Meeting of the Board of Governors
of
Doncaster and Bassetlaw Hospitals NHS Foundation Trust ('the Trust')
on
Thursday 30 June 2016 at 6.00 pm
at
Lecture Theatre, Postgraduate Centre, Bassetlaw Hospital

AGENDA

No	Item	Action	Enclosures
1.	**Welcome and Apologies**	*Note*	(Verbal)
2.	**Declaration of Governors' Interests** Maria Dixon, Head of Corporate Affairs	*Note*	Enclosure A
3.	**Minutes of the meeting held on 19 April 2016**	*Approve*	Enclosure B
4.	**Matters Arising from the Minutes**	*Note*	Enclosure C
5.	**Chair's Report and Correspondence** Chris Scholey, Chair	*Note*	Enclosure D
EXECUTIVE REPORTS			
6.	**Chief Executive's Report** • **Corporate Objectives 2016/17** Mike Pinkerton, Chief Executive	*Note*	Enclosure E
7.	**Matters Arising from Board of Directors minutes** All Governors	*To take questions*	Enclosure F
8.	**Finance Report** Jeremy Cook, Interim Director of Finance	*Discuss*	Enclosure G (to follow)
9.	**Business Intelligence Report** Richard Parker, Director of Nursing, Midwifery & Quality David Purdue, Chief Operating Officer Sewa Singh, Medical Director	*To take questions*	Enclosure H
10.	**Strategy & Improvement Report** Dawn Jarvis, Director of Strategy & Improvement	*Discuss*	Enclosure I
11.	**People & OD Quarterly Report** Karen Barnard , Director of People & Organisational Development	*To take questions*	Enclosure J
GOVERNANCE			
12.	**Chair Appointment** Geraldine Broderick, Senior Independent Director	*Approve*	Enclosure K (to follow)

13.	**External Auditors** Jeremy Cook, Interim Director of Finance	*Approve*	Enclosure L
14.	**NED Objectives 2016/17** Chris Scholey, Chair	*Approve*	Enclosure M
SUB-COMMITTEES OF THE BOARD OF GOVERNORS			
15.	**Minutes of the Agenda Planning meeting held on 19 May 2016**	*Note*	Enclosure N
16.	**Minutes of the Communications, Engagement & Membership meeting held on 7 June 2016**	*Note*	Enclosure O
MEMBERSHIP			
17.	**Feedback from members** All governors	*Note*	(Verbal)
GOVERNOR REPORTS			
18.	**Governor reports from committees and other activities** All governors	*Note*	(Verbal)
INFORMATION ITEMS			
19.	**Any Other Business** **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.*** Chris Scholey, Chairman	*Note*	(Verbal)
20.	**Date of Next Meeting :** Date: 21 September 2016 Time: 6:30 pm Venue: Ivanhoe Centre, Gardens Lane, Conisbrough	*Note*	(Verbal)

Doncaster and Bassetlaw Hospitals NHS
NHS Foundation Trust

Register of Governors' Interests as at 21 June 2016

The current details of Governors' Interests held by the Trust are as follows:

Ruth Allarton, Partner Governor
School Governor, Tuxford Academy
Parish Councillor, Weston Parish

Dr Utpal Barua, Public Governor
Retired member, British Medical Association
Senior medical member, Court and Tribunal Services, Leeds

Philip Beavers, Public Governor
Judge, The Single Family Court
Magistrate (and previously Chairman), Doncaster Bench
Independent Person under the Localism Act, Doncaster MBC; Rotherham MBC; & North Yorkshire Fire and Rescue Service

Shelley Brailsford, Public Governor
Independent Custody Visitor, South Yorkshire Police and Crime Commissioner
Volunteer, British Red Cross Charity Shop, Doncaster

Hazel Brand, Public Governor
Member, Bassetlaw District Council

David Cuckson, Public Governor
Justice of the Peace, Scunthorpe
Member, Worksop 41 Club

Vivek Desai, Staff Governor
DBH Consultant Representative, BMA Trent Regional Consultant Committee
Advisor and Negotiator, DBH Local Negotiating Committee

Nicola Hogarth, Public Governor
Employee, BT Health (BT PLC)

Peter Husselbee, Public Governor
School Governor, Redlands School, Worksop
Member, Rotary Club of Worksop
Member, Worksop 41 Club

Pat Knight, Partner Governor
Member, Labour Party
Chair, Doncaster Health and Wellbeing Board
DMBC Cabinet Member for DMBC Public Health and Wellbeing
Member, DN7 Community Food Bank
Trustee, East Doncaster Development Trust

Bev Marshall, Public Governor
Member, Labour Party
Governor, Hall Cross Academy
Member, Yorkshire Ambulance Service NHS Trust

Brenda Maslen, Public Governor
Expert by Experience, CQC (acting as part of CQC inspection teams)

Jackie Pederson, Partner Governor
Employee and Representative of NHS Doncaster Clinical Commissioning Group

Rupert Suckling, Partner Governor
Director of Public Health, DMBC
Non-executive Director, Doncaster Children's Services Trust
Trustee, Club Doncaster Foundation

Clive Tattley, Partner Governor
Member, Worksop Rotary Club

The following have no relevant interests to declare:
Mike Addenbrooke, Public Governor
Oliver Bandmann, Partner Governor
Dev Das, Public Governor
Eddie Dobbs, Public Governor
Lynn Goy, Staff Governor
Shahida Khalele, Staff Governor
Susan Overend, Public Governor
John Plant, Public Governor
Patricia Ricketts, Public Governor
Lorraine Robinson, Staff Governor
Denise Strydom, Public Governor
Roy Underwood, Staff Governor
George Webb, Public Governor
Maureen Young, Public Governor

The following have not yet declared their interests:
Dennis Benfold, Public Governor
Lisa Bromley, Partner Governor
Ainsley MacDonnell, Partner Governor
Susan Shaw, Partner Governor
Andrew Swift, Staff Governor

Governors are requested to note the above and to declare any amendments as appropriate in order to keep the register up to date.

Maria Dixon
Head of Corporate Affairs

Minutes of the meeting of the Board of Governors held on
Tuesday 19 April 22016
in the Lecture Theatre, Education Centre, Doncaster Royal Infirmary

	Present:	Apologies:
Chair	Chris Scholey	
Public Governors	Mike Addenbrooke	Dennis Benfold
	Utpal Barua	David Cuckson
	Philip Beavers	Dev Das
	Shelly Brailsford	Susan Overend
	Hazel Brand	Maureen Young
	Eddie Dobbs	
	Nicola Hogarth	
	Peter Husselbee	
	Bev Marshall	
	Brenda Maslen	
	John Plant	
	Patricia Ricketts	
	Denise Strydom	
	George Webb	
Staff Governors	Vivek Desai	Shahida Khalele
	Lynn Goy	
	Lorraine Robinson	
	Andrew Swift	
	Roy Underwood	
Partner Governors	Cllr Pat Knight	Ruth Allarton
	Susan Shaw	Oliver Bandmann
	Dr Rupert Suckling	Lisa Bromley
	Clive Tattley	Ainsley MacDonnell
		Jackie Pederson

In Attendance:	Emma Bodley	Head of Communications & Engagement
	Jeremy Cook	Interim Director of Finance
	David Crowe	Non-executive Director
	Maria Dixon	Head of Corporate Affairs
	Dawn Jarvis	Director of Strategy & Improvement
	Alison Luscombe	Foundation Trust Office Coordinator
	Martin McAreavey	Non-executive Director
	John Parker	Non-executive Director
	Richard Parker	Director of Nursing, Midwifery and Quality
	Mike Pinkerton	Chief Executive
	David Purdue	Chief Operating Officer
	Willy Pillay	Care Group Director
	Kate Sullivan	Trust Minute Secretary
Apologies:	Alan Armstrong	Non-executive Director

Geraldine Broderick	Non-executive Director
Philippe Serna	Non-executive Director
Sewa Singh	Medical Director

Public: 4 members of the public were in attendance

Action

Welcome and apologies

G/16/04/1 Chris Scholey welcomed those present to the meeting, including Shelly Brailsford and Brenda Maslen who were attending their first meeting. Apologies as recorded above were noted.

Declaration of governors' interests

G/16/04/2 Eddie Dobbs reported that the interests he had previously declared no longer applied, and should be removed from the register. **MD**

Minutes of the meeting held on 19 January 2016

G/16/04/3 The minutes of the meeting held on 19 January 2016 were APPROVED as a correct record of the meeting subject to following amendments:

G/16/04/4 G/16/01/9 – "reduction" to be replaced with "increase".

G/16/04/5 G/16/01/23 – "the number" to be amended to "the lowest number".

G/16/04/6 G/16/01/39 – "signed off" to be amended to "quality impact assessed".

G/16/04/7 G/16/01/41 – "He commented" to be amended to "He considered".

Matters arising and action notes

G/16/04/8 Actions from the previous meetings were reviewed and updated. No further matters arising were raised.

Chair's report and correspondence

Chris Scholey reported the following:

G/16/04/9 NHS Improvement (NHSI) – Chris Scholey and Mike Pinkerton had recently met with NHSI and it had been a very positive meeting. NHSI had also met with a number of governors on the same day; Chris Scholey thanked them for their attendance.

G/16/04/10 Financial position – The forecast for 2016/17 had improved as the run rate had reduced. The financial position was moving in the right direction and this was encouraging.

G/16/04/11 Board Advisor – George Webb, Bev Marshall and Non-executive Directors had met with Chris Mellor, Board Advisor, to discuss his role in the Trust and his previous roles in other organisations. It had been a good meeting and all parties had endorsed Chris's role within the Trust.

Chris Mellor would provide a monthly report to the Board of Governors and he would attend the Trust 2 days a week.

G/16/04/12 Governor Timeout Session – The recent timeout had been a good session and there had been good discussion. The timeout had covered 2016/17 planning; External Audit, led by Philippe Serna; CIP; and Turnaround. The next timeout would be held on 10 June when the external auditors would be attending.

G/16/04/13 Member Communications – As a cost saving measure there would be one hard copy of Foundations for Health per year mailed out to members in future. Members had been asked for their email addresses to enable the Trust to send them an electronic version, and there had been a positive response to this.

G/16/04/14 Trust Board Secretary – Maria Dixon would be leaving the Trust in July. An advert for Maria's replacement was out and interviews would take place in due course.

The Chair's Report was NOTED.

Chief Executive's Report

G/16/04/15 Mike Pinkerton presented an overview of the report, which included a detailed executive summary reflecting on the events surrounding the financial misreporting, the resulting licence breach and consequences as the Trust moved into turnaround.

G/16/04/16 The Trust now had a clear and achievable plan for 2016/17, which had been shared with Monitor, partners, governors and staff. The 2017/18 and five year plans would need to be considered in detail during the coming year.

G/16/04/17 Finance was only one of the priorities for delivery, with quality also a key focus. Many of the measures the Trust would take to improve efficiency would also positively impact on quality and patient experience. It was noted that all turnaround decisions would be quality impact assessed.

The Chief Executive's Report was NOTED.

Matters arising from the Board of Directors minutes

G/16/04/18 No matters were raised. The minutes of the Board of Directors meetings held on 22 December 2015, 26 January 2016 and 22 February 2016 were NOTED.

Finance Report

G/16/04/19 Jeremy Cook presented the month 11 financial performance report and executive summary.

G/16/04/20 Prior year accounts – 2014/15 – It was noted that there was a risk

relating to the prior year accounts. The accounts were to be revised and re-stated and a re-audit of the accounts by the external auditors had commenced in April.

G/16/04/21 Financial performance - £31.2m deficit at month 11 (£30.3m behind plan). The run rate had improved, and because of this the forecast had improved by £2m from £38.4m to £36.4m.

G/16/04/22 CIP – There had been a slight improvement but the continued under-delivery of CIP was a major contributing factor to under-performance against the 2014/15 and 2015/16 plans.

G/16/04/23 Creditor days – This continued to reduce.

G/16/04/24 It was noted that the report was very detailed. Going forwards, Jeremy Cook had undertaken to provide a simplified report in a new format to the Board of Directors and Board of Governors from Month 2 2016/17, with a more detailed report going to the Financial Oversight Committee. A governor observer attended the Financial Oversight committee, and would therefore receive the more detailed report. **JC**

G/16/04/25 Charitable Funds - Pat Ricketts noted that the submission of the Trust's Charitable Funds Accounts to the Charitable Funds Commission was overdue and she asked for an update on this. Jeremy Cook advised that the Charitable Funds accounts were with external auditors; he gave assurance that they would be submitted shortly.

G/16/04/26 Care Group performance – George Webb noted that all Care Groups were over budget and he queried how, on this basis, they were to make savings. This was discussed and Jeremy Cook stated that it had been acknowledged that the 2015/16 budgets had been unrealistic. All budgets for 2016/17 would be rebased using the outturn position for months 10 to 12. This meant any historical deficits would be wiped clean. The same applied to historical CIP budgets, in that they had not been achievable.

G/16/04/27 George Webb raised concern that the Trust was unlikely to ever achieve a surplus under the current circumstances. During further discussion George Webb, Hazel Brand and others commented that if funding for acute trusts were not increased in future, this would impact on the Trust's ability to make capital investment and maintain infrastructure. Ultimately this would impact on patient care. This matter was discussed at length.

G/16/04/28 Mike Pinkerton provided an update on the 5 year plan in terms of the move to look at place based care rather than organisation based services. Jeremy Cook advised that the Trust was looking at all areas of potential income. It was also noted that there was a significant back-log of maintenance work and this was being assessed.

G/16/04/29 John Parker undertook to take the concerns expressed through the **JP**

Financial Oversight Committee to seek further assurance.

G/16/04/30 Chris Scholey stated that in the longer term it was essential that the Trust was able to invest in capital in order to sustain services.

G/16/04/31 NHSLA Claims – In response to concerns raised by Dr Utpal Barua, Jeremy Cook advised that although the Trust's CNST premium had increased by 9.8% on the previous year, the national average increase was 17%. Whilst recognising that there had been an increase, there had been a comparative reduction in relation to the rest of the NHS.

The Finance Report was NOTED.

Business Intelligence Report

G/16/04/32 David Purdue, and Richard Parker presented the report and drew attention to the following:

G/16/04/33 Cancer – 62 day pathways had been failed in January due to continued capacity and pathway issues primarily with Urology. David Purdue gave an overview of the issues.

G/16/04/34 ED 4hr Access – The Emergency Department had been under pressure due to agency caps, with which the Trust had been compliant. Although the target had been failed it continued to be in the upper quartile of best performing trusts nationally.

G/16/04/35 Ambulance Handover Times – Joint targets had been set for YAS and EMAS. There had been a dip in performance due to data quality issues caused by the EMAS ceasing to use the electronic handover system.

G/16/04/36 Bev Marshall asked whether there were any underlying issues and asked for assurance that the fall in performance was purely an issue of recording rather than actual delays, and this was discussed. David Purdue advised that there were some issues. There had been an increase in acuity of patients and a rise in the number of admissions and this had resulted in an increase in handover times. However, he gave assurance that the key reason for the rise was recording issues.

G/16/04/37 CaMIS – In response to a query from Susan Shaw about whether previously reported issues had been resolved, David Purdue advised that CaMIS was now working well across the board and that the majority of issues had been resolved. In response to further queries, David Purdue advised that there would be a post-implementation review of CaMIS later in the year.

G/16/04/38 Quality – There had been significant improvements on the previous year's performance. C.diff cases had reduced by 27% compared to the previous year. There had been a 49.5% reduction in HAPUs and the previous year's falls performance had been equalled with 12 cases despite a rise in admissions. This was commended.

G/16/04/39 Pat Ricketts commended the falls performance and the work of the falls team. She noted that the Fred and Ann Green Legacy had supported the funding of a falls practitioner and she expressed concern about the future of this role. Richard Parker advised that all roles funded through charitable funds were under review, as they needed to be considered on a more commercial basis. The work of Advance Nurse Specialists was being standardised and the falls practitioner role fell in to this category.

G/16/04/40 Never Event – Richard Parker provided an overview of a case relating to a retained swab.

G/16/04/41 HSMR – The rolling 12-month HSMR to December 2015 stood at 95.3. The unvalidated HSMR for the month of January was below the expected range.

The Business Intelligence Report was NOTED.

Q3 People and Organisational Development Report

G/16/04/42 Dawn Jarvis presented the report, noting that it had been a good year overall. She highlighted the following:

G/16/04/43 Appraisals – Appraisal rates had risen to 86%, a significant increase on the 27% reported in early 2014/15. There had been a positive response to work to support managers. Tools were now in place to help managers achieve good quality appraisals and work in this area would continue.

G/16/04/44 Staff survey and engagement – Overall, the results had been good in the context of the challenges faced by the Trust in the previous 6 months. There had been an improvement in the annual staff engagement score and response rates.

G/16/04/45 Absence & Wellbeing – Sickness absence had been £3.89%. There had been a slight rise and this was above the Trusts internal target of 3.5%.

G/16/04/46 Casework – There had been continued steady progress in addressing capability issues.

G/16/04/47 In response to concerns raised by Peter Husselbee, Dawn Jarvis gave assurance that staff nearing retirement would not be discriminated against in terms of their age in the context of applications for the Mutually Agreed Resignation Scheme (MARS).

G/16/04/48 Peter Husselbee asked what staff morale was like generally, and this was discussed. The organisation had been through one of its worst times but it was noted that there had been no marked increase in staff turnover and there had been no downturn in people applying for positions in the Trust.

G/16/04/49 Hazel Brand reported that during two recent ward visits at Bassetlaw

staff had expressed their disappointment regarding the misreporting of the financial position and the impact this was having on the Trust. However, they had been focussed on providing the best care possible to patients and she commended this. Mike Pinkerton echoed this.

G/16/04/50 Staff Survey – In light of some of the staff survey results for the Children and Families Care Group, Clive Tattley raised concern regarding staff confidence in the whistleblowing policy and how they might be treated for raising concerns. This was discussed. The Board of Directors would be reviewing the staff survey results in depth and plans would be put in place regarding any areas of concern for each Care Group and directorate. It was noted that the CQC had reported that the Trust was good in terms of openness and staff feeling able to raise concerns.

G/16/04/51 It was noted that at the time of the staff survey there had been some issues within the Children and Families Care Group relating to the outcome of a coroner's report, and Richard Parker gave an overview of the issues. It was believed that this may have influenced staff responses at the time.

G/16/04/52 It was noted that Richard Parker had met with Lynn Goy several times to discuss whistleblowing in the Trust. It was felt that not all groups of staff understood how to escalate their concerns and work to address this would be taken forward.

G/16/04/53 It was noted that Lyn Goy had discussed whistleblowing and the role of the Freedom to Speak Up Guardian with a number of governors prior to the meeting and it was agreed to circulate the slides from this. **LG**

G/16/04/54 Rewarding Staff - Roy Underwood asked whether the Trust would continue to ensure staff achievements were acknowledged. Mike Pinkerton agreed this was very important and stated that the Trust would continue to acknowledge staff achievements through, amongst other things, the DBH Star and annual staff awards.

The Q3 People & Organisational Development Report was NOTED.

Annual Plan Update

G/16/04/55 Jeremy Cook delivered a presentation on the 2016/17 annual plan. It was noted that the plan had been submitted to NHSI.

G/16/04/56 An overview of the following was provided:

- Forecast outturn
- Prior year adjustments
- Planning assumptions
- NHS Litigation Authority
- Contract negotiations (CCGs and specialist commissioning)
- 2016/17 plan
- Bridge analysis
- Budget setting, including cost pressures

- CIP - risk analysis and phasing
- Sensitivity analysis
- Capital plan

G/16/04/57 In response to a query from Pat Ricketts about how the DRI ophthalmology development was to be funded, Jeremy Cook confirmed that this would be funded through a combination of sources including the Fred & Ann Green Legacy.

G/16/04/58 Pat Ricketts and John Plant queried advice that had previously been received to the effect that a share of the surplus generated from ophthalmology development could not be used to repay Fred and Ann Green Legacy funds as this would be ultra vires. Jeremy Cook undertook to ensure legal advice was sought regarding this **JC**

The Annual Plan Update was NOTED.

Strategy & Improvement Report

G/16/04/59 Dawn Jarvis presented the report, which provided an overview of the work of the Strategy & Improvement Team, readiness for turnaround, planning context, the cost improvement programme, grip and control, future plans, the QIA process and the financial accountability structure.

G/16/04/60 In discussing governance, Dawn Jarvis drew attention to the matrix approach, which had been approved by NHSI, and gave examples of work being undertaken.

G/16/04/61 The Strategy and Improvement team was maintaining a spreadsheet supporting the turnaround workstreams, and she offered to share this with governors if they wished.

G/16/04/62 An overview of the accountability process was provided. Accountability meetings were held every Wednesday, with grip and control meetings every 4 weeks. As part of the grip and control process, Care Groups and directorates were taken through budgets line by line.

G/16/04/63 Rupert Sucking endorsed the report and approach.

G/16/04/64 The Strategy & Improvement Report was DISCUSSED and NOTED.

Vice Chair and Lead Governor Appointments

G/16/04/65 Chris Scholey presented the paper, reporting that there were two nominations for each of the Lead Governor and Vice-Chair posts. It was agreed for a paper ballot to be conducted during the meeting for each post.

G/16/04/66 The outcome of the ballot was as follows, and the appointments APPROVED accordingly:

- Vice Chair – Mike Addenbrooke

- Lead Governor – George Webb

Agenda Planning Group minutes

G/16/04/67 The minutes of the Agenda Planning Meeting held on 4 March 2016 were NOTED.

Appointments & Remuneration Committee

G/16/04/68 The minutes of the Appointments & Remuneration Committee meeting held on 14 March 2016 were NOTED.

Communications, Engagement & Membership

G/16/04/69 The minutes of the Communications, Engagement & Membership Committee meeting held on 9 February 2016 were NOTED.

Health and Care of Adults Committee minutes

G/16/04/70 The minutes of the Health and Care of Adults Committee meeting held on 8 March 2016 were NOTED.

Health and Care of Young People Committee minutes

G/16/04/71 The minutes of the Health and Care of Young People Committee meeting held on 5 April 2016 were NOTED.

Feedback from members

G/16/04/72 iHospital Scanners - Mike Addenbrooke raised concern about the purchase of document scanners that were now not to be used as part of the iHospital Programme. He asked how much the scanners had cost and this was discussed.

G/16/04/73 David Purdue advised that the scanners were not to be used as originally intended and that following a review of the iHospital Programme it had been determined that they were not suitable. The scanners had cost in the region of £250k and the Trust was making enquiries with regard to returning them. David Purdue undertook to provide further information to governors outside of the meeting. **DP**

Governor reports

G/16/04/74 Financial Oversight Committee – Bev Marshall reported that he had attended all meetings of the Financial Oversight Committee and provided an overview of his role on the committee. It was noted that the committee had become a permanent sub-committee of the Board of Directors in February 2016.

G/16/04/75 Bev Marshall reported that he had taken confidence from the committee that the financial reporting of the Trust could now be relied upon as accurate and that the 116 recommendations form the KPMG report were being taken forward. The key task of the committee now

was to ensure Turnaround and delivery of CIP.

Any other business

G/16/04/76 None

Member questions

G/16/04/77 Mr Sprakes expressed concern regarding the process for obtaining consent from patients for procedures, stating that a form he had previously signed had been lost which had resulted in him being asked to sign another one. This was discussed and Richard Parker advised that best practice had been followed as it was essential that clinicians ensured that patients had consented to any procedures performed.

G/16/04/78 Mr Sprakes asked whether the misreporting of the Trust's financial position went back further than 2 years. Chris Scholey advised that following the independent investigation by KPMG, this was not believed to be the case.

