m was funded from Charitable Trust Funds leaving £8m. The major areas of expenditure were on fire safety improvements, property works, medical equipment replacement and IT developments. Charitable Funds expenditure was focused on the Ophthalmology scheme.

- There was a cash draw down of £3 million to meet the anticipated high volume of creditors resulting from clearance from Agresso to the new Oracle system.

17/04/39 The Board briefly discussed the challenges on capital for the forthcoming year and it was agreed this would return to Board for discussion. If the Trust was successful in levering in STF funding for capital works then there may be opportunities to address a number of priorities.

17/04/40 It was AGREED that the Finance Report be NOTED.

Business Intelligence Report as at 31 March 2017

17/04/41 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 12.

17/04/42 Performance against key metrics included:

- 4 hour access - In March the Trust achieved 92.7% (93.4% including GP attendances) against the 95% standard. The Trust continued to perform within the top quartile of trusts and at the end of the financial year was the top performing adult service in South Yorkshire.

- RTT - In March, performance remained below the standard, achieving 90.5%, with eight specialities failing to achieve the 92% standard for the month.

- Diagnostic waits – The Trust missed the 99% standard in March achieving 97.4%.

- Cancer - In February, two-week waits were 85.5% against the 93% standard. The key issues related to patient choice and capacity in Dermatology and Urology departments. The 62-day performance achieved 86.8% against the 85% standard.

- HSMR – The Trust's rolling 12-month position at the end of December was 92.8, positively remaining below 100.

- C.Diff – In 2016/17 there was a 19% reduction in the number of C. Diff cases than in 2015/16.

- Falls – In 2016/17 there was a 14% reduction in the number falls resulting in harm than in 2015/16.

- Pressure ulcers - In 2016/17 there was a 25% reduction in the number of hospital acquired pressure ulcers than in 2015/16.

17/04/43 Further to a question from Martin McAreavey, Board were advised of recruitment issues within Ophthalmology and Audiology that had affected the month's performance. Issues with patient transfers from Bassetlaw to Doncaster were being addressed and issues relating to miscoding in pain management were being reviewed. In response to a question from the Chair, the Board was advised of plans to change the existing trauma model to increase capacity.

17/04/44 Neil Rhodes emphasised the importance of ensuring objective setting and appraisals at senior management level were undertaken early in the year to ensure dissemination of actions further down the structure. The Director responsible was seeking to remodel the appraisal timetable over an April-September time period.

17/04/45 The Chief Operating Officer advised of changes to the way in which emergency activity could be reported from 1 April. This would be measured in shadow format until confirmation of the requirements from NHSI.

17/04/46 The Business Intelligence report was NOTED.

Quarter 4 People and Organisational Development Update

17/04/47 The Board considered a report of the Director of People and Organisational Development which set out progress made in Q3 to deliver the current P&OD Strategy in 2016/17; the annual workforce related KPIs, corporate objectives and P&OD led projects.

17/04/48 The report advised that the cumulative sickness rate for the year was 4.46%, with a reduction in the numbers of long-term sick and an increase in sickness capability discussions. Compliance with Statutory and Essential Training (SET) continued to rise each month and at the end of March the rate was 69.54%. Official appraisal rates stood at 61.27% across the Trust although the staff survey indicated that 82% of staff had been appraised. The Directorate would continue to focus on improving the quality of appraisals as reported by staff.

17/04/49 The Q4 People and OD Update was NOTED.

Nursing Workforce Report

17/04/50 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.

17/04/51 The overall planned versus actual hours worked in March 2017 was 99%, one per cent down on February. Care Hours Per Patient Day (CHPPD) stood at 7.5 across the Trust, up 0.3 on February.

17/04/52 Details of the quality and safety profile were provided in the report. Three wards triggered red in the month; the Acute Medical Unit, C2/CCU and Ward 25. These areas would be reviewed through a quality summit.

17/04/53 Further to a question from Linn Phipps, non-executives would be invited to attend a future quality summit. **MH**

17/04/54 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.

Complaints, Concerns, Comments and Compliments Quarter 4 and Annual Report 2016/17

17/04/55 The Board considered a report of the Acting Director of Nursing, Midwifery and Quality which set out Quarter 4 performance using the information available from Datix and the learning points from the organisation, summarising the end of year activity.

17/04/56 Key points contained in the report were as follows:

- There had been a steady increase in numbers of complaints and concerns since December (less than 100 a month) to March (150 per month).

- Individual care groups had seen normal variation of complaints with the exception of Obstetrics and Gynaecology. Reasons for the increase in Obstetrics and Gynaecology were set out to the Board.

- Included for the first time in the report were concerns, comments and complaints from Members of Parliament.

- The main reason for complaints remained as communication. Training was being offered to staff around improving interactions with patients.

- Numbers of complaints being investigated by the Ombudsman were reducing.

17/04/57 The complaints, concerns, comments and compliments report was NOTED.

Junior Doctors Safe Working quarterly report

17/04/58 The Board considered a report of the Guardian for Safe Working that set out background and context around the introduction of the Guardian of Safe Working as part of the 2016 Terms and Conditions for Junior Doctors and implementation of that role within the Trust together with the second quarter update.

17/04/59 The report advised that no gross safety issues had been raised with the Guardian by any trainee. There had been 37 exceptions raised by junior doctors that had been resolved without any fines being levied. The processes for the payments highlighted in the report were being addressed.

17/04/60 The report of the Guardian of Safe Working was NOTED.

Chair's Log: Audit & Non-clinical Risk Committee and Clinical Governance Oversight Committee

17/04/61 The reports of the chairs of Audit & Non-clinical Risk Committee and Clinical Governance Oversight Committee were NOTED.

Reports for Information

17/04/62 The following items were NOTED:

- Learning from Deaths in the NHS
- EU General Data Protection Regulations
- Physical Assaults 2016/17
- Financial Oversight Committee minutes, 27 March 2017
- STP Collaborative Partnership Board, 17 March 2017

17/04/63 It was agreed that the item on Learning from Deaths would be brought back to Board in June. It was agreed that future reports on physical assaults would include normalised data. **MK**

Items escalated from Sub-Committees

17/04/64 None.

Any other business

17/04/65 There were no items of other business.

Governors questions regarding business of the meeting

17/04/66 None.

Date and time of next meeting

17/04/67 9.00am on Tuesday 23 May 2017 in the Boardroom, Doncaster Royal Infirmary.

Exclusion of Press and Public

17/04/68 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

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

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

ACTION

Welcome and apologies for absence

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

Declarations of Interest

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

Actions from the previous minutes

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

Research and Development at DBTH

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

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

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

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

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

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

17/05/10 The presentation was NOTED.

Annual report (including quality accounts)

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

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

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

Draft Accounts 2016/17

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

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

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

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

NHS Self-Certification

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

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

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

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

Review of Committee Structure

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

17/05/23 Board APPROVED to:

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

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

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

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

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

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

Managing Conflicts of Interest in the NHS

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

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

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

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

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

17/05/28 Board APPROVED to:

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

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

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

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

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

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

National Cyber Security Issues and Response at DBTH

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

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

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

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

for assurance.

DBTH approach to recruitment

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

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

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

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

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

17/05/38 The Board NOTED the update.

Strategy & Improvement Update

17/05/39 The Board considered a report of the Acting Director of Strategy and Improvement that included updates on CIP progress, the 2017/18 CIP programme, the strategic planning process and the move from turnaround to transformation.

17/05/40 The planned delivery for the Improvement Programme for FY17/18 was £14.5m, with a reported actual delivery at M1 of £340k against a forecast delivery to NHSI of £489k. This was behind plan by £149k mainly as a result of underperformance in the procurement and locum work streams.

17/05/41 To date £8.252m of the £14.5m remained unidentified, although it was

expected that there would be £2.5m of non-recurrent grip and control savings. There were over 30 new projects in the pipeline list being evaluated to help to bridge this gap. It was reported that care group and corporate department meetings are underway with the PMO and Finance to sign off implementation of identified schemes and discuss new ideas.

17/05/42 Updates were also provided in relation to grip and control, the strategic direction and quality, improvement and innovation.

17/05/43 In response to a question from Alan Armstrong regarding how the current year's opportunities compared with the last, the Board was advised that this was likely to be a more challenging year given that opportunities for savings were less clear.

17/05/44 The Board RECEIVED the Strategy and Improvement Report for assurance.

Finance Report as at 30 April 2017

17/05/45 The Board considered a report of the Director of Finance that set out the Trust's financial position at month 1, 2017/18.

17/05/46 The month one position for the 2017/18 financial year was £39k ahead of the planned deficit that was phased throughout the year.

17/05/47 The income level was £207k lower than expected for the month. However, non-pay underspends and current vacancies had counterbalanced this helping the Trust to achieve the overall position. The cash position was healthy.

17/05/48 The Board NOTED that the reported financial position was a deficit of £3.9m, which was £39k ahead of the planned position after month 1.

Business Intelligence Report as at 30 April 2017

17/05/49 The Board considered a report of the Chief Operating Officer, Medical Director, Acting Director of Nursing, Midwifery and Quality and Director of People and Organisational Development that set out clinical and workforce performance in month 1, 2017/18.

17/05/50 Performance against key metrics included:

4 hour access – In April the Trust achieved 90.37% (91.46% including GP attendances) against the 95% standard. Performance above 90% was maintained over the Easter bank holiday period. The second national programme 'Action on A&E' had been launched which aimed to review urgent care across the system.

RTT – In April performance remained below the standard, achieving

90.4%, with eight specialities failing to achieve the 92% standard for the month.

Diagnostic rates – The Trust missed the 99% standard in April achieving 97.4%. It was as a result of some capacity issues in audiology, which have been addressed.

Cancer targets – In March two-week waits were 88.5% against 93% standard. The key issues related to patient choice and capacity in Dermatology and Urology departments. A full action plan was in place. The 62-day performance achieved 86.6% against the 85% standard.

HSMR – The Trust's rolling 12-month position remained better than the expected level of 100.

C.Diff – The Trust's target for 2017/18 remained the same as this year (40 cases). The number of cases in April was significantly higher than trajectory and investigations had identified how antibiotic choice was a factor in the cases where there were lapses in care. The IPC team would be working with staff across the Trust to ensure that it continued to adhere to the highest standards of IPC practice.

Falls – There were no cases of serious falls in April.

Pressure ulcers - In 2016/17 there was a 25% reduction in the number of hospital acquired pressure ulcers and the Trust had added a further 10% reduction target for 2017/18. In April there were seven cases.

Appraisal rate – The appraisal rate at the end of April was at 57.72%.

SET training – There had been a slight decrease in compliance with Statutory and Essential Training (SET) and at the end of April the rate was 68.42%.

Sickness absence –The cumulative sickness rate for the 2017/17 year was 4.46%, which compared favourably to trusts across Yorkshire and Humber.

17/05/51 Board was advised that executives were currently addressing issues relating to GPs letters to patients, complaints response performance, stroke and the Surgical Care Group. Work on complaints and the DNA working group would be brought to Board through the Finance and Performance Committee following quarter two. **DP**

17/05/52 The Business Intelligence report was NOTED.

Nursing Workforce Report

17/05/53 The Board considered a report of the Acting Director of Nursing, Midwifery and Quality which provided detailed information relating to the nursing workforce, highlighting issues that could impact on the Trust's ability to sustain appropriate staffing levels and skill mixes.

17/05/54 The overall planned versus actual hours worked in March 2017 was 100%, up one per cent from March. Care Hours Per Patient Day (CHPPD) stood at 7.6 across the Trust. Details of the quality and safety profile were provided in the report. The data for April illustrated no wards being assessed as red for quality.

17/05/55 Further to a question from Linn Phipps, the Board was advised that a recent review of the Quality Assessment Tool had seen some wards move from green to amber. Details were also provided around the QAT celebration event.

17/05/56 The report in respect of Nursing Workforce was NOTED and the actions identified to ensure that the risks associated with inappropriate nurse staffing levels were appropriately managed was SUPPORTED.

Corporate Risk Register and Board Assurance Framework

17/05/57 The Board considered a report of the Trust Board Secretary, which presented the Q4 Board Assurance Framework and Corporate Risk Register, which was used to inform the Annual Governance Statement.

17/05/58 The report provided a review of where key risks had started and finished the year together with plans for future development of the tool.

17/05/59 The report was NOTED.

Reports for Information

17/05/60 The following items were NOTED:

- Chair and NEDS' report
- Chief Executive's report
- Financial Oversight Committee minutes, 24 April 2017
- Board of Directors' Calendar

Items escalated from Sub-Committees

17/05/61 None.

Minutes

17/05/62 The minutes of the meeting of the Board of Directors on 25 April was APPROVED as a correct record with an amendment to minute number 17/04/20 where the word "sale" should be replaced by "lease".

Any other business

17/05/63 The Chair consented to the following item of other business being taken in the public session of the meeting:

Medical records

Martin McAreavey raised an issue escalated through Clinical Governance and Quality Committee relating to the current state of the medical records department.

The Board was advised that there were a disproportionate number of temporary records but changes were being made to improve the library at DRI. The two areas with the most issues were Ophthalmology and Urology. A number of the notes storage bays had been reviewed and that work continued.

Changes in place for November including the implementation of the RFID project would see the library become a closed area and a full action plan would be put in place. It was noted that while capital was not available for an electronic patient record system it was on the Executive Team's list of priorities.

Governors questions regarding business of the meeting

17/05/64 David Cuckson asked questions on the consequences of breaching conflicts of interest regulations, noted the new workforce information and commented on the new RFID system.

Date and time of next meeting

17/05/65 9.00am on Tuesday 27 June 2017 in the Boardroom, Doncaster Royal Infirmary.

Exclusion of Press and Public

17/05/66 It was AGREED that representatives of the press and other members of the public be excluded from the remainder of the meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest.

Suzy Brain England
Chair of the Board

Date

Minutes of the meeting of the Board of Directors
Held on Tuesday 27 June 2017
In the Boardroom, Doncaster Royal Infirmary

Present:	Suzy Brain England OBE	Chair of the Board
	Alan Armstrong	Non-executive Director
	Karen Barnard	Director of People and Organisational Development
	Moira Hardy	Acting Director of Nursing, Midwifery and Quality
	Martin McAreavey	Non-executive Director
	Richard Parker	Chief Executive
	John Parker	Non-executive Director
	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
In attendance:	Marie Purdue	Acting Director of Strategy and Improvement
	Simon Marsh	Chief Information Officer
	Matthew Kane	Trust Board Secretary
	Emma Shaheen	Head of Communications and Engagement
	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. **MK**

17/06/35 The Board RECEIVED the Strategy and Improvement Report for assurance.

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 **Date**
Chair of the Board

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Title	**Strategic Direction**		
Report to	**Board of Governors**	**Date**	**27 July 2017**
Author	**Marie Purdue, Deputy Director of Strategy & Improvement**		
Purpose			Tick one as appropriate
	Decision		
	Assurance		
	Information		x

Executive summary containing key messages and issues
The final version of the Strategic Direction is attached for Governors to note. Following Board of Directors approval on 25 July the final version will be submitted to NHSI as required as part of our undertakings. Work on enabling strategies continues to enable further development of a three year plan to support the vision.
Key questions posed by the report
Does the approach taken to developing the Strategic Direction assure Governors that the Trust will comply with best practice and our undertakings to NHSI?
How this report contributes to the delivery of the strategic objectives
The report contributes to all strategic objectives.
How this report impacts on current risks or highlights new risks
The report impacts on all corporate risks.
Recommendation(s) and next steps
Governors are asked to NOTE the attached Strategic Direction.

NHS
Doncaster and Bassetlaw
Teaching Hospitals
NHS Foundation Trust

DRAFT Strategic Vision for 2017- 2022

Doncaster & Bassetlaw Teaching Hospitals NHS Foundation Trust

PRIVATE & CONFIDENTIAL

Contents Page – finalise when formatted

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.

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)

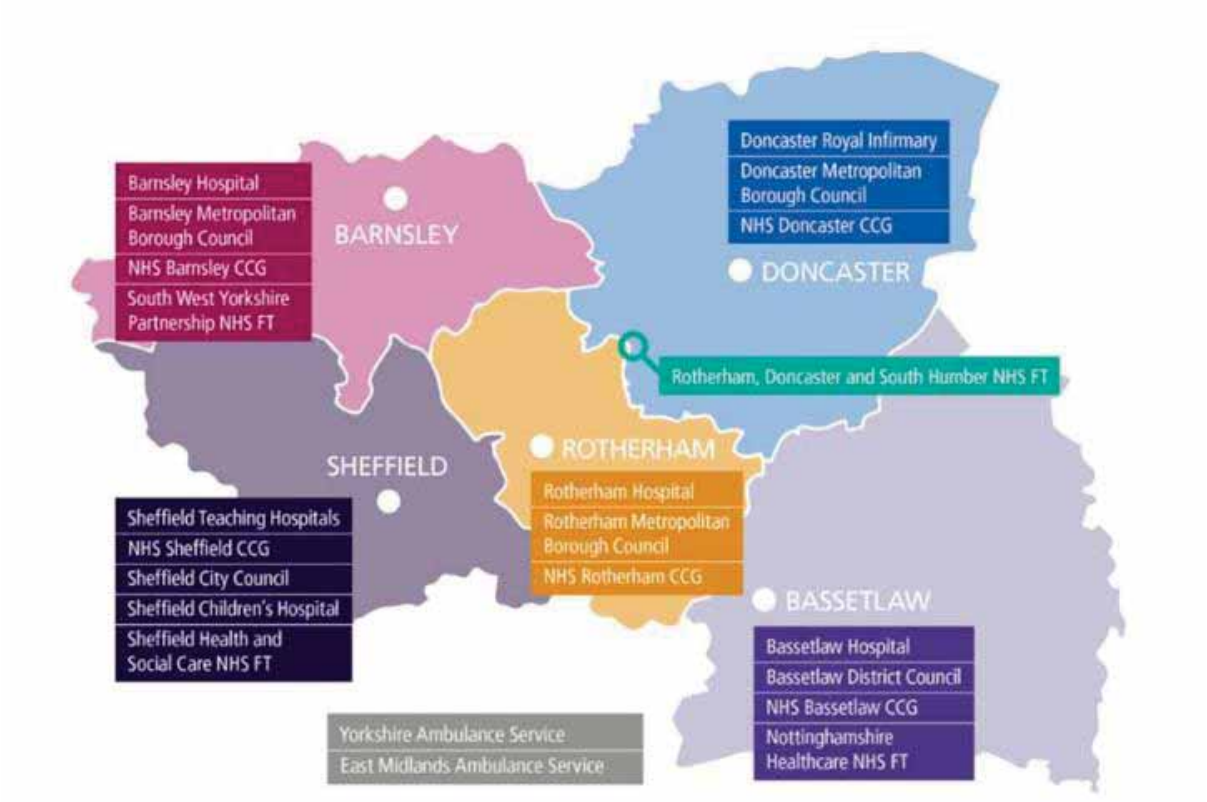
We are an integral partner of the South Yorkshire and Bassetlaw Sustainability and Transformation Partnership (STP) which has now become a first wave Accountable Care System (ACS). As part of the ACS we work together with many health and social care partners across the South Yorkshire & Bassetlaw footprint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

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
• Healthy lives, living well and prevention • Primary and community care • Mental health and learning disabilities • Urgent and emergency care • Elective and diagnostic services • Children's and maternity services • Cancer • Spreading best practice and collaborating on support services	1. We will reduce inequalities for all and help you live well and stay well for longer 2. We will join up health and care services so they are responsive to your needs and accountable 3. We will invest in and grow primary and community care, with general practice at the centre 4. We will treat care for whole person, looking after their mental and physical health 5. We will standardise acute hospital and specialised care – improving access for everyone, reducing inequalities and improving efficiencies 6. We will simplify urgent and emergency care, making it easier for people to access the right services closer to home 7. We will develop the right workforce, in the right place with the right skills – for now and in the future 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 9. We will create a financially sustainable health and care system 10. And we will work with you to do this

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

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 ensure our services are high performing, developing and enhancing elective care facilities at Bassetlaw Hospital and Montagu Hospital and ensuring the appropriate capacity for increasing specialist and emergency care at Doncaster Royal Infirmary.*

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. *We will 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. *We will 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

NHS
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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.