Date and time of the next meeting:

G/16/04/79 Date: Tuesday, 30 June 2016
Time: 6pm
Location: Lecture Theatre, Postgrad Centre, Bassetlaw Hospital

Doncaster and Bassetlaw Hospitals NHS
NHS Foundation Trust

Action Notes

Meeting: Board of Governors

Date of meeting: 19 April 2016

Location: Doncaster Royal Infirmary

No.	Minute No	Action	Responsibility	Target Date
1.	**G/15/06/12**	National policy agenda update at future timeout session.	**MP**	**Timeout June 2016**
2.	**G/15/09/34**	BIR / RTT reporting - Consider including the number of patients who had not been seen within the target times alongside the percentages.	**DP**	
3.	**G/16/01/44 G/16/04/24**	Provide explanatory notes to go with balance sheets in finance reports. Finance Report to be simplified and updated in line with best practice.	**JC**	**June 2016 onwards**
4.	**G/16/01/67**	Consider reporting outcomes of Health Education England Multi-disciplinary Review at a future timeout session.	**KB (with AS)**	**Timeout June 2016**
5.	**G/16/04/2**	Amendment to Eddie Dobbs' entry in the register of interests to reflect changes.	**MD**	**Immediate**
6.	**G/16/04/12**	PwC to present on 2014/15 and 2015/16 audits at next timeout.	**MD/PwC**	**Timeout June 2016**
7.	**G/16/04/53**	Circulate slides on whistleblowing and the role of the Freedom to Speak Up Guardian.	**LG/MD**	**Immediate**
8.	**G/16/04/58**	Seek legal advice regarding whether a share of surplus generated from ophthalmology development could be used to repay Fred and Ann Green Legacy funds.	**JC**	**Report back June 2016**
9.	**G/16/04/73**	Brief governors regarding money spent on unused scanners and financial impact.	**DP**	**June 2016**

Date of next Meeting: 30 June 2016
Action Notes prepared by: Maria Dixon
Circulation: Chair, Governors, NEDs, EDs

Doncaster and Bassetlaw Hospitals NHS
NHS Foundation Trust

Title	**Report of the Chair**		
Report to:	**Board of Governors**	Date:	**30 June 2016**
Author:	**Chris Scholey, Chair**		
For:	**Information Discussion**		

Purpose of Paper: Executive Summary containing key messages and issues

To provide an update regarding the activities of the Chair.

Recommendation(s)

The Board is asked to RECEIVE and NOTE the report

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

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

- *By openly and honestly discussing financial and governance issues*

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

- *By working openly with regulators and partners to improve financial governance*

Board Assurance Framework

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

Chair's Report

NHS Improvement

I recently discussed the Trust's financial position with Stephen Hay, along with agency cap rates and the agency cost pressures. NHSI agreed to visit local trusts in the region to discuss the issues further. Overall, I would comment that relationships with NHSI are good, although they are pressing for an increase in our CIP. I will attend a meeting with NHSI on the 28th June and will pass on my comments regarding this in the Board of Governors meeting on 30th June.

Board Advisor

NHSI appointed Chris Mellor as Board Advisor in April. I arranged for a group of governors and NEDs to meet with Chris in late April, and they were satisfied regarding his suitability to advise the Trust. His monthly reports to the Board of Directors are circulated to the Vice Chair and Lead Governor so they are able to monitor his input.

Working Together

The main focus of the Chair and Chief Executive meetings of the Working Together Programme has been Sustainability and Transformation Plans (STP). It has been agreed that trusts should be working closely in relation to the use of locums and agency staff. Despite this, there are areas where it is not possible to maintain the agency cap, most notably in A&E.

April Board of Governors meeting

Overall it was a good meeting, and governors will be aware that in order to reduce costs an internal venue (the education centre) was chosen. This was the subject of some discussion at the last agenda planning meeting and the conclusion was that despite the financial situation we needed to provide a more suitable environment for a public meeting. The AGM will be held in the Ivanhoe Centre in Conisbrough, which has proved a good venue in the past.

Governors

Mike Addenbrooke has been elected as Vice Chair and George Webb has been elected as Lead Governor.

Trust Medical Committee (TMC)

I attended a recent TMC meeting to report on events leading up to and following the misreporting of the Trust's financial position. I took consultants through the sequence of events that had led to the discovery of the misreporting in October 2015. Overall, it was a positive meeting and there was an atmosphere of wanting to help with cost improvement.

2016/17 objectives/appraisals

The corporate objectives are now complete. There is a heavy emphasis on improving financial performance and rebuilding the finance team, whilst maintaining our strong quality position. The NED appraisals and objective setting processes are also complete, and the objectives are in this pack for approval.

Care Groups visits
John Parker and I are making a series of visits to departments around the Trust, and have visited half the Care Groups so far. What has been impressive is that there is a clear understanding of our financial position and the need to improve efficiency. It was heartening to listen to the ideas that were being generated, and we experienced a high level of positive energy to help improve our financial position.

CCGs
I attended a recent Bassetlaw CCG board meeting, at which the STP was a key discussion topic. The CCG was very complimentary about the quality of care provided by the Trust, citing Bassetlaw's A&E as outstanding performer in the present difficult climate.

Bassetlaw Hospital
John Mann MP has written to governors to invite them to a public meeting to discuss the future of Bassetlaw Hospital. After discussions with Mike Addenbrooke, Vice-Chair, it was felt appropriate that he respond on behalf of all governors. As yet there has been no response from John Mann MP that I am aware of.

New Trust Board Secretary
Matthew Kane will be joining the Trust on 4 July.

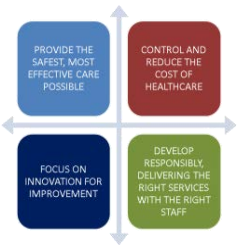
Board of Governors Timeout
Unfortunately, the Timeout was scheduled across the morning and afternoon to accommodate our external auditors, which resulted in lower attendance that would be normal. I gave governors an overview of the national Sustainability and Transformation Programme process, and a particular highlight was the excellent results of the recent NADIA audit, work which governors have previously supported.

NHS Providers
Mike Pinkerton and I recently attended the NHS Providers conference in London. Key points included the continuing difficult financial position and the pressure being put on Boards with regard to finance. There is considerable national concern regarding continuing deterioration in A&E. Simon Stevens introduced a new team, including a national lead for A&E, and I'm sure we can expect more to come on this.

Chris Scholey
Chairman

23rd June 2016

Chief Executive's Report
30th June 2016



Executive Summary

Overall, we have made encouraging start to the year. The challenge I set for the organization at the start of the year was one of pursuing safety, quality and performance and also delivering focus on finances, as both have to be delivered for sustainable progress. Overall our performance in key areas has maintained or improved, albeit with particular pressures in four hour wait, and we are moderately ahead of our financial plan and the CIP that underpins that plan. Continuing that level of diligence and focus will be essential to deliver our commitments to our patients and our regulator, while we develop our longer term strategy.

Performance Overview

Preliminary month 2 finance figures indicate continued progress at the rate set in month 1, both in terms of overall delivery and the contribution of the cost improvement programme to that, with a cumulative positive variance to plan of circa > £.5M. At Q1 point, a review and reforecast will be considered.

Performance for RTT, Cancer and CDiff has remained compliant or better than trajectory with continued progress in HSMR. Four hour wait was compliant in April, below target in June and remains under pressure with both volume and intensity increases. A Perfect Week is underway at the time of writing which is an Emergency Care Intensive support Team (ECIST) recommended methodology to ensure a multi organizational focus on improving flow and identifying barriers and bottlenecks in pathways.

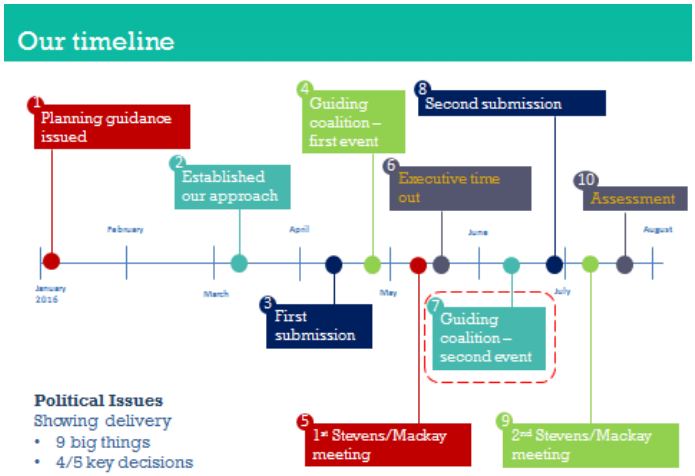
Strategy Development Update

Trust level

The Executive considered and agreed an overall way forward for developing the Organizations service strategy at a timeout session on 21 June, which would see the Directorate of Strategy and Improvement responsible for aligning and coordinating nine key long term strategies which would be delivered by annual plans. We will also initiate a detailed piece of work to understand the options available to recast our longer term service offer and their financial implications.

STP (Sustainability and Transformation Plan) level

Work continues to develop the South Yorkshire and Bassetlaw STP and the timelines are set out below, alongside proposed shadow governance arrangements that are analogous to similar arrangement in Manchester. The detail behind these and other developments was discussed at



the Board Briefing on Monday 20 June. A draft STP submission will be considered at the Steering Group meeting on the 27th June and a verbal update will be given.

Working Together Partnership Level

This month the Board of Directors were asked to approve an Acute Federation Board as part of the work of the Acute Services Vanguard. This would form part of the STP Delivery Unit.

Place level

An Exec/Exec meeting is being arranged with Bassetlaw CCG to finalize the arrangements for entry into an Accountable Care Partnership with other local organisations. Further discussions on the Doncaster Place plan are scheduled shortly.

STP level outcome expectations of the place plans are set out in the adjacent slide. Current approaches to delivering these outcomes vary considerably within the STP communities.

Turnaround

A series of drop-in Turnaround Workshops for staff have been hosted by the Turnaround Team across the Trust. The workshops have been set up to give staff the opportunity to discover how far we are in to our recovery journey, to share ideas and speak one-to-one with members of the

Turnaround Team. Over 150 members of staff attended the workshop at DRI on 25th April, with further workshops delivered/planned for Montagu and Bassetlaw respectively.

The inaugural meeting of the Turnaround Programme Board was on 16/5/16. This completes the "classical" design of the Turnaround programme in terms of best practice for project and programme management and the Board will focus on

- accountability and support for Senior responsible owners of work streams,
- ensuring coordination and scheduling between workstreams,
- alignment with overall trust strategy,
- ensuring stakeholder and quality assurance is delivered,
- providing challenge to the programme
- assurance to FoC on continued delivery.

The Trust has received the NHSI Phase 1 Financial Improvement Programme Report, which in brief summary provides a solid assurance and affirmation of the approach taken with regards turnaround and the operation and early delivery of the key work streams making up the Cost Improvement Programme. The report also identifies a small number of areas which can be developed within a Phase 2 of the programme where external expertise may be helpful to the Trust. Expected savings are moderate, but useful if deliverable. The Report and was presented by KPMG at the Board Brief on Monday 20th June and will be considered in full at the Finance Oversight Committee.

The transfer of payroll services to NHS Shared Business Services has now taken place and guidelines restricting the usage of catering hospitality have been issued, pending a new policy.

Surgical Pathway at Bassetlaw Hospital

Actions have had to be taken quickly to maintain the safety and efficacy of key elements of the emergency surgical service at Bassetlaw, following inability to replace junior doctors that have left the service. An overview of the pathway now in place is as follows:

Surgical patients attending Bassetlaw ED, are triaged using an agreed tool, shared with ED, to assess which of 4 categories patients will follow.

1. Acutely unwell patients will be transferred to DRI for inpatient treatment.
2. Patients who require a review in ED will be seen by the consultant in the week until 6pm and by the SAS doctors out of hours
3. "Hot" clinics will be available twice daily to book patients into for review if appropriate
4. A cohort of patients will be directly discharged with advice.

Over forthcoming weeks, we will be able to transfer more elective surgical patients, currently treated at Doncaster, back to Bassetlaw and Bariatric Surgery has now commenced on site. We expect that this will more than re-balance the number of emergency patients admitted to Doncaster, which is anticipated to be in the region or 10 -14 per week.

National Reporting and Learning System (NRLS)

The period April 2015 to September 2015 showed that DBH has moved up the table 20 places to 42nd best out of 136 Trusts. This is an improvement from the period October 2014 to March 2015 when the Trust was ranked 62nd best. The Trust is only 8 places short of being in the top 25% of reporters. 6,158 incidents were reported for this time period. The reporting rate per 1000 bed days has increased to 42.2 incidents up from 36.08 incidents (Oct 14 – Mar 15); above the median reporting rate for this time period (38.25)

Picker Inpatient Survey

The survey was published 8 June 2016. The survey looked at the experiences of 83,116 people who received care at an NHS hospital in July 2015. Between August 2015 and January 2016, a questionnaire was sent to 1250 recent inpatients at each trust.

Responses were received from 568 patients at DBH. Results in all categories were within "as expected" category but overall compare favourably with local trusts. The overall trust score was 8.2/10. The detailed report will be reviewed by the Patient Experience Committee.

SSNAP (Stroke Audit) Results January 2016 to March 2016

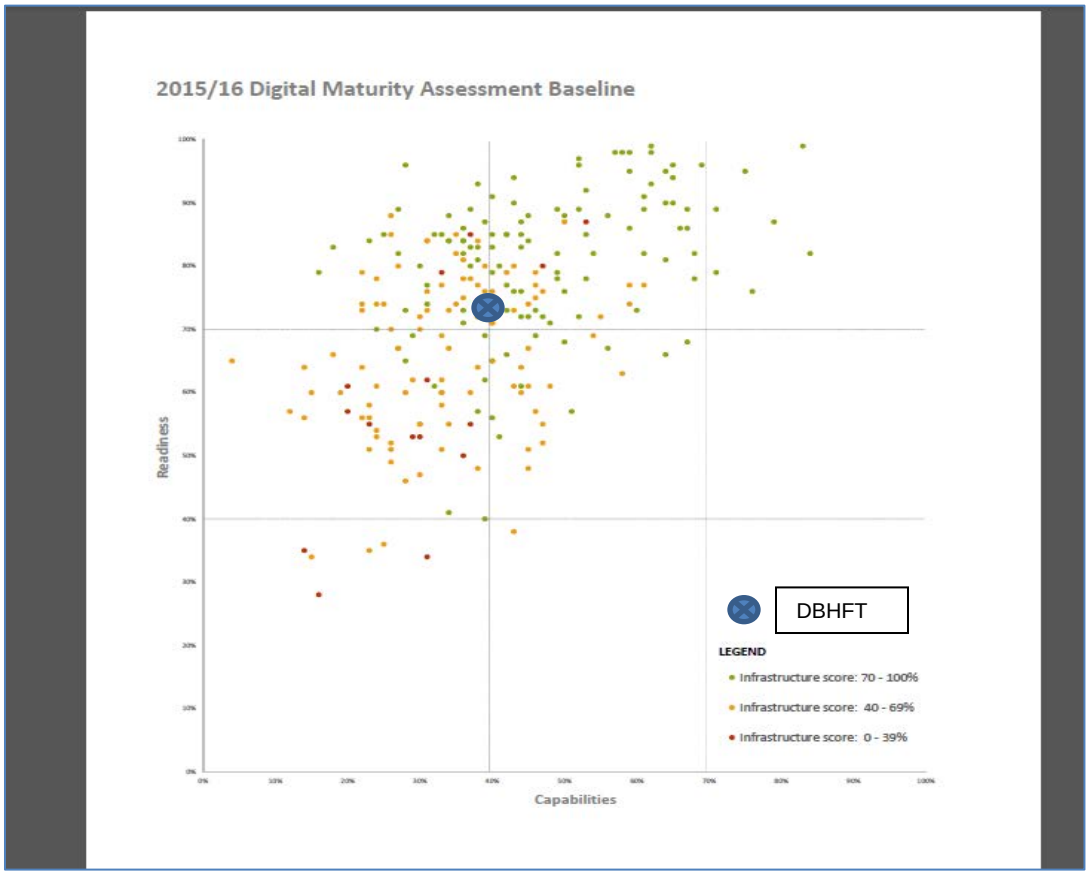
The Trust is now achieving an A rating overall – a significant achievement and only matched by Scunthorpe in Yorkshire and South Humber. A number of areas have improved including specialist assessment and discharge processes. Making early decisions on future location of hyper acute stroke services has been identified as a priority within the emerging STP plan.

Routinely Admitting Teams		Number of patients		Overall Performance			
Trust	Team Name	Admit	Disch	SSNAP Level	CA	AC	Combined KI Level
North of England - Yorkshire and The Humber SCN							
Barnsley Hospital NHS Foundation Trust	Barnsley Hospital	163	160	D↓	A	B↓	D↓
Bradford Teaching Hospitals NHS Foundation Trust	Bradford Royal Infirmary	120	138	D	A	C↓	C↑
Calderdale and Huddersfield NHS Foundation Trust	Calderdale Royal Hospital	117	153	B↑↑	A	C	B↑
Chesterfield Royal Hospital NHS Foundation Trust	Chesterfield Royal	129	125	C	A	A	C
Doncaster and Bassetlaw Hospitals NHS Foundation Trust	Doncaster Royal Infirmary	155	155	A↑	A	A	A↑
Harrogate and District NHS Foundation Trust	Harrogate District Hospital	94	97	D↓	A	B↓	D↓
Hull and East Yorkshire Hospitals NHS Trust	Hull Royal Infirmary	201	209	D↓	A	B	C↓
Leeds Teaching Hospitals NHS Trust	Leeds General Infirmary	264	261	D	A	B	D
Mid Yorkshire Hospitals NHS Trust	Pinderfields Hospital	230	220	D	A	A	D
Northern Lincolnshire and Goole Hospitals NHS Foundation Trust	Scunthorpe General Hospital	149	145	A	A	A	A
Rotherham NHS Foundation Trust	Rotherham Hospital	122	127	D↓	A	B	D↓
Sheffield Teaching Hospitals NHS Foundation Trust	Royal Hallamshire Hospital	230	221	D	A	B	D
York Teaching Hospital NHS Foundation Trust	York Hospital	214	201	C	A	B	C

NHS England assessment of "digital maturity"

DEVELOP RESPONSIBLY, DELIVERING THE RIGHT SERVICES WITH THE RIGHT STAFF

Based on Health Service Journal (HSJ) analysis of NHS England Data the Trust was ranked as the most mature Trust in South Yorkshire in terms of 'digital maturity'. The Digital Maturity Assessment measures the extent to which healthcare services in England are supported by the effective use of digital technology. It will help identify key strengths and gaps in healthcare providers' provision of digital services at the point of care and offer an initial view of the current 'baseline' position across the country. The Assessment builds on existing evidence about how investing and effectively using IT can achieve better patient outcomes, reduce bureaucracy, improve patient safety and deliver efficiencies.



The i Hospital programme was suspended shortly the point of financial disclosures, to allow a review of projects and strategy and a reassessment of priorities in the new operating context. Good progress has been made in infrastructure, Symphony implementation for EDs and MIU, PACs/RIS replacement for Imaging, Patient Administration System replacement and K2 Implementation for Maternity. Limited progress has been made in the delivery of electronic document management as a pathway to paper light or paperless records (EPR). A new post of Chief Informatics Officer (CIO) to replace but also develop the previous post of Deputy Director of IT is currently out to recruitment. This post will cover IT and Information functions and will report direct to the CEO. A top priority will be to redefine our Informatics Strategy, ensuring a high level of clinical involvement in setting our path to EPR.

Public Health England Antenatal and Newborn Screening QA Visit 5th May 2016

Verbal feedback was received on the day which was overall very positive. The QA team commended

- Commissioning relationships
- Team ethos and team leadership
- Support post investment
- Audit support and coordination

In terms of the ANS Screening programme KPIs, 9 were achieved/exceeded and five were below requirement, some of which link to the nature of the population served as opposed to the Trust screening programme per se.

The Trust and Team were commended on the implementation of the K2 Maternity system from a screening perspective, which was described as "outstanding" and by far the best and most complete they had seen anywhere in the QA programme nationally.

Colorectal Chemotherapy

The Trust has expanded its outreach chemotherapy portfolio. Previously colorectal patients were attending Doncaster to see the oncologist and then travelling to Sheffield a couple of days later to receive their chemotherapy treatment. Stacey Nutt, Lead Nurse for Cancer undertook a review of capacity within Chatsfield Suite and developed a business case to increase staffing to enable colorectal patients to be treated in Doncaster. This service expansion was accommodated by extending the working day by 1 hour and increasing staffing numbers and better organisation of the daily activity.

The case was supported by the Trust on the proviso that STH paid the increased costs – which was agreed in January 2016. A 2 phased implementation was planned taking the first wave of regimens from February and second wave from 1st April. We are now offering all colorectal patients treatment at Doncaster and repatriating current patients being treated in Sheffield. The uptake has been very positive and the patient experience is much improved. The current profile of regional chemotherapy services is now as below:

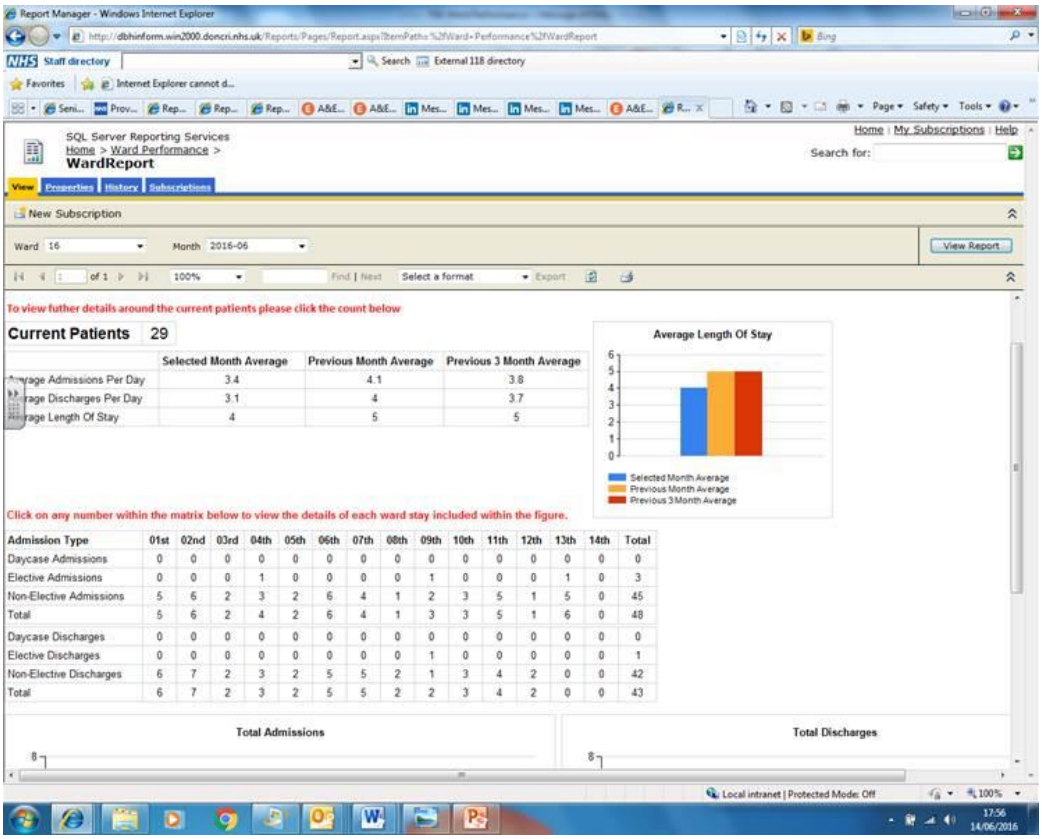
Outreach Locality	Breast	Gynae	UGI	Lung	Prostate	Colorectal	Renal
Barnsley	X			X		X	
Rotherham	X			X		X	
Doncaster	X	X	X	X	X	X	X
Chesterfield	X			X	X	X	X
Sheffield	X	X	X	X	X	X	X

Respiratory Unit

On 6th June 2016, Ward 26 and Ward 27 have amalgamated and will now be known as the Respiratory Unit. The Unit will be managed by Michele Bruce, Nicola Severein-Kirk and Donna Smith. The unit will have 56 funded beds with 2 escalation beds and 1 closed bed.

Ward Report

As part of the Length of Stay work, Information Services are developing tools to help ward managers and care groups easily track patient flow performance and drill down to individual patients where necessary to ensure progress in discharge. This is a real step forward in practical informatics to help clinical management.