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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 and performing, 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

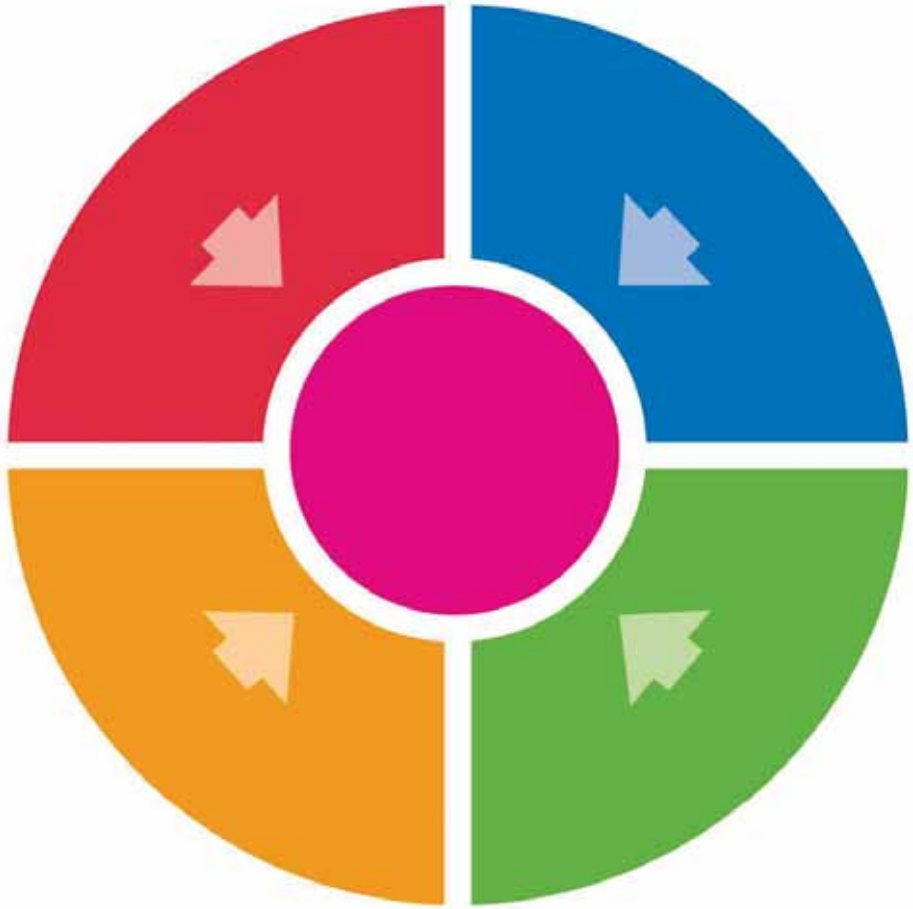
We provide a number of screening and community based services and intend to continue to do so. We will work in partnership to develop and implement appropriate models to provide care with the best outcomes in the right environment for patients and families.

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

NHS
Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust



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 ensure our services are high performing, developing and enhancing elective care facilities at Bassetlaw Hospital and Montagu Hospital and ensuring the appropriate capacity for increasing specialist and emergency care at Doncaster Royal Infirmary.

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.

www.dbth.nhs.uk

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 / Services	Doncaster Royal Infirmary	Bassetlaw District General Hospital	Mexborough Montagu	Other Community Sites
Urgent & Emergency Care	✓	✓	✓	
Elective Care	✓	✓	✓	✓
Maternity & Childrens 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.

Governance and Assurance Strategy

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	• Streaming Developments with partners • ED footprint expansion in line with ACS* • Development of MIU	• Implement actions following Bassetlaw FDASS Pilot in March 2017 – April 2017 • National requirement full FDASS by October 2017 • Development of ED footprint in line with ACS timescales yet to be determined
	Hyper Acute Stroke	• Expansion of the service in line with ACS	• Public Consultation ended February 2017 • Outcome of consultation awaited June 2017 • ACS Capital funding application made May 2017. • Full implementation of HASU developments expected Spring 2018
	CT Development	• Development of business case for increased activity* and co-location with ED	• CIG approved operational and clinical aspects of the business case • P21+ capital process final approval to be completed following confirmation of funding. • ACS Capital funding application made May 2017. • Summer 2018 estimated build completion if capital funding secured May 2017.
Cancer Services	Chemotherapy Development	• Continue to develop services as key satellite unit	• Continuous developments in partnership with STH
Women's & Children's	Implementing Better Births	• Review and implementation of any actions	• Timescales to be defined by ACS requirements. • Estates plans be developed in 2017 in terms of Neonatal and Labour unit developments
	Acutely Unwell Child	• Development in line with ACS	• Timescales to be defined by ACS requirements

Elective Care	Elective Development – Site review	• Determine appropriate site(s) for each service	• Commenced January 2017, ongoing developments throughout 2017
	Future provision of outsourcing of operations/ Private Provision review in line with lease expiry	• Develop plan for outsourcing • Develop plan for future private delivery of care	• Underway • Contract negotiations and options appraisals in development to confirm timeline
Intermediate Care	Doncaster	• Continue to be an active partner in review • Work in partnership to review new models of care	• Rapid response pilot January 2017- May 2017 • Timescales in line with • Project Board meeting monthly work ongoing
	Bassetlaw	• Development of Independence & re-ablement unit	• Confirm specification with Commissioners • Mobilisation from Autumn 2017 – April 2018, subject to commissioning timelines

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Title	**Financial Performance – June 2017**		
Report to	**Board of Governors**	**Date**	**27th 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 Governors 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; • Provide the safest, most effective care possible • Control and reduce the cost of healthcare • Focus on innovation for improvement • Develop responsibly, delivering the right services with the right staff
How this report impacts on current risks or highlights new risks
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.

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

FINANCIAL PERFORMANCE

P3 June 2017

25th July 2017

1. Income and Expenditure vs. Forecast

Performance Indicator	Monthly Performance Actual £'000	Monthly Performance Variance £'000	YTD Performance Actual £'000	YTD Performance Variance £'000	Annual Plan £'000	Forecast £'000
I&E Perf Exc Impairments	1,524	(361) F	7,993	(15) F	16,489	16,489
Income	(31,124)	(588) F	(91,006)	(1,563) F	(361,298)	(361,298)
STF Incentive	(577)	0 F	(1,731)	0 F	(11,547)	(11,547)
Operating Expenditure	32,141	177 A	97,490	1,397 A	376,498	376,498
Pay	22,178	450 A	65,456	1,867 A	254,396	254,396
Non Pay	9,963	(273) F	32,034	(470) F	122,102	122,102

F = Favourable A = Adverse

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

2. CIPs

Performance Indicator	Monthly Performance Actual £'000	Monthly Performance Variance £'000	YTD Performance Actual £'000	YTD Performance Variance £'000	Annual Plan £'000	Forecast £'000
Employee Expenses	174	(378) A	562	(669) A	11,675	
Drugs	0	0	0	0 A	65	
Clinical Supplies	56	(32) A	72	(191) A	1,156	
Non Clinical Supplies	0	0	0	0 A	10	
Non Pay Operating Expenses	17	(97) A	46	(136) A	1,224	
Income	28	(3) A	28	(65) A	369	
Total	**274**	**(510) A**	**708**	**(1,061) A**	**14,500**	

3. Statement of Financial Position

All figures £m	Opening Balance 01.04.17	Current Balance 30.04.17	Movement in year
Non Current Assets	**196,907**	**195,137**	**(1,770)**
Current Assets	33,612	64,737	31,125
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)**
Total Tax Payers Equity	**119,204**	**111,214**	**(7,990)**

4. Other

Performance Indicator	Monthly Performance Plan £'000	Monthly Performance Actual £'000	YTD Performance Plan £'000	YTD Performance Actual £'000	Annual Plan £'000	Forecast £'000
Cash Balance	1,900	2,180	1,900	2,180	1,900	1,900
Capital Expenditure	357	207	769	537	6,481	6,481

5. Workforce

	Funded WTE	Actual WTE	Bank WTE	Agency WTE	Total in Post WTE	Under / (over)
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
Total Position Before Impairments	**1,885**	**1,524**	**-361**	**8,009**	**7,993**	**-15**	**5,730**	**4,230**	**-1,500**	**16,489**	**16,489**
4.Impairments	0	0	0	0	0	0	0	0	0	0	0
Total Position After Impairments	**1,885**	**1,524**	**-361**	**8,009**	**7,993**	**-15**	**5,730**	**4,230**	**-1,500**	**16,489**	**16,489**

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
Reported position	1,885	1,524	-361	16,489

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
Grand Total	**-31,114**	**-31,701**	**-588**	**-91,175**	**-92,737**	**-1,563**	**-372,845**

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
Total Expenditure Position	**31,964**	**32,139**	**175**	**96,093**	**97,488**	**1,395**	**96,660**	**95,605**	**-1,006**	**376,414**	**376,414**

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

Title	**Business Intelligence Report**		
Report to	**Board of Governors**	**Date**	**27 July 2017**
Author	**David Purdue, Chief Operating Officer** **Sewa Singh, Medical Director** **Moira Hardy, Acting Director of Nursing, Midwifery and Quality** **Karen Barnard, Director of People and Organisational Development**		

Purpose		Tick one as appropriate
	Decision	
	Assurance	x
	Information	

Executive summary containing key messages and issues

The Business intelligence report highlights the key performance and quality targets required by the Trust to maintain Monitor compliance.

The report focuses on the 4 main performance area for Monitor Compliance

• Cancer, measured on average quarterly performance

• 4hr Access, measured on average quarterly performance

• 18 weeks including Diagnostic waits, measured quarterly but on monthly performance against active waiters, performance measured on the worst performing month in the quarter

• Infection control against CDiff annual trajectory

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

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

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

Key questions posed by the report

N/A

How this report contributes to the delivery of the strategic objectives

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

How this report impacts on current risks or highlights new risks

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

Recommendation(s) and next steps

That the report be noted.

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 5th 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.

David Purdue Chief Operating Officer July 2017

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. Mortality has improved with overall Trust HSMR down to 90. The HSMR for BDGH has also improved to 105.

Fractured Neck of Femur:

Achievement of BPT has deteriorated to 50% due to theatre capacity. Theatre capacity is due to be increased in September

Serious Incidents:

For the month of June, 5 HAPU and 2 Care Issue SIs. 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

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 e 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 Trusts 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.

Karen Barnard, Director of People and OD

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Title	**Doncaster Place Plan**		
Report to	**Board of Governors**	**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	• There is strong commitment to the proposals and an eagerness to progress	• Strengthened system leadership is needed and a clearer understanding of Doncaster's role within South Yorkshire & Bassetlaw
2. Culture	• There is a culture of honesty and transparency	• There is a need to develop a common language and continue to build understanding and trust
3. Governance	• There has been strong engagement with regards to governance processes	• Strengthened processes are required to drive the programme forward effectively
4. Services	• There is a clear direction of travel and view on what should be included	• Benefit and working frameworks need agreement
5. Finance	• Strong relationships and a wiliness to share information in a transparent way	• There is a need to devise a collaborative approach on group accounting
6. Operational and Commercial	• There is good alignment of plans and ambitions	• There is a need to form a collaborative approach and refinement of focus

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

Governors are asked to note the report.

End of Phase Report

The Doncaster Place Plan

May 2017

DRAFT FOR CIRCULATION

Building a better working world

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1. Executive Summary

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.

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

Headline Assessment:

	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 their 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

Introduction & Context

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 providers 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
[illegible]	[illegible]	[illegible]
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

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

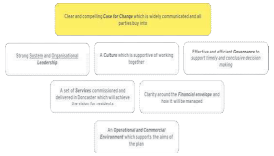
Doncaster is seeking to engage in a change programme of a significant size and complexity – and one which is vital to get right for its residents. There are a key set of success factors which a programme such as this needs to consider to increase the chance of success.

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

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.

Leading Practice Pointers

- Clear & Consistent leadership at both organisational and system level recognised by all involved
- SRO in place with recognised authority
- Clear links back to each statutory organisation's board/ decision-making structures
- Clarity on STP inter-dependencies

Doncaster Strengths

- Demonstrating commitment in the room to moving forward together
- Demonstrating positive working relationships in shared forums
- Formation of the GP Federation
- Keenness to engage with staff and residents but need narrative to support

Doncaster Area of Focus

- How to operate as system leaders to progress detailed work
- Connectivity with levels within organisations on this agenda
- Clarifying role within STP and each other roles within the place plan

Evidence

- 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.
- All leaders are in slightly different places, despite some clear strengths in a shared commitment, with a marked difference between providers and commissioners.
- Commissioning – there is currently some joint commissioning through the Better Care Fund and a strong shared vision.
- Providers - each organisations leadership team's lead their own organisation and workforce.
- System leadership – there is currently limited system leadership in place.
- More detailed information is found at appendix I.

Culture - Headlines

Definition

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.

Leading Practice Pointers

- Blended culture where both commissioners (local authority & CCG) speak similar language and respect each others distinct & complementary roles
- Similar mature relationships amongst providers based on mutual respect between all parties and understanding of the unique strengths of each to the system

Doncaster Strengths

- Level of honesty that has developed over past three months on readiness and understanding
- Senior leaders spend lots of time talking and working together

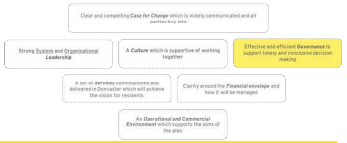
Doncaster Area of Focus

- Developing a Common Language
- Need to engage frontlines further to be part of the design
- Find barriers
- Conversation and action not always linked

Evidence

- The leadership readiness assessment, along with observations during phase 1 showed that there were some differences in culture across and among providers and commissioners.
- Examples of mismatches with language include understanding of models such as ACP.
- There are also differing levels of tolerance of risk, although these have yet to be fully tested.
- 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.

Governance - Headlines



Definition

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.

Leading Practice Pointers

- Clear governance which promotes timely and considered decision making at all levels: system, organisational, project
- Clarity on migration required from plan development to service delivery phases
- Delegated authority to joint arrangement which support integrated action with a clear scope and terms of reference

Doncaster Strengths

- Leaders are relatively engaged in governance processes
- Keenness to participate in strategic decision making and place shaping

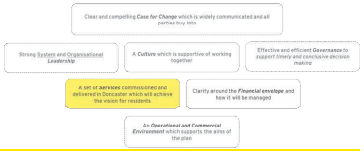
Doncaster Area of Focus

- Relationships between individual bodies, collective decision making, HWWB board
- Ownership is unclear
- Missing the 'engine' – require a more detailed programme plan that is actively managed to make this happen

Evidence

- Despite engaged and extensive governance arrangements the routes to decision making are unclear with those arrangements which are advisory vs decision making unclear.
- 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.
- Further information in found at appendix II.

Services - Headlines



Definition

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.

Leading Practice Pointers

- Services clearly defined and linked to populations and their needs
- Service scope and specifications which drive an outcome focused approach and system commissioning
- Integrated pathways

Doncaster Strengths

- Begun to identify the areas of opportunity that have buy in across commissioners and providers
- Aligned neighbourhoods but not using them
- Aligned view on the focus on prevention and EI

Doncaster Area of Focus

- Not always clear on the cohorts ambition and definition
- Require some structuring and prioritisation of activity
- Lack of clarity on the scope of the place plan

Evidence

- 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.
- The link between cohorts and services in not clear with some difficulty in fully defining cohorts at this stage.
- Further information on defining the cohorts and areas of opportunities can be found in the phase 2 report.

Finance - Headlines

Definition

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.

Leading Practice Pointers

- Collective and individual financial positions understood and respected
- Range of mechanisms for financing integrated services understood and employed
- Group accounts used to track collective action
- Risk sharing supporting a common financial strategy

Doncaster Strengths

- Good relationships – built on trust and transparency e.g. BCF
- Shared understanding of the collective financial problem and "conflict" caused
- Information sharing
- Established transformation plans within organisations with solid evidence base

Doncaster Area of Focus

- No Group approach to accounting
- Lack of sense of scale of investment required
- Availability of information
- Measurement of impact and benefits tracking needs to be stronger to show the progress

Evidence

- There is a lack of transparency across stakeholders regarding their shared financial position – although all have agreed the shared approach.
- 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.
- 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.

Operational & Commercial Environment - Headlines

Definition

The market, workforce and commissioning environment which will support the Doncaster Place Plan.

Leading Practice Pointers

- Operational & commercial environment understood and shaped as appropriate
- Workforce plan which supports and promotes new roles and skills
- Consideration of new ways of working for operational managers

Doncaster Strengths

- Recognition that the form needs to be around something that works
- Relative alignment on plans for integrated commissioning
- Understand that we need to define where we focus efforts and when

Doncaster Area of focus

- Principles to agree risk/benefit share prior to joint working
- Some fundamental misunderstandings about the principles
- Confusion on the proposed provider 'form' Lack of discussions on form have resulted in confusion
- Ability of the Children's Trust to join a new form
- Ability of GPs to speak as one

Evidence

- Transformation plans – there are a range of transformation plans & 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.
- 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.

The Stakeholder Landscape

Introduction

The effective delivery of the Place Plan will be highly dependent on the successful interaction of a wide range of stakeholders form 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.

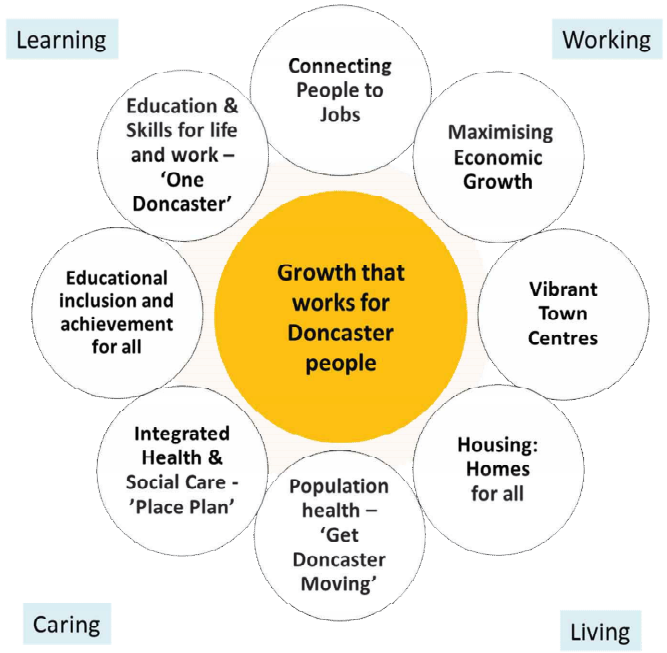
Growing Doncaster Together

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

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 needs 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

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

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.

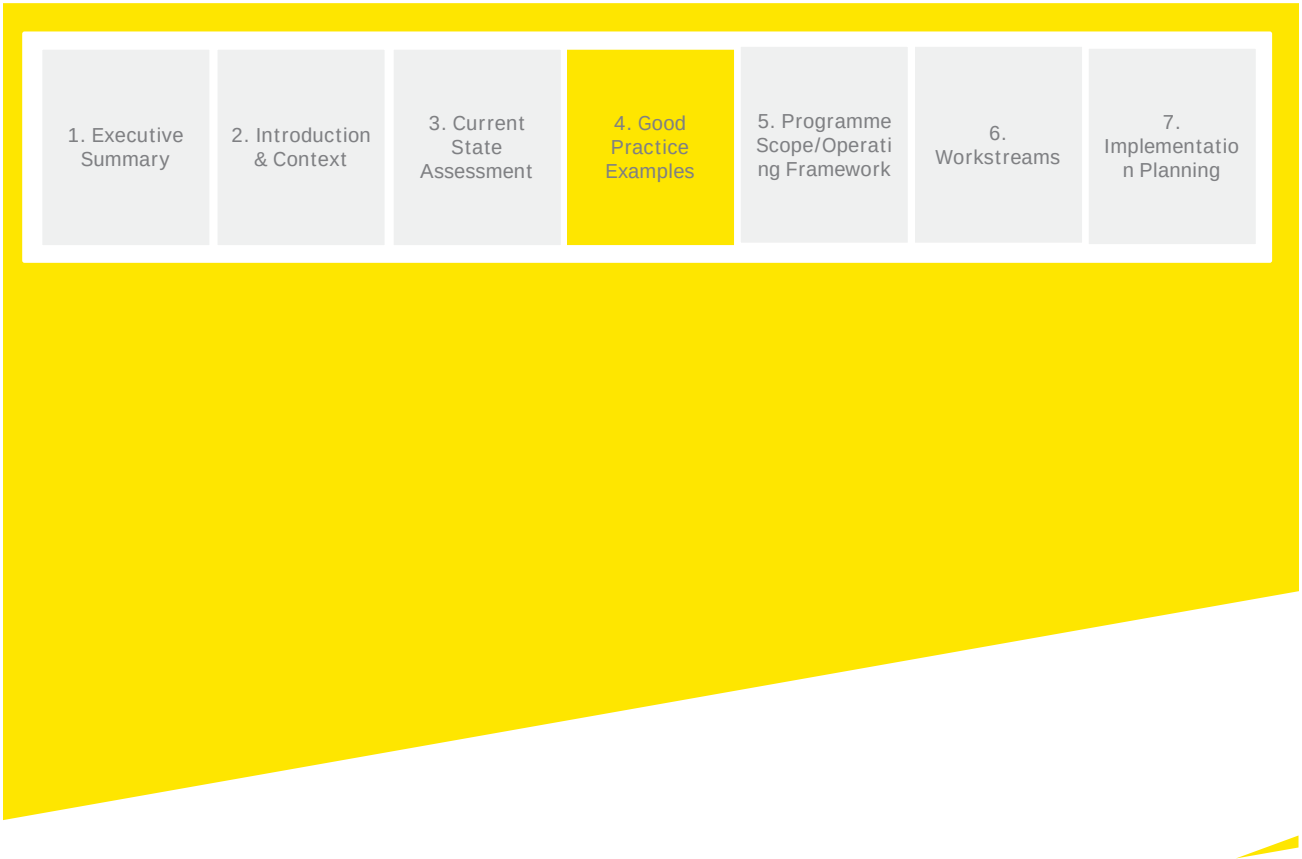
Doncaster Local Medical Committee/GP Federations

- 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



Good practice summary

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 our 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 peoples 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

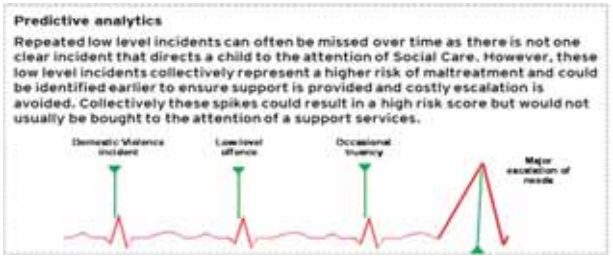
There are a number of models for Early Intervention across the country, varying across age groups. Within this section we will explore:

- 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

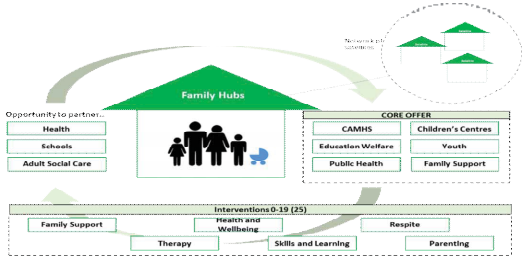
Good practice summary

Integrated Family support

Notable examples include:

East Sussex: 0-5 offer has been integrated across public health and children' 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 that 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

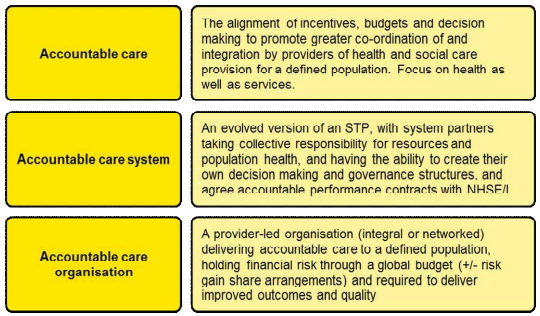
Good practice summary

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.



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 faired 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:

Northumbria CCG and Northumbria Healthcare

- A primary and acute systems vanguard that is seeking to develop an ACO with agreed outcomes for a population of 330k
- The ACO would involve mental health and social care services
- Initial work involved the transformation of urgent and emergency care via the Northumbria Specialist Emergency Care Hospital
- Key to its development is the creation of primary care hubs and seven-day services in primary care

Manchester City CCGs

- Seeking to procure a local care organisation based on the MCP model
- The ACO would include some local authority services and children's services
- The work is also aligned to the city's Single Hospital Service and the potential to integrate the city's three CCGs.

Tameside Care Together

- ACO led from the previous acute trust
- All DGH and community services currently integrated
- Adults social work and commissioning of community services will be transferred within next 12 months
- Joint CEX of CCG and Council, single commissioning budget but managed through 3 main arrangements (E.G S75 and aligned budget)
- Contract in development, performance levers key points of discussion at present

Dudley

- Seeking to procure an accountable care organisation based on the MCP model
- Focusing on three key areas: Integrated Care, Planned Care and Urgency and Emergency Care
- Within these areas services to be covered include primary care, A&E, ambulatory care and out-patients
- The MCP will create a series of integrated MDTs across physical and mental health and the voluntary sector

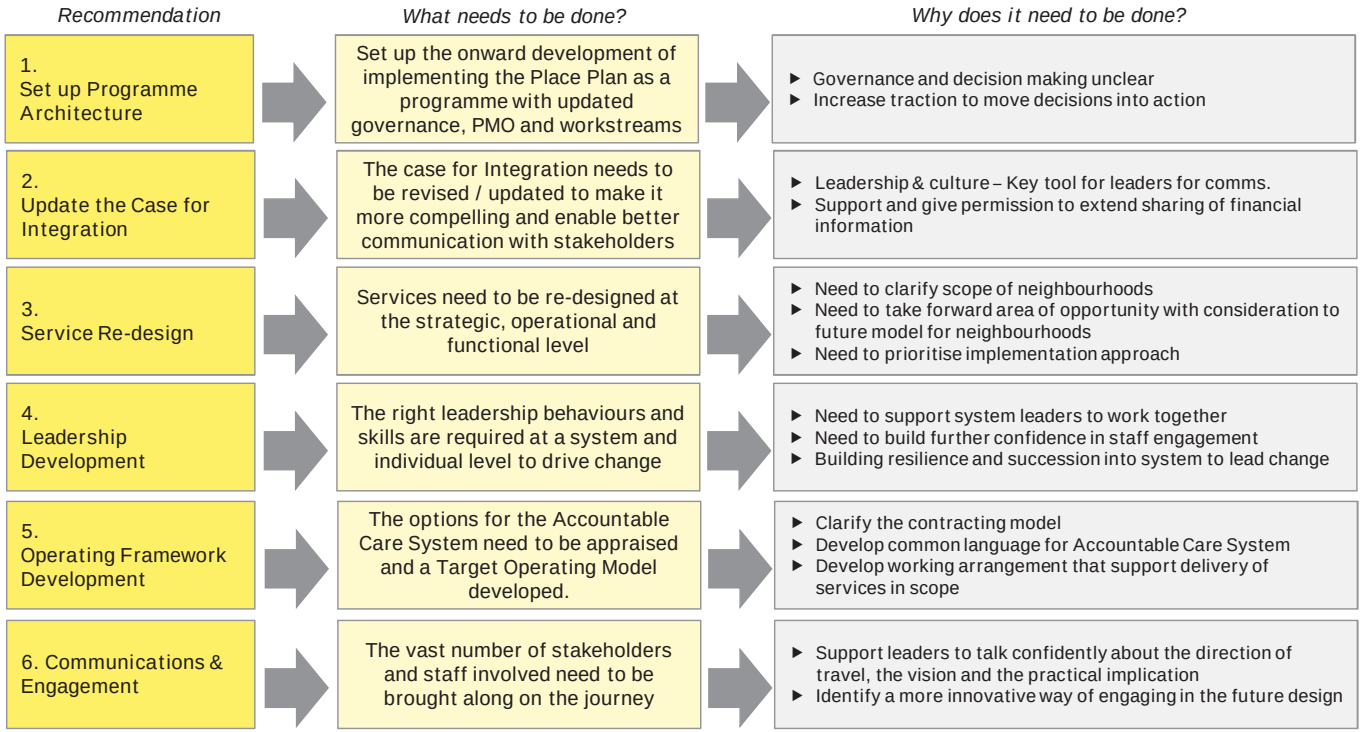
Relevance for Doncaster

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.

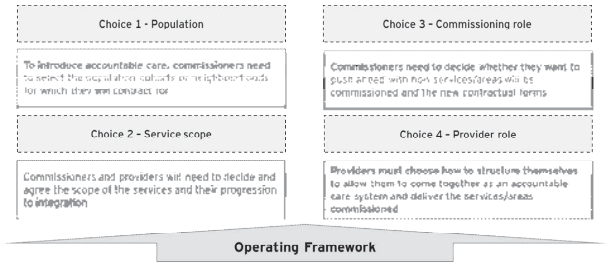
What is accountable care?

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/I
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

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 mean 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

Strategic	*The development of the end to end service model at a neighbourhood level. A life course approach, How they will be delivered and how they will define the TOM.*
Operational	*Specific services or groups or services that can be progressed now to test the wider model and approach, deliver quicker wins and generate pace and momentum to support the strategic approach*
Functional	*Common functions provided by all/ most of partners where there are clear synergies and opportunities to drive better ways of working together.*

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 identity 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 or 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	• This will reduce costs by moving patients into more appropriate services • Reduction inappropriate patients hitting the core bed base
Intermediate Care	• Patients have a more ‘joined up’ service and get out of Acute hospital sooner and inappropriate admissions are avoided • This will reduce costs by early discharge and admission avoidance from the acute sector
Starting Well (1001 days)	• By intervening in children’s lives sooner, where required, the cycle of lifelong intervention can be avoided and overall costs reduced • This is a preventative measure to reduce future reliance on support
Continuing Healthcare (CHC)	• Removal of duplication • Better market management • Improved review and assessment processes
Dermatology	• 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. • Patients would be able to access services more locally. Referrals to secondary care would reduce.
Vulnerable Adolescents (Tier 4 Specialist Services)	• Reduce adolescents transitioning into adults dependent on support. • Develop co-ordinated support which can steer adolescents away from a lifetime of support. • Improve outcomes for adolescents and reduce future reliance on support
Complex Lives	• Improving outcomes for people with complex needs and reducing overall demand on services by breaking the cycle of need.
Children on the Edge of Care	• Avoiding high cost LAC
Domestic Abuse	• Improve outcomes - The numbers of high risk cases referred are well above the average against both regional and national figures. • This is a preventative measure to reduce future reliance on support

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?	▸ 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 ▸ Develop common processes and approach to reduction in duplication of work/effort		▸ Develop baseline of current estates ▸ Agree policy re charging ▸ Id quick wins	▸ Develop Community assets and resilience ▸ Staff will have more flexibility and freedom to innovate leading to increased morale	▸ Detailed population trends of service users aligned to neighbourhoods to be produced ▸ Governance Arrangements to be put in place
How & When?	▸ Identify lead organisation and project manager (Suggest Local Authority and Children's Trust ▸ Agree scope, objectives, deliverables and timelines ▸ Identify approval required for changes ▸ Work should begin in May		▸ Engage with strategic estates group ▸ Agree timelines	▸ Identify project leads and resources ▸ Kick off Meetings (Scoping/sign up) ▸ Define governance ▸ Agree level of consultation required ▸ Work should begin in June following programming into wider programme planning activity	

Choice Three - Commissioning Role

Introduction

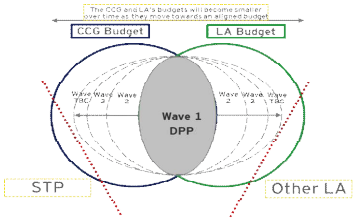
This element of scope is to define the approach to Commissioning within the Doncaster Place plan and to support the Accountable Care System.

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

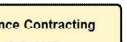
There are currently 6 main providers in Doncaster:

- 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 3rd 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.

Alliance Contracting 	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.
Joint Venture 	Providers come together as equals in a new corporate entity, requiring some form of multilateral decision making.
Lead Provider 	A lead provider is commissioned to provide services and sub-contracts with other providers as needed.
Single integrated provider 	Single integrated provider is formed to all services.

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

Operating Framework

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

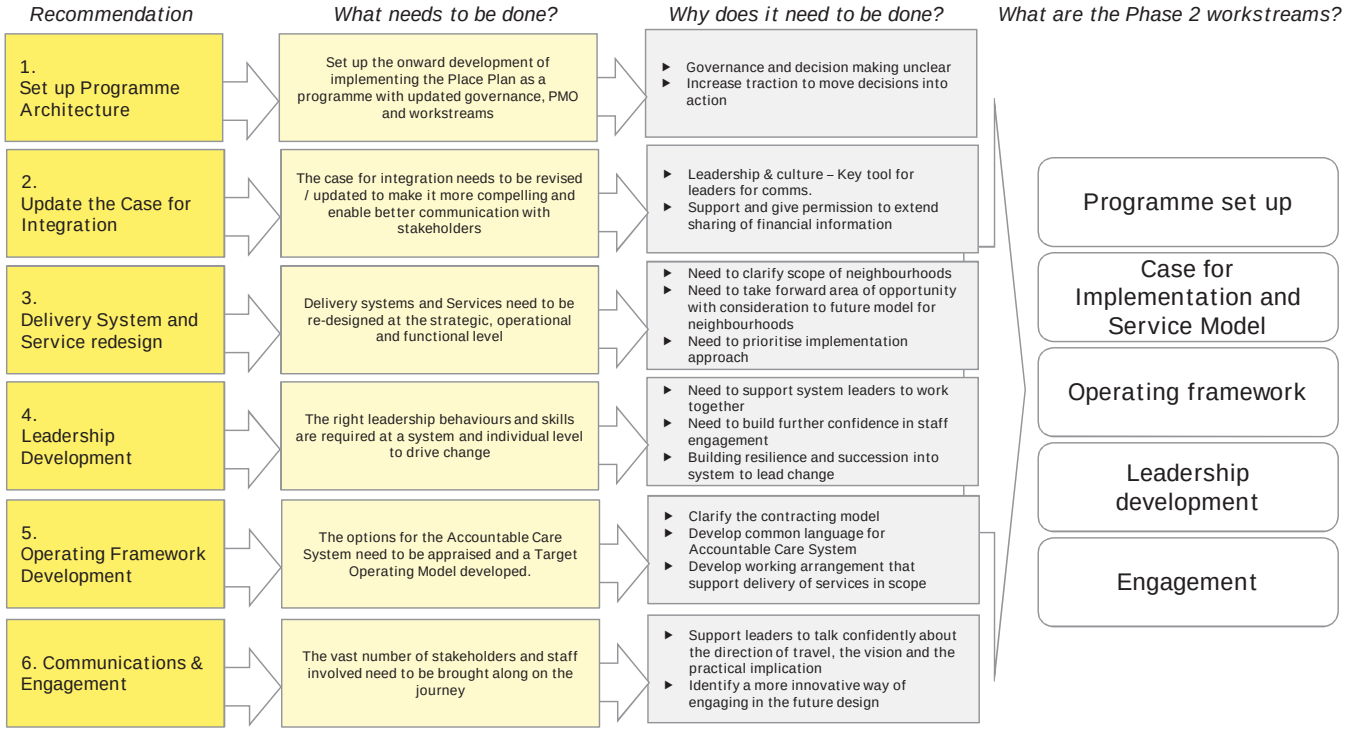
Broader financial strategy (medium term activity)

- 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

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 governances 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 archtechture, 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:

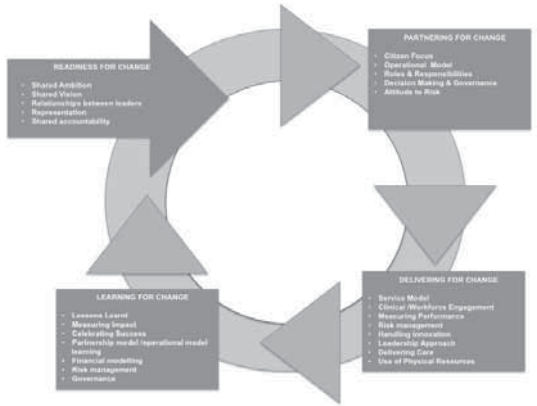
This work-stream will focus on the leadership that is in place across the health and social care system from two aspects – system leadership to drive the required change and individual leadership to provide personal coaching to drive confidence and the right behaviours to support the system change**.**

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

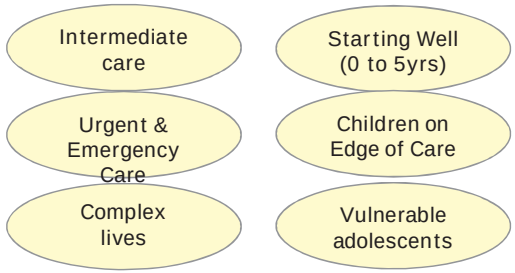
Three areas have been selected to accelerate over the next seven weeks, it is anticipated a second wave will the progress over the summer.
The project manager for this workstream will also support providers in the progression of work on some of the functional quick wins.