Frailty Education Sessions

335 staff from all sites have attended awareness session recently as part of Frailty Week following a superb team effort led by Cindy Storer and the frailty team. The aim was to raise awareness of how best to support our older patients, and reduce levels of inpatient harm including:

- Understanding and developing Person-centred care in the clinical environment
- Reducing negative stereotypes sometimes associated with ageing
- Care of people with dementia and or delirium

- De-escalation of acute distress in older people
- Falls awareness and prevention
- Continence, nutrition, hydration and mobility
- Supporting older people within a legal framework of care

Feedback has been overwhelmingly positive and will help support good practice and improved outcomes for these patients.

Local Digital Roadmaps

The NHS has been tasked with achieving paper free care delivery by 2020 as described in the "NHS 5 Year Forward View". To achieve this, CCGs working with acute Trusts have been asked to develop Local Digital Roadmaps (LDRs) covering their footprint. The LDR is based on an assessment of infrastructure and systems in situ (capability) and then describes how IT systems will be implemented to enable digital medical records to be available to all professionals who contribute to health and social care for an individual to facilitate joined up care.

DBHFT is working with RDASH, our local councils and both CCGs to develop our LDR. One of the first steps will be to implement the "Medical Interoperability Gateway" or MIG, which will enable primary care to view secondary care digital records and vice versa. It is envisaged that central funding will be made available to progress LDRs.

Research and Development

Global First Patient

- Congratulations to Dr Chee-Seng Yee and Team on the confirmation that the global first patient on the H 2315 study was recruited here in the UK at Doncaster Royal Infirmary. This is an international clinical trial evaluating the safety, tolerability and efficacy of secukinumab in patients with active nonradiographic axial spondyloarthritis. This is the first patient to be screened and successfully entered in to the study in the world, out of 21 countries, so this is a huge achievement. Doncaster Royal Infirmary was the first site to be initiated here in the UK out of all 12 sites on the study.

NIHR (National Institute for Health Research) Portfolio Recruitment Delivery 15/16

- The Trust recruited 1073 participants to NIHR portfolio research, against a target of 1000, which is the best position achieved to date. This not only delivers future and current patient benefits, but also secures our core NIHR funding for next year 16/17.

Funding Projections

- Our NIHR core funding is confirmed for 2016/2017 with an additional Research Capability Funding (RCF) of £30k; £10k received for every 500 participants recruited, and £10k for first

global patient. The wealth of our research programme for 16/17 is projected to be a minimum of £949 000, comprised of £350K Programme Grant and associated RCF (majority pass-through cost), £374K NIHR funding and associated RCF, £30K CLAHRC contribution and circa £200K commercial income based on 15/16 income. We anticipate the possibility of further CLARHC projects and commercial development in 16/17.

Discharge Improvement Recognition

The Trust has received formal thanks from NHS Improvement and the Patient Safety Collaborative Discharge Cluster for sharing the discharge improvement work. NHS England have published the information in the form of an exemplar case study on the Patient Safety pages of NHS England's website: https://www.england.nhs.uk/patientsafety/discharge/ .

The case study has been combined with others and a portfolio of best practice information to form a resource library to support organisations to improve their discharge process and the communication between health and social care providers when a patient is discharged from hospital.

Staff & Appointments

- Thanks to Ruth Cooper Deputy Director of POD who has now retired.
- Welcome to the new deputy director of POD, Anthony Jones who will start in July 2016.
- Congratulations to Andrew Jones, Director of Estates and Facilities, for winning the 2016 Outstanding Service Award by the Health Estates and Facilities Management Association (HEFMA). Andrew will be retiring shortly and this is a fitting accolade to recognise his career achievements.
- Mr M Shahed Quraishi Consultant Otolaryngologist, Thyroid and Parathyroid Surgeon, has been appointed as a visiting Professor at a major Chinese Medical University in Beijing and is the first British ENT surgeon to be so honoured. Congratulations to "Q" on this unique achievement.
- Juan Ballesteros has been selected for a Clinical Teaching Award by The Medical School, University of Sheffield. Medical students were asked to nominate individuals who fulfilled the following criteria: Congratulations to Juan on this award
- Non-Executive Director Geraldine Broderick is set to leave DBH and join Norfolk Community Health and Care NHS Trust as Chair. Geraldine joined the Trust as Non-Executive Director in 2009. Many congratulations to Geraldine and our grateful thanks for her significant service to the Trust and its patients.

Mike Pinkerton
Chief Executive

Minutes of the meeting of the Board of Directors
held on Tuesday 22 March 2016
in the Fred & Ann Green Boardroom, Montagu Hospital

Present:	Chris Scholey	Chairman
	Alan Armstrong	Non-executive Director
	Geraldine Broderick	Non-executive Director
	Jeremy Cook	Interim Director of Finance
	David Crowe	Non-executive Director
	Dawn Jarvis	Director of Strategy & Improvement
	Martin McAreavey	Non-executive Director
	John Parker	Non-executive Director
	Richard Parker	Director of Nursing, Midwifery & Quality
	Mike Pinkerton	Chief Executive
	David Purdue	Chief Operating Officer
	Philippe Serna	Non-executive Director
	Sewa Singh	Medical Director
In attendance:	Emma Bodley	Head of Communications & Engagement
	Ruth Cooper	Deputy Director of HR
	Maria Dixon	Head of Corporate Affairs
	Chris Mellor	Board Advisor
	Kate Sullivan	Corporate Secretariat Manager
Public:	Karen Barnard	Director of People & OD Designate

ACTION

16/3/1 Chris Scholey welcomed Chris Mellor and Karen Barnard to the meeting. Karen Barnard would commence in post as Director of People & Organisational Development on 2 May 2016.

Apologies for absence

16/3/2 None.

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

16/3/3 No amendments were noted.

Minutes of the meeting held on 23 February 2016

16/3/4 The minutes of the meeting held on 23 February 2016 were APPROVED as a correct record of the meeting, subject to the correction of one typographical error and the following amendments:

16/3/5 16/2/35 – "balance sheet" to be amended to "trial balance" and "variance" to be amended to "negative variance".

16/3/6 16/2/39 – "work was underway to review each business case." to be amended to "a more detailed review of each business case was

underway".

16/3/7 16/2/43 – "non-medical" to be amended to "non-clinical".

16/3/8 16/2/44 - "CIP" to be amended to "15/16 CIP".

16/3/9 16/2/46 – "not £1.9m" to be amended to "above the minimum of £1.9m".

16/3/10 16/2/50 – "by outsourcing" to be amended to "by clinical outsourcing".

16/3/11 16/2/51 - Second sentence to be amended to "A business case to appoint substantive staff to the team was being taken forward."

16/3/12 16/2/52 – "length of stay workstream" to be amended to "non-medical workforce review".

16/3/13 16/2/66 – "conditions" to be amended to "conditions to be treated".

16/3/14 16/2/68 – "HSMR for the month" to be amended to "unvalidated HSMR for the month".

16/3/15 16/2/72 – "had met" to be amended to "would meet".

16/3/16 16/2/83 – "as in terms of the committee the role had been superseded by the Turnaround Director." to be added to the end of sentence.

16/3/17 16/2/94 – "and were taking steps to reduce reliance on agency staff" to be added to the end of the sentence.

Actions from the previous minutes

16/3/18 The action notes from the meeting held on 22 February 2016 were reviewed and updated.

Matters arising

16/3/19 16/2/18 – In response to a query from David Crowe, Mike Pinkerton advised that he was due to meet with John Mann MP on 18 April 2016.

16/3/20 16/2/23 - Consultant engagement – Weekly meetings were taking place to enable Mike Pinkerton to meet with small groups of consultants. In response to a query from David Crowe, Mike Pinkerton provided an overview of discussion topics and concerns raised by the consultant body. These included how the turnaround programme was being handled and the level of redaction of the publicly available KPMG Investigation Report.

16/3/21 Dawn Jarvis had met a member of LNC and the Chair of the Trust Medical Committee (TMC) to discuss the framework of the Turnaround Programme.

16/3/22 With regard to concerns raised about the level of redaction of the KPMG

report, a proposal was being developed to arrange for controlled access to the unreacted report for the Chair of TMC as well as staff governors and the Financial Oversight Committee governor observer. Access would be provided under a confidentiality agreement.

16/3/23 John Parker commended the involvement of governors in this. There was further discussion about staff and governor engagement and Geraldine Broderick commented that communication was a key issue to ensuring staff were engaged and well led.

Chairman's correspondence

Chris Scholey reported the following:

16/3/24 Monitor enforcement action – Chris Scholey, Mike Pinkerton, Dawn Jarvis and Jeremy Cook had met with representatives from Monitor on 31 March to discuss progress against enforcement actions, amongst other things. Monitor had also provided an update to governors later the same day.

16/3/25 Board Brief – Board brief sessions would be reinstated from 18 April 2016 and used to focus on strategic issues, including service delivery models. **BoD**

16/3/26 Governor timeout – The session had been well attended, with around two thirds of Governors present, and there had been a good agenda.

16/3/27 Corporate objectives – Development of the 2016/17 objectives was progressing well.

16/3/28 Governor election - The recent round of elections had concluded. Two new governors had been appointed and all existing Governors who had stood for election had been re-elected.

16/3/29 Trust Board Secretary and Chair posts – Maria Dixon and Chris Scholey would be leaving the Trust later in the year. Both the Trust Board Secretary and Chair positions had been advertised.

16/3/30 Foundations for Health – The magazine would now be circulated electronically with only one printer copy mailed to members per annum.

The Chairman's correspondence was NOTED.

Chief Executive's report

Mike Pinkerton presented the report, highlighting the following:

16/3/31 Performance overview – The Business Intelligence Report had not been available at the time of writing the report. At the time of the meeting the Trust was failing the ED 4hr wait target but performance was relatively good in the context of the national position.

16/3/32 Turnaround programme – Mike Pinkerton drew attention to the medical

locum cap breaches graph included in the report, which illustrated an example of early progress. However, he emphasised that this should be carefully managed to ensure quality of patient care.

16/3/33 David Crowe asked whether there were any provisions for relaxing the cap in order to ensure quality of care and whether there were any consequences to breaching the cap and this was discussed. Mike Pinkerton and David Purdue gave an overview of the process and clarified that each instance was dealt with on a case by case basis.

16/3/34 Geraldine Broderick asked for assurance that Trust staff were not working excessive hours because of the cap on agency staff. Sewa Singh advised that concerns relating to quality of care and gaps in rotas were being escalated by Care Groups to the Clinical Governance & Quality Committee. In some instances, care groups had taken the step of closing parts of some services in order to ensure patient safety and this was a recurring theme.

16/3/35 David Purdue advised that the Trust was looking at new models of care including greater use of Advanced Nurse Practitioners. It was agreed to raise the matter of services that had been suspended with Monitor at the meeting due to take place on 31 March. It was also agreed to provide medical workforce data, including rota gaps, to support the strategic discussion at the next Board Brief. **SS/DP**

[Post meeting note: With regard to which services had been suspended, it was later clarified that Paediatric Service at Bassetlaw had been suspended overnight.]

16/3/36 During further discussion, it was noted that the cap could only be broken within 24hrs of the shift for which the locum was required and in some instances, locums had not been available as they were working elsewhere. Concern was raised that not all local trusts were working to the same principles in relation to breaking cap. It was important for the Working Together trusts to have a common understanding. It was agreed for further information to be provided to support discussion in more detail at the next Board Brief, including an update on instances where locums had been provided though agencies not on the framework. **DP/DJ**

16/3/37 Martin McAreavey asked whether the Trust was looking in general at non-value adding activities at Care Group level. Richard Parker advised that this was being considered as part of a national piece of work relating to allied healthcare professionals and nurses and looking at how much time was spent with patients.

16/3/38 Martin McAreavey asked whether there was a mechanism in place to ensure the Trust was picking up on ideas from staff. Dawn Jarvis advised that there had been good follow up on ideas from staff so far and she gave an overview of work taking place to engage staff in the turnaround programme.

16/3/39 Mutually Agreed Resignation Scheme (MARS) – The net impact of the scheme would see an overall recurrent pay cost reduction of £730k. Alan Armstrong asked for assurance that plans were in place to ensure areas where staff had left through the scheme were adequately resourced. It was reported that each MARS release had been quality impact assessed by an executive director. Some areas would require reorganisation and some staff had been released from areas where the work they undertook would no longer continue.

[Post meeting note: It was later reported that the overall recurrent pay cost reduction was £811k and not £730k as had been reported.]

16/3/40 Monitor – Mike Pinkerton thanked Monitor for its handling of the announcement of the Trust's breach of licence and resulting enforcement action to remedy the breach. He welcomed Chris Mellor who had been appointed by Monitor as Board Advisor to the Trust. A monthly report on enforcement action progress would be provided to the Board. **MP**

16/3/41 Picker Inpatient Survey 2015 – Overall, the Trust's results were very positive. John Parker noted that the percentage of patients that had answered that they felt threatened by either patients or visitors had increased by 3% compared to the 2014 survey. It was noted that there would be further action to address this.

16/3/42 Tour de Yorkshire 2016 – Care Groups were developing statements of readiness to provide assurance in preparation and planning for stage 2 of the event and any other risks identified.

16/3/43 Staff – On behalf of the Board, Mike Pinkerton commended Mr Muhamad Quraishi on being elected as President at the Royal Society of Medicine Head and Neck section.

16/3/44 Building on the Best – The Trust had been selected as one of 10 trusts in England to take part in the 'Building on the Best' programme to support improvement in the quality and experience of palliative and end of life care across the UK. Chris Scholey commended this.

16/3/45 Student nurse feedback – Geraldine Broderick commended the continued improvement in the overall placement satisfaction of student nurses at the Trust, which was reflected in a recent SHU feedback report, and she commented that further benchmarking data would be useful.

The Chief Executive's report was NOTED

Finance Report as at February 2016

Jeremy Cook presented the report and drew attention to the flowing;

16/3/46 Improvements had been made to the trial balance process, which now linked to the Monitor report. This was commended by Philippe Serna who stated that this was a significant improvement in control. Five additional

interim members of staff were now in place in the finance team to provide additional resource.

16/3/47 Financial performance - £31.2m deficit at month 11 (£30.3m behind plan). The run rate had improved and because of this the forecast had improved by £2m from £38.4m to £36.4m.

16/3/48 Expenditure - £29.9m at month 11, the same as at month 10. This represented a reduction of £1.5m against the November expenditure of £31.4m. Medical agency costs had fallen further to £1.04m in February, a reduction of £134k on January and below the average for months 6 to 8 of £1.5m. The run rate across medical staff costs had again fallen and was £160k better in February than for the year to month 10.

16/3/49 Income - £3.837m below plan, a deterioration of £19k in month. NHS clinical income had benefited from an in month adjustment of £787k to reflect no fines for readmissions in Q4.

16/3/50 CIP – There had been a slight improvement but the continued under-performance of CIP schemes was a major contributing factor to under-performance against the 2014/15 and 2015/16 plans.

16/3/51 2016/17 financial plan – The draft plan had been submitted to Monitor in February. Budget setting principles and processes had been approved by the Financial Oversight Committee. Further detail would be provided at an extraordinary meeting of the Board of Directors on 7 April 2016, prior to the Monitor submission date. It had been agreed with Monitor that a revised plan would be submitted in May after sign off by budget holders.

16/3/52 John Parker commented that the reported over establishment of medical staff did not reflect the true position and raised concern about how this might be perceived outside of the organisation, it was agreed to clarify the information in future reports. **JC**

16/3/53 With regard to whether all trusts were reporting financial information on the same basis, Geraldine Broderick asked whether there were plans to consider reporting EBITDA. Jeremy Cook advised that the Trust would look at this. New ways of reporting financial information were being considered in light of best practice. Jeremy Cook had asked KPMG and Monitor to advise on this and there would be a new format for the finance report in future. This would be reviewed by the Financial Oversight Committee. **JC**

16/3/54 In response to a query from Philippe Serna with regard to the level of nursing vacancies reported in the Emergency care group, Jeremy Cook and Richard Parker advised that work was underway to validate this.

16/3/55 In response to a query from Philippe Serna about the recovery of car parking income, Richard Parker gave an overview of work being undertaken in this regard.

16/3/56 Cash – £1.9m at M11, £5.6m below plan. External cash support would be required during 2015/16 and beyond. Jeremy Cook provided an update on the temporary working capital facility secured through Monitor, which was detailed in the report.

16/3/57 Martin McAreavey expressed concern regarding underperformance against the outpatient follow-up cap, it was noted that progress was being made; the Trust had reported an overall reduction in outpatient follow-ups for 3 consecutive months.

The Finance Report was REVIEWED and NOTED.

Staff Survey and Action Plan

16/3/58 Ruther Cooper presented the report, which outlined the outcomes of the Trust's 2015 staff survey, recommendations and key actions to be taken at corporate and local level.

16/3/59 Response rate – 44% (2788 respondents). A slight improvement on the previous year (42%). This was the third year surveying all staff (a census) and as such the views expressed were fairly representative of the Trust as a whole. The national response rate, with trusts using varying methods, was 41%. Geraldine Broderick endorsed the census approach and commended the sample size.

16/3/60 Summary of key findings - The results were relatively positive and consistent with the previous year. There had been an improvement in the staff engagement score. In the context of the current climate, this was a good achievement. Over 50% of responses had been received after the announcement about the Trust's financial position.

16/3/61 Appraisals – 88% of respondents reported they had been appraised, a significant improvement on previous years.

16/3/62 Top 20% - The Trust was in the best 20% of acute trusts for the percentage of staff reporting experiencing discrimination at work (9%).

16/3/63 Actions – The report detailed planned actions to be taken:

- Appraisals – maintain progress to increase appraisal rates and begin to address the quality of appraisals.
- Statutory & Essential to Role training - increase uptake and source higher levels of training
- Management, leadership and coaching skills training – focus attention on turnaround and managing projects.
- Health & Wellbeing - develop low cost and collaborative schemes to maintain appropriate levels of support for staff.

The Staff Survey was DISCUSSED and the areas for action and plans for the survey cycle were APPROVED.

Business Intelligence Report as at 29 February 2016

16/3/64 David Purdue, Richard Parker and Sewa Singh presented the report and drew attention to the following:

16/3/65 4hr access – 92.48% as a Trust for January. The report included attendances and the percentage of patients treated by site, and this had increased at both sites. The Symphony system had been simplified to improve efficiency.

16/3/66 A key issue had been covering middle grade staffing hours in the rota due to agency cap rates. David Purdue provided details of the number of hours not covered in recent months. Staff had gone to work at neighbouring trusts which were breaking the cap rates. This had been raised through the Working Together Group to agree a unified approach.

16/3/67 With regard to the increase in activity, Alan Armstrong asked whether the appropriate assumptions had been made in the 2016/17 budget. It was noted that the CCGs had been provided with activity data. At this stage the CCGs had indicated that there were no plans to assume any growth in activity; the Trust had proposed 4% growth.

16/3/68 Martin McAreavey asked whether the Trust understood the reasons for the growth in activity. David Purdue advised that 3 audits had been undertaken and key issues included access to GPs and patients wanting a second opinion. Work was needed to look at the frailty pathway. A Geriatrician was due to commence in post in April and work to ensure healthy patients stayed out of hospital would be taken forward.

16/3/69 Ambulance handover times – The reported position had deteriorated. Key issues had been increased attendance and acuity of patients and this was compounded by EMAS ceasing to use the electronic system used to manage waiting times.

16/3/70 RTT – Achieved as a Trust at 92.1%.

16/3/71 Cancer – All targets achieved for Q3, including the 62 day target.

16/3/72 Stroke – The pathway had failed to improve and this was discussed. There had been some improvements but the Trust remained an outlier. It was noted that outcomes for stroke patients at the Trust were one of the best in the region and the treatment of stroke patients at DRI started in the ED.

16/3/73 The trusts reporting the best results had direct stroke access. In order to provide this there would need to be a much more robust rota, which would mean additional cost. Richard Parker provided an overview of models used at better performing trusts.

16/3/74 David Purdue undertook to circulate patient outcome data outside of the meeting. There would be a more in depth discussion about the issues at a future date. **DP**

16/3/75 DNAs – There had been a further improvement. The rate for February stood at 7.6% (9.5% in December and 7.9% in January). Chris Scholey welcomed this.

16/3/76 Outliers – Geraldine Broderick raised concern about the impact of outliers on quality and patient experience, and this was discussed. Work had been carried out to improve processes, including the timeliness of decision-making, which was now undertaken much earlier in the day. David Purdue undertook to re-communicate the process and it was agreed for the bed plan, including an outliers target to be factored in to the 2016/17 corporate objectives. **MP/DP**

16/3/77 HSMR – There had been continued improvement. The rolling 12-month HSMR to November 2015 stood at 99 and the un-validated HSMR for the month of December was reported at 96. SHMI was also improving and was within the expected range.

16/3/78 SIs – There had been an increase in the number of incidents reported in February due to an increase in reported pressure ulcers. Some care issues had been identified and these were being addressed.

16/3/79 Sewa Singh reported that a 5-year-old child who had been admitted through Bassetlaw emergency department had sadly died. This was being investigated as an SI jointly with Sheffield Children's Hospital. Sewa Singh expressed his sympathy to the family for their loss.

16/3/80 In response to a query from Martin McAreavey with regard to level of SIs reported for the Children and Families Care Group (6 in the previous month) it was reported that Richard Parker and Sewa Singh were undertaking a review to reconfigure some services within the care group. Meetings were scheduled with the obstetric teams across both sites to take this forward.

16/3/81 NHSLA claims – David Crowe noted that it had been reported to the ANCRC that the Trust was in the best 10% of Trusts for claims. He raised concern about this, and the issue was discussed. It was noted that the NHSLA claims profile reflected the historical claims position. Sewa Singh advised that he and the Ray Cuschieri reviewed every claim and that there had been a decrease in the number and value of claims over the previous year. This was welcomed by Chris Scholey.

16/3/82 Quality – There had been continued good progress for C.diff and HAPUs.

16/3/83 Complaints – In month response performance had been poor. Key issues had included activity levels and changes in the patient experience team.

The Business Intelligence Report was REVIEWED and NOTED.

Nursing Workforce Update

16/3/84 Richard Parker reported that overall planned versus actual hours worked had been 98% in February. This included staff for additional escalation beds opened on a number of wards for most of February.

16/3/85 Nurse manager clinical time – HoN and Matron clinical time targets had not been achieved in January for the Children and Families Care Group due to sickness absence. The majority of ward managers had been unable to completely maintain two days a week of supernumerary ward supervisory time as they had been working clinically due to staffing pressures.

16/3/86 Hard Truths – Alan Armstrong noted that the report was a monthly snap shot which did not provide historical data, and he suggested that a review be undertaken for wards that had been rated red for both workforce and quality profiles for 2 consecutive months.

The Nursing Workforce Update was DISCUSSED and NOTED.

Strategy & Improvement Report

16/3/87 Dawn Jarvis presented the update on readiness for turnaround, progress to deliver Grip & Control and Turnaround and progress to deliver the high level CIP Plan for 2016/17 and beyond. She drew attention to the following:

16/3/88 Regaining Grip & Control – A reduction in the run rate was being seen each month. A planned approach to grip and control was now in place and the first set of meetings had been completed.

16/3/89 David Crowe asked for assurance that there was good engagement with the organisation as a whole. Dawn Jarvis stated that it was key to engage as many staff as possible. Amongst other things, she had attended Care Group meetings and this had worked well. There had also been a turnaround edition of DBH Buzz. Mike Pinkerton reported that there had been good progress where specific issues had been discussed.

16/3/90 CIP – Dawn Jarvis provided a detailed overview of remaining plans to build on the initial plan submitted to Monitor in February and timescales for delivery.

16/3/91 In response to a query from Martin McAreavey, Dawn Jarvis advised that the vast majority of schemes could not be delivered without service redesign and this would need to be taken forward by all executives.

16/3/92 Chris Scholey commended the paper. John Parker echoed this and commented that a robust approach had been demonstrated through the information provided to the Financial Oversight Committee.

The Strategy & Improvement Report was DISCUSSED and APPROVED.