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

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 16th 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

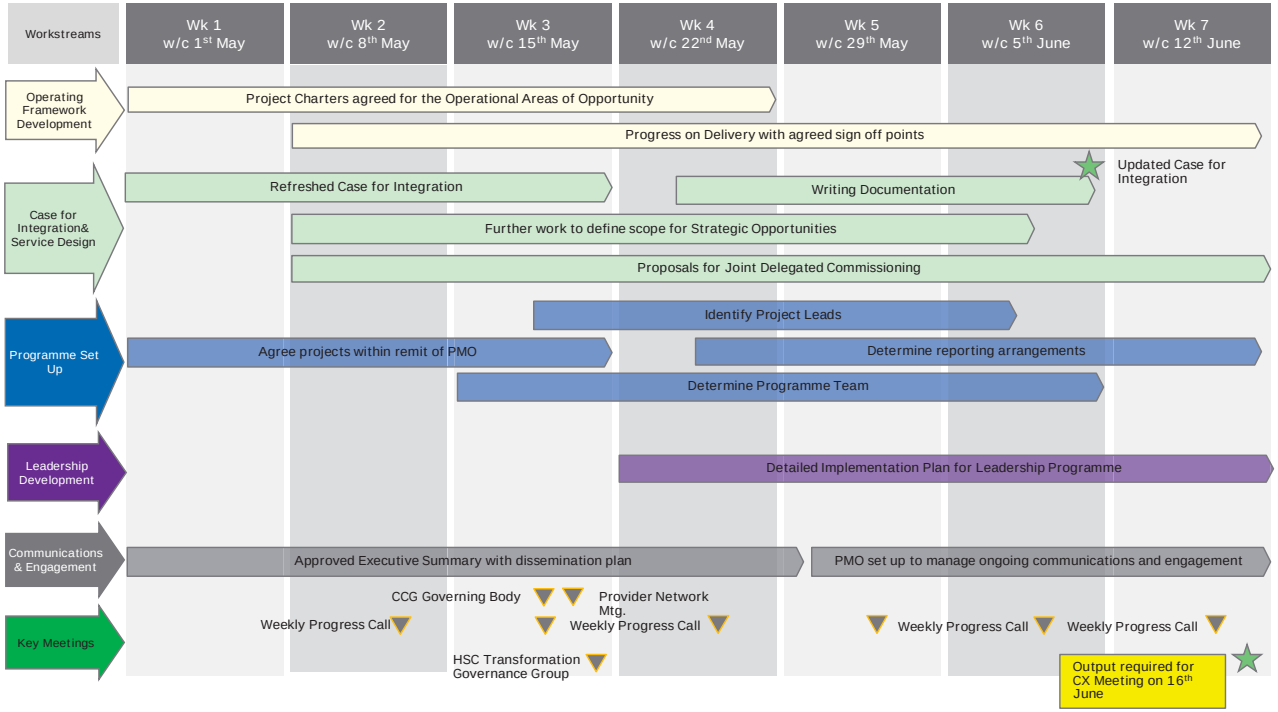
- Detailed implementation plan for the leadership programme

WORKSTREAM: COMMUNICATION AND ENGAGEMENT

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

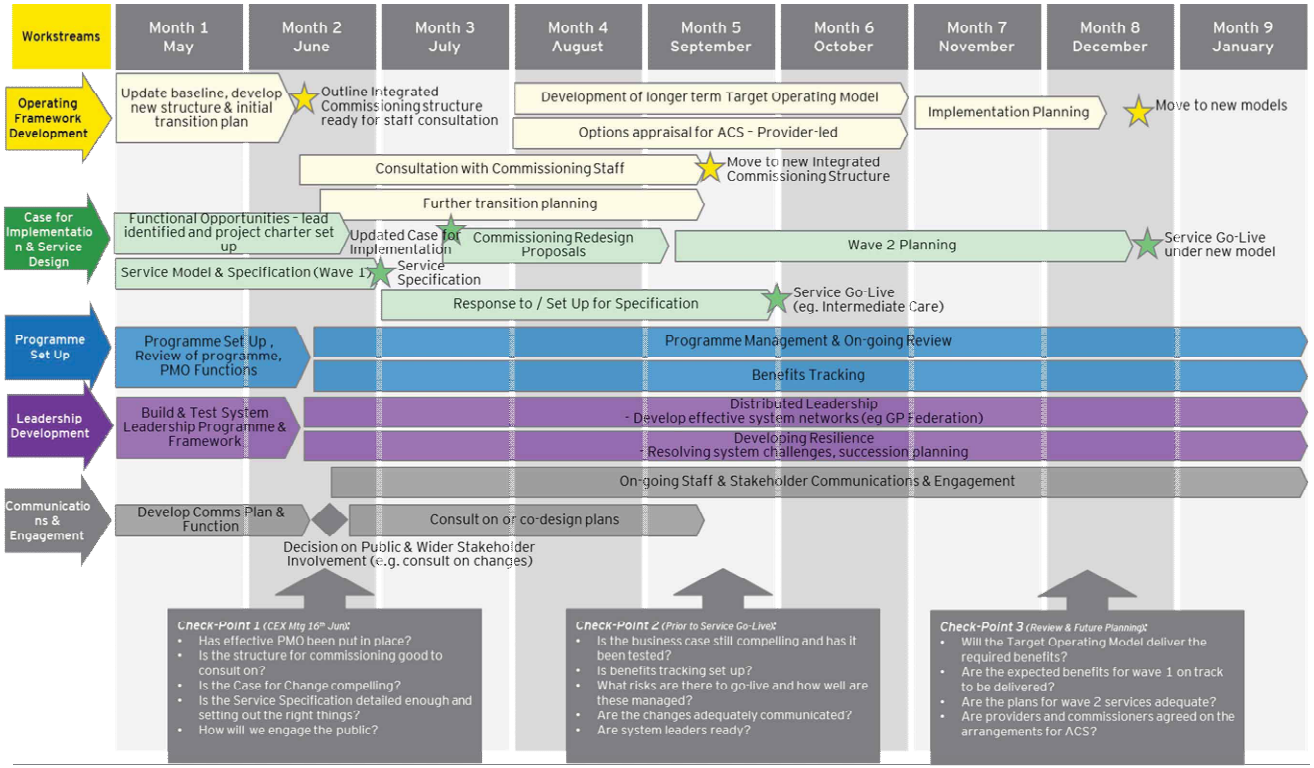
Immediate activity plan

The agreed areas of focus for the next seven weeks of activity are on the creation of the infrastructure to support the five agreed work-streams – 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

Objective

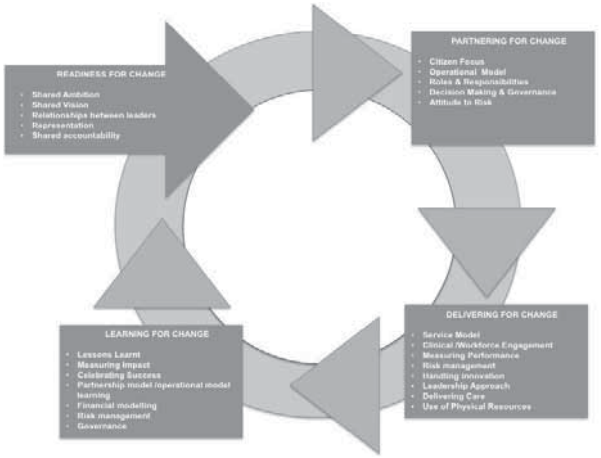
The Doncaster Place Plan and the requisite partnership arrangements that need to be in place to deliver it, require a very different approach to the planning and delivering of health and care services, than has previously been in place. As part of the diagnostic for Phase 1, we carried out a maturity 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	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. 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.	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. 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.

Leadership

System Leadership Component 2: Partnering for Change	Commissioners	Providers
Roles & Responsibilities	The commissioners need to work through in a little more detail their levels of work and responsibility– i.e. A. What will continue to be done by health B. What will be done through the joint commissioning arrangement C. What will continue to be done by the LA 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.	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.
Attitude to Risk	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. Risk is referred to here in its broadest sense – role of the partnership, future direction, financial and organisational.	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.
Decision-Making & Governance	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.	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.

Leadership

Other Issues Raised as part of the Maturity Assessment	
A Programme Approach	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. 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. 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.
Joining the Strategic Dots	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 & 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.
Developing the Compelling Narrative & Engagement	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.
Organisational Development	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

Leadership

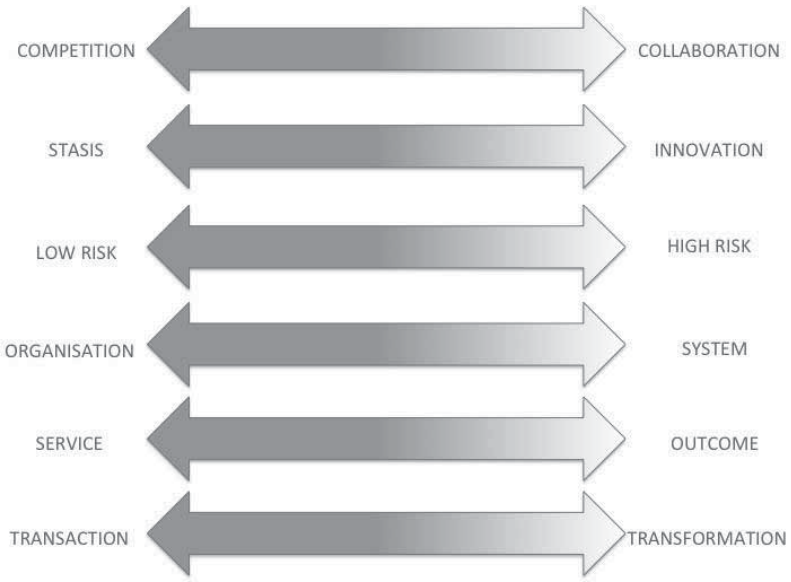
Next Steps

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.

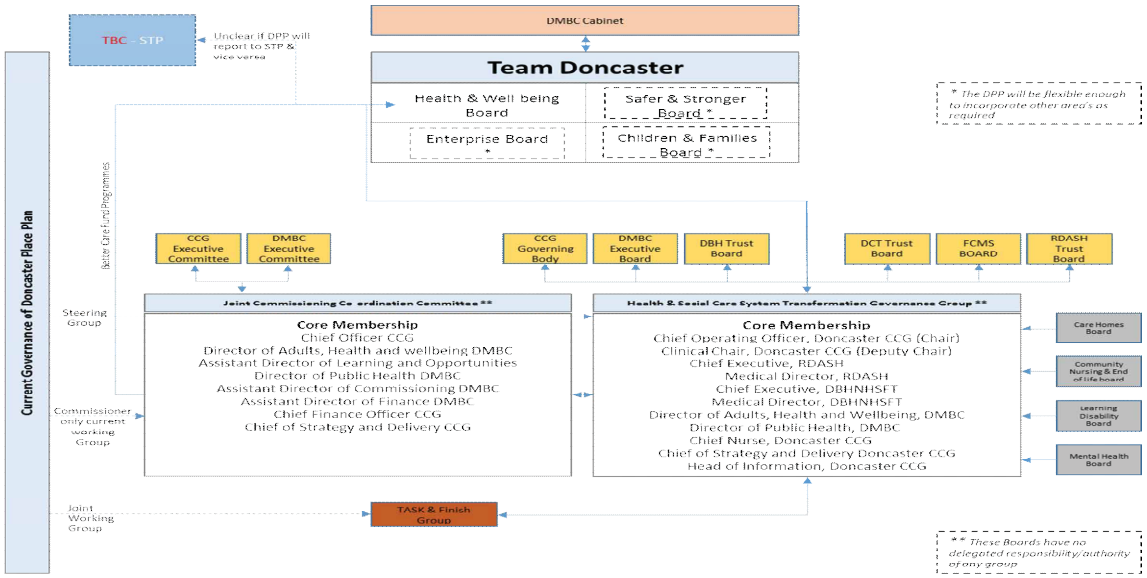
Example System 'Polarities'



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

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 formulae 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

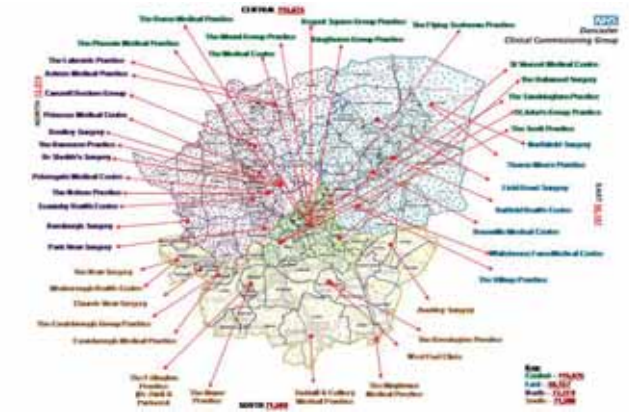
- The CCG employs 166.81 WTEs with a total direct pay cost of £6,258,482.
- These figures do not include a number of services which the CCG outsources. The outsourced services include:
  - Payroll
  - HR Shared Services
  - Occupational Health
  - Health and Safety
  - Legal Advice
- Costs for the services 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.

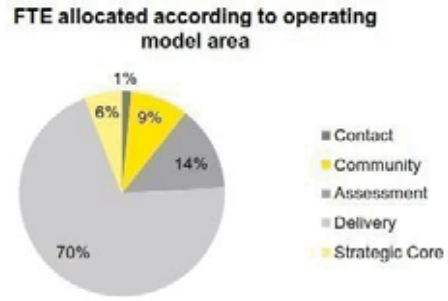
The LMC currently represent the GP Practices within Doncaster. We do not have access to their workforce figures.



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	FTE
ADULTS SOCIAL CARE	Total	25,291,340	17,442,000	173.63
	CARE MANAGEMENT	7,947,240	5,401,700	140.76
	COMMUNITY PROVISION	8,617,500	1,324,600	162.57
	REFLRCT SERVICES	5,100	5,100	
	DIRECTORATE MANAGEMENT	25,600	25,000	0
	SPECIALIST CARE	10,991,640	9,494,620	240.93
COMMUNITIES	Total	14,773,600	8,474,600	247.89
	COMMUNITIES	5,668,300	5,668,700	89.26
	COMMUNITY SAFETY	3,629,700	1,629,280	69.27
	LEISURE & CULTURE	0	0	0
	LIBRARIES & CULTURE	5,266,140	4,377,440	90.06
	TRANSLATION SERVICES	209,460	199	3.70
	TROUBLED FAMILIES	-22	-22	2.68
DIRECTOR OF ADULT SERVICES	DIRECTORATE MANAGEMENT	187,000	187,000	0
MODERNISATION & COMMISSIONING	Total	91,307,400	83,840,900	88.49
	COMMISSIONING & CONTRACTS	89,488,080	82,121,620	69.67
	MODERNISATION & IMPROVEMENT	1,703,760	1,647,180	15.77
	SAFEGUARDING ADULTS	1,115,640	1,078,110	13.25
PUBLIC HEALTH	Total	22,276,750	176,440	27.00
	COMMISSIONING	10,098,320	10,098,320	
	PUBLIC HEALTH	1,965,990	19,046,200	
	WELL PROGRAMMES	9,175,520	9,175,520	
Other (Unallocated)				0
Grand Total		152,340,290	90,120,980	947.00

Workforce

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

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.

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:	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: • Reduce out of area placements – step down from locked rehabilitation • Development of Enhanced Community Team • Enhanced primary care support for people with a learning disability including annual health check • Implement intermediate care model – step down and step-up crisis management • Enhancement acute liaison services	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: • Implementation of Single Point of Access for all age mental Health services; • Development of collaborative pathways to deliver physical health for people with severe and enduring mental health problems; • Development of community based model to improve perinatal mental health; • Modernise the adult mental health acute care and home treatment pathway • progress development of Early intervention in psychosis services • Deliver IAPT Plus and start the development of IAPT to include employment advisors improving access to employment opportunities • Develop the IAPT pathway to include joint care management of people with long term conditions • Core 24/ MH liaison development • 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 • Comms both to staff/ primary care and out to general public • Bringing OOA patients back from locked rehabilitation and children also done (tripartite funding)	• 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 due to improved access to crisis prevention and crisis support services; • Reduction in A&E attendances of people who are supported to better manage their 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.

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		Population-all adults, not condition specific, no exclusions but tends to be older frail people and very old ie 85 plus Place Plan Cohort: 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): whole of Doncaster; some elements could be delivered through neighbourhoods		November 2016- April 2017 1. Test and refine delivery model by implementing and evaluating a series of discrete projects with providers 2. Undertake skills audit and agree workforce development plan 3. Further engagement with patients, carers and the public to develop the model 4. Complete financial and activity modelling 5. Continue to develop appropriate joint commissioning and provision model 6. Identify any procurement processes required and plan accordingly. (Intention is to work with current providers to develop existing services) 7. Develop a joint dashboard for intermediate care May 2017 onwards 1. Sign off new service model following testing 2. Ongoing public engagement and formal consultation, if required 3. Jointly commission new service model and a phased implementation plan with existing providers 2017/18 4. Or procure early 2017/18 and implement with successful bidder 5. Or combination of 3 or 4 6. Evaluate new model and 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. 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&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&E for people aged 75 and over 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&E attendances by a cost of - not yet quantified Reduced emergency admission episodes by - not yet quantified. Reduction in excess bed days - not quantified. Reduced A&E attendances - refer to Urgent & Emergency Care Plan. Reduced conveyance to A&E - refer to Urgent & 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

CCG & Council Shared Transformation Plans:

Primary Care Project

Cohort	Scope / vision	Capabilities / changes	Focus area	Stage of development	Timescale	Benefits
A - delivered in localities	Patients of all ages will be able to access a range of primary care in different settings, dependent on clinical need Greater focus on health promotion, prevention, early diagnosis and interventions via the Keeping People Well pillar specification Timely access to the right skilled clinician Patients able to make informed decisions about their healthcare Patient independence is supported 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		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) Place Plan Cohort: Cohort A: Prevention & Early Help; Neighbourhood or geographical area (include footprints wider than Doncaster): 5 GP localities, ? federations but 1 overarching	Conceptual- responsive or Defined- keeping well and extended (PC committee and engagement group all received) or Live- proactive pillar	Quality 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 Investment 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). Workforce Ring-fenced funding via CCG towards training for receptionists in active signposting and upskilling clerical staff to manage correspondence (Dec 2016 – March 2019). Practice Manager Development Programme. Second wave of the clinical pharmacist in practice scheme. Investment into the General Practice Nurse Development Strategy. Workload Releasing Time for Care programme Support practice EOIs 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 (national scheme). October 16 – April 18 Practice Infrastructure Capital investment in estates and technology infrastructure, Cohort 1 practice by March 2017, Cohort 2 by March 2019. Extra investment to support practices to adopt online consultation. Implementation of the national specification from April 2017.	

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 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.	Expended 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	► Smoother access to intermediate care via access function ► Aiming to reduce the length of stay by harnessing the role of home based intermediate care and the community treatment teams. ► Clinical oversight provided by the integrated geriatricians service	► Supported, smoother transition from hospital ► Additional step sideways capacity to support people to prevent a hospital admission	► NHS benchmarking – The first National Audit of Intermediate Care	► Avoiding admissions ► Reduction in excess bed days ► Reduction in attendance due to alternative settings
Home based intermediate care	► Consolidating reablement and CARA into a single service that supports hospital discharge and provides a longer term intervention where required from urgent response	► Supporting more people to remain at home with the right support ► Prevention of residential care admissions	► Bristol PCT and Bristol County Council – net savings of £3.6m	► Joint impact of UT, UAR, HBIC and RAP ► Admissions, attendances and bed days avoided
Rapid Access Packages	► 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.	► Enabling timely access to short term domiciliary care provision to enable people to return/remain at home	► Barking, Havering and Redbridge	► Reduction in residential care admissions ► Reduction in acute admission ► Reduction in excess bed days
Residential Healthcare Service	► A GP led service supporting care homes. ► Delivers more proactive care ► Focus on ensuring palliative care arrangements in place. ► Up-skilling care home staff to have better health input. ► Supported by Pharmacy undertaking medicine usage review and prescription services. ► Supported by integrated community treatment team where needed ► Provides own out of hours service ► Provides medical cover for short term residential beds	► Improved equality and access to health care for care home residents. ► Reduction in medical needs requiring secondary care. ► Improved end of life care. ► Improved quality in care home provision	► Improving care in residential care homes: a literature review (JRF, 2008)	► Reduction in admissions ► Potential to reshape continuing health care and commissioning of nursing placements ► Supports hospital discharge

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

Service	Description	Qualitative Benefit	Evidence	Financial Benefit
Hospital Transfer Team	► Increasing the efficacy of the health and social care hospital discharge team. ► Increase use of discharge planning tools across all ward staff. ► Development of hub and spoke model to up-skill ward staff in discharge planning. ► Critical friend role to clinical staff re appropriateness for discharge of clinically stable patients – risk management and enablement through better skilled staff	► Supporting people to get back to home or a home based setting in a safe, efficient way. ► Better discharge planning ► Better access to step down options	► NHS St Helens ► Cambridge University Hospital foundation trust ► NHS Camden – Reach Early Discharge Team	► Reduction in excess bed days ► Reduction in readmissions
Integrated locality teams	► Integrated health and social care staff ► Reablement and homecare attached to team for clients referred from community ► Expectation that for existing clients who require reablement their home carer is up-skilled to deliver ► Move to named carer model in homecare contracts ► Key worker model which can be utilised in urgent scenarios to support decision making	► Co-ordinated health and social care support with the individual at the centre of the co-ordination of care ► Proactive identification and management of risks to reduce escalation of needs ► Efficiencies in working practice and better continuity of care ► Better understanding of the person to be able to manage their conditions and support them to navigate the health and social care system	► North West London Integrated Care Pilot: 6.6% reduction in non-elective admissions ► Cockermouth – prevention: £2.20 return for every £1 ► Community Budgets Health and Social Care expected 50% reduction in non contact time due to streamlined referral processes in Solihull	► Admissions, attendances and bed days avoided. ► Reduction in need for unplanned care through better management of client holistic needs and quicker access to low level support to prevent escalation/ exacerbation.
Increasing the use of equipment	► Further investment in more equipment to target falls and preventing admissions to residential care ► Pharmacies provide non-complex items potentially reducing the cost of logistics as an additional benefit	► People are more independent and able to live in their own homes for longer	► 'Interventions for the prevention of falls ... meta-analysis " BMJ 2004	► Prevention of hospital admissions ► Prevention of residential care admissions ► Prevention of need for urgent response and intermediate care

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

Service	Description	Qualitative Benefit	Evidence	Financial Benefit Description
Triage	► Providing a single point of access to urgent community assessment and response. ► Includes social care, nursing and specialist clinical support. ► Acts as one of two access points to intermediate care.	► Alternative call for help at home. ► Provide care and support in the home in urgent situations. ► Rapid assessment and access to professionals, ► Liaison with key worker for existing cases to ensure holistic management and right response.	► Bristol PCT and Bristol County Council – net savings of £3.6m ► NHS Salford – Rapid Response Health and Social Care Crisis Team ► South-east Essex Community Services	► Supports attendance and admission avoidance through providing a home base alternative. ► Avoids admission to residential care due to additional community cover for more at risk clients.
Assessment and Response	► Assessment and provision in urgent circumstances to identify most appropriate pathway of care for individual ► Where needed will provide 1-2 days care to eliminate need for acute care. ► Part of 'access function' and can allocate intermediate care where longer term support may be needed ► Initiate crisis MH beds or facilitate access back to CMHT where needed	► As above ► 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 ► Support GPs to identify and deliver ambulatory care pathways as well as understand other service options for patient management	► Royal National Orthopaedic Hospital NHS Trust/King's College NHS FT Trust/Medihome – support for acute patients at home ► King's College Hospital NHS FT – Older Person's Assessment Unit	► As above
Use of Integrated Case Management in primary care	► Proactive case finding of at risk clients including social risks such as isolation or depression ► Supported by locality teams, with a coordination role of community matrons and the health improvement team ► Locality teams members attached to GP practices to coordinate the relationship and increase visibility of support options ► Bring resources together, identify cases	► Better communication ► Co-ordinated case planning across primary care, health, and social care services. ► Better management of conditions ► Better continuity of care ► Up-skilling of staff re different options available to support patients	► Cockermouth: £2.20 return on every £1 invested. ► Barking and Dagenham ► North West London care pilots 6.6% reduction in admissions	► Cost of locality teams has allocated resource to undertake coordination ► The GP cost and benefit analysis is out of scope

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	► Multi-Disciplinary Teams (MDTs) ► Enhance nursing and therapies in care homes – especially for those with complex needs ► Improvements in oral health, hydration, and nutrition ► Improvement in end of life care ► Promotion of mental health and wellbeing	► Improved health outcomes ► Enhanced satisfaction for residents ► More efficient use of resources	► Islington MDTs: 26% decrease in admission and 87 less bed days per month. ► Worcestershire community nurse: 23.1% reduction in A&E attendances ► Peterborough review: 27% reduction in admissions	► Reduction in bed days ► Reduction in admissions

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.

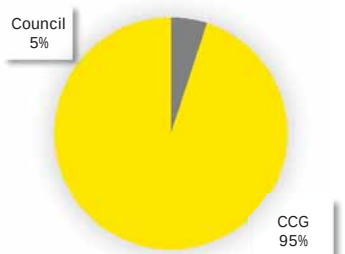
Case for Implementation

- 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.

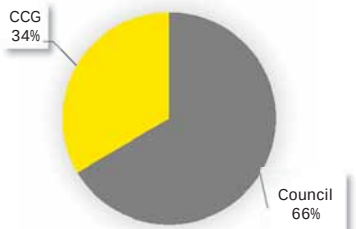
Case for Implementation

- 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 EOIs 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

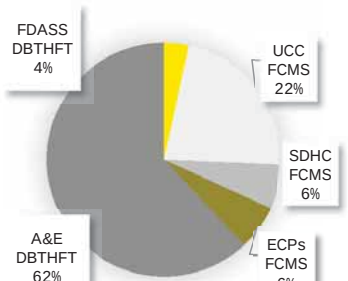
- Providing better support for people and their families to self-care.
- Helping people who need urgent care to get the right advice in the right place, first time.
- Ensuring that adults and children with more serious or life threatening emergency needs receive treatment in centres with the right facilities
- 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)

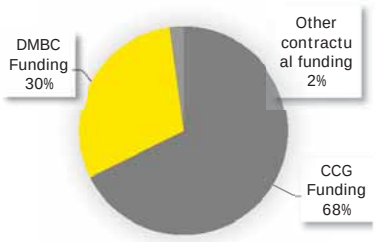
Case for Implementation

- 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

- This is about ensuring that all children across Doncaster have the opportunity to a good start in life.
- It is about developing support so that our children have the best possible opportunity to thrive
- It is about offering appropriate support to families and children at the right time.

Scope

- 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. This will mean look at areas such as:
  - Smoke free homes
  - Breastfeeding
  - Diet & healthy start vitamins
  - Safe sleeping
  - Maternal mental health
  - Stop smoking in pregnancy
  - Immunisation uptake
  - Illnesses

Case for Implementation

- All families supported through universal services at the earliest opportunity.
- Resilience in families.
- Reduction in referrals to specialist services.
- Sustainable youth offer
- Healthier children who will develop into health adults
- Breaking the cycle of poor health and social outcomes by intervening early

Finances and Activity

Area	Volume	Metric

- xxx.

Assumptions

- Limited to children aged 0 to 5 years old
- Focussed on those most at risk to break the cycle of life long dependency on health and social care services

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

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

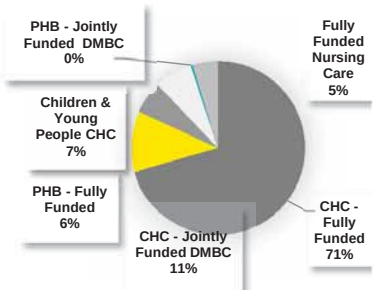
Case for Implementation

- 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

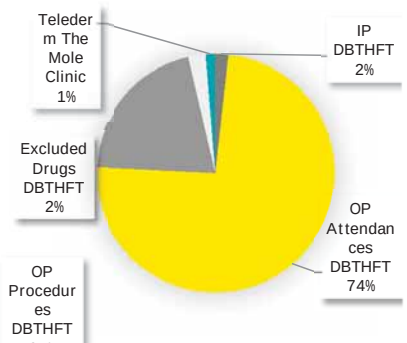
Case for Implementation

- 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.

Context

- It is often the case that young people struggle during adolescence.
- This is the age when life paths can be determined
- This is exacerbated for those who've grown up around dysfunction, substance abuse, crime or domestic violence.

Scope

- These young people face distinctive challenges and, too often, poor prospects in education and employment.
- Robust, tailored, wide-ranging support is needed to challenge these issues

Case for Implementation

- Reduce adolescents transitioning into adults dependent on support
- Develop co-ordinated support which can steer adolescents away from a lifetime of support
- Improve outcomes for adolescents

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 are 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 2nd May

Context

- There is clear evidence of the need for services to support young people thought to be 'on the edge of care,'
- The aim is to prevent the need for them to enter care in the first place or to rapidly return them to their families if they do enter care.
- Attention to services to support children and young people thought to be at risk of care or accommodation is imperative.

Scope

- Create co-ordinated packages of care to break the cycle of support required during childhood, adolescence and adulthood

Case for Implementation

- Reduce the cycle of reliance on state support to deal with vulnerable young people.
- Prevent the number of children entering care
- Reduce the length of time spent in care.
- Intervene early to support families to prevent long term residential care where possible,

Finances and Activity

Area	Volume	Metric

- xxx.

Assumptions

- Need to define age group this project will focus on

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

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.

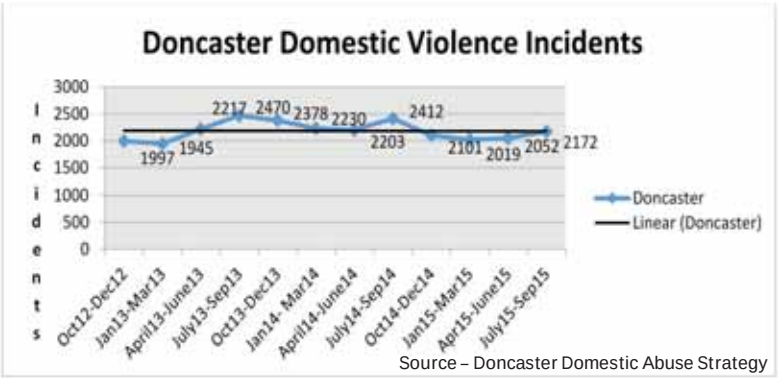
Scope

- 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



Source – Doncaster Domestic Abuse Strategy

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 associate 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 compile 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

Context

- Estates is a key enabler for services across Doncaster
- Currently estates is manged by each individual stakeholder with only limited sharing of estates to deliver services
- Some partners may have old estates which is over utilised and others may have new estate which is underutilised
- This project is about exploring the possibilities across Doncaster to use estate effectively across all partners

Scope

- Focus must be on understanding the age and utilisation of current estate across all partners. This must be linked to ownership and current usage (ie freeholds leased to third parties etc..). This will allow a picture which will allow a Doncaster wide strategy for estates across all partners.
- This project will, crucially, need to map current estates and future clinical need.
- Care must be taken as the future state may lead to a greater requirement for services within neighbourhoods and reduce the requirements for centrally held estate.
- Opportunities may exist to share estates across partners, dispose of excess estates and use the current estate more effectively

Case for Implementation

- By ring fencing estates, stakeholders are potentially using the estates across Doncaster inefficiently
- Estate is an expensive overhead and flexible use across partners is likely to lead to significant savings
- This project will aim to reduce recurrent estates costs across Doncaster

Finances and Activity

Area	Volume	Metric

- xxx

Assumptions

- Arrangement will need to be discussed around sharing any proceeds for disposals of estates and/or investment in estates
- Arrangements will need to be agreed for the potential of sharing estate and splitting costs
- Partners will need to agree to share information on estates data

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

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	**ACS & WTP Update**		
Report to	**Board of Governors**	**Date**	**27 July 2017**
Author	**Richard Parker, Chief Executive**		
Purpose			Tick one as appropriate
	Decision		
	Assurance		X
	Information		

Executive summary containing key messages and issues

The purpose of this report is to update Governors on the current developments within the Working Together Partnership Vanguard (WTP) and Accountable Care System (ACS) for South Yorkshire and Bassetlaw.

The WTP is a collaborative partnership arrangement involving Barnsley NHS FT, Chesterfield Royal Hospital NHS FT, Doncaster and Bassetlaw Teaching Hospitals NHS FT, The Mid Yorkshire Hospitals NHS Trust, The Rotherham NHS FT, Sheffield Children's NHS FT and Sheffield Teaching Hospitals NHS FT. There are four aims of the WTP: sharing and adopting good practice; developing a sustainable service configuration; assuring sustainable service quality; and informatics. The overall aim is to improve and sustain the quality of clinical services whilst also providing them more efficiently and effectively. We are one of 50 vanguard sites chosen nationally and one of 13 acute care collaborations.

The ACS is a wider partnership, involving hospital trusts but also CCGs and local councils to develop proposals and make improvements to health and care. Doncaster and Bassetlaw is part of the South Yorkshire and Bassetlaw ACS which is one of 44 areas covering England. The plans are place-based and built around the needs of the local population. The main ambition of the ACS is to give everyone in South Yorkshire and Bassetlaw a great start in life, with support to stay healthy and live longer. There are ten draft priorities to help achieve this:

1. Reduce inequalities for all, helping people to live well and stay well for longer
2. Join up health and care services, so they respond better to people's needs
3. Spend more money on care in communities, focusing on local healthcare centres
4. Treat and care for people's mental and physical health

5. Make hospital care the same for everyone, everywhere 6. Make urgent and emergency care simpler so that it's easier for people to get care 7. Develop a workforce in the right place and with the right skills 8. Use technology to support people to be well at home, manage their own care & for staff to be connected better 9. Have health and care services that are funded long term 10. Work with people, staff and communities to make all this happen This paper sets out the current developments within both partnerships.
Key questions posed by the report
N/A
How this report contributes to the delivery of the strategic objectives
N/A
How this report impacts on current risks or highlights new risks
N/A
Recommendation(s) and next steps
Governors are asked to note the report.

SYB in first wave of Accountable Care Systems

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

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

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

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

SYP ACS 'Outstanding'

NHS England and NHS Improvement published the first ever ACS Progress Dashboard on 21 July and SYB will be among just a handful of areas in the country to be named as 'outstanding'.

The Dashboard is an initial assessment of 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.

DBTH considers ACS MoU

DBTH will consider the final Memorandum of Understanding for the ACS on 25 July. As a core partner, DBTH is a 'party to' the Agreement. 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.

'Parties to' have majority relationships (patient flows and contracts) within and across SYB and DBTH must sign the agreement to be part of the emerging ACS in SYB. The Trust 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.

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.