Board Assurance Framework & Corporate Risk Register

16/3/93 Maria Dixon presented the paper, highlighting that the Audit and Non-clinical Risk and Clinical Governance Oversight committees received reports which had provided assurance or advice in relation to a number of BAF risks and controls.

16/3/94 The six month Executive Team review of the BAF and CRR was due to take place later in the month, after which the updated report would be circulated to board members.

16/3/95 The Board Assurance Framework was APPROVED.

Trust Seal

16/3/96 It was noted that sealing number 75 had inadvertently not been carried out in compliance with the Standing Orders and this was discussed.

16/3/97 It was agreed that the register of sealing would be taken to the Executive Team for approval in future and for the process to be revised accordingly. **MD**

16/3/98 The Trust Seal report was NOTED.

Minutes of the Management Board meeting held on 29 February 2016

16/3/99 MB/16/03/03 – In response to a query from Martin McAreavey about the approval process for business cases, it was clarified that cases could be taken to either the Executive Team or Management Board meetings.

16/3/100 MB/16/03/46 – Parenteral nutrition team – In response to a query from Geraldine Broderick, Richard Parker advised that the team had been performing well and provided an update on the work taken forward.

16/3/101 Geraldine Broderick commented that she had taken assurance from the minutes that the Management Board meetings were more focussed and engaged with the need to deliver turnaround.

16/3/102 The minutes of the Management Board meeting held on 29 February 2016 were NOTED.

Minutes of the Fred & Ann Green Legacy Sub-committee meeting held on 22 December 2015

16/3/103 Minutes of the Fred & Ann Green Legacy Sub-committee meeting held on 22 December 2015 were NOTED.

Items for escalation from sub-committees

16/3/104 None.

Board of Directors and Board Briefing Agenda Calendars

16/3/105 The agenda calendars were NOTED.

Q3 Monitor Feedback

16/3/106 The Q3 2015/16 Monitor Feedback letter was NOTED.

Any other business

16/3/107 None.

Governor questions

16/3/108 None.

Date and time of next meeting

16/3/109 It was confirmed that the next meeting of the Board of Directors would be held at 9am on Tuesday 26 April in the Boardroom, DRI.

…… ……

Chris Scholey **Date**
Chairman

Minutes of the meeting of the Board of Directors
held on Tuesday 26 April 2016
in the Boardroom, DRI

Present:	Chris Scholey	Chairman
	Alan Armstrong	Non-executive Director
	Geraldine Broderick	Non-executive Director
	Jeremy Cook	Interim Director of Finance
	Dawn Jarvis	Director of Strategy & Improvement
	Martin McAreavey	Non-executive Director
	John Parker	Non-executive Director
	Richard Parker	Director of Nursing, Midwifery & Quality
	Mike Pinkerton	Chief Executive
	David Purdue	Chief Operating Officer
	Philippe Serna	Non-executive Director
	Sewa Singh	Medical Director
In attendance:	John Bane	Deputy Director of Diagnostics & Pharmacy *(observing)*
	Emma Bodley	Head of Communications & Engagement
	Ruth Cooper	Deputy Director of HR
	Maria Dixon	Head of Corporate Affairs
	Kate Sullivan	Corporate Secretariat Manager
	Chris Mellor	Board Advisor
Public:	Mike Addenbrooke	Public Governor
	Philip Beavers	Public Governor
	George Webb	Public Governor

ACTION

Apologies for absence

16/4/1 Apologies were received for David Crowe. David Purdue would be arriving later during the meeting.

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

16/4/2 Mike Pinkerton would forward details of a change to the register to Maria Dixon outside of the meeting. **MP**

Minutes of the meeting held on 22 March 2016

16/4/3 The minutes of the meeting held on 22 March 2016 were APPROVED as a correct record of the meeting, subject to the correction of three typographical error and the following amendments:

16/4/4 16/3/21 – "met the Chair" to be amended to "met a member of the LNC and the Chair"

16/4/5 16/3/30 – The second half of the sentence to be amended to read "with only one printer copy mailed to members per annum".

16/4/6 16/3/35 – Addition of a post meeting note: "With regard to which services had been suspended, it was later clarified that Paediatric Service at Bassetlaw had been suspended overnight."

16/4/7 16/3/37 – "looking at" to be amended to "looking in general at"

16/4/8 16/3/39 – Addition of a post meeting note: "It was later reported that the overall recurrent pay cost reduction was £811k and not £730k as had been reported."

16/4/9 16/3/46 - "linked to Monitor" to be amended to "linked to the Monitor report".

16/4/10 16/3/52 – "In response to concern raised by John Parker with regard to how the reported over establishment of medical staff" to be replaced with "John Parker commented that the reported over establishment of medical staff did not reflect the true position and raised concern about how this".

16/4/11 16/3/54 – "(81.08 wte for February)" to be removed.

16/4/12 16/3/59 – "response rate was" to be amended to "response rate, with trusts using varying methods, was".

16/4/13 16/3/62 and 16/3/81 - "top" to be amended to "best".

16/4/14 16/3/60 - "There had been an improvement in the staff engagement score." to be added after the first sentence.

16/4/15 16/3/66 – "agency caps" to be amended to "agency cap rates"

16/4/16 16/3/69 – "The position" to be amended to "The reported position"

16/4/17 16/3/79 – "Teaching Hospitals" to be replaced with "Children's Hospital". Final sentence to be amended to read "Sewa Singh expressed his sympathy to the family for their loss."

16/4/18 16/3/83 – "In month performance" to be replaced with "In month response performance".

16/4/19 16/3/96 – "had not been" to be amended to "had inadvertently not been".

16/4/20 16/3/100 – "parental" to be replaced with "parenteral".

Actions from the previous minutes

16/4/21 The action notes from the meeting held on 22 March 2016 were reviewed and updated.

Matters arising

16/4/22 None raised.

Chairman's correspondence

Chris Scholey reported the following:

16/4/23 NHS Improvement – Chris Scholey had discussed the Trust's financial position with Stephen Hay, along with agency cap rates and the agency cost pressures. NHSI had agreed to visit local trusts in the region to discuss the issues further.

16/4/24 Working Together – Chris Scholey had chaired the recent meeting of working together chairs. The main discussion topic had been Sustainability and Transformation Plans (STP).

16/4/25 Board of Governors meeting – Overall it had been a good meeting, although there had been mixed feedback regarding the venue.

16/4/26 John Parker echoed concerns raised by Mike Addenbrooke at the meeting regarding waste following the purchase of document scanners for the electronic records strand of the iHospital project, which were now not to be used. He raised concern that the Board had not been aware of this.

16/4/27 It was noted that it had been previously reported to the Financial Oversight Committee that the iHospital Project had been suspended pending review due to the Trust's financial position, but the details above had not been reported.

16/4/28 With regard to electronic records proposals, Sewa Singh had been working closely with CGDs for several months to understand future requirements. The requirement to scan all historical records was being considered and the whole strategy for electronic records was being reviewed and refreshed. A proposal would be developed for the board to consider.

16/4/29 There was further discussion and it was noted that, although purchasing document scanners had presented a short term cost, new proposals could generate a cost saving in the longer term.

16/4/30 Governors – Mike Addenbrooke had been elected Vice Chair and George Webb had been elected Lead Governor. Two new Governors had also been elected and commenced in post.

16/4/31 Trust Medical Committee (TMC) – Chris Scholey had attended the recent meeting to report on events leading up to and following the misreporting of the Trust's financial position.

16/4/32 2016/17 objectives – The corporate objectives were now complete.

16/4/33 Non-executive Director appraisals – The majority of non-executive director appraisals had been undertaken.

The Chairman's correspondence was NOTED.

Chief Executive's report

16/4/34 Mike Pinkerton presented an overview of the report, which included a detailed executive summary reflecting on the events surrounding the financial misreporting, the resulting licence breach and consequences as the Trust moved into turnaround.

16/4/35 The Trust now had a clear and achievable plan for 2016/17, which had been shared with Monitor, partners, governors and staff. The 2017/18 and five year plans would need to be considered in detail during the coming year.

16/4/36 Finance was only one of the priorities for delivery, with quality also being a key focus. Many of the measures the Trust would take to improve efficiency would also positively impact on quality and patient experience.

16/4/37 Sustainability & Transformation Plan (STP) – The South Yorkshire and Bassetlaw STP Update and overview for boards was included in the papers for directors' information.

16/4/38 At the March meeting of the Working Together Partnership (WTP), chief executives and chairs had discussed the STPs, and how the WTP would fit within the new approach in particular. The STP was about service delivery on a place-based rather than organisation-based basis.

16/4/39 Mike Pinkerton reported that he was the executive lead for the STP cancer workstream.

16/4/40 An STP system-wide event had been held on 25 April 2016 and more meetings were planned over the coming weeks. The plan was to be delivered to a very short timescale.

16/4/41 Monitor / NHSI agency caps – Unavailability of agency staff to populate rotas now posed an escalating continuity of service risk to this and other trusts. The Trust was in ongoing discussion with NHSI to ensure they were aware of the position and the issues had also been raised directly with other trusts via the Working Together Steering Group.

16/4/42 2015 National Diabetes Inpatient Audit (NADIA) – There had been significant improvements in NADIA scores and the national NADIA audit team had written to the Trust to congratulate staff. The team were also interested in finding out how the Trust had made these improvements in order to share learning with other hospitals nationally. This was an outstanding result and was commended by Chris Scholey.

16/4/43 Fire notices – There had been good progress against the action plans in response to the enforcement notices.

16/4/44 NHSLA / CNST premium – The Trust's CNST premium had increased by

9.8% on the previous year against a national average increase of 17%. Whilst recognising that there had been an increase, there had been a comparative reduction in relation to the rest of the NHS.

16/4/45 Contracts / Commissioners – Contract volumes and finance had been agreed with both Doncaster and Bassetlaw CCGs.

16/4/46 Jackie Pederson had been appointed Accountable Officer for NHS Doncaster CCG and Dr Andrew Perkins had been appointed as Interim Clinical Chair for NHS Bassetlaw CCG. Mike Pinkerton had met with both of them in their new roles.

16/4/47 Objectives - Chris Mellor commented that the prime objective of the Trust was to develop a medium term sustainability plan, including clinical and financial plans. Chris Scholey concurred and it was agreed to reflect this in the objectives. It was also agreed to reflect the enforcement undertakings. NEDs would provide feedback on the objectives following the meeting. **NEDs**

16/4/48 Martin McAreavey commented that it was important to convey how challenging the financial position was in the context of the national savings to be made in the NHS. This was discussed. John Parker stated that it was important to recognise that the Trust could make improvements in quality but only within the funds available to it.

16/4/49 Making the required savings would be very challenging but the Trust was in a good position to review all of its initiatives. Key to delivering efficiencies while still delivering quality of care was the reorganisation of services and discussions with CCGs in this regard were underway.

The Chief Executive's report was NOTED

Q4 People & OD Report

16/4/50 Ruth Cooper reported that, overall, there had been good progress in spite of the challenges of the previous 6 months.

16/4/51 Absence – P&OD continued to work closely with managers to ensure absence rates were addressed. This had resulted in an increase in casework and capability action. Absence rates were being challenged at Grip and Control and Accountability meetings.

16/4/52 Health and Wellbeing Strategy – Due to the financial position, previous plans had been paused and lower cost initiatives were being explored. A key issue was mental health in the workplace and there was now a health and wellbeing CQUIN for this area.

16/4/53 John Parker expressed concern that the Health & Wellbeing Strategy had been paused and queried the strength of the Trust's commitment to health promotion and wellbeing. This was discussed and Ruth Cooper clarified that the strategy had not been fully suspended and work in this area was still being taken forward.

16/4/54 Staff survey and engagement – Overall, the results had been good in the context of the challenges faced by the Trust in the previous 6 months. There had been an improvement in the annual staff engagement score and response rates.

16/4/55 Appraisals – Appraisal rates had risen to 86%, a significant increase on the 27% reported in early 2014/15. There had been a positive response to work to support managers. Tools were now in place to help managers achieve good quality appraisals and work in this area would continue.

16/4/56 Turnover – It was anticipated that staff turnover would be affected by the impact of some turnaround workstreams over the coming year.

16/4/57 Martin McAreavey queried whether there were clear links between the turnaround programme, staff objectives and Care Group plans, and this was discussed. It was reported that Corporate objectives were assigned to executive leads and would flow down through the organisation. It was agreed to consider including a section in the objective setting documentation to link individual objectives to turnaround plans. **RC**

16/4/58 Alan Armstrong noted that there had been an increase in staff absence rates and queried what plans were in place to address this. This was discussed and Ruth Cooper undertook to consider what actions were required to reduce sickness absence to the target level of 3.5%. **RC**

The Q4 P&OD Report was DISCUSSED and NOTED.

Strategy & Improvement Report

16/4/59 Dawn Jarvis presented the report, noting that it had been taken to the Financial Oversight Committee. She provided an overview of updates since the time of the meeting.

16/4/60 The Executive Team had agreed to reintroduce the accountability, quality and performance meetings which had been replaced with Grip & Control meetings. The proposed cycle of meetings was detailed in the report and a revised timetable would be circulated. The second full round of 'grip and control' meetings were scheduled to take place during May and June. **DJ**

16/4/61 Remaining plans and delivery timescales - There had been a slight change to the reported timetable; a 2-year recovery plan would be delivered in August 2016, the draft strategy for financial sustainability would be delivered in October 2016, and the final strategy by December 2016.

16/4/62 Future reporting – The next report would include a narrative and graphical report for each work stream. The minutes and outputs from the Turnaround Programme Board meeting would also be provided in future.

16/4/63 CIP 2016/17 – Good progress continued to be made across the work streams to develop plans. Chris Scholey queried whether there was

further CIP potential and this was discussed. Further information would be provided in future reports.

16/4/64 Geraldine Broderick commended the work done so far.

The Strategy & Improvement Report was DISCUSSED and NOTED.

Hyper Acute Stroke Services (HASS) Review

16/4/65 Mike Pinkerton provided a detailed update on the assurance review undertaken by each of the three sub-regions of Yorkshire and the Humber to ascertain the resilience of their HASS model and next steps.

16/4/66 Following Senate discussions and CCG pre-consultation exercises, the principles and criteria for hyper-acute stroke services unit (HASU) status had been shared and were consistent with local expectations. All options included DBH, specifically DRI, as a HASU and current volumes and clinical outcomes supported this.

16/4/67 Locally the Trust was planning to respond positively to commissioners to enable the Trust to provide stroke services to a wider footprint than it currently did.

16/4/68 The report was discussed, with a focus on strategic significance. Consideration was given to further work required to understand quality, workforce and financial modelling, available investment, timescales, impact and downsides. Outline proposals would be included in STP plans to be submitted in June.

16/4/69 It was noted that there would be further strategy discussion, including a medium term recovery sustainability plan at a future Board Brief. **All**

The Hyper-Acute Stroke Review report was DISCUSSED and NOTED.

Finance Report as at 31 March 2016

16/4/70 Jeremy Cook presented the report and noted that the deadline for submission to NHSI of the 2015/16 financial accounts was 22 April 2016.

16/4/71 Financial performance – The forecast deficit of £36.4m deficit had been achieved at M12, prior to impairments arising from the revaluation of property, which were excluded when assessing financial performance. Including impairments of £10.4m, the total deficit stood at £46.8m.

16/4/72 The Trust had made a number of additional provisions at year end for bad debt. These were detailed in the report and Jeremy Cook provided an overview of the impact of this.

16/4/73 Expenditure – £378.6m, £33.6m worse than plan. Pay remained the single largest contributing factor due to the continued overspends on medical staff. Total pay costs in March had been the 3rd equal lowest in the year,

indicating that strong controls remained in place. However, non-pay expenditure had increased on previous months, partly due to non-recurrent costs and activity covered by income.

16/4/74 Income - £2.880m below plan, an improvement of £957k in month. Outpatient performance continued to be behind plan and Jeremy Cook provided an overview of the impact of the outpatient cap on follow-ups by speciality.

16/4/75 CIP – £1.86m achieved, a shortfall to retracted budget of £2.75m.

16/4/76 Cash – The reported cash position should state £2.2m and not £1.9m. This would be corrected.

16/4/77 2016/17 budgets – A revised financial plan had been submitted to NHSI on 13 April 2016, ahead of the national deadline. The plan stated that the Trust would achieve the control total deficit of £27.1m.

16/4/78 Geraldine Broderick discussed the format of the report, noting that it predominantly compared to budget, which did not provide a complete picture. She highlighted the lack of comparative data from previous years and stated that there should be greater integrated reporting across performance, turnaround and finance, and stronger links between income and expenditure, volume and case mix.

16/4/79 Jeremy Cook concurred and this was discussed in detail. The format of the report was currently being reviewed and the suggestions would be factored into the work. Chris Mellor also undertook to provide input. The revised format report would be provided from M2; for M1 there would be a focus on key variances and performance against CIP. It was proposed that a summary report would be provided to the board, with a more detailed report going to the Financial Oversight Committee, and this was endorsed. **JC** **CM**

16/4/80 Contingencies – In response to a query from Philippe Serna regarding the allocation of and accountability for contingencies, Jeremy Cook advised that going forward there would be more detail and transparency regarding what reserves and contingencies were being held for and who was responsible for them. Contingencies and reserves would only be moved upon proof of cost pressure.

16/4/81 In the context of grip and control, Dawn Jarvis raised concern that a detailed finance report would not be available for month 1. It was agreed that Dawn Jarvis and Jeremy Cook would discuss this outside of the meeting. **DJ/JC**

The Finance Report was REVIEWED and NOTED.

Business Intelligence Report as at 31 March 2016

16/4/82 David Purdue, Richard Parker and Sewa Singh presented the report and

drew attention to the following:

16/4/83 ED 4hr Access – 92.46% as a Trust for March 2016. Although the standard had been missed, the Trust was in the upper quartile of trusts despite having the highest level of attendances all year in March. Performance for the year ended at 94.51% as a Trust, which was also in the upper quartile nationally; national performance stood at 84.6% for the year.

16/4/84 Bassetlaw had achieved 95.64% in March and this was commended. Richard Parker stated that this reflected changes in the leadership and management of the ED.

16/4/85 In response to a query from Martin McAreavey about high ED activity levels, Richard Parker explained the factors that impacted on this. There was discussion about ED conversion rates, patient acuity, length of stay and underlying issues in the community, such as chest infections.

16/4/86 Richard Parker highlighted the success of the frailty pathway at DRI in relation to length of stay. Sewa Singh and others were now working on a similar model for Bassetlaw Hospital, with the aim of getting patients home at the earliest point possible.

16/4/87 John Parker queried the quality of data and this was discussed. Richard Parker reported that data quality for ED was good. Each month, a sample of 50 patients who had waited for 3hrs and 59 minutes were reviewed. Following further discussion, it was agreed that NEDs would follow up on any data quality concerns through relevant departments. **NEDs**

16/4/88 Ambulance handover times – As had previously been reported, EMAS had ceased to use the electronic system to manage waiting times. As a result of this, issues relating to data quality had continued.

16/4/89 RTT – Achieved as a Trust at 92.2%. There were no patients waiting more than 52 weeks.

16/4/90 Cancer – All targets achieved with the exception of consultant upgrade. As previously reported, the 62 day target was at risk with the key area of non-compliance being the urology pathway.

16/4/91 Diagnostic waits – Non-compliant at 98.36% against a standard of 99%. The target had been achieved in 11 out of 15 areas.

16/4/92 Stroke – There had been slight improvement but the Trust remained an outlier. Outcomes for stroke patients at the Trust were among the best in the region.

16/4/93 Cancelled operations – Theatre cancellations had improved.

16/4/94 Bed plan – The bed plan would be discussed in more detail in May.

16/4/95 Quality – There had been significant improvements on the previous year's performance. C.diff cases had reduced by 27% compared to the previous year. There had been a 49.5% reduction in HAPUs and the previous year's falls performance had been equalled with 12 cases despite a rise in admissions. This was commended.

16/4/96 Mike Pinkerton highlighted the impact of improved quality measures on bed requirements. Continued improvements in quality were key to enabling the Trust to reduce beds.

16/4/97 HSMR – The rolling 12-month HSMR to December 2015 stood at 95.3. The un-validated HSMR for the month of January was below the expected range.

16/4/98 Fractured neck of femur – There had been an improvement in March. A new electronic system which alerted clinicians to move patients along the pathway had been piloted in April and was to be rolled out.

16/4/99 SIs – There had been a reduction in the number of SIs reported in March compared to February.

16/4/100 Claims – There had been a reduction in the number of claims in 2015/16 compared to 2014/15. There had also been a significant reduction in the value of claims. Although there had been a rise in the Trust's NHSLA premium for 2016/17, the level of the increase was lower than the national average.

The Business Intelligence Report was REVIEWED and NOTED.

Nursing Workforce Update

16/4/101 Richard Parker reported that overall planned versus actual hours worked had been 97% in March (98% in February). This included staff for additional escalation beds.

16/4/102 Nurse manager clinical time – HoN clinical time targets had not been achieved in March for the MSK & Frailty Care Group due to the HoN currently being seconded to Strategy & Improvement.

16/4/103 A new way of recording patient care hours per day was to be introduced from 1 May 2016. The Trust had taken part in a pilot for the new system, which had been recommended in the Carter Report. The new system would provide hours worked per patient and would provide some national benchmarking data once embedded.

16/4/104 In response to a query from Martin McAreavey, Richard Parker advised that wards receiving red ratings for both workforce and quality triggered a quality meeting.

The Nursing Workforce Update was DISCUSSED and NOTED.

Q4 Complaints, Compliments, Concerns and Comments Report

Richard Parker drew attention to the following:

16/4/105 There had been a national increase in the level of reported concerns and complaints.

16/4/106 The number of reported complaints for A&E had reduced following the introduction of the new triage system.

16/4/107 Care Croups were using the data to set learning goals and events with staff groups were being held to share learning.

16/4/108 In response to a query from Alan Armstrong regarding the level of complaints in the MSK & Frailty Care Group, Richard Parker advised that the majority of complaints related to outpatient consultations. Patients had been invited to share their experience with clinicians and following this there had been an improvement in this area.

16/4/109 It was noted that trends in complaints were monitored, including complaints by consultant.

16/4/110 The Q4 Complaints, Compliments, Concerns and Comments Report was NOTED

Draft Annual Report & Quality Account 2015/16

16/4/111 Emma Bodley presented the draft report and drew attention to the timetable for submission to Monitor. All comments and feedback regarding content should be submitted to Emma Bodley by 6 May 2016. The final report would be approved at the next meeting. **ALL**

16/4/112 Chris Mellor made a number of suggestions regarding content. Amongst other things, he suggested that the report outline the reasons behind the misreporting of the financial accounts, and this was discussed. Chris Mellor undertook to provide any further suggestions outside the meeting.

16/4/113 The draft Annual Report and Quality Account 2015/16 was NOTED, and would be brought back to the next meeting for approval.

Trust Seal

16/4/114 Maria Dixon agreed to provide the chair with clarification of position regarding the reported breach of standing orders in March 2016. **MD**

16/4/115 Maria Dixon presented the schedule which detailed the Register of Sealing number 76 and this was NOTED.

Minutes of the Management Board meeting held on 29 March 2016

16/4/116 The minutes of the Management Board meeting held on 29 March 2016 were NOTED.

Report from the Chair of the Audit Committee

16/4/117 It was noted that one of the recommendations of the KPMG investigation into financial misreporting at the Trust was for the Chair of the ANCR committee to report to the Board after each meeting to escalate any significant control weaknesses or other risks.

16/4/118 Philippe Serna presented the report which provided a summary of the ANCR Committee meeting held on 18 March 2016. The report was NOTED.

Items for escalation from sub-committees

16/4/119 Statutory & Essential to role Training (SET) – Martin McAreavey asked for assurance about the reported levels of training. Dawn Jarvis advised that to ensure the accurate recoding of training data, a project similar to that undertaken in respect of the recording of appraisals was underway.

16/4/120 SET data was being validated to ensure it had been accurately recorded and reporting would be monitored through the CGOC. Ward SET levels would also be monitored as part of QAT.

Board of Directors and Board Briefing Agenda Calendars

16/4/121 The agenda calendars were NOTED.