WTP Committees in Common agreed

Last month DBTH in common with other acute trusts across SYB approved the committees in common governance structure. This involved creating a committee of the Trust comprising the Chair and Chief Executive who would meet with the other committees in common to take decisions on issues of commonality between the partners.

The arrangements have been subject to a number of revisions since first being considered however they have now been implemented and the first meeting is planned to take place shortly. We will of course ensure Governors are kept updated on progress.

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Title	**Well Led Governance Review**		
Report to	**Board of Governors**	**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

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

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

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

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

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

Key questions posed by the report

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

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

How this report contributes to the delivery of the strategic objectives

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

How this report impacts on current risks or highlights new risks

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

Recommendation(s) and next steps

Governors are asked to note progress in respect of the Well Led action plan.

Board Level Actions

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

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

Operational Actions

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

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Title	**Governor effectiveness review 2017**		
Report to	**Board of Governors**	**Date**	**27 July 2017**
Author	**Matthew Kane, Trust Board Secretary**		

Purpose		Tick one as appropriate
	Decision	x
	Assurance	
	Information	

Executive summary containing key messages and issues
The Board of Governors commissioned a review of their effectiveness at their meeting in January and a proposal was brought to them at their April meeting. Attached at Appendix A is the draft report which contains 12 recommendations for consideration and approval.
Key questions posed by the report
• Are the recommendations reasonable in view of the evidence gathered during the review?
How this report contributes to the delivery of the strategic objectives
Not applicable, although there is a requirement under the NHS FT Code of Corporate Governance to undertake a review of governor effectiveness on a regular basis.
How this report impacts on current risks or highlights new risks
N/A
Recommendation(s) and next steps
Governors are asked to APPROVE the recommendations on page 15 of the attached report. Next steps will involve the development of an action plan which will be brought to this meeting for monitoring.

DONCASTER & BASSETLAW TEACHING HOSPITALS NHS FOUNDATION TRUST

Review of Governor Effectiveness

2017

Contents

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Background

This review has been undertaken in accordance with section B.6.5 of the *NHS Foundation Trust Code of Corporate Governance* which states:

Led by the chairperson, the council of governors should periodically assess their collective performance and they should regularly communicate to members and the public details on how they have discharged their responsibilities, including their impact and effectiveness on:

- *holding the non-executive directors individually and collectively to account for the performance of the board of directors.*

- *communicating with their member constituencies and the public and transmitting their views to the board of directors; and*

- *contributing to the development of forward plans of NHS foundation trusts.*

The council of governors should use this process to review its roles, structure, composition and procedures, taking into account emerging best practice.

Methodology

The review's scope was agreed by the Board of Governors in April 2017. It broadly consisted of the following elements:

- A survey of governors undertaken between 7 and 22 June, the cut-off date being the last day before newly elected governors took their positions. A total of 18 responses were received from a maximum of 31 governors (58%), which was slightly better than the two previous surveys (see table below). There were four vacancies at the time of the survey.

Governor type	2017 Response Count	2016 Response Count	2014 Response Count
Partner	2	3	1
Public -Rest of England & Wales	1	1	1
Public - Bassetlaw	2	3	4
Public - Doncaster	11	8	6
Staff	2	1	2
TOTAL	18	16	14

- A separate survey of key stakeholders (including Execs, NEDs) undertaken over the same time period which yielded five responses out of a possible 16 (31.25%). Given the small numbers, little weight has been given to the quantitative aspect of these responses. However, mention has been made in the report of the qualitative comments where appropriate.

- Observations of governor committees by non-executives and governors from neighbouring trusts. We are grateful to Annette Laban (Sheffield Teaching Hospitals NHS Foundation Trust), Linda Challis, Alan Craw, Glenis Bartle and Margaret Rotchell (Chesterfield NHS Foundation Trust), Sarah Jones (Sheffield Children's Hospital NHS Foundation Trust) and Simon Stone (Mid Yorkshire NHS Trust) for giving up their time to take part in this review.

The following pages set out the findings from the review. Where questions have been asked in previous years (similar surveys were carried out in 2016 and 2014) comparison data is provided.

Findings - The Governor Role

- 88.9% said they understood the role of the foundation trust governor and 87.8% said they understood the role of the Board of Directors. This was roughly the same as in 2016 and 2014. Slightly fewer governors said they understood the Chair and NEDs roles but this was still comparatively high (85.6%).

- Four in five governors said the training and development provided was sufficient to enable them to be effective in their role which was a slight increase on 2016's figure of 78.8%.

- 78.9% of governors said the Trust provided them with the right information to enable them to be effective in their role which was a slight increase on 2016 but still behind 2014's figure when 87.1% gave a positive response.

- A sizeable number of governors (78.9%) felt their workload had increased over the last year.

Selected governor comments from this section

"I believe the work of a Governor far exceeds what new candidates probably expect. The rewards however are tangible. Financially robust following the historic difficulties. New CEO, Chair and Finance Director to lead the Trust. Teaching Status, a flagship on the road to continued improvement."

"The work has increased particularly with the monthly briefings: however, these are a welcome addition and very beneficial."

"Still concerns regarding receiving BoD minutes. BoG not holding NEDs to account sufficiently. BoG meeting in danger of becoming too simplistic in style partially due to governors requests."

The last comment above raises a key point about the governors' role in holding to account. The 2013 guidance '*NHS foundation trust governors: your legal obligations'* provides a number of examples of how governors exercise this key duty. DBTH governors generally do the things suggested with the exception of questioning non-executives at governors meetings. Although governors do ask questions on the matters before them at Board of Governors meetings these are by and large to executives. Whilst it is accepted that executives will have the familiarity and knowledge to answer most technical questions, governors could perhaps ask non-executives more questions around how assured they are that correct processes are in place. Other opportunities for this sort of holding to account could be provided through, for example, informal meetings between Governors and NEDs.

We also asked governors what they thought had gone well, what they enjoyed and what they had found difficult. Amongst the issues that governors found difficult NHS acronyms and jargon were mentioned a number of times. Given the number of new governors that have taken their places since this survey was launched, there is an even more pressing need to ensure that they find the business of the Trust accessible.

Recommendations:

1. **Explore the possibility of holding informal meetings between NEDs and governors twice per year to provide a further opportunity for holding to account.**

2. **All governors be provided with a plain English guide to NHS jargon and acronyms.**

3. **A briefing be prepared for everyone who presents to governors encouraging them to use Plain English and avoid acronyms and jargon.**

Working with Members

- Only 62.2% felt that there were adequate opportunities to meet and engage with members, down from 65% in 2016 and 2014. There was a perception however that governors looked to staff to find a solution to this issue (see comments below).

- Governors broadly felt that they were supportive of the aims and objectives of the Trust (88.9%) and that they were clear on the priorities for patients and service users (86.7%). Four in five felt confident that they could represent or were representing the needs of the public.

- Only 11% of respondents said members raised issues with them on a regular basis.

Selected governor comments from this section

"Governors should be more proactive in making themselves available to members, eg as I have done through setting up an open surgery at Bassetlaw Hospital - not rely on staff to do it all for them."

"Still worried re Bassetlaw and public perceptions. Despite tremendous efforts we still have to continue to counter misinformation on a regular basis."

Member Communications

- Support for the Foundations for Health member magazine rose almost 12% since last year to 90.6% but, as in previous years, only three quarters felt the member information on the website was good.

- Almost all governors commended the new evening governor briefings (96%) and satisfaction with member events saw an 8% improvement on last year. There was also an 8% increase on the value of the Annual Members' Meeting as a tool for member communications (now 78%).

- When asked how member engagement could be improved, respondents wanted to see something similar to what Bassetlaw governors do each year replicated at DRI (see comments overleaf).

Selected governor comments from this section

"More meet the governor events - Perhaps events where governors spend a day at the front entrance."

"I think you can make your own opportunities to engage with members - but I would like a similar 'how was your experience today' stand at DRI as the one which I understand operates in Bassetlaw. This of course would not cover members exclusively, but anyone attending the hospital."

"Knowledge of what community groups there are that governors could attend. Governors should know what is available in their area and could make their own arrangements to attend (coffee mornings, tenants/residents association meetings, Soroptimists, etc, etc) but good to know that staff can back them up with the necessary materials."

Recommendations:

4. **Consult with governors over the content of the members' pages of the Trust's new website.**

5. **A 'community pack' be developed for governors to use in communities setting out information about the Trust, the role of governors and how members can give their views.**

Involvement and Influence

- The number of governors who felt there were sufficient opportunities for them to work, and have informal discussions, with the Board of Directors dropped by over 7% to 61.1% since last year.

- However, there was a 10% increase in the number of governors who felt their views made a difference to the forward plans of the Trust and a similar increase in the number of governors who felt they were receiving the right amount of information to enable them to hold the Board of Directors to account.

- Governors welcomed the level of involvement they had in executive appointments (85.6%, up almost 8% since 2016) and generally felt they were viewed as an asset to the Trust (84.4%). There was some divergence of view on the need for greater diversity on the Board (see comments below).

Selected governor comments from this section

"Diversity should never be allowed to be given priority over ensuring the best applicant at interview is appointed. Application criteria whilst seeking to widen diversity cannot dilute the requirements of the post being filled."

"More work on diversity is required for both the board of governors and board of directors (for future NED appointments) particularly around ethnicity."

In addition, we asked governors where they felt they added the most value, what could be done to make their role better and challenged them to think about how they could make a bigger contribution.

In the stakeholder survey of directors, there was a feeling that the governor role had developed and been enhanced in 2017 and that governors' greatest value was acting as a bridge between patients and the Trust. It was felt that governors often gave staff the patient's perspective of Trust services.

Among those areas identified to make governors' role better was improved communication between governors and the Board of Directors although it was acknowledged that this had improved and that the Chair was introducing a number of new initiatives that needed time to bed down.

In respect of a question about what governors could do to make a bigger contribution, at least four said they wanted to attend more meetings.

Recommendation: 6. Further work be undertaken with the Chair and Chief Executive to explore how the Trust can achieve better discussions between governors and the Board of Directors.

Governance

- Four-fifths of respondents felt DBTH had an appropriate number of governors for a trust its size. A comparison with a demographically similar group of trusts revealed the following:

Trust	No of governors
Bradford Teaching Hospitals NHS FT	16
Calderdale and Huddersfield NHS FT	28
Derby Teaching Hospitals NHS FT	31
Doncaster and Bassetlaw Teaching Hospitals NHS FT	**35**
County Durham and Darlington NHS FT	39
North Tees and Hartlepool NHS FT	31
North Lincolnshire and Goole NHS FT	23
York Teaching Hospitals NHS FT	26

- 77.8% of governors felt the Board of Governors' sub-committees added value but there was a reduction in the number of respondents who felt that there was effective interaction between the Board of Governors and the governor sub-committees. This dropped from 82.9% in 2014 to 78.8% last year to 73.3% in 2017.

- There was an equally sharp dip in the number of governors who felt they were briefed about emerging issues in a timely manner. This stood at 87.1% in 2014, reduced to 80% in 2016 and now stands at 75.6%. Some of the comments below potentially shine a light on why this might be the case.

Selected governor comments from this section:

"I think the interaction between [governor] sub-committees and the board of governors could be better. I think this may either need … proactive engagement from the governors on the committees or a brief overview from the committee attendees at a time out (avoiding the burden of further work). Committee attendees previously read out a report at the board of governors meetings but I believe this environment was too formal to be useful not promoting any discussion/questions. Governors are usually informed of emerging issues in a timely manner but not always provided with enough of the information, recent example: Bassetlaw paediatrics to Doncaster issue."

"Feel governors must be briefed in a more timely way. Doing ward visits at BH this week, I heard that C1 has closed - governors have not been informed." [Clarification: Ward C1 had not closed but eight beds had been closed as part of the summer bed reductions.]

"Personally, I think there are too many governors at the trust, some of whom appear only to attend the main governor meeting and no more. The number makes it a little unwieldy to get any cohesive decision making. This does not, of course apply to the sub-committees - but their powers are limited."

Governor committees

The Governors' committee structure comprises:

- Agenda Planning Committee which plans the agenda for Board of Governors meetings and informally considers other constitutional matters affecting the governors.

- Appointments and Remuneration Committee which has responsibility for shortlisting, interviewing and deciding the remuneration and appraisal process for non-executives.

- Communications, Engagement and Membership Committee which deals with governors' communications and its wider engagement with members.

- Health and Care of Adults Committee which monitors the Trust's approach to adult services and forward planning of adult services, performance against CQC standards and provides views back to the Board regarding proposed strategic plans relating to adult services.

- Health and Care of Young People which provides a similar function as Health and Care of Adults but in respect of young people's services.

Observers from four local trusts attended meetings of the Communications, Engagement and Membership, Health and Care of Adults and Health and Care of Young People Committees in June and July 2017. They were then invited to submit feedback to the Trust Board Secretary.

Appointments and Remuneration Committee is the only the governor committee the Trust is required to operate. The rest are optional. The Chair attends both Agenda Planning and Appointments and Remuneration Committees but there is currently no non-executive involvement in the other meetings.

The following points were noted:

- Chairing was generally considered to be good although it could be improved by chairs summarising actions and due dates after each topic. Staff contribution to the committees was commended, particularly that of the Communications Team.

- It was clear that governors were acting in the interests of the Trust although it was sometimes hard to split personal views from wider member views.

- The committees were impacted by a low governor attendance. Two of the three committees were only just quorate with three governors in attendance. This may have been a result of the changeover following the governor elections and the timing of meetings.

- Observers commented that committees' focus tended to drift at times and this would be helped by having clearer and more focussed papers. One observer challenged the committee to ask itself the question: "has this made a difference"?

- There was uncertainty as to how the committee reported back assurance to the Board of Governors. At the Health and Care of Adults meeting, a key item was considered around ambulance handover in ED. It was unclear how the wider Board of Governors receives assurance on these matters.

- There was a need for stronger ownership of committees at executive and particularly NED level. At least three observers found it surprising there was no non-executive presence at the committees. Not only would NED involvement give assurance to governors, governor committees could provide an important mechanism through which NEDs could be held to account and feed issues of concern back up to Board level.

- In one committee, discussion was dominated by the chair although this may have been to compensate for the lack of engagement by other governors. Observers also felt this particular meeting lacked purpose. It should be noted that a late change to the agenda led to some items going on at late notice and being more of an update than a facilitated presentation.

Health and Care committees

The main purpose of the two Health and Care committees covering adults and young people is to provide assurance back to the Board of Governors. It was not clear to our observers how this was achieved. One way would be through a report to Board of Governors although it is understood that this was done previously and did not work particularly well in the context of a formal meeting.

The value of the two Health and Care governor committees also has to be weighed in the context of the other demands on governors' time, particularly the Board of Governors meetings, timeouts and evening briefings that are now taking place and the current attendance figures at the Health and Care committees which are poor.

While the Health and Care committees attract good speakers (indeed, one observer said that Dr Cutler's presentation at Health and Care of Adults on sepsis management was the best presentation she had seen given by a clinician) these are being shared amongst only a handful of governors (three, in the case of the example given). This is not really an effective use of the Trust's resources.

To ensure that these sorts of presentations are heard in a wider forum, without the need for presenters to give them twice, one proposal would be to bring the work of the Health and Care committees into the existing Board of Governors' meetings, giving an even broader range of governors the opportunity to hear about some of the good work taking place across the Trust.

Governors would still have a range of opportunities to input into clinical matters, as there are governor representatives on the Quality and Effectiveness and Clinical Governance Committees as well as on a number of other bodies (End of Life Strategy Group, Bone Health Group, etc).

In addition, the care groups are currently exploring the establishment of three new committees to drive service development in the areas of children and families, elective care and urgent care and the Chief Operating Officer would welcome governor representation on these bodies.

If governors agreed to disestablish the two Health and Care committees, the three governor committees that would be retained are the Appointments and Remuneration, Agenda Planning and Communications, Engagement and Membership committees. These three committees have specific roles and officer attendance is generally limited to the Trust Board Secretary and the Head of Communications and Engagement in any case so is markedly cheaper than clinician or executive attendance.

Recommendations:

7. **Align a non-executive to any governor committees where the Chair does not already attend.**

8. **Agree to moving the work of the two Health and Care governors committees into the established Board of Governors' meeting to facilitate wider engagement on these issues.**

Finally, we asked governors for their views on how they could make a greater contribution to the governance of the trust. A number believed that a dedicated training programme would be a good idea (though note the previous answer where 80% felt the training and development provided by the Trust was sufficient to enable them to be effective in their role).

In the stakeholder survey, directors also felt that greater exposure and understanding of care delivery and some more training to increase effectiveness would help governors.

Recommendation: 9. Explore the possibility of a more formalised governor training programme involving occasional outside speakers.

The Chair

- Scores in respect of the Chair were commensurate with previous years. Whilst acknowledging that the chair was still new into her role, there were a number of positive comments (see below). There was one comment about the Trust appearing 'less open' due to concerns regarding Bassetlaw's services.

Selected governor comments from this section

"A good appointment."

"The chair is new however seems very good and pro-active."

"I have only met her on one occasion and was impressed with how issues were handled."

Governor Support

- All questions in this section saw increases in satisfaction. In particular, the overall support provided by the Trust Board Secretary's Office saw an almost 5% increase to 92.2% since last year and the timeliness and quality of the information governors received from the Office saw a 6% increase (to 88.9%). There was however still an acknowledgement of the shortage of staff within the team.

Recommendation: 10. Address the ongoing staffing issue within the Secretariat as soon as possible to ensure support to governors is maintained.

Overall Effectiveness

- Governors rated their own effectiveness at 81.1% which was very similar to previous years. Ideas for improving the effectiveness of governors included:

  - Capping the governor term at six years;
  - Reducing the number of governors;
  - Monitoring attendance at meetings.

- This final suggestion had already been identified as an issue for improvement by the Agenda Planning Committee. In the stakeholder survey, directors also suggested formally recording the involvement of governors in Trust events, training and business.

Recommendation:

11. **Explore the issues with respect to governor terms and numbers of governors at a future governor session.**

12. **Agree with governors a schedule of what good attendance looks like (and which meetings it includes) and actively monitor and share this amongst governors to promote attendance.**

Recommendations

1. Explore the possibility of holding informal meetings between NEDs and governors twice per year to provide a further opportunity for holding to account.

2. All governors be provided with a Plain English guide to NHS jargon and acronyms.

3. A briefing be prepared for everyone who presents to governors encouraging them to use Plain English and avoid acronyms and jargon.

4. Consult with governors over the content of the members' pages of the Trust's new website.

5. A 'community pack' be developed for governors to use in communities setting out information about the Trust, the role of governors and how members can give their views.

6. Further work be undertaken with the Chair and Chief Executive to explore how the Trust can achieve better discussions between governors and the Board of Directors.