South Yorkshire & Bassetlaw STP update & Overview for Board.

16/4/122 The South Yorkshire and Bassetlaw STP update and overview was NOTED.

Any other business

16/4/123 None raised.

Governor questions

16/4/124 In response to a query from George Webb regarding consultant engagement with turnaround, Dawn Jarvis advised that although there remained some concern amongst consultants with regard to the pace of the turnaround work, overall engagement had started to improve.

16/4/125 George Webb welcomed the proposed changes to the finance report.

16/4/126 In response to a query from George Webb about proposed savings through the introduction of multifunction printing devices, Dawn Jarvis undertook to share the business case outside of the meeting. **DJ**

16/4/127 In response to a query from Mike Addenbrooke with regard to the recovery of income for patients from outside the UK, Jeremy Cook advised that this was part of an income work stream. He undertook to provide an update outside of the meeting. **JC**

Date and time of next meeting

16/4/128 It was confirmed that the next meeting of the Board of Directors would be held at 9am on Tuesday 24 May 2016 in the Boardroom at Bassetlaw Hospital.

…… ……

Chris Scholey **Date**

Chairman

Doncaster and Bassetlaw Hospitals NHS
NHS Foundation Trust

Title	**Financial Performance – May 2016**		
Report to:	**Board of Governors**	Date:	**30 June 2016**
Author:	**Jeremy Cook (Interim Director of Finance)**		
For:	**Approval**		

Purpose of Paper: Executive Summary containing key messages and issues

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

Recommendation(s)

The Board is asked to NOTE that the reported financial position is a deficit of £4.9m.

The variance against plan for Month 2 is £0.5m favourable. CIP performance is also favourable against the plan by £0.3m.

Delivering the Values – We Care

- Not applicable

Related Strategic Objectives

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

Analysis of risks

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

Board Assurance Framework

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

Finance Performance Report

Financial Year 2016/17
Month 2 (May 2016)

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  - 1.1 Finance Overview
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1.0 Executive Summary

1.1 Finance Overview

The Month 2 financial position is £4.863m deficit against a revised planned deficit of £5.392m – a favourable variance of £0.529m. The position includes a £2.1m provision in expenditure to match planned YTD cost pressures that have yet to materialise.

The Trust has submitted a draft annual plan to NHS Improvement in April showing a deficit of £27.1m. It is now forecasting to reduce this deficit by £2.4m to **£24.7m** at year end to reflect a technical adjustment for donated asset income. The Trust will submit a final plan to NHS Improvement to reflect the revised forecast and profile changes.

Key points to note in the Month 2 year to date (YTD) income and expenditure position are:

- £1.97m accrued for Sustainability and Transformation Funding (£11.8m in annual plan). Cash payment will be made quarterly in arrears and subject to meeting the control total and performance targets
- £0.7m over performance in clinical income mainly due to non elective (NEL) admissions (£0.3m), HCDs (£0.3m), A&E (£0.2m), maternity (£0.1m) and other (£0.4m) offset by OP follow up caps penalty (£0.3m) & marginal rate reduction for NEL income above the threshold (£0.2m)
- £0.4m under spend against operational budgets. This is mainly due an improvement in run rate.
- £1.28m achievement of CIP against a YTD plan of £1.0m – a favourable variance of £0.3m. This equates to CIP delivery of £8.2m in year and £8.4m full year effect

Cash balance at the end of May was £2.0m against the £1.9m plan. The cash draw down in May was £2.0m in line with plan.

Capital expenditure YTD was £1.6m against a plan of £2.1m The slippage of £0.5m is due to medical equipment (£0.3m) and Water Safety (£0.2m).

The Finance Dashboard in 1.2 summarises the financial position through a set of key metrics, the Summary of Comprehensive Income in 1.3 provides further detail at Trust level and 1.4 shows I&E by Care Group.

1.2 Finance Dashboard

	Plan to Month 2 £'m	Actual to Month 2 £'m	Cumulative Variance to Month 2 £'m	Cumulative Variance to Month 1* £'m	Month 1 vs Month 2 Run Rate
Deficit before technical adjustment	-5.4	-4.9	0.5	0.3	**+ve**
Income	61.3	61.4	0.1	0.4	**-ve**
Operating expenditure (inc CIP)	-64.4	-64.0	0.4	-0.2	**+ve**
CIP	1.0	1.3	0.3	0.1	**+ve**
Agency and bank expenditure	-4.2	-3.4	0.8	0.4	**+ve**
Financing costs	-2.3	-2.3	0.0	0.0	**-**
Cash balance	1.9	2.0	-0.1	0.0	**-ve**
Cash draw down	4.2	6.4	-2.2	-2.2	**-**
Capital expenditure	-2.1	-1.6	0.5	-0.2	**+ve**
	Target Score	**Actual Score**	**Cumulative Variance to Month 2**	**Cumulative Variance to Month 1**	**Month 1 vs Month 2 Run Rate**
Financial sustainability risk rating	1	1	0	0	**-**

* Month 1 performance is the reported position against draft annual plan

1.3 Summary of Comprehensive Income

	2015/16	2016/17	Month 2 2016/17			Month 2 YTD 2016/17			Month 2 YTD 2015/16	2015/16 vs. 2016/17
	Outturn	Plan	Plan	Actual	Variance	Plan	Actual	Variance	Actual	Variance
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Income										
Clinical income	321,011	334,299	27,868	28,001	133	54,974	55,689	715	53,193	2,496
Other income	26,712	30,441	2,393	2,255	-137	4,674	4,504	-171	2,653	1,851
Income recharges	9,848	10,294	898	599	-299	1,659	1,226	-433	1,547	-321
Total income	**357,571**	**375,034**	**31,158**	**30,855**	**-303**	**61,307**	**61,419**	**111**	**57,393**	**4,026**
Expenditure										
Pay	-247,909	-251,994	-21,026	-20,827	199	-42,070	-41,571	498	-40,772	-800
Drugs	-32,493	-33,348	-2,464	-2,728	-264	-4,951	-5,476	-525	-5,127	-349
Clinical supplies & services	-29,988	-28,592	-2,333	-2,058	275	-4,669	-4,358	310	-5,162	804
Other non pay	-57,616	-58,917	-4,227	-4,566	-339	-8,607	-9,187	-581	-9,556	369
Contingency and Reserves	-664	-2,193	-1,361	-796	565	-2,403	-2,150	253	1,442	-3,592
Recharges	-9,848	-10,294	-831	-599	231	-1,661	-1,226	435	-1,547	321
Total expenditure	**-378,518**	**-385,338**	**-32,241**	**-31,574**	**667**	**-64,360**	**-63,970**	**390**	**-60,722**	**-3,247**
EBITDA	-20,947	-10,304	-1,083	-719	364	-3,053	-2,551	502	-3,329	778
Finance costs	-15,410	-14,396	-1,172	-966	206	-2,340	-2,312	28	-2,576	264
Impairment	-10,382	0	0	0	0	0	0	0	-1,730	1,730
Deficit for the year	**-46,739**	**-24,700**	**-2,255**	**-1,685**	**570**	**-5,392**	**-4,863**	**529**	**-7,636**	**2,772**

1.4 Income and Expenditure by Care Group

Care Groups	Average Actual Worked 15/16	Income			Expenditure			Net Budget Position Variance £'000	May 2015 Reported Variance £'000
		Budget to date £'000	Actual to date £'000	Variance £'000	Budget to date £'000	Actual to date £'000	Variance £'000		
Children & Families Care Group	624.6	8,246	8,450	203	7,471	7,301	170	374	-313
Diagnostic & Pharmacy Care Group	583.6	1,691	1,840	149	5,456	5,518	-62	87	-94
Emergency Care Group	845.6	9,940	10,724	784	8,344	8,428	-84	700	-1,116
MSK & Frailty Care Group	860.4	11,696	11,636	-60	9,721	9,995	-274	-334	-17
Specialty Services Care Group	601.4	9,995	9,777	-218	7,525	7,277	248	31	-310
Surgical Care Group	1,065.0	10,713	10,290	-423	12,001	11,724	277	-146	-977
Corporate Directorates, Recharges and Contingency	1,096.6	9,023	8,702	-321	13,842	13,727	115	-206	2,623
Trust Total	**5,677.2**	**61,305**	**61,418**	**112**	**64,360**	**63,969**	**391**	**502**	**-205**

(+ Favourable / - Unfavourable)

1.5 Summary of CIP Position

The Table opposite summarises the Trusts CIP performance for Month 2

- The Trust has a 2016-17 CIP target of £11.0m against which it has delivered £8.2m part year effect (PYE) and £8.4m full year effect (FYE)
- The year to date delivery is £1.28m against a YTD plan of £1.0m – a favourable variance of £0.3m
- At the end of May 2016 the Trust is forecasting to deliver £12.6m in year and £17m FYE. Of this £4.3m PYE and £8.2m are risk rated as either amber or red
- The Trust's CIP stretch target is £13m of which £12.4m has been included within Care Group Budgets. This leaves an in year gap of £0.4m

To date Finance has actioned around £4m of the £8.2m of schemes identified as delivered by the PMO. Finance and the PMO are working closely to harmonise monitoring and reporting processes and to ensure that all CIP delivered are actioned for Month 3

	Month 2 YTD £'000	In Year £'000	FYE £'000
Target	**998**	**11,000**	
Expenditure CIP delivered	1,156	7,762	7,974
Income CIP delivered	125	425	425
Total CIP delivered	**1,281**	**8,187**	**8,399**
YTD Variance	**283**	**-2,813**	
Delivered		8,187	8,399
Forecast delivery green		91	359
Forecast delivery amber		2,391	4,684
Forecast delivery red		1,900	3,562
Total forecast delivery		**12,570**	**17,004**
Forecast variance against target		**1,570**	**17,004**
Gap against £13m stretch target		**-430**	

	Month 1	Month 2 YTD	Movement
Delivered	8,008	8,187	179
Forecast delivery green	131	91	-40
Forecast delivery amber	2,341	2,391	50
Forecast delivery red	1,900	1,900	0
Total forecast delivery	**12,380**	**12,570**	**190**

1.6 Changes to 2016-17 Annual Plan

The Trust has submitted a draft annual plan to NHS Improvement in April showing a deficit of £27.1m.

However, since then changes the forecast deficit has reduced from £27.1m to £24.7m

The 1st table opposite summaries the changes to the plan due to profile difference and the non recurrent technical adjustment relating to Donated Asset income

The 2nd table shows the Trust's YTD financial performance against both plans

Month	April Draft Plan £'000	Profile changes £'000	Donated Asset Income £'000	Revised Plan £'000	Cumulative Revised Plan £'000
April	-3,426	803		-2,623	-2,623
May	-2,603	-172		-2,775	-5,398
June	-2,386	155	1,880	-351	-5,749
July	-2,267	-278	225	-2,320	-8,070
August	-2,910	411	175	-2,324	-10,393
September	-2,174	-8	120	-2,062	-12,455
October	-1,749	-374		-2,123	-14,578
November	-1,435	-13		-1,448	-16,027
December	-3,026	-147		-3,173	-19,200
January	-1,884	-77		-1,961	-21,161
February	-3,004	-141		-3,145	-24,306
March	-236	-158		-394	-24,700
Total	**-27,100**	**0**	**2,400**	**-24,700**	

Month	April Draft Plan £'000	Actual £'000	Variance Draft Plan £'000	Revised Plan £'000	Actual £'000	Variance Revised Plan £'000
April	-3,426	-3,178	248	-2,623	-3,178	-555
May	-6,029	-4,863	1,166	-5,392	-4,863	529

2.0 Financial Risks & Sensitivity Analysis

2.1 Sensitivity Analysis

A sensitivity analysis has been undertaken which shows more upside opportunities than downside risks – see table below.

The downside case shows a deficit of £27.7m reflecting cost pressures for nursing and medical imaging and the upside case is a deficit of £16.7m reflecting a continuation of the favourable run rates shown in Months 1 and 2.

A review of the forecast will be undertaken from Month 3 onwards

	Downside case	Base case	Upside case	
	£'m	£'m	£'m	Comments
Forecast outturn	-36.4	-36.4	-36.4	
Donated asset income 16/17	2.4	2.4	2.4	
Non recurrent and full year effects	-0.1	-0.1	-0.1	
Run rate improvement	3.5	3.5	6.5	Upside +£3.0m
Budget setting cost pressures	-12.3	-10.3	-8.3	Downside -£2.0m , upside +£2m
Baseline budgets	**-42.9**	**-40.9**	**-35.9**	
Pay inflation	-7.7	-7.7	-7.7	
Non pay inflation	-3.9	-3.9	-2.9	Upside +£1.0m
Tariff uplift	5.5	5.5	5.5	
Drug growth	-0.5	-0.5	-0.5	
CIP	10	11	13	Downside -£1m, upside +£2m
Sustainability and transformation funding	11.8	11.8	11.8	
	-27.7	**-24.7**	**-16.7**	

2.2 Summary of Financial Risks (1)

Financial risk	Potential risk	Risk mitigation
Delivery of revised deficit plan of £24.7m.		The revised plan is based on prudent planning assumptions. A sensitivity analysis show an 'upside case' of £16.7m deficit and a 'downside case' deficit of £27.7m
Delivery of CIP	Failure to achieve £12.4m CIP will impact on the Trust's ability to maintain a contingency reserve of £2.2m	Work is ongoing to identify CIP opportunities and since Month 1 a further £0.2m has been delivered. PMO and Finance are working closely to together to validate all CIP schemes and ensure that they are appropriately actioned within Care Group budgets
Underperformance against acute contracts	Trust is currently over performing but is underperforming against its outpatient plan due the outpatient follow up cap penalty (£0.3m).	A review by the Care Groups is required to address those specialties in breach of the outpatient follow up cap. The top 5 specialties breaching the cap are: Haematology, Dermatology, Pain Management, and Urology
CQUIN income risk	Plan assume 100% CQUIN achievement at £6.5m. Last year CQUIN achievement was between 70% to 80%	The Trust has agreed more realistic CQUIN standards in its 2016-17 CCG contracts.
Escalating cost pressures	Cost pressures exceeding financial cost envelope of £9.5m Increase in expenditure run rate	The Trust's financial plan includes a risk contingency reserve of £0.8m and an additional £1.4m from CIP over performance against its £11m target. Non pay inflation reserve of £3.5m is still held centrally to support any price increases Finance is currently reviewing all cost pressures and will start to allocate funding from Month 3 based on evidence of costs incurred

2.2 Summary of Financial Risks (2)

Financial risk	Potential risk	Risk mitigation
Failure to meet conditions of STF £11.8m	Trust has currently assumed £2.0m within its Month 2 YTD position	Trust has achieved its performance trajectory to date and is expected to achieve this for the rest of the year
Winter cost pressures	Trust currently has unfunded beds open and has yet to identify its funding requirements for Winter pressures	Bassetlaw CCG has converted 1% of its CQUIN monies to fund additional beds for Winter A Trust wide Winter Plan is required with appropriate funding
Rebasing of ward nursing budgets from outturn funding to funding in line with AUKUH guidance could result in some wards being funded at less than outturn	Establishment control, unfunded bank and agency nursing and service developments e.g. Stroke ward nursing to achieve best practice	Executive Director of Nursing has communicated to budget holders the change in budget setting approach and the importance of maintaining budgetary control
Cash funding not agreed for the year – covered on month by month basis	The Trust requires an additional £22.7m of cash support for the rest of the financial year - £29.1m in total	Executive Director of Finance is in discussion with NHS Improvement to agree a cash support for the rest of the financial year
Restrictions on capital spend due to cash issues	Impact on backlog maintenance	Completion of risk assessment required to better understand the risks

3.0 Income Position

3.1 Income Summary

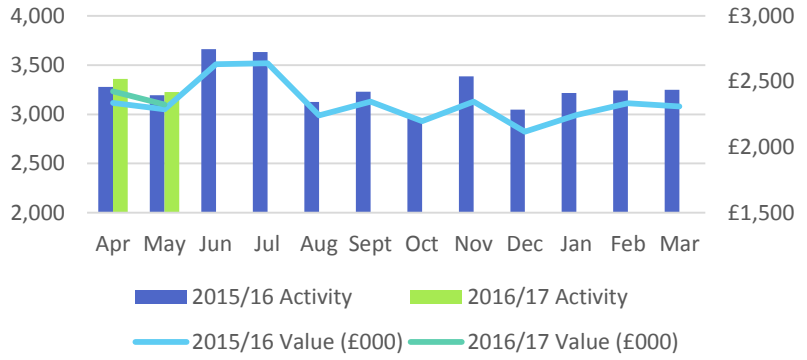
- NHS Clinical Income is £729k ahead of plan at the end of Month 2, largely driven by Non PBR drugs expenditure being ahead of plan and the non delivery of CCG QIPP targets that are included in contract baselines.
- Contract income related to Daycase and Elective activity is slightly ahead of plan at the end of May, but with significant variances between specialities. T&O, Ophthalmology and Urology activity are below target levels, offset by over performance within General Medicine, GI Surgery and Haematology.
- Both the volume and case mix of Emergency activity is ahead of plan at the end of Month 2. The only speciality with notable underperformance in this area is GI Surgery, with an adverse price and volume variance.
- The vast majority of the Non PBR drugs over performance relates to the new Hep C drugs that are funded by NHS England outside of the main contract. The over-recovery of income will have a corresponding offset in expenditure.
- The in month income performance of £105k is artificially low due to a phasing adjustment made between month 1 and 2 in the plan. The restated in month May performance would an over-recovery of income of £457k. The cumulative position is unaffected.
- The table in 3.2 below analyses the NHS Clinical Income and Activity and the table in 3.10 provides an analysis of Other Income

3.2 NHS Clinical Income & Activity

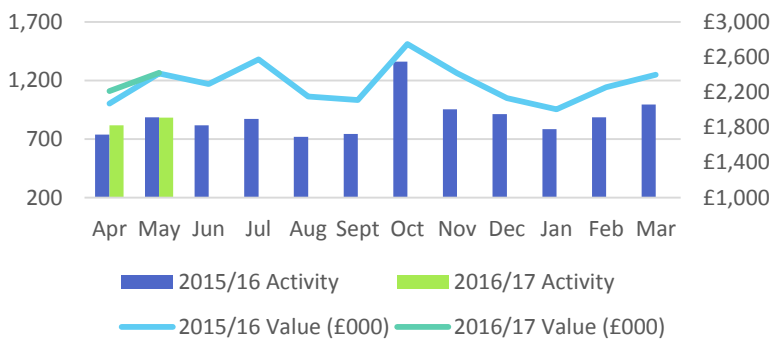
	Annual Plan		Cumulative to May 2016						May 2016 Only					
			Plan YTD		Actual YTD		Variance YTD		Plan		Actual		Variance	
	Activity	£000	Activity	£000	Activity	£000	Activity	£000	Activity	£000	Activity	£000	Activity	£000
Daycase	40,135	29,385	6,446	4,719	6,589	4,747	143	28	3,179	2,379	3,224	2,324	45	(55)
Elective	9,857	28,001	1,624	4,614	1,700	4,633	75	19	839	2,290	859	2,396	20	107
Emergency	38,421	68,378	6,362	11,350	6,577	11,637	215	287	3,228	5,965	3,364	5,833	136	(131)
Readmissions	4,972	11,488	834	1,927	1,233	2,828	399	902	414	957	606	1,367	192	410
Readmissions - Income Adj.	0	0	0	0	0	(928)	0	(928)	0	0	0	(418)	0	(418)
ERT	0	(1,426)	0	(237)	0	(435)	0	(198)	0	(120)	0	(269)	0	(150)
Reinvestment of ERT	0	907	0	151	0	151	0	0		76	0	76	0	0
Non Emergency	2,385	2,749	402	461	326	317	(76)	(144)	210	238	167	159	(43)	(79)
	95,770	**139,481**	**15,668**	**22,985**	**16,424**	**22,951**	**756**	**(35)**	**7,870**	**11,785**	**8,220**	**11,468**	**350**	**(317)**
Outpatients First	112,739	17,526	18,537	2,882	19,352	2,997	815	116	9,212	1,432	9,358	1,452	146	20
Outpatients Follow Up	242,972	21,844	40,285	3,622	40,531	3,667	245	45	19,546	1,896	20,146	1,842	600	(54)
Outpatient Procedures	75,556	11,576	12,419	1,902	11,838	1,786	(580)	(116)	5,950	912	5,598	838	(352)	(74)
Outpatient CAP	0	0	0	0	0	(313)	0	(313)	0	0	0	(135)	0	(135)
	431,267	**50,945**	**71,241**	**8,405**	**71,721**	**8,138**	**480**	**(267)**	**34,709**	**4,240**	**35,103**	**3,997**	**394**	**(243)**
Drugs	0	24,547	0	3,769	0	4,072	0	303	0	2,078	0	2,027	0	(51)
A&E	142,510	16,148	24,512	2,777	26,166	3,008	1,654	230	12,541	1,421	13,700	1,583	1,159	162
Maternity	15,417	20,329	2,565	3,376	2,615	3,514	50	138	1,288	1,692	1,294	1,733	6	41
Critical Care	14,848	13,044	2,485	2,181	2,490	2,187	5	6	1,271	1,119	1,259	1,111	(12)	(8)
CPC	181,803	22,449	29,665	3,666	29,113	3,605	(552)	(61)	18,046	2,236	20,873	2,381	2,827	145
Block	0	23,329	0	3,888	0	3,888	0	(0)	1,441	1,188	1,749	1,215	308	26
Block Transition	0	(2,613)	0	(436)	0	(436)	0	0	0	(218)	0	(218)	0	0
CQUIN	0	6,457	0	1,076	0	1,076	0	0	0	482	0	538	0	56
STP Funding	0	11,800	0	1,967	0	1,967	0	0		983		983	0	0
Other	67,153	7,946	10,682	1,305	12,494	1,719	1,812	414	473	1,948	546	2,240	73	293
	421,731	**143,435**	**69,910**	**23,569**	**72,878**	**24,600**	**2,968**	**1,031**	**35,060**	**12,930**	**39,421**	**13,594**	**4,361**	**665**
Total	**948,768**	**333,862**	**156,818**	**54,960**	**161,023**	**55,689**	**4,205**	**729**	**77,638**	**28,955**	**82,744**	**29,060**	**5,106**	**105**