7. Align a non-executive to any governor committees where the Chair does not already attend.

8. Agree to moving the work of the two Health and Care governors committees into the established Board of Governors' meeting to facilitate wider engagement on these issues.

9. Explore the possibility of a more formalised governor training programme involving occasional outside speakers.

10. Address the ongoing staffing issue within the Secretariat as soon as possible to ensure support to governors is maintained.

11. Explore the issues with respect to governor terms and numbers of governors at a future governor session.

12. Agree with governors a schedule of what good attendance looks like (and which meetings it includes) and actively monitor and share this amongst governors to promote attendance.

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Title	**Membership of Board of Governors Committees & Other Activities**		
Report to	**Board of Governors**	**Date**	**27 July 2017**
Author	**Matthew Kane, Trust Board Secretary**		
Purpose			Tick one as appropriate
	Decision		
	Assurance		
	Information		x

Executive summary containing key messages and issues
The attached appendix sets out the current allocation of governors to committees and other activities. Following the elections in July, all governors who were elected or re-elected were invited to submit expressions of interest for vacancies. Vacancies arose where the previous occupier of the position was up for election. Vacancies were also open to existing governors. Where more governors expressed an interest in a role than vacancies existed the roles were filled by an election amongst govenors. Any new or re-appointments are given in **bold** in the attachment. Any remaining vacancies are given in ***bold italics***. All new appointments last for the remaining term of the governor.
Key questions posed by the report
N/A
How this report contributes to the delivery of the strategic objectives
N/A
How this report impacts on current risks or highlights new risks
N/A

Recommendation(s) and next steps
Governors are asked to note the report.

Governors Involvement in Committees & Other Activities

Committees of the Board of Governors

Committee / Activity	Number of Seats	Seat held by	Term of office end date
Appointments & Remuneration	Vice Chair	Mike Addenbrooke	31 March 2019
	4 Public	**Phil Beavers**	21 September 2018
		David Cuckson	22 June 2020
		George Webb	31 March 2019
		Brenda Maslen	31 March 2019
	1 Staff	Roy Underwood	31 March 2019
	2 Partner	Clive Tattley	8 January 2019
		Ruth Allarton	26 June 2018
Communications, Engagement & Membership	5 Public	**Hazel Brand**	31 March 2019
		Philip Beavers	21 September 2018
		Dev Das	31 March 2019
		Susan Overend	31 March 2019
		David Cuckson	22 June 2020
	2 (preference for 1 Staff & 1 Partner)	**Duncan Carratt**	31 March 2019
		Vacancy	
Health and Care of Young People	5 Public	**Andrina Hardcastle**	22 June 2020
		Dev Das	31 March 2019
		Maureen Young	31 March 2019
		Mike Addenbrooke	31 March 2019
		Eddie Dobbs	31 March 2019
	2 (preference for 1 Staff & 1 Partner)	**Karl Bower (from 21 Oct '17)**	20 October 2020
		Susan Shaw (Partner)	19 May 2018

Health and Care of Adults	5 Public	**Sharon Cook**	21 September 2018
		Mike Addenbrooke	31 March 2019
		Lynne Logan	22 June 2020
		Brenda Maslen	31 March 2019
		Hazel Brand	31 March 2019
	2 (preference for 1 Staff & 1 Partner)	*Vacancy*	
		Clive Tattley (Partner)	8 January 2019

Other activities & roles

Committee / Activity / Role	**Number of Seats**	**Seat held by**	**Term of office end date**
Vice-Chair	1	Mike Addenbrooke	31 March 2019
Lead Governor	1	George Webb	31 March 2019
Audit & Non-clinical Risk Committee	2 observers	Bev Marshall	21 September 2018
		George Webb	31 March 2019
Quality and Effectiveness Committee	2 observers	**Peter Abell**	22 June 2020
		Clive Tattley	8 January 2019
Finance & Performance Committee	1 observer	**Bev Marshall**	21 September 2018
Charitable Funds Committee	1 observer	**Phil Beavers**	21 September 2018
Bone Health Group	1 Public	**Sharon Cook**	21 September 2018
Employer Based Excellence Awards Committee	2 Public	Anthony Fitzgerald	17 July 2019
		Shelley Brailsford	31 March 2019
End of Life Strategy Group	1 Public	*Vacancy*	
Fred & Ann Green Legacy Advisory Group	3 Public (preferably with links to MH)	**Phil Beavers**	21 September 2018
		David Cuckson	22 June 2020
		Maureen Young	31 March 2019
Health and Well Being Staff Group	1	**Lynn Goy**	16 October 2018

Infection, Prevention & Control committee	2	*Vacancy*	
		Susan Overend	31 March 2019
Information for Service Users group (ad hoc, not a regular meeting)	1	**Brenda Maslen**	31 March 2019
Nutrition Steering Group	1 Public	Susan Overend	31 March 2019
Organ Donation Committee	1	*Vacancy*	
PAS Project Board	1	Mike Addenbrooke	31 March 2019
Patient Safety Review Group	1 Public	Maureen Young	31 March 2019
Patient Experience & Engagement Committee	2 Public	Mike Addenbrooke	31 March 2019
		David Cuckson	22 June 2018
PLACE Team	8 Public	Susan Overend	31 March 2019
		David Cuckson	22 June 2020
		Andrina Hardcastle	22 June 2020
		Mark Bright	22 June 2020
		Lynne Logan	22 June 2020
		Peter Abell	22 June 2020
		Liz Staveley-Churton	22 June 2020
		Sharon Cook	21 September 2018
Smoking Cessation Group	1 Public	Susan Overend	31 March 2019
Strategic Safeguarding People Board	2 Public	**David Cuckson**	22 June 2020
		Vacancy	
Freedom to Speak Up Guardians	Staff governors and others	Lynn Goy Lorraine Robinson *Vacancy (staff)* Roy Underwood George Webb **Mike Addenbrooke**	
Workforce & Education Committee	1 Public	Shelley Brailsford	31 March 2019

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Meeting of the Agenda Planning Sub-committee of the Board of Governors held on 13 June 2017 at 3pm in the Boardroom, DRI

Present:	Suzy Brain England	Chair
	Mike Addenbrooke	Public Governor
	Susan Overend	Public Governor
	Clive Tattley	Partner Governor
	Maureen Young	Public Governor
	George Webb	Public Governor
In attendance:	Matthew Kane	Trust Board Secretary

Action

Apologies for absence

17/6/11 Apologies had been received from David Cuckson, Bev Marshall and Pat Ricketts.

Minutes of the meeting held on 13 June 2017

17/6/21 The minutes of the meeting held on 13 June were APPROVED as an accurate record.

Matters arising

17/6/31 There were no matters arising from the previous meeting.

Review of previous Board of Governors meeting

17/6/4 The Committee felt that the meeting on 27 April had gone well, given a sizeable turnout of public and governors from other trusts. The issues with sound had been resolved and while the size of the room comfortably accommodated those in attendance this may become more of an issue once new governors took their seats.

17/6/5 The update was NOTED.

Draft Board of Governors Agenda: 27 July 2017

The following reports were agreed for inclusion on the agenda:

17/6/6 Standing Items - The usual standing items, including Chair's Report and correspondence, and matters arising from Board of Directors minutes, were agreed.

17/6/7 Executive Reports

- Chief Executive's Report
- Finance Report
- Business Intelligence Report
- Strategic Direction

17/6/8 Governance & Statutory Compliance

- STP/WTP update
- Review of Governors' effectiveness
- Place Plan

17/6/9 Governor/Member matters

- Feedback from members
- Minutes of the sub-committees (combined into one item)
- Governor reports from committees and other activities (including Brenda Maslen and Roy Underwood's attendance at the Governor Focus conference)

17/6/10 For a future Governors' meeting it was agreed to bring something on the time taken for customers' calls to be answered. **MK**

17/6/11 The Committee raised the matter of staff apparently being quoted in third party material and were advised that the matter had been taken up with the Chief Executive. Governors felt that the Trust should more openly challenge false information circulating about its services.

17/6/12 The meeting on 27 July would be the first meeting involving the newly elected governors at the Trust and it was agreed to let the Vice Chair have further information about those who had been elected. It was important that existing governors set the standard of behaviour they wished to see in and outside meetings. **MK**

17/6/13 Some ideas for encouraging and assisting the new governors including buddying and one-to-ones were discussed. Some members of the committee expressed disappointment in the attendance of some governors at meetings and training and examples were provided. The Trust Board Secretary undertook to provide information, following the next Board of Governors' meeting, on the attendance of each Governor at Board of Governors' meetings. **MK**

Any Other Business

17/6/14 In response to a question from the Chair, Governors confirmed their preference to continue with the current pre-agenda meetings face-to-face.

17/6/15 Details of the upcoming Timeout were provided. The Chair undertook to attend meetings of the Health and Care of Adults and Health and Care of Young People in the near future.

Date & Time of Next Meeting

17/6/16 15 September 2017 at 10am at Doncaster Royal Infirmary.

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Communications, Engagement and Membership Sub-committee

Minutes of meeting held at 10 am on 22 June 2017
in the Members' Room, DRI

Present:	David Cuckson	Public Governor (Chair)
	Philip Beavers	Public Governor
	George Webb	Public Governor
In attendance:	Linda Challis	Chesterfield Royal Hospital (observing)
	Alan Craw	Chesterfield Royal Hospital (observing)
	Emma Shaheen	Head of Communications and Engagement
	Matthew Kane	Trust Board Secretary
	Alison Parker	Communications & Marketing Assistant

Action

Apologies for absence

17/6/1 There were no apologies presented to the meeting.

Minutes from meeting held on 7 February 2017

17/6/2 With the addition of George Webb's apologies, the minutes of the meeting held on 7 February 2017 were APPROVED as a correct record.

Matters arising from the minutes

17/6/3 Updates were given in respect of listed actions.

Communications and Engagement Update

17/6/4 The Sub-committee received an update in respect of recent communications and engagement activity:

- There had been a concerted effort to ensure staff were given accurate information in relation to Bassetlaw and Montagu following a number of rumours during recent election campaigns.
- Communications had worked alongside the Trust Board Secretary in promoting the Governor elections.
- The STAR awards would take place on 7 September and ideas for sponsorship and nominations of staff were sought.

- A 'bright ideas' and 'bugbears' postcard scheme as part of the strategic refresh had been launched and proven popular with staff.

- Work was taking place with the local press to ensure better take up of cancer appointments.

- The new website was demonstrated using the Wordpress system.

17/6/5 The presentation was NOTED.

Member Communications - Foundations for Health editorial panel

17/6/6 The August edition would include a feature on the new governors and Montagu Hospital as a centre of rehabilitation excellence. There was a broader discussion about the value of a printed copy. Details of exposure through social media versus readership of local newspapers were provided.

17/6/7 Proposals for the August issue of Foundations for Health were AGREED.

Feedback

17/6/8 The Committee reviewed the feedback from the Timeout that took place on 9 March 2017. The new approach was commended.

17/6/9 The Committee proposed that a buddying scheme for new governors be offered to assist them with hitting the ground running and it was proposed that this be offered. **MK**

17/6/10 The update was NOTED.

Membership Update

17/6/11 Current membership stood at 16,235 with Bassetlaw constituency having seen a rise from 2,566 to 2,898 since the end of March 2017.

17/6/12 The information was NOTED.

Review of Terms of Reference

17/6/13 The Committee's terms of reference were presented for discussion following amendments proposed at the last meeting. Suggested changes were shown as tracked.

17/6/14 In view of NHSI's reduced focus on increasing membership, the Committee felt it was more important to engage with patients and backed a governor's surgery similar to the one that took place in Bassetlaw.

17/6/15 The Committee felt that they needed to be more proactive than reactive in their approach to communications and engagement.

17/6/16 The terms of reference were RECOMMENDED to the Board of Governors for approval. **MK**

Any Other Business

17/6/17 At the end of the meeting the two observers gave their impressions of the meeting and these would be fed into the Governor Effectiveness Survey that would be reported to Board of Governors in due course.

Date of Next Meeting

17/6/18 Tuesday 3 October 2017 at 10am in the Blyth Room, Bassetlaw.

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Notes of the meeting of the Fred and Ann Green Legacy Advisory Group
Held on Friday 12 May 2017
in the Fred & Ann Green Boardroom, Montagu Hospital

Present:	Alan Armstrong	Non-executive Director (Chair)
	Peter Brindley	Co-opted member of the Group
	John Plant	Public Governor
	Pat Rickets	Public Governor
In Attendance:	Matthew Kane	Trust Board Secretary
	Jon Sargeant	Director of Finance
	Kate Sullivan	Corporate Secretariat Manager

ACTION

Apologies for absence

17/05/1 Apologies were received from, Andy Thomas, Maureen Young and Betty Willis.

Notes of the meeting held on 17 February 2017 and matters arising

17/05/2 The notes of the meeting held on 17th February 2017 were APPROVED as a correct record.

17/05/3 Matters Arising

17/05/4 17/02/30 - In response to a query from Pat Rickets, Andy Thomas had agreed to clarify whether there had been a duplication of the funding relating to overseas recruitment. Initial investigations did not point to duplication; the matter would be investigated further. **JS**

Developments at Montagu Hospital

17/05/5 Jon Sergeant provided an update on the Rehabilitation Centre. Work was ongoing with CCGs and the STP with regard to a process for potentially closing some beds and moving patients to the Rehab Centre but no number had been provided at this stage. The potential for stroke pathways to come through rehab were also being considered, these discussions were live and ongoing. The Trusts preference would be for all those pathways to be merged through the Montagu site.

17/05/6 An overview was provided of the role of CCGs and STPs in the decision-making processes with regard to pathways and how they were looking at the centralisation of specialist services. An overview of current and

planned stroke services and how MMH may fit in to that was also provided. It was noted that due the pending general election and period of Purdah, all decisions were currently on hold.

17/05/7 Alan Armstrong asked when a decision was expected and this was discussed. The Trust needed to be clear about its strategy and aspirations for all sites; AN update would be provided at the next meeting. **JS**

17/05/8 John Plant raised concerned about reputational risk to the Trust in the context of commissioner involvement in these matters where there might be a public perception that decisions relating to patient pathways were taken by the Trust. He provided an example of a patient that had paid to be treated privately for a procedure considered to be of limited clinical value for which commissioners did not provide funding; the patient had perceived this to be a decision taken by the Trust. This was discussed and Jon Sargent gave assurance that the Trust would have the opportunity to input in to the public documentation and was working closely with commissioners on this.

17/05/9 The update was noted.

Progress Report on Approved Schemes

17/05/10 The report was reviewed by exception;

17/05/11 **Hospital Shuttle** – The tendering process would be re-entered in to at the same time as the DRI and Park & Ride Shuttle Services were due for re-tender. This was being taken forward by the Executive Team. The DRI Park & Ride was discussed and in response to a query, Jon Sergeant advised that to address issues around lighting and security, options to re-locate the Park & Ride car park were being considered.

17/05/12 The matter of the Trust taking over the cost of the F&AG Shuttle Bus was discussed. It had been agreed that, once the Ophthalmology centre was fully up and running and generating a surplus for the Trust, the Trust would cover the costs Montagu Shuttle Service. Jon Sergeant advised that a review would be undertaken by the Trusts Auditors in May. The Group had previously asked what would be considered a 'Surplus' and this was discussed; it was agreed that Jon Sergeant would meet the committee to agree on this at a future date and that the outcome of the review would be presented at a future meeting. **JS/ALL** **JS**

17/05/13 John Plant reiterated concerns he had raised previously about waiting times for the new Ophthalmology Centre and he questioned whether the service had seen any improvement from the investment by the F&AG Legacy Fund. Jon Sergeant advised that there had been issues with waiting

times due to sickness of medical staff and this had resulted in a backlog; a recovery plan to improve this was sin place and was being monitored through Care Group accountability meetings.

17/05/14 **Legacy Project Manager** – The Trust recognised that Group had experienced a lack of continuity in terms of dedicated support since the previous role holder had left the Trust some time ago. Jon Sergeant would discuss this with Andy Sidney, the new Head of Financial Accounts, to ensure that a new permanent arrangement was in place form the next meeting. Andy Sidney would attend all future meetings. In response to concerns raised by John Plant about whether Andy would have the capacity to provide the Group with support, Jon Sergeant gave assurance that Andy had large team to assist him.

17/05/15 Jon Sergeant reported that as part of the review of governance processes the capital fund would be linked to charitable funds, this would enable the Trust to link issues such as charitable funds funded projects that resulted in on-costs for the Trust.

17/05/16 John Plant commented that he had received feedback from ward staff to say that only 40% of their departments charitable funds donations were available to them and that the Trust could use the rest as part of general Trust funds unless explicitly set out otherwise by the donator. Jon Sergeant provided clarity about different types of donations and funds and how they could be used by the Trust. There had been issues in the past with regard to accessing funds and it was recognised that there needed to be a clearer donation form and a policy for the Trust and this would be formalised. There was also the matter of Gift Aid donations and the Trust was taking advice on this.

17/05/17 Peter Brindley asked whether revenue from revenue generating schemes could be reimbursed back to charitable funds and this was discussed. Jon Sergeant advised that this went against the principals set out by the NHS Regulators and the Charities Commission, as the underlying principals were to encourage the spending of charitable funds not to invest them.

17/05/18 **Falls Prevention Practitioner** – It was clarified that the Falls Prevention Practitioner role had been mainstreamed.

17/05/19 **Satellite Radiotherapy** – It was confirmed that this was ongoing and Jon Sergeant provided an update matters relating to the project including:

- Discussions with Sheffield Teaching Hospitals (STH) and the STP with regard to technical issues and funding.
- Discussions with the Doncaster Cancer Detection Trust with regard to further fundraising for a scanner.

17/05/20 **Genesis System** – The system was being rolled out and interfaced with new ordering system. A plan was being developed to roll the system out to all theatres and all specialties to get better grip on stock control. Jon Sergeant commented that this had been helpful investment and he thanked the Group for their support.

17/05/21 **Endobronchial Ultrasound** – There had been no charge to Charitable funds at this stage as discussions with commissioners about payment for procedures were ongoing. Alan Armstrong raised concern about the length of time the funds had been available to the Trust and Jon Sergeant echoed this; this would be picked up as part of the overall tightening of procedures around all Charitable Funds.

17/05/22 **Film Array -** An update had been circulated outside of the meeting.

17/05/23 The update was NOTED.

Community Input – New Schemes / ideas/initiatives

17/05/24 An update on any matters arising from the Strategic Direction would be provided at future meetings. **JS**

17/05/25 The update was NOTED.