3.3 Income & Activity Graphs by Point of Delivery (1)

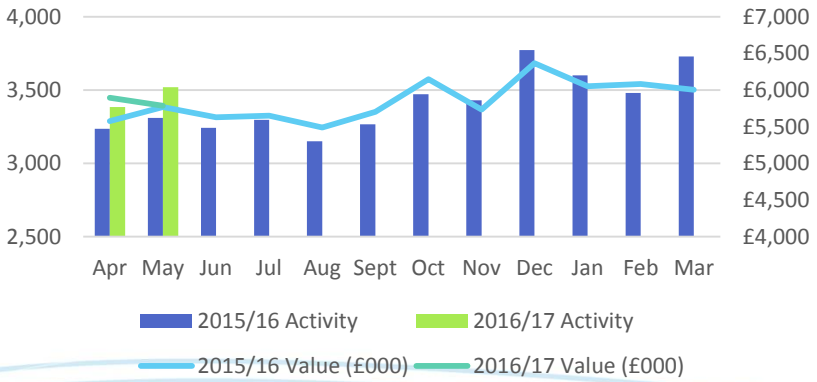
Daycase



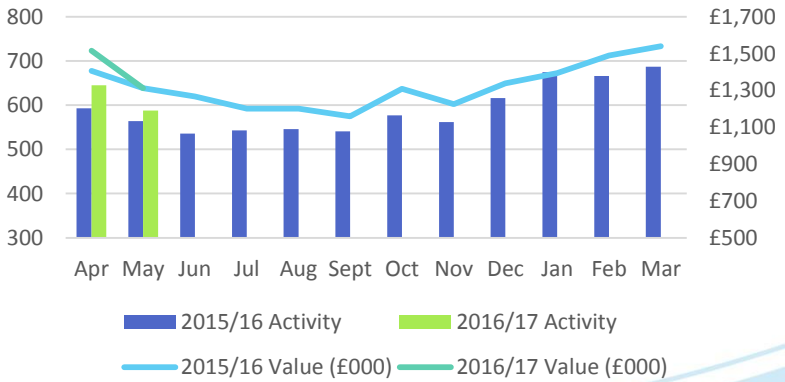
Elective



Emergency & Non-Emergency

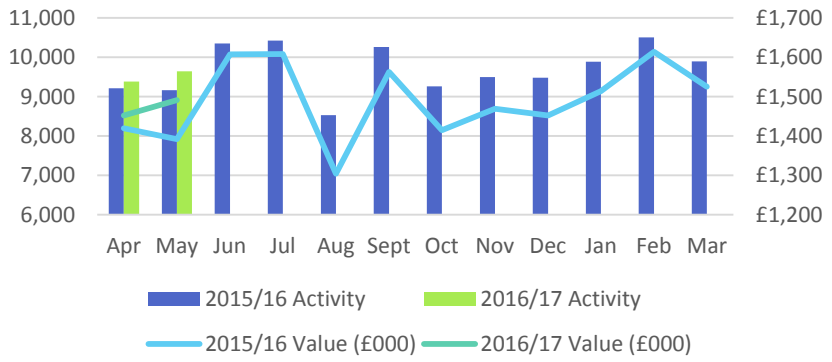


Emergency Readmissions

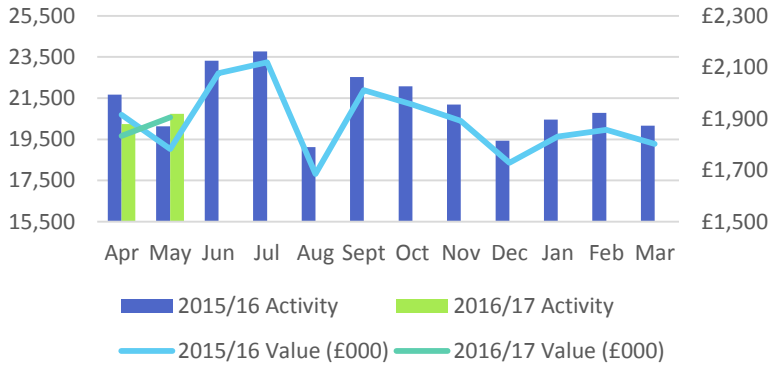


3.3 Income & Activity Graphs by Point of Delivery (2)

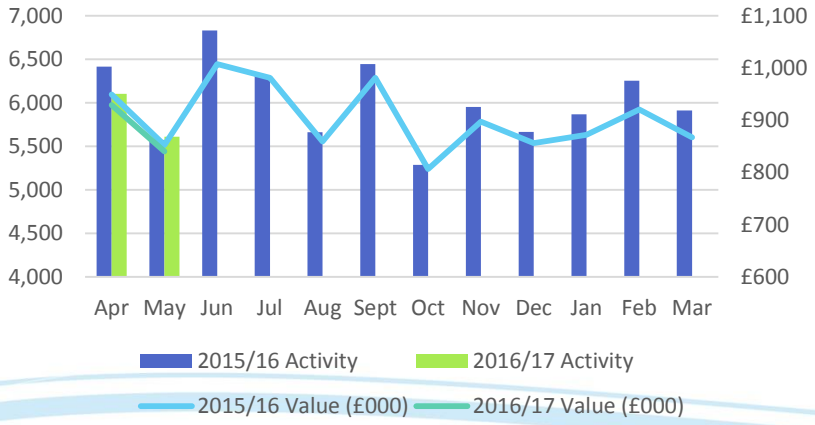
Outpatient First Appointments



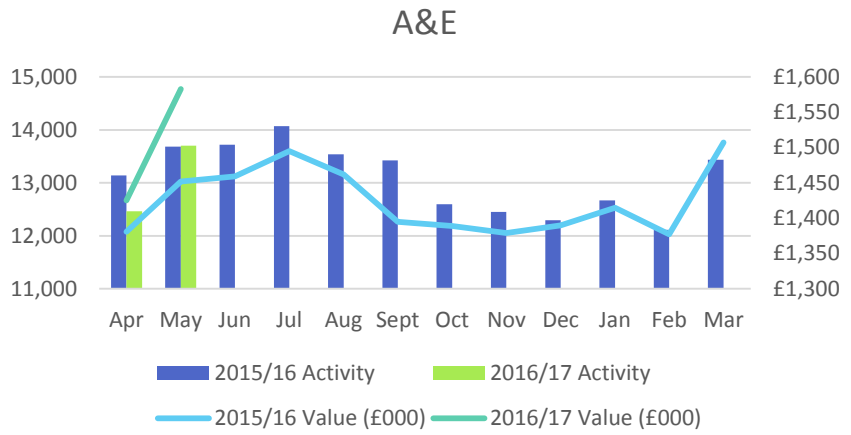
Outpatient Follow Up Appointments

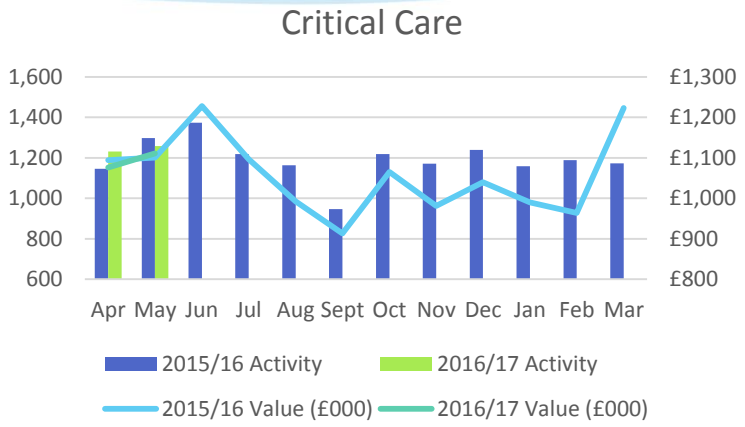


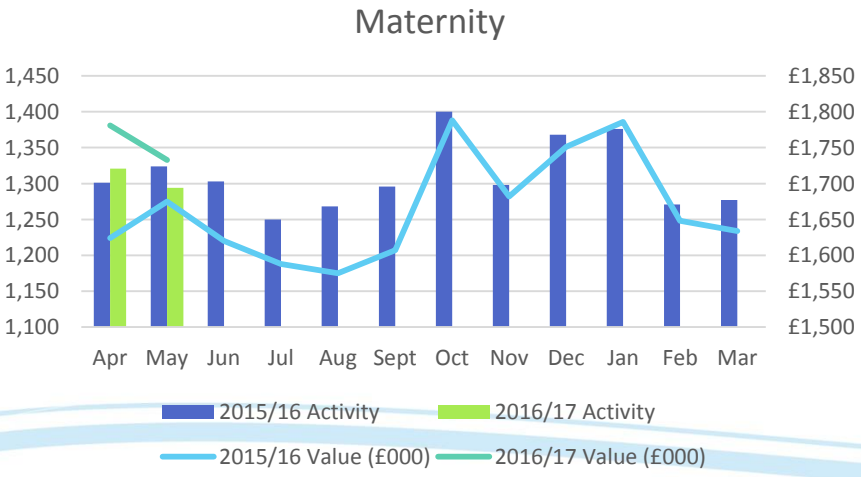
Outpatient Procedures



3.3 Income & Activity Graphs by Point of Delivery (3)







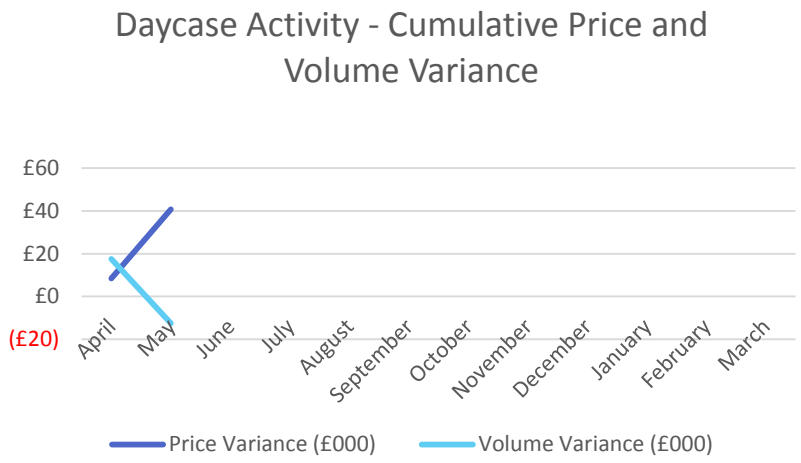
N.B The reduction in A&E activity from Oct 15 corresponds with the new Front Door Assessment model.

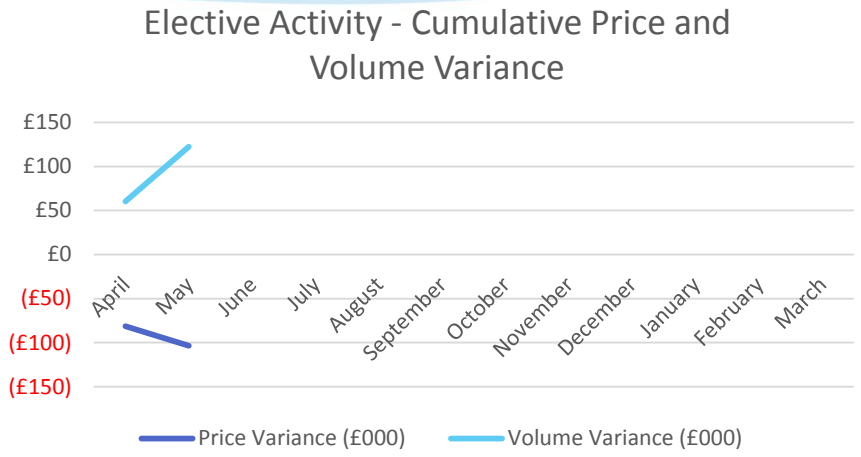
The spike in Elective activity in Oct 15 relates to CAMHIS coding changes between Daycase and Elective activity.

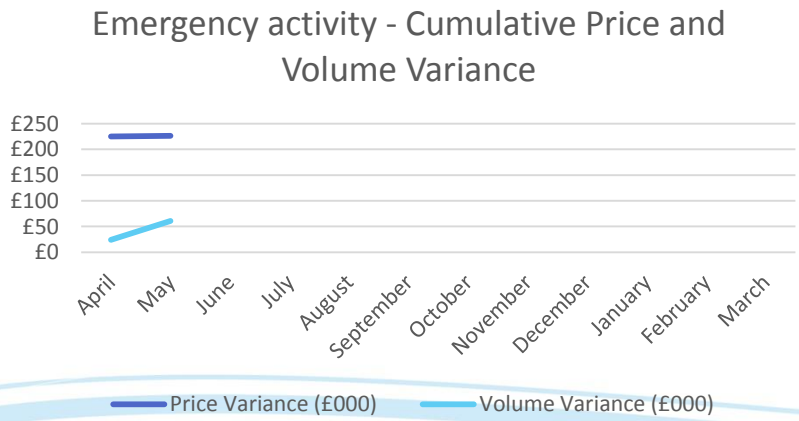
3.4 Price and Volume Analysis

	Cumulative to May 2016					May 2016 Only				
POD	**Plan (£000)**	**Actual (£000)**	**Variance (£000)**	**Volume Variance (£000)**	**Price Variance (£000)**	**Plan (£000)**	**Actual (£000)**	**Variance (£000)**	**Volume Variance (£000)**	**Price Variance (£000)**
Inpatients										
Daycase	4,719	4,747	28	(13)	41	2,379	2,324	(55)	(30)	(25)
Elective	4,614	4,633	19	122	(104)	2,290	2,396	107	62	45
Emergency	11,350	11,637	287	61	226	5,965	5,833	(131)	37	(168)
Readmissions	1,927	2,828	902	867	34	957	1,367	410	369	41
Non Elective Non Emergency	461	317	(144)	(161)	17	238	159	(79)	(86)	7
	23,071	**24,163**	**1,092**	**877**	**215**	**11,829**	**12,080**	**251**	**352**	**(101)**
Outpatients										
New	2,882	2,997	116	109	7	1,432	1,452	20	104	(84)
Follow Up	3,622	3,667	45	48	(3)	1,896	1,842	(54)	80	(135)
Procedures	1,902	1,786	(116)	(120)	4	912	838	(74)	(49)	(24)
	8,405	**8,451**	**46**	**38**	**8**	**4,240**	**4,132**	**(108)**	**135**	**(243)**
Other PbR Income										
A&E	2,777	3,008	230	187	43	1,421	1,583	162	131	31
Critical Care	2,181	2,187	6	4	2	1,119	1,111	(8)	(88)	80
Maternity	3,376	3,514	138	66	72	1,692	1,733	41	8	33
	8,334	**8,709**	**375**	**257**	**117**	**4,232**	**4,428**	**195**	**51**	**145**

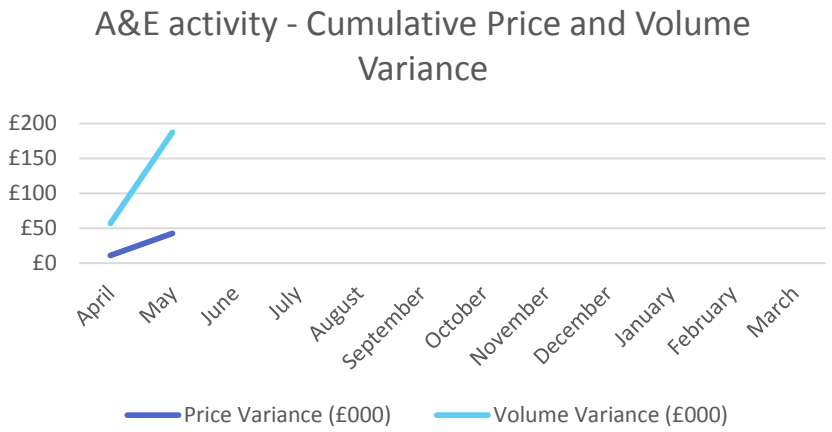
3.5 Price and Volume Graphs (1)

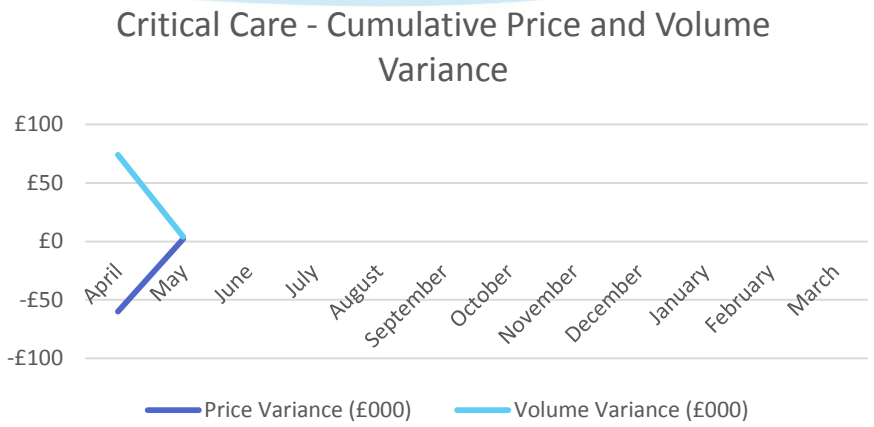


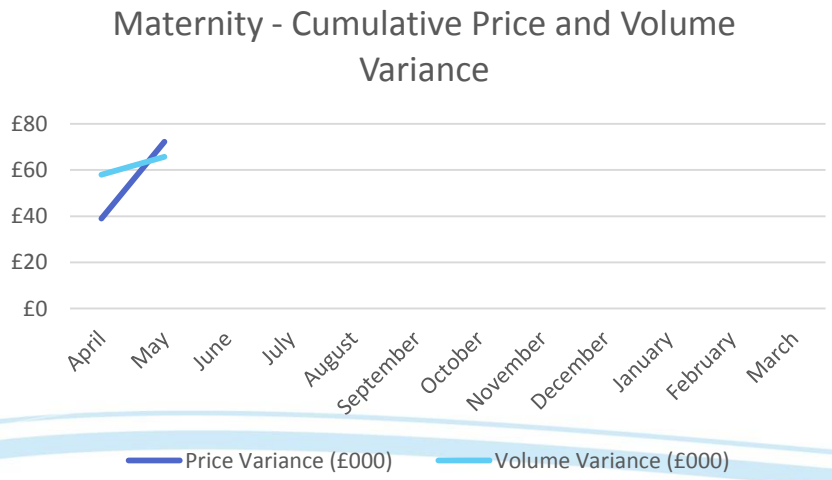




3.5 Price and Volume Graphs (2)







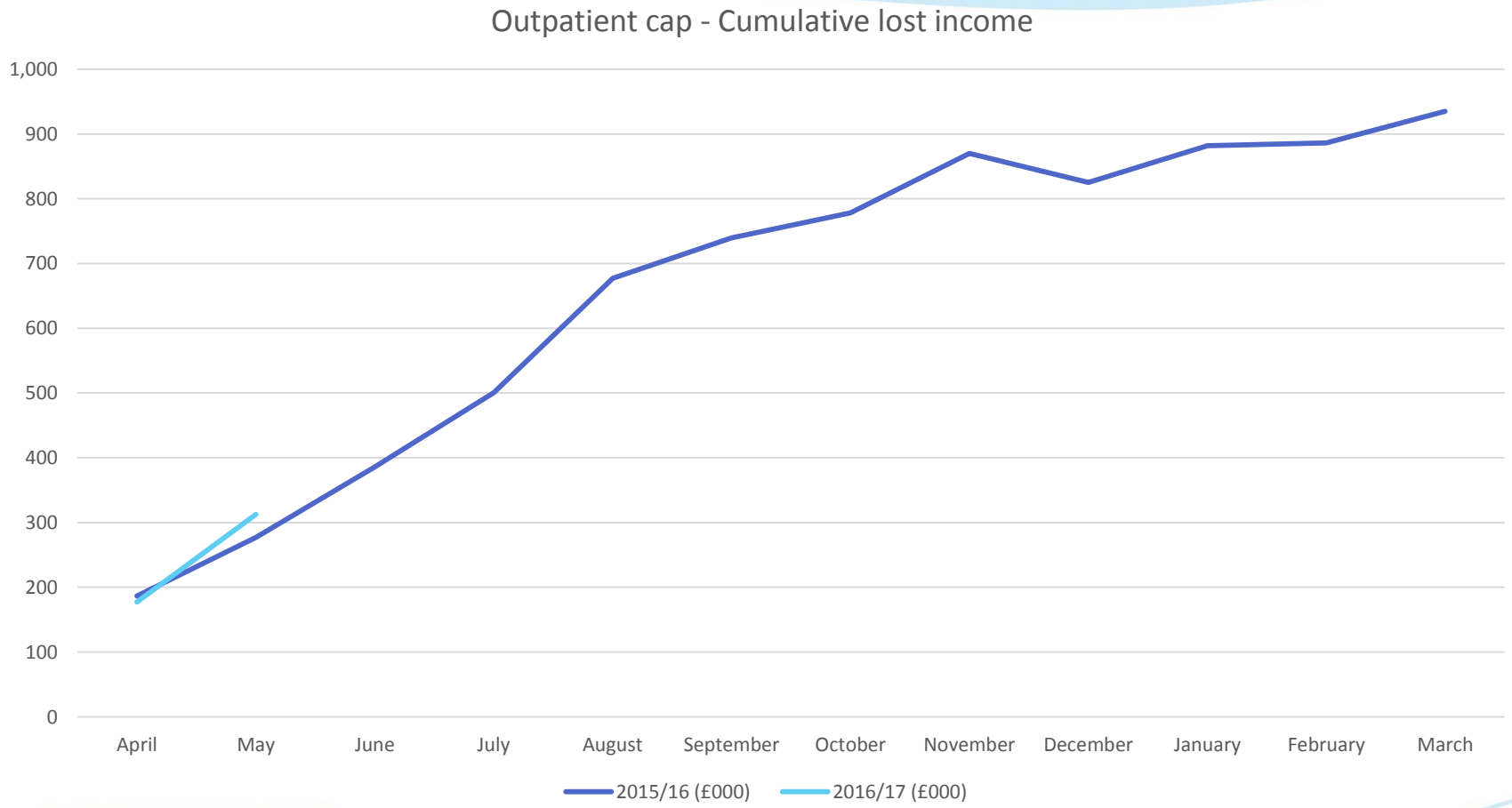
3.6 Income and Activity by Care Group

Specialties		Activity			Income (£000)		
		Target to date	Actual to date	Variance	Budget to date	Actual to date	Variance
Children & Families Care Group	Daycase and Elective	482	419	-63	559	483	-76
	Emergency	1,809	2,048	239	1,335	1,381	45
	Outpatient	6,198	6,510	312	909	929	20
	Other	6,632	7,138	506	5,443	5,657	214
Total Children & Families Care Group		**15,122**	**16,115**	**993**	**8,246**	**8,450**	**203**
Diagnostic & Pharmacy Care Group	Other	8,096	8,833	737	1,691	1,840	149
Total Diagnostic & Pharmacy Care Group		**8,096**	**8,833**	**737**	**1,691**	**1,840**	**149**
Emergency Care Group	Daycase and Elective	1,687	1,922	235	882	1,084	203
	Emergency	2,301	2,611	310	4,479	4,648	169
	Outpatient	4,892	5,254	362	677	723	46
	Other	26,507	27,620	1,113	3,902	4,269	367
Total Emergency Care Group		**35,387**	**37,407**	**2,020**	**9,940**	**10,725**	**785**
MSK & Frailty Care Group	Daycase and Elective	1,512	1,541	29	3,536	3,405	-131
	Emergency	2,105	1,074	-1,031	2,765	2,786	21
	Outpatient	14,803	14,352	-451	1,552	1,515	-37
	Other	2,642	2,391	-251	3,842	3,930	88
Total MSK & Frailty Care Group		**21,062**	**19,358**	**-1,704**	**11,696**	**11,636**	**-60**
Specialty Services Care Group	Daycase and Elective	1,362	1,464	102	1,547	1,600	53
	Emergency	1,212	1,094	-118	2,769	2,643	-126
	Outpatient	19,573	20,312	739	2,589	2,424	-165
	Other	14,432	15,413	981	3,090	3,110	21
Total Specialty Services Care Group		**36,579**	**38,283**	**1,704**	**9,995**	**9,777**	**-218**
Surgical Care Group	Daycase and Elective	3,027	2,942	-85	2,810	2,809	-2
	Emergency	1,223	1,309	86	2,114	1,961	-153
	Outpatient	25,774	25,293	-481	2,678	2,547	-131
	Other	11,492	10,877	-615	3,111	2,974	-137
Total Surgical Care Group		**41,516**	**40,421**	**-1,095**	**10,713**	**10,290**	**-423**
Total Corporate Directorates & Recharges					9,007	8,683	-324
Trust Total		**157,763**	**160,417**	**2,654**	**61,288**	**61,400**	**112**

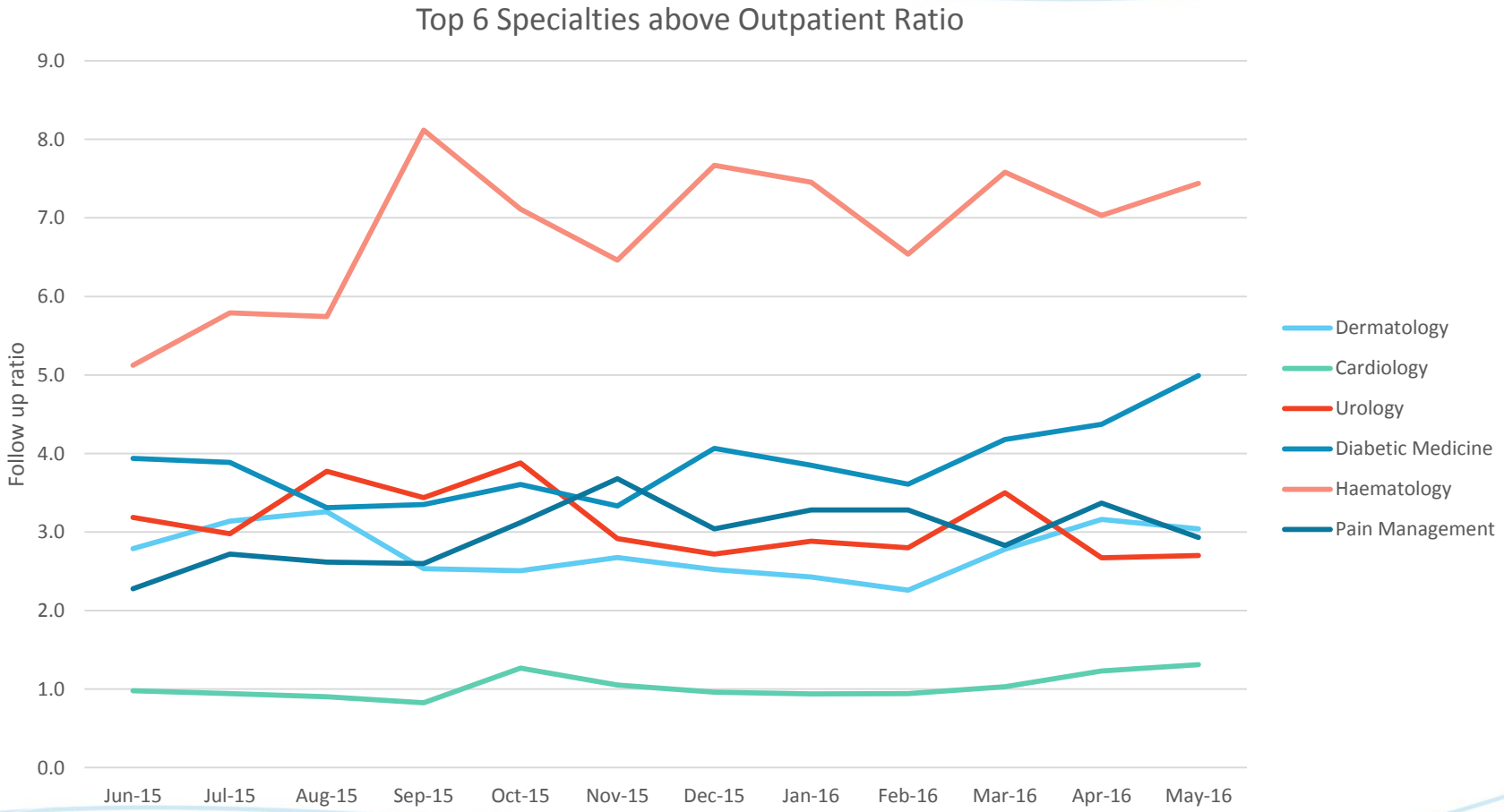
3.7 Outpatient Cap

		Actual Ratio		
Specialty	Average Contract Ratio	April 16	May 16	Total Financial Penalty (£000)
GI	2.56	3.02	2.11	-3
Urology	2.4	2.67	2.7	-30
Breast Surgery	1.07	1.1	1.22	-1
Orthopaedics	2.11	1.68	1.51	-4
Fracture	1.57	1.32	1.32	0
ENT	1.88	2.11	2.02	-17
Ophthalmology	3.03	3.05	3.4	-21
Pain Management	2.48	3.37	2.93	-21
General Medicine	1.91	1.95	1.6	-12
Haematology	5.96	7.03	7.44	-27
Diabetic Medicine	3.47	4.37	4.99	-28
Cardiology	1.18	1.23	1.31	-38
Stroke	1.6	1.66	1.25	0
Transient Ischaemic Attack	0.85	0.47	0.57	0
Dermatology	2.6	3.16	3.04	-56
Respiratory Medicine	2.94	1.82	1.48	-2
Nephrology	7.5	8.76	7.65	-6
Rheumatology	4.99	5.99	5.64	-20
Paediatric Endocrinology	3.39	7.4	5.14	-1
Paediatric Cardiology	0.44	0.95	0.78	-3
Paediatrics	1.47	1.5	1.53	-4
Elderly Medicine	1.81	1.91	1.72	0
Medical Ophthalmology	4.47	4.8	6.36	0
Gynaecology	3.09	3.03	2.4	-18
				-313

3.8 Outpatient Cap - Trend



3.9 Outpatient Cap Graph



3.10 Other Income Analysis

Income Category	Annual Plan	Plan YTD	Actual YTD	Variance YTD	In Month Plan - May	In Month Actual - May	In Month Variance - May	YTD Actual 15/16	16/17 v 15/16
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Private Patient Income	£371	£165	£150	(£15)	£86	£68	(£18)	£149	£1
Education Income	£9,225	£1,538	£1,558	£20	£825	£789	(£36)	£1,474	£84
Research & Development	£374	£62	£57	(£5)	£31	£29	(£2)	£55	£2
RTA's	£1,570	£260	£248	(£12)	£129	£117	(£12)	£417	(£169)
Miscellanous Contract Income	£289	£48	£63	£15	£24	£32	£8	£42	£21
Overseas Visitors	£230	£55	£27	(£28)	£52	£10	(£42)	£0	£27
Provider to Provider	£7,007	£1,216	£1,224	£8	£623	£636	£13	£1,035	£189
Internally Generated Income	£5,708	£887	£812	(£75)	£409	£420	£11	£927	(£115)
ParkHill Income	£2,605	£275	£261	(£14)	£148	£128	(£20)	£255	£6
Other Staffing Income IB	£654	£109	£86	(£23)	£51	£35	(£16)	£84	£2
Fred & Ann Green Reserve	£0	£0	£4	£4	(£14)	(£8)	£6	£14	(£10)
Recharges	£9,957	£1,659	£1,226	(£433)	£898	£599	(£299)	£1,547	(£321)
Donated Assets	£2,745	£58	£13	(£45)	£28	£0	(£28)	£133	(£120)
Govt. Assets, Sale of Assets & Land Sale Grant	£0	£0	£0	£0	£0	£0	£0	£322	(£322)
Total Other Income	**£40,736**	**£6,332**	**£5,729**	**(£604)**	**£3,290**	**£2,855**	**(£435)**	**£6,454**	**(£725)**

4.0 Expenditure Position

4.1 Expenditure Summary

- Total expenditure is £390k favourable against the YTD plan. Within this position there is an expenditure provision of £2,085k against cost pressures and contingency reserves of £2,365k in the YTD plan – see table below. This equates to a 'release' of £280k of reserves utilised in Months 1 and 2 leaving £14,911k of reserves available.
- Pay is £498k favourable against the YTD plan, whilst other non-pay is £581k unfavourable against the YTD plan. However, as the unachieved CIP target sits in the other non-pay category these variances are expected to flatten out for Month 3 once CIP budget retraction for Q1 is fully complete and committed cost pressure reserves are allocated to Care Group budgets.
- Drug expenditure is £525k unfavourable against the YTD plan but is partially offset by income over performance for high cost drugs of £303k which is funded on a pass through basis by commissioners.
- Clinical supplies and services are £310k favourable against YTD plan but the full devolvement of CIP is expected to reduce this at Month 3.
- Recharges show a favourable variance of £435k but this is off-set with a corresponding shortfall on income resulting in a zero impact to the bottom-line.
- Financing costs are broadly in line with budget at £28k favourable against YTD plan.
- An exercise will be undertaken in Month 3 to review agreed cost pressures and whether they have materialised in Months 1 and 2. Based on this review budget will transfer from the cost pressure reserve to Care Group budgets in Month 3.

4.2 Movement on Reserves

The Trust's annual plan identifies total reserves of £15.2m. The Month 2 YTD plan was £2.4m.

The table opposite show the position against reserves at the end of May. It shows that an expenditure provision of £2.1m has been made to prudently manage the release of the reserves.

Reserves are made up of:

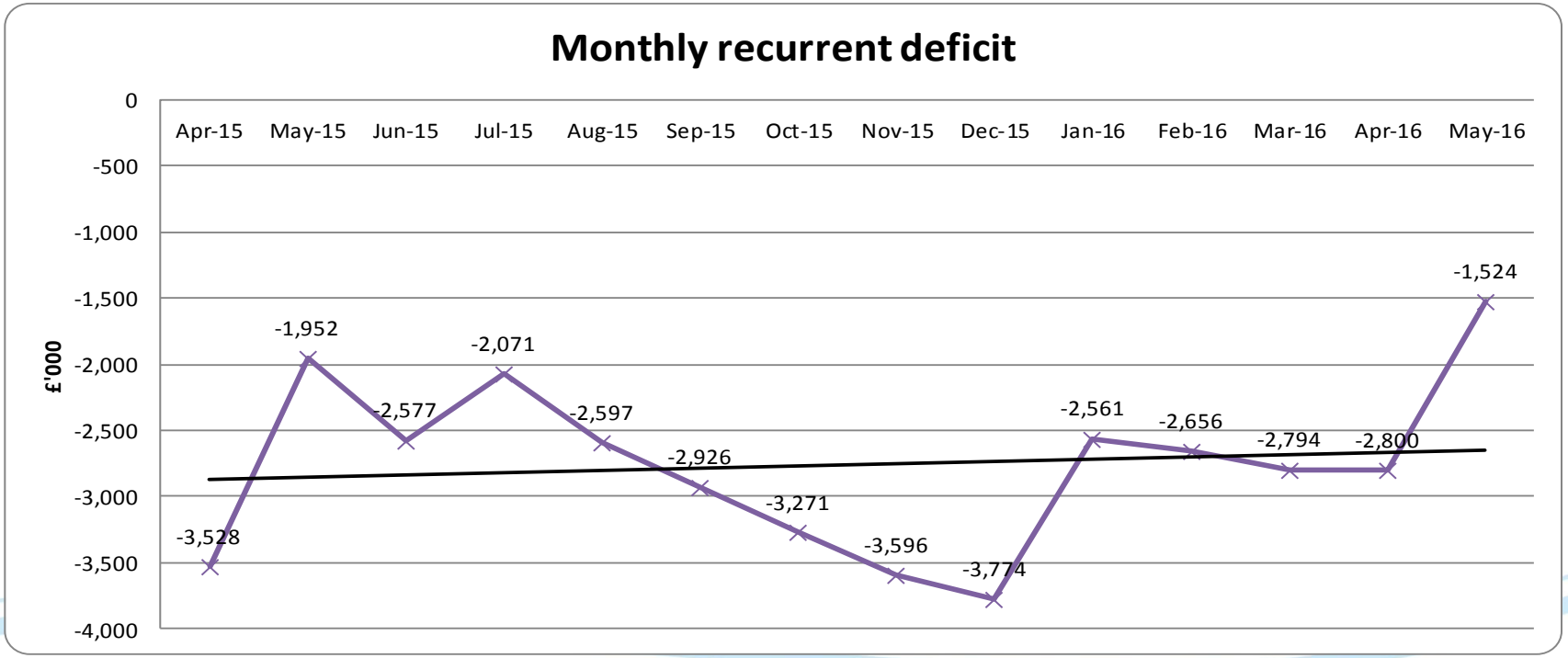
- Cost pressure reserve of £9.5m. The phasing of the budget was based largely on estimates from Care Groups. However, the anticipated costs have not materialised to planned levels and only £0.3m has been 'released'. This has yet to be transferred to Care Group budgets. Finance are reviewing all cost pressures and will release budget into Care Groups for Month 3 based on evidence of costs incurred
- Non pay inflation of £3.5m. This has been phased evenly in the plan but as the expenditure run rate is decreasing no budget has been released. Non pay costs and procurement CIP will be closely monitored
- Contingency reserve of £2.1m. This has been largely phased evenly but as £1.4m of this depends on the full delivery of the £12.4m CIP this only leaves £0.8m available for any contingencies going forward at this stage so no budget has been released

	2016/17 Plan	Month 2 YTD planned release of reserves	Expenditure provision	Release of reserves	2016/17 Balance of reserves available
	£'000	£'000	£'000	£'000	£'000
Cost pressure reserve	9,505	1,482	1,202	280	9,225
Non-pay inflation reserve	3,493	582	582	0	3,493
Contingency reserve	2,193	301	301	0	2,193
Total reserves	**15,190**	**2,365**	**2,085**	**280**	**14,911**
Other adjustments		38	65	-27	
Total		**2,403**	**2,150**	**253**	

4.3 Monthly Recurrent Position

The graph below shows that the run rate improved by £1.3m between April and May. This is consistent with the improvement shown between April and May last year.

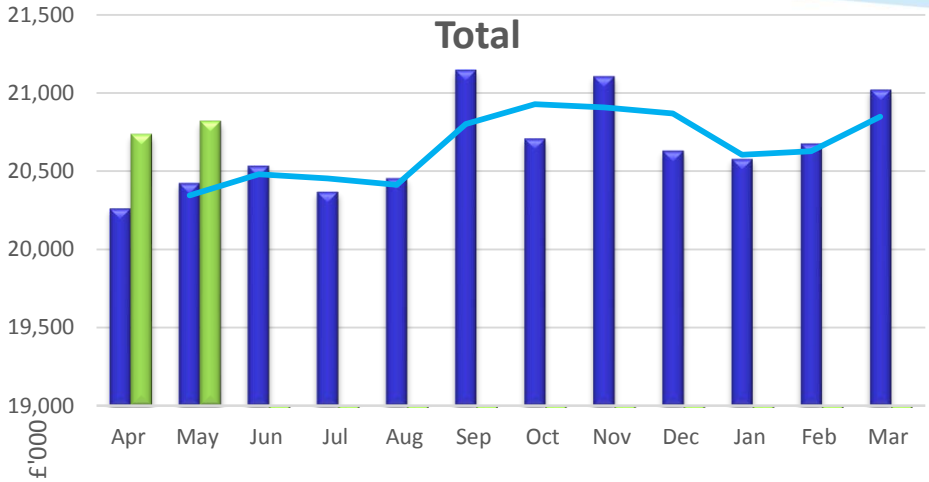
The improvement between April and May 2016 this year comprises clinical income (£0.2m), clinical supplies (£0.2m) and other non pay (£0.8m)

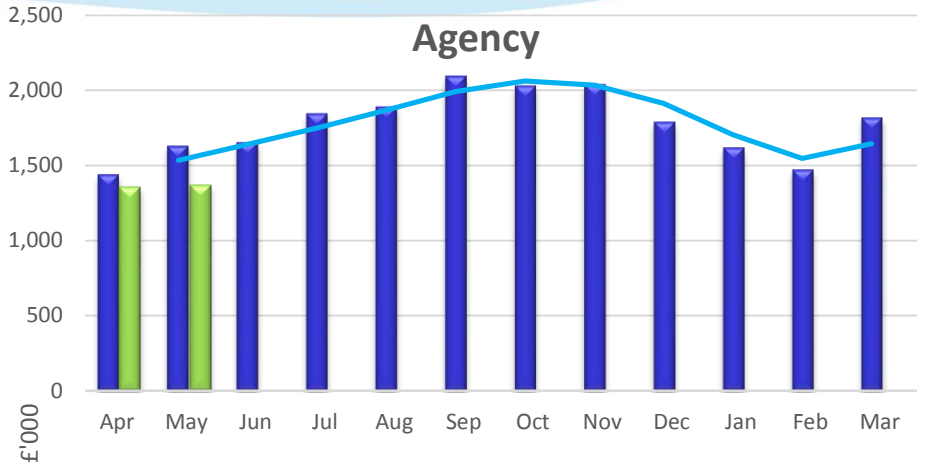


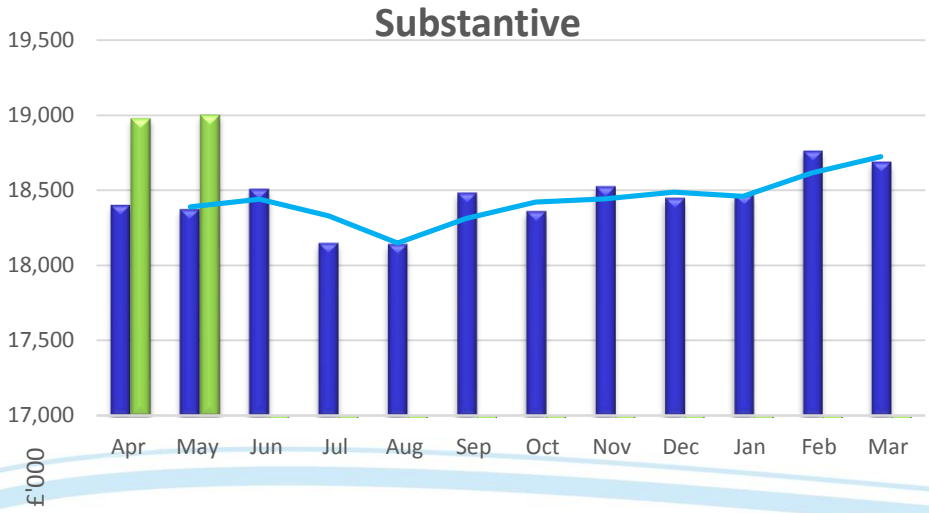
4.4 Pay Expenditure Summary

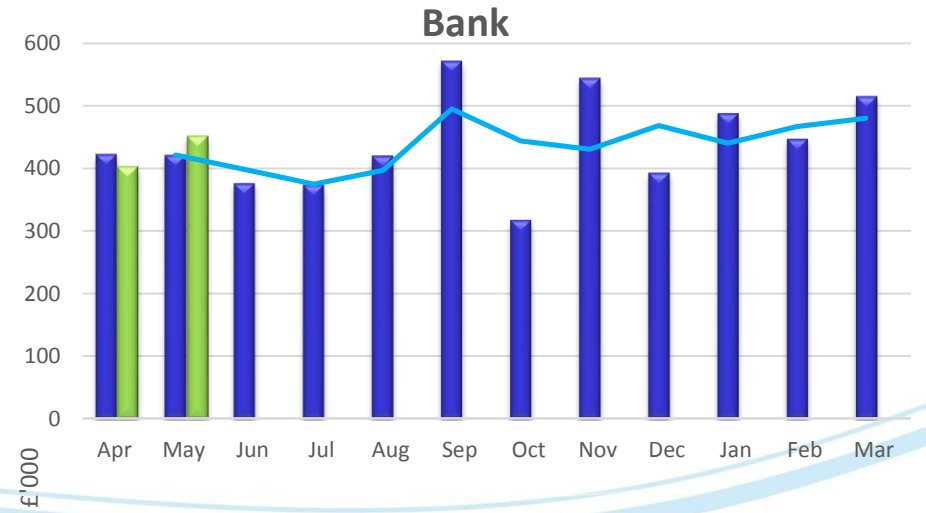
- Total pay is favourable by £299k and £199k respectively for Months 1 and 2.
- In line with pay awards and national insurance contribution increases the substantive pay bill (excludes bank staff) has increased from 2015/16 levels by 3.27% compared to the same point last year.
- Agency expenditure has fallen once again and was under £1.4m in both Months 1 and 2. Extrapolated at this rate for the full year would see the trust with a total spend of £16.3m for the year, still some way above our £13.5m cap target, but 23.4% down on last years spend of £21.3m.
- Bank expenditure is broadly in line with last years spend for the YTD at £853k.
- Management and Admin & Clerical have adverse variances. Both charts show that expenditure is higher than 2015-16 levels and both are unfavourable than plan by £108k and £359k respectively. As mentioned in the summary committed cost pressures have yet to be released and both these categories of staff have CIP projects aligned to them, with the admin & clerical project not due to start until the second half of the year.
- All clinical staff groups are favourable compared to YTD plan with medical staff being at 5.5% or £710k favourable.