Summary of Fred & Ann Green Legacy Funded Schemes

17/05/26 No 45 – Overseas Recruitment – Check for duplication. **JS**

17/05/27 The report was Noted.

Current value of Funds

17/05/28 The report, which set out expenditure for the year, allocation of investment returns, unrealised investment gains and commitments, was reviewed.

17/02/18 It was noted that the Trust had used the same investments advisors for a number of years. The Trust was in the process of reviewing the investment policy and would consider tendering for investment advice services once that was complete. In future monthly charitable fund statements for all funds would be produced in the in same format.

17/02/19 The Summary of Balances report to 31st March 2017 was NOTED.

Appointment of Replacement Member of the Group

17/05/29 Matthew Kane updated the Group on the process for the appointment of a new member to the Group. He went on to explain the work being undertaken to review the Board Committee structure and he advised that the membership of the F&AG Advisory Group was being considered as part of those deliberations. These discussions would be concluded by the end of the month and an update would be provided at the next meeting. John Sargeant suggested that a member of the Charitable Funds Committee and a member of league of friends be considered as part of the membership and this was supported.

Any Other Business

17/02/20 Peter Brindley wished to donate to the Trust a photograph of Fred and Anne Green's son. This was discussed and the Group recommended that the picture be displayed in the Boardroom at Montague along with those of his parents. This would be taken forward. **KS**

17/02/21 Mexborough 1st Communication – It was reported that some leaflets of a political nature which had made some assertions about, amongst other things, the use of the F&AG Legacy Fund, had been circulated across the local community of Mexborough. The CE & Chair had been made aware of the matter and the CE had written to the author of the correspondence to rebut the assertions and seek assurance that they would assure the public of the accurate position. The communications team had published a myth buster and Q&A for staff and had published similar information on the Trust website for the public. The CE and Chair wanted to assured staff, patients and the public that Montagu Hospital remained at forefront of the Trusts Strategic Direction; one of the aims of the Trust was to for the Fred & Ann Green Rehabilitation Centre to become a centre of excellence.

17/02/22 The matter was discussed and it was clarified that the Trust's refreshed Strategic Direction was due to be presented to the Board of Directors at the July meeting.

Date and time of next meeting

17/02/23 18 August 2017 & 17 November 2017 at 10am at Montagu Hospital.

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Minutes of the Health and Care of Adults Sub-committee Meeting Held at 10am on 20 June 2017 in the Boardroom, Doncaster Royal Infirmary

Present:	Clive Tattley	Partner Governor (Chair)
	Mike Addenbrooke	Public Governor
	Brenda Maslen	Public Governor
In attendance:	Sarah Jones	Sheffield Children's Hospital (observing)
	Margaret Rotchwell	Chesterfield Royal Hospital (observing)
	Dr Lee Cutler	DCC Critical Care Nurse Consultant
	Sharron Nelson	Emergency General Manager
	Louise Povey	Head of Patient Safety and Experience
	Matthew Kane	Trust Board Secretary

Action

Apologies for absence

17/7/1 Apologies for absence were submitted by Hazel Brand.

Minutes of meeting held 14 March 2017

17/7/2 The minutes of the meeting held on 14 March 2017 were APPROVED as a correct record.

Matters Arising

17/7/3 None. **MK**

SY Ambulance Service

17/7/4 The Committee considered a presentation from Sharron Nelson, Emergency General Manager, on the Trust's work with Yorkshire Ambulance Service on handover.

17/7/5 The Committee was provided with details of the process and the steps that staff must take when receiving a patient. The Trust's figures were shared which compared favourably with other trusts in the area.

17/7/6 The current layout of the DRI handover area was discussed together with some of the reasons why it had not been redesigned up to now. Issues relating to ambulances waiting outside the hospital were also considered.

17/7/7 Key challenges included:

- Several ambulance arrivals at once (sometimes up to 10) in succession
- Recent restructure within YAS has meant little or no engagement from YAS
- ED Bassetlaw – EMAS' main provider / small ED compared to other ED's that EMAS work with so again very little engagement
- Getting the balance right of timely handover & ED performance targets

17/7/8 The update was NOTED.

Sepsis Update

17/7/9 The Committee received an update from Dr Lee Cutler, DCC Critical Care Nurse Consultant, in relation to sepsis management.

17/7/10 The Trust had always taken a 'prevention is better than cure' approach to sepsis given the seriousness of the condition. Approximately 44,000 people die of sepsis each year with 150,000 diagnosed. Whilst developed countries were better at managing the condition there were no magic drugs and critical care was often too late to be effective. Steroids had been used to treat the condition but there were sometimes complications in using them.

17/7/11 In basic terms, sepsis was the over-reaction of the immune system to bacteria. As the immune system became more aggressive in attacking the foreign bodies it was liable to collapse leading to multi-organ failure. The Committee was advised that delaying treatment of sepsis by just one hour led to a 7.6% higher mortality rate.

17/7/12 At risk groups included the very young, very old, pregnant women or those who had just given birth, those with low immunity and those with trauma, who had just had surgery or other invasive procedures.

17/7/13 Experts had seen a much improved survival rate since January 2013, from 78.1% then to 87.3% now. Much of this was due to better adherence to clinical procedures by medical professionals. A trial in March 2014 found that if procedures were followed survival rate leapt from 78.6% to 93.9%.

17/7/14 The update was noted.

Serious Incidents

17/7/15 Louise Povey was introduced as the new Head of Patient Safety and Experience who was responsible for 23 staff dealing with Complaints and PALS, Risk and Legal Services.

17/7/16 Details of current SIs were provided to the Committee. The importance of logging incidents and learning lessons was emphasised. Additional patient safety leads would be recruited shortly.

17/7/17 Details of the serious incident framework and never events were provided. There was a requirement to investigate all serious incidents within 60 days and scope them within 48 hours. An SI Panel met every Monday to review the cases.

17/7/18 All serious incidents that met the criteria would be investigated. It was reported that care groups would take greater ownership of the process in future. Training on carrying out investigations would be taking place soon along with Datix training. Governors highlighted current issues relating to incident reporting.

17/7/19 A new regular report called 'Risky Business' would set out lessons learned. In response to questions about pressure ulcers, the Committee was advised that, if significant, pressure ulcers could be recognised as an SI. There was some discussion regarding patient safety in tower blocks and the need to assure the public.

17/7/20 The update was NOTED.

Any Other Business

17/7/21 The Committee discussed the following issues in light of the presentations given:

- The need to avoid waiting ambulances outside of the hospital.
- The importance of cascading what governors felt was an incredibly insightful presentation on sepsis, the education of staff to recognise the signs of sepsis and the right to speak up where things were not right.

- Issues around patient perception of tower blocks.
- Was there a need to have a governor or NED involved in the SIs Panel?

17/7/22 Items for future meetings:

- Readiness for CQC
- Adult services – quality account
- Strategic direction
- Relationship with Parkhill Hospital

Date and Time of Next Meeting

17/7/23 10 am, Tuesday 10 October 2017, Blyth Room, Bassetlaw Hospital.

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Health and Care of Young People Sub-committee Meeting
held at 10 am on Tuesday 6 July 2017
in the Boardroom, DRI

Present:	Maureen Young	Public Governor (Chair)
	Mike Addenbrooke	Public Governor
	Eddie Dobbs	Public Governor
	Dev Das	Public Governor
	Susan Shaw	Partner Governor
In attendance:	Annette Laban	Sheffield Teaching Hospital (observing)
	Simon Stone	Mid Yorkshire Hospitals (observing)
	Glenis Bartle	Chesterfield Royal Hospital (observing)
	Chris Beattie	Head of Paediatric Nursing
	Jill Edwards	Play Team Leader
	Matthew Kane	Trust Board Secretary

Before the meeting, the Committee undertook a visit of the Paediatric ward at Bassetlaw Hospital.

Action

Welcome and apologies

21/07/1 There were no apologies.

Minutes of the previous meeting

21/07/2 Minutes of the meeting held on 21 March 2016 were APPROVED as an accurate record.

Matters arising

21/07/3 None.

Play Areas

21/07/4 The Committee received an update on the Trust's play areas from Chris Beattie, Head of Paediatric Nursing and Jill Edwards, Play Team Leader.

21/07/5 The Committee were advised of new play areas in Bassetlaw's outpatients and in the Eye Centre at DRI. Following receipt of some funding through charitable funds, both areas had been fully renovated.

21/07/6 Further to a question from Mike Addenbrooke, the Committee were advised that all electronic gadgets were PAT tested by the IT team. The Chair referred to a recent trip to a supermarket where play equipment had been fixed to a wall. It was felt that this may overcome some of the issues the Trust had encountered with its play areas.

21/07/7 The update was NOTED.

Poverty and Child Health – views from the frontline

21/07/8 The Committee considered a report from the Royal College of Paediatrics and Child Health into poverty and child health.

21/07/9 The report concluded that child poverty was worsening and called for urgent action to address some of its impacts. In particular the report cited poor housing, food insecurity and worry, stress, stigma and mental health as key factors in the exacerbation of child poverty.

21/07/10 Whilst commending the report and noting the findings, governors noted the limitations a hospital trust could have in impacting on child poverty, although health visiting did play its part.

21/07/12 The report was NOTED.

To consider items for future meetings

21/07/14 The Committee suggested items on the hospital's approach towards autistic children, paediatric services and the development of paediatric nurse practitioners be brought to the next meeting.

Any Other Business

21/07/15 There was some discussion about changes to tier two children surgery that may result in more pressure at DRI.

22/07/16 The Committee was further advised of a nursing university course being developed between the Trust and Sheffield Hallam University. Other members of the Committee reflected on the current pressures within the nursing sector generally.

Date and Time of Next Meeting

21/03/17 Tuesday, 17 October 2017

10.00am, Blyth Room, Bassetlaw

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Title	**Communications, Engagement and Membership Terms of Reference**		
Report to	**Board of Governors**	**Date**	**27 July 2017**
Author	**Matthew Kane, Trust Board Secretary**		
Purpose			Tick one as appropriate
	Decision		x
	Assurance		
	Information		

Executive summary containing key messages and issues
The Communications, Engagement and Membership Committee have revised their terms of reference in light of discussions amongst governors about the changing focus of Foundation Trust membership. The revised terms of reference are attached for approval.
Key questions posed by the report
N/A
How this report contributes to the delivery of the strategic objectives
N/A
How this report impacts on current risks or highlights new risks
N/A
Recommendation(s) and next steps
Governors are asked to APPROVE the attached terms of reference.

Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

Communications, Engagement and Membership Sub-Committee of the Board of Governors

Terms of Reference

1 The Committee

1.1 The Communications, Engagement and Membership Sub-committee is a sub-committee of the Board of Governors of Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust.

1.2 The Communications, Engagement and Membership Sub-committee in its workings will be required to adhere to the Constitution of the Doncaster and Bassetlaw Hospitals NHS Foundation Trust and the Terms of Authorisation issued by NHSI, the Independent Regulator.

1.3 The Board of Governors in establishing the Communications, Engagement and Membership Sub-committee does not delegate any of its authority or powers to the sub-committee. The Communication, Engagement and Membership Sub-committee is established to advise and assist the Board of Governors in carrying out its functions.

1.4 As a Sub-committee of the Board of Governors, the Standing Orders of the Board of Governors shall apply to the working of the Communications, Engagement and Membership Sub-committee.

2 Frequency

2.1 The committee will meet at least four? times a year.

3 Notice of Meetings

3.1 The Secretary shall give at least 21 days written notice of the date and place of every meeting to all members of the committee.

4 Membership and Voting

4.1 Membership of the committee shall be determined through the submission of nominations followed, if necessary, by a ballot of the Board of Governors.

4.2 The committee will have the following membership:

- 5 Public Governors, of whom at least one should be from the Doncaster Constituency and at least one from the Bassetlaw Constituency
- 2 other Governors, of whom it is desirable that there be one Partner Governor and one Staff Governor

In attendance:

- Trust Board Secretary
- Head of Communications & Engagement

4.3 The Chair of the committee will be elected from within the membership of the sub-committee with each Governor having one vote.

4.4 The term of office of the Chair is three years, subject to annual review.

4.5 On cessation of the incumbent Chair's term of office, a new Chair shall be elected in accordance with paragraph 4.3. The incumbent Chair shall be eligible to stand for re-election.

4.6 Neither the Trust Board Secretary nor Head of Communications & Marketing may vote or hold the position of Chair of the committee.

4.7 The committee may seek advice or assistance from an external person with relevant knowledge and experience. Such a person shall act only as an advisor with no voting rights or other status.

5 Additional Members

5.1 The committee shall have the freedom to invite additional members, over and above the membership list above, and seek ratification of the amendment to its terms of reference at the next general meeting of the Board of Governors.

6 Removal of Members

6.1 A Governor's membership of the committee may be terminated by not less than 75% of the Governors present and voting at a meeting of the committee if they have failed to attend two consecutive meetings of the committee unless the Chair is satisfied that:

6.1.1 the absence was due to reasonable cause; and

6.1.2 attendance shall be resumed within a period the Chair considers reasonable.

6.2 Any Governor who is removed from the committee shall have the opportunity to appeal to the Board of Governors to have this decision reversed.

7 Quorum

7.1 The committee will be deemed quorate if at least three of the Governors nominated to sit on the committee are present.

8 Duties

8.1 The committee will undertake the following duties:

Communications

8.1.1 Work to improve communication with members, patients and the wider public by overseeing the planning of Membership communications and determining the content and focus of those communications.

8.1.2 Encourage Governors, patients and the wider public to make better use of social media in their interactions with the Trust.

8.1.3 Have oversight of the communications with members, patients and the wider public, receiving regular updates on current and emerging activities.

Engagement

8.1.4 Encourage Governors to involve, listen and feedback to members, patients and the wider public on the work of the Board of Governors and the activities, services and future plans of the Trust through a variety of public engagement activities.

8.1.5 Work to positively engage members, patients and the wider public by:

- Putting in place opportunities for Governors to meet and speak with members and encouraging governors to attend.
- Seeking members' views on forward planning in relation to the strategic direction of the trust.
- Enabling people to meet Governors.
- Seeking the views of members to ensure that Governors represent the interests of each of their given constituencies.

8.1.6 Seek engagement with a variety of membership groups including groups currently underrepresented on the Trust's membership.

Membership

8.1.7 Monitor the implementation of the Trust's Membership Strategy.

8.1.8 Advise on developing and increasing the membership of Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust.

8.1.9 Play an active role in the recruitment of new Governors including monitoring plans for Governor elections, induction and succession planning.

8.1.10 Seek to encourage patients and the wider public, and especially those from diverse backgrounds, to become members and stand for governor roles.

8.2 The committee will not have any responsibility for the operational day to day management of any of the functions or services provided within the Trust.

9 Reporting arrangements

9.1 The Chair of the committee is responsible for reporting all activities of the committee to the Board of Governors.

9.2 The minutes of the committee shall be formally recorded by the Trust Board Secretary and submitted to the Board of Governors quarterly. The Chair of the committee shall draw to the attention of the Board of Governors any issues that require disclosure or action.

10 Amendments

10.1 These Terms of Reference may be subject to review and alteration. Any amendment or change of membership on the Committee must be approved by a properly constituted meeting of the Board of Governors.

11 Equality and Diversity

Trusts have a legal duty under the Equality Act (2010) and the Public Sector Equality Duty (2011) to eliminate inequality and discrimination in relation to the nine recognised groups with protected characteristics. These include age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief (including lack of belief), sex and sexual orientation.
In relation to all of our communications and engagement activities, we aim to:

- Reach a representative cross section of our population when engaging the public, including people with a disability, minority groups and those not traditionally engaged with NHS services
- Hold our meetings and events in accessible venues that comply with the requirements of the Equality Act 2010, particularly with respect to disability access
- Consider provision of materials in alternative formats where a specific need is identified
- Test the accessibility of our materials through engagement with groups who share protected characteristics

In paying due regard to equality under our public sector duties, we will ensure that feedback from people who share protected characteristics, or those representing them, will form part of the decision making and equality analysis process, which is embedded in the governance of our organisation.

NOTES FROM GOVERNOR FOCUS CONFERENCE 2017

An interesting and informative day which covered a number of topics – but for which these notes will focus upon the presentations around STP's (and for plans now read partnerships) and the Governor's role within that.

A great opportunity from which I felt I had learned a lot, not least of all that STP's are not just another change in the NHS which has a history of frequent changes without sequential consolidation, but that, without them – or a huge injection of money (unlikely) – the NHS will cease to exist as we know it in the reasonably near future..

Chris Hobson CEO NHS Providers

- Current situation in NHS unsustainable
- Funding is going down but activity needs to go up
- Bed occupancy (some Trusts 96%) unsustainable and unsafe
- Care fragmented and medicalised

Changes needed

- Combined care with the focus on health and maintaining it
- Workforce planning (currently staff 'carrying' NHS through their commitment)
- Barriers to change to overcome; cultural, financial, historical
- Change beginning to happen – Vanguard hospitals

Sustainability and Transformation Partnerships

- Not all areas need to move at same pace (may be slowed by General Election)
- Key Challenges focus around:
  - Clarity of purpose
  - Meaningful engagement
  - Ambitious timeline (see 5yr Forward View on NHS website)

STP's are here to stay!!

Governor's Role

- Statutory duties remain
- Important part of role engaging with the public on changes

Amber Davenport Head of Policy NHS Providers

Amber spoke about the link moving on from STPs to ACO's (accountable care organisations, which are systems in which NHS Organisations (both commissioners and providers take on clear collective responsibilities for resources and population health. This is a vision for the future.

She had this to say about the role of the Governor

- Represent the community
- Hold Board's to account
- Formal approval on specific service proposals and plans
- Play a role in public engagement
- Promote patient participation and co-production of plans.

She identified some good points in the SPT process:-

- Few could object to place-based planning, conversations & coordination
- Started conversations never had before in the NHS
- Started conversations with local authorities for the first time in some areas
- Provided the place we needed for service change
- Starting to tackle long-standing problems

Four facts under current law:

Trusts and CCG's have statutory powers – STP's don't.
You can't take away decision-making rights from trusts and CCG's.
Trusts and CCG's cannot hand their decision making powers to a third party.
So –
STP's can only be a shared decision making forum, they cannot make decisions by themselves.

Some final thoughts borrowed from Chris Hopson

Governor role in a cold climate

Getting the governor support/challenge balance right
Help engage the public in transforming care, while providing reassurance
Assure yourself that the Board has right balance between operational and strategic
Running harder with existing model vs heading for a new one
Being cognisant of balance between institutional versus system focus for Boards
Maintaining positivity and optimism in face of growing challenge – continue to act as an advocate.