4.5 Pay Graphs by Category



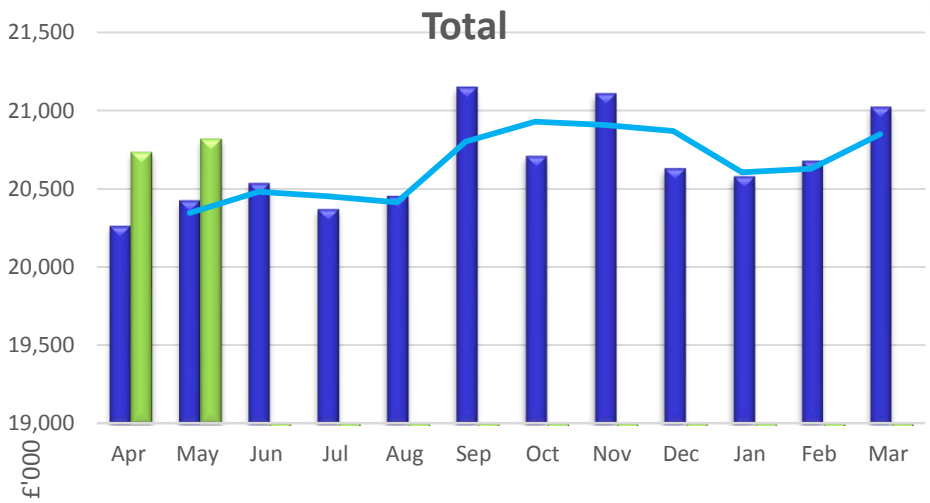


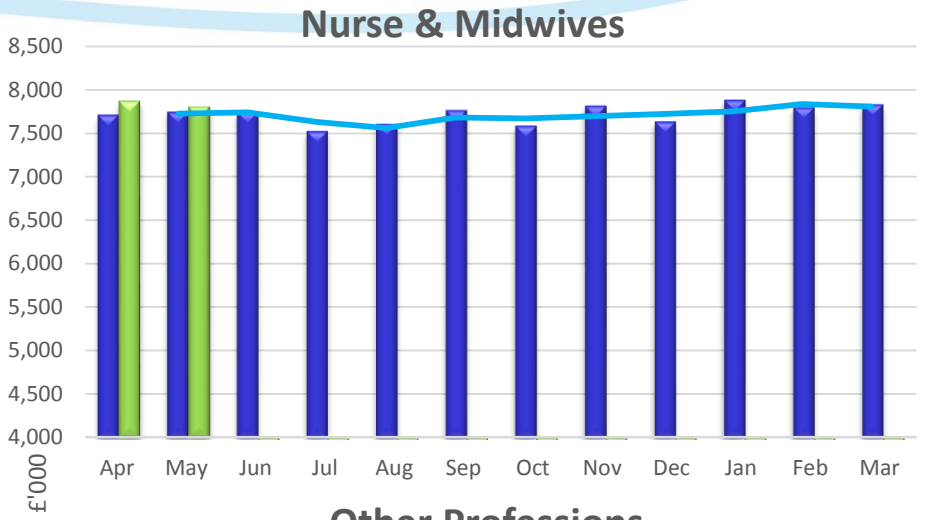


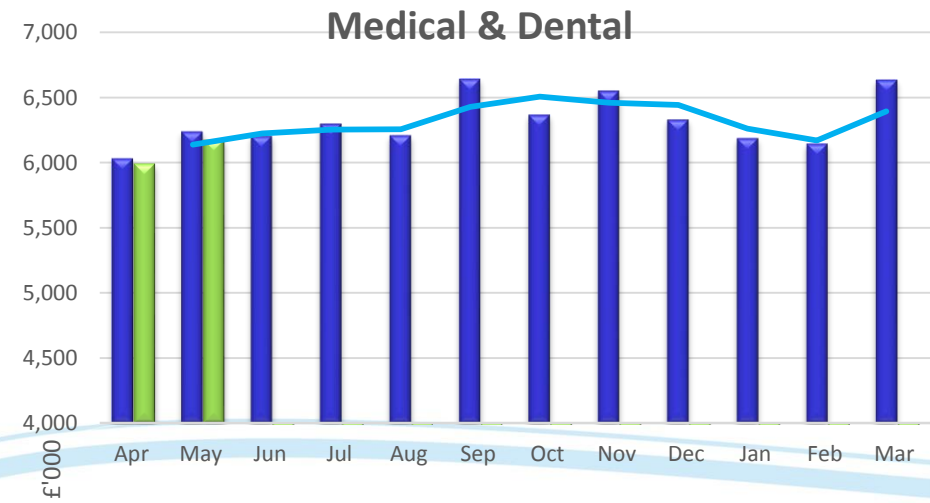


2015/16 2016/17 Moving Average 15/16

4.6 Pay Graphs by Staff Type (1)

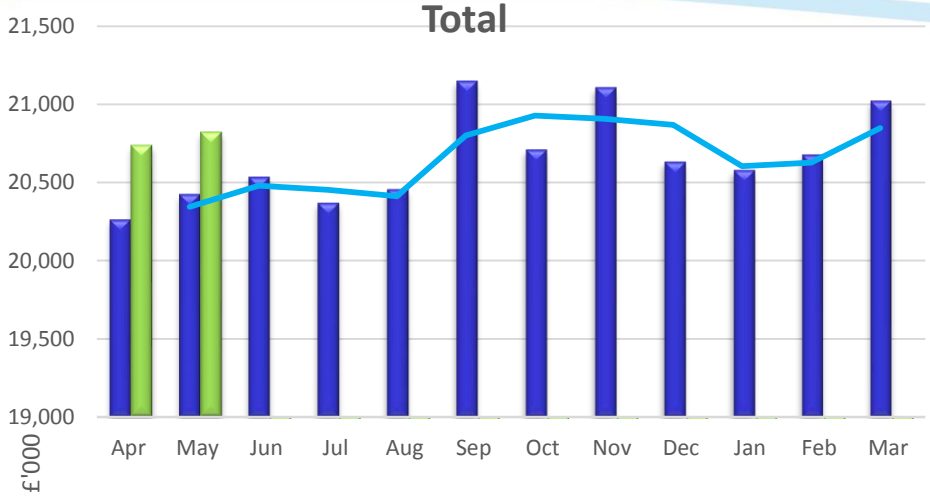


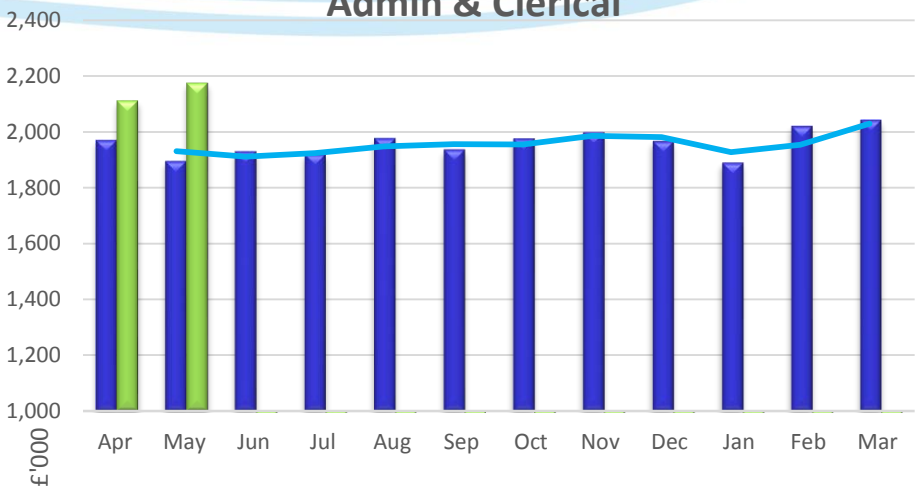


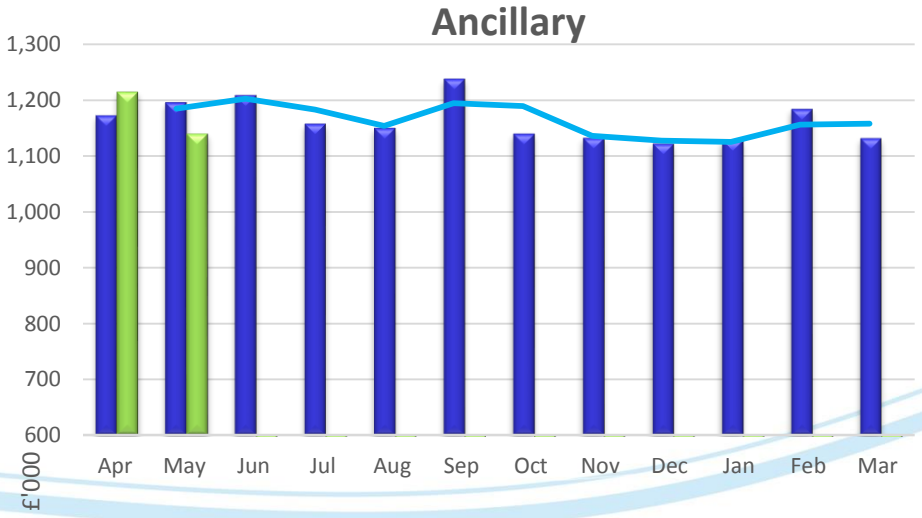


2015/16 2016/17 Moving Average 15/16

4.6 Pay Graphs by Staff Type (2)





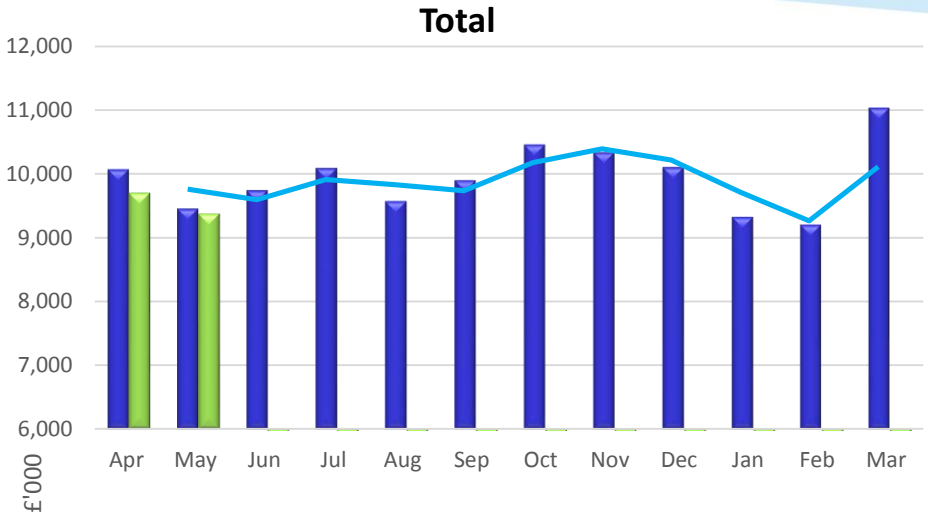


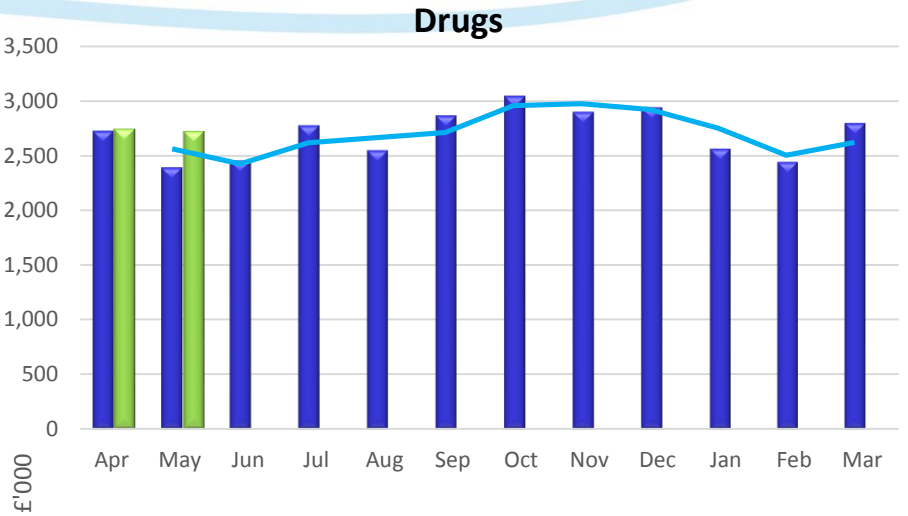
2015/16 2016/17 Moving Average 15/16

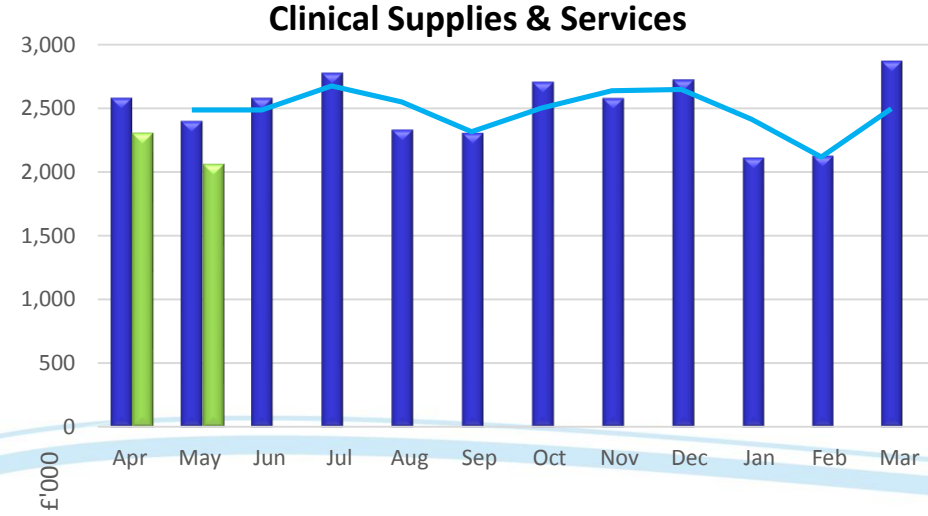
4.7 Non-Pay Expenditure Summary

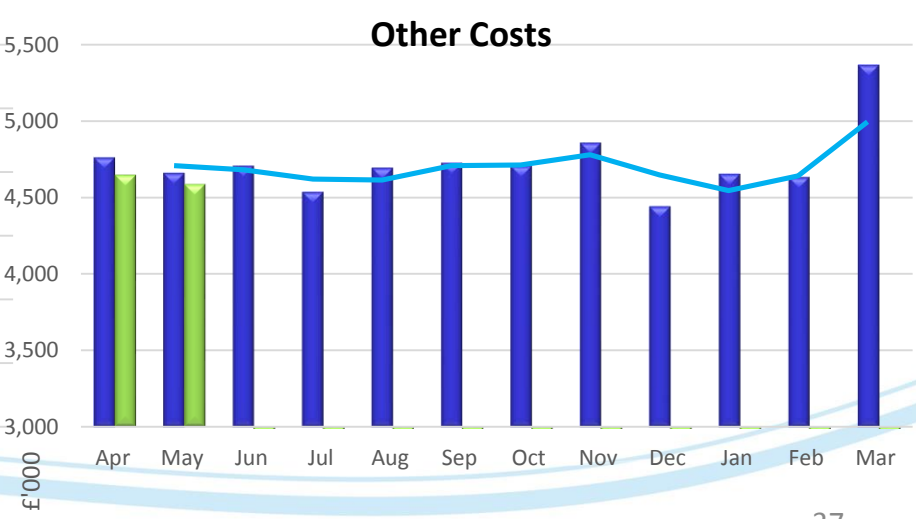
- Total non-pay has an adverse variance against plan by £795k for the year to date. As out-lined previously the reserves for committed cost pressures are yet to be factored into these figures but will be completed for month three.
- Clinical supplies & services are £310k favourable, with underspends on medical supplies (£258k better) and x-ray consumables (£60k better).
- As out-lined in the summary Drugs have an adverse variance by £525k for the year to date with expenditure on Non-PbR drugs at £547k adverse.
- Other non-pay has an £581k adverse variance to plan to the end of Month 2. Overspends were present in; Outsourcing (£232k over-spent), Other non-medical consumables (£210k over-spent), Staff related expenses (£191k over-spent) and on Efficiency (£268k over-spent). These were partially off-set by underspends on Office related expenses (£163k favourable) and Building costs (£99k favourable).
- As out-lined in the expenditure summary it is anticipated that by the end of Q1 the £268k deficit on the efficiency line would have been allocated out to the relevant areas of achievement.

4.8 Non-Pay Graphs









2015/16 2016/17 Moving Average 15/16

4.9 Non Recurrent Consultancy Costs

	2015-16	Month 1	Month 2	YTD	Forecast Outturn	Commentary
	£'000	£'000	£'000	£'000	£'000	
KPMG: financial investigation & cash review	265	83	34	117	117	
KPMG: financial improvement programme	0	0	251	251	750	TBC
Kingsgate & associates	203	70	78	148	520	To support theatre productivity CIP (forecast PYE £544k, FYE £1,039k & delivery to date £48k) & medical productivity CIP (forecast PYE £441k, FYE £966k & delivery to date £0)
Finance interim support	359	130	154	284	900	To provide fit for purpose finance function
Total	**827**	**283**	**517**	**800**	**2,287**	

5.0 CIP Performance

5.1 Summary of CIP Position

- The CIP target reflected in the annual plan is £11m with a stretch target of £13m
- To date the PYE CIP forecasts stands at £12.6m which is £1.6m above plan and £0.4m short of the stretch target.
- A total of £1.9m is rated as high risk CIP (15.1%) – no change from last month
- Of the £12.6m the recurrent element is £12.0m and £0.6m non recurrent
- At Month 2 delivery is £1.3m against a plan of £1.0m a favourable variance of £0.3m
- £4.6m is due for delivery in the first 6 months and £8.0m in the second six months (36:64)
- Pay schemes total £7.6m, non pay £2.5m and income £2.5m
- The current year effect of schemes delivered is £8.2m leaving £4.4m of schemes still to be delivered
- The full year effect is £12.6m and the full year effect £17.0m
- The tables below analyses the CIP position by work stream, Care Groups and risk rating

5.2 CIP by Work Stream

	Annual Plan	In Month			YTD			Actual CIP Achieved 2016-17		CIP Forecast 2016-17	
		Plan	Actual	Variance	Plan	Actual	Variance	PYE	FYE	PYE	FYE
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Theatres	520	0	4	4	0	8	8	48	48	544	1,039
Outpatient Productivity	259	20	15	-5	31	26	-5	140	142	254	287
Medical Productivity	441	0	0	0	0	0	0	0	0	441	966
Non Medical Clinical	261	0	5	5	0	10	10	75	85	285	1,188
Management & Corporate Services Review	987	69	64	-5	116	104	-12	853	982	918	1,079
Bed Plan / LOS	2,683	172	172	0	217	226	9	1,949	2,067	2,692	3,816
Procurement	2,003	115	110	-5	298	295	-3	1,584	1,636	2,033	2,250
Clinical Admin Review	250	0	0	0	0	0	0	0	0	250	250
Infrastructure	894	26	65	39	44	111	66	670	671	1,119	1,599
Income	1,325	50	40	-10	135	125	-10	425	425	1,215	1,851
Care Group & Corporate - Local	1,779	115	106	-9	230	213	-18	1,396	1,280	1,761	1,604
Grip & Control	978	81	93	12	155	163	8	1,048	1,062	1,057	1,073
Contingency	-1,380										
TOTAL	**11,000**	**647**	**673**	**26**	**1,228**	**1,281**	**53**	**8,187**	**8,399**	**12,570**	**17,004**

5.3 CIP by Care Group

	Annual Plan	In Month			YTD			Actual CIP Achieved 2016-17		CIP Forecast 2016-17	
		Plan	Actual	Variance	Plan	Actual	Variance	PYE	FYE	PYE	FYE
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
MSK & Frailty Care Group	1,344	81	76	-5	158	153	-6	937	947	1,336	1,794
Emergency Care Group	2,407	156	148	-8	230	227	-3	1,713	1,783	2,337	3,289
Surgical Care Group	1,813	92	95	3	137	141	4	1,079	1,106	1,833	2,784
Speciality Services Care Group	471	25	27	2	50	54	4	333	334	469	779
Children's & Family Care Group	255	6	6	0	12	12	0	22	22	245	428
Diagnostic & Pharmacy Care Group	624	41	30	-10	81	60	-20	466	408	564	691
Chief Executive	42	2	2	0	4	4	0	40	50	42	56
P&OD	426	30	27	-3	58	53	-5	399	484	409	520
Facilities, Estates & Hotel Services	1,543	61	99	38	114	180	66	1,199	1,195	1,769	2,202
Finance, Information & Procurement	2,484	93	103	10	293	305	12	1,362	1,456	2,556	3,431
Medical Director	7	0	0	0	0	0	0	1	2	6	13
Director of Nursing Services	262	24	23	0	26	25	0	262	284	262	284
IM&T	92	11	11	0	21	21	0	85	42	92	51
Performance	610	26	25	-1	44	45	1	288	287	651	682
Strategy & Improvement	0	0	0	0	0	0	0	0	0	0	0
Contingency	-1,380									0	0
TOTAL	**11,000**	**647**	**673**	**26**	**1,228**	**1,281**	**53**	**8,187**	**8,399**	**12,570**	**17,004**

5.4 CIP risk rating and analysis

	Total Efficiency £000s	Proportion of total %
Recurrent schemes	11,958	92%
Non-recurrent schemes	612	5%
Total needed to be identified	430	3%
CIP stretch target	**13,000**	**100%**

	Total Efficiency £000s	Proportion of total %
Pay	7,579	58%
Non pay	2,473	19%
Income	2,518	19%
Total needed to be identified	430	3%
CIP stretch target	**13,000**	**100%**

	Total Efficiency £000s	Proportion of total %
CIPs - High risk - red	1,900	15%
CIPs - Medium risk - amber	2,391	18%
CIPs - Low risk - green	8,279	64%
Total needed to be identified	430	3%
CIP stretch target	**13,000**	**100%**

	Total Efficiency £000s	Proportion of total %
CIPs - Fully developed	8,217	63%
CIPs - Plans in progress	2,642	20%
CIPs - Opportunity	1,136	9%
CIPs - Unidentified	575	4%
Total needed to be identified	430	3%
CIP stretch target	**13,000**	**100%**

6.0 Statement of Financial Position

6.1 Statement of Financial Position - Commentary

Cash – also see section 7

- The cash balance at the end of Month 2 was £2.0m in line with the minimum cash balance required under the conditions of the cash support
- The cash drawdown in May was £2.0m compared to the plan of £2.3m. YTD variance is £1.9m more than planned.
- The 2016/17 plan includes £29.1m of cash support from NHSI, this is requested monthly based on the predicted cash needs over the next 4 weeks. The additional cash support is based on the Trust achieving the £27.1m control total including full delivery of the £11m CIP in year.

Working Capital

- Debtors are above plan due to :

  Amounts due from the Charitable Fund including the Ophthalmology development, the Charity are in the process of selling a proportion of their investments in order to pay the Trust.

  Accrued income for over performance against contracted activity.

6.2 Statement of Financial Position

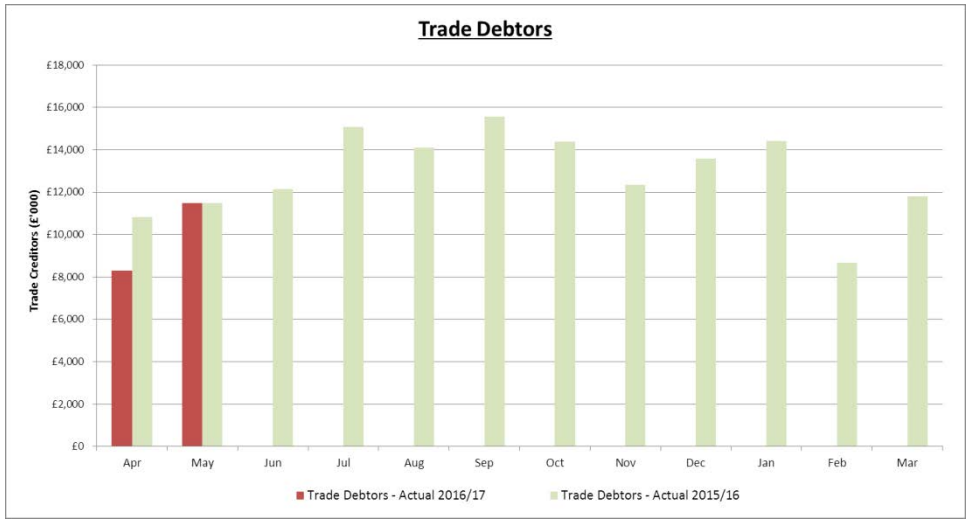
	31 March 2016 Actual	As at 31st May 2016		
		Plan	Actual	Variance
	£'000	£'000	£'000	£'000
Non-current assets				
Intangible assets	2,937	2,547	2,499	(48)
Property, plant and equipment	188,652	189,539	189,205	(334)
Trade and other receivables	1,592	1,601	1,592	(9)
Total non-current assets	**193,181**	**193,687**	**193,296**	**(391)**
Current assets				
Inventories	5,474	5,500	5,546	46
Trade and other receivables	15,676	18,510	20,805	2,295
Cash and cash equivalents	2,169	1,900	2,030	130
Total current assets	**23,319**	**25,910**	**28,381**	**2,471**
Non-current assets held for sale	300	300	300	-
Current liabilities				
Trade and other payables	(32,029)	(36,665)	(36,417)	248
Borrowings	(2,775)	(2,775)	(2,775)	-
Provisions	(524)	(524)	(524)	-
Total current liabilities	**(35,328)**	**(39,964)**	**(39,716)**	**248**
Total assets less current liabilities	**181,472**	**179,933**	**182,261**	**2,328**
Non-current liabilities				
Borrowings	(59,037)	(62,894)	(64,693)	(1,799)
Provisions	(728)	(728)	(728)	-
Total non-current liabilities	**(59,765)**	**(63,622)**	**(65,421)**	**(1,799)**
Total assets employed	**121,707**	**116,311**	**116,840**	**529**
Financed by (taxpayers equity)				
Public dividend capital	128,780	128,780	128,780	-
Revaluation reserve	29,939	29,939	29,939	-
Income and expenditure reserve	(37,012)	(42,408)	(41,879)	529
Total taxpayers equity	**121,707**	**116,311**	**116,840**	**529**

6.3 Trade Debtors

Trade Debtors

Summary	Apr £'000s	May £'000s
Not Due	£2,179	£2,800
Total Overdue	£4,466	£4,849
Total Oustanding	**£6,645**	**£7,649**
% age Overdue	67.20%	63.39%

Days Overdue		
0-30	£1,945	£1,005
31-60	£243	£1,439
61-90	£293	£230
91-120	£454	£288
120 +	£1,530	£1,887
Total Overdue	**£4,466**	**£4,849**



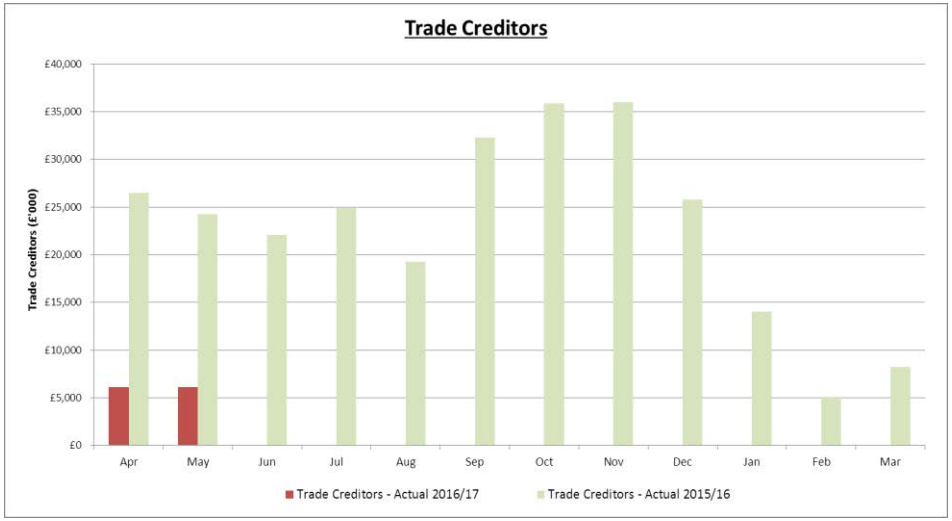
The Trust is working on reducing the value of the older outstanding debts and resolving issues with other NHS organisations to improve our cash position

6.4 Trade Creditors

Trade Creditors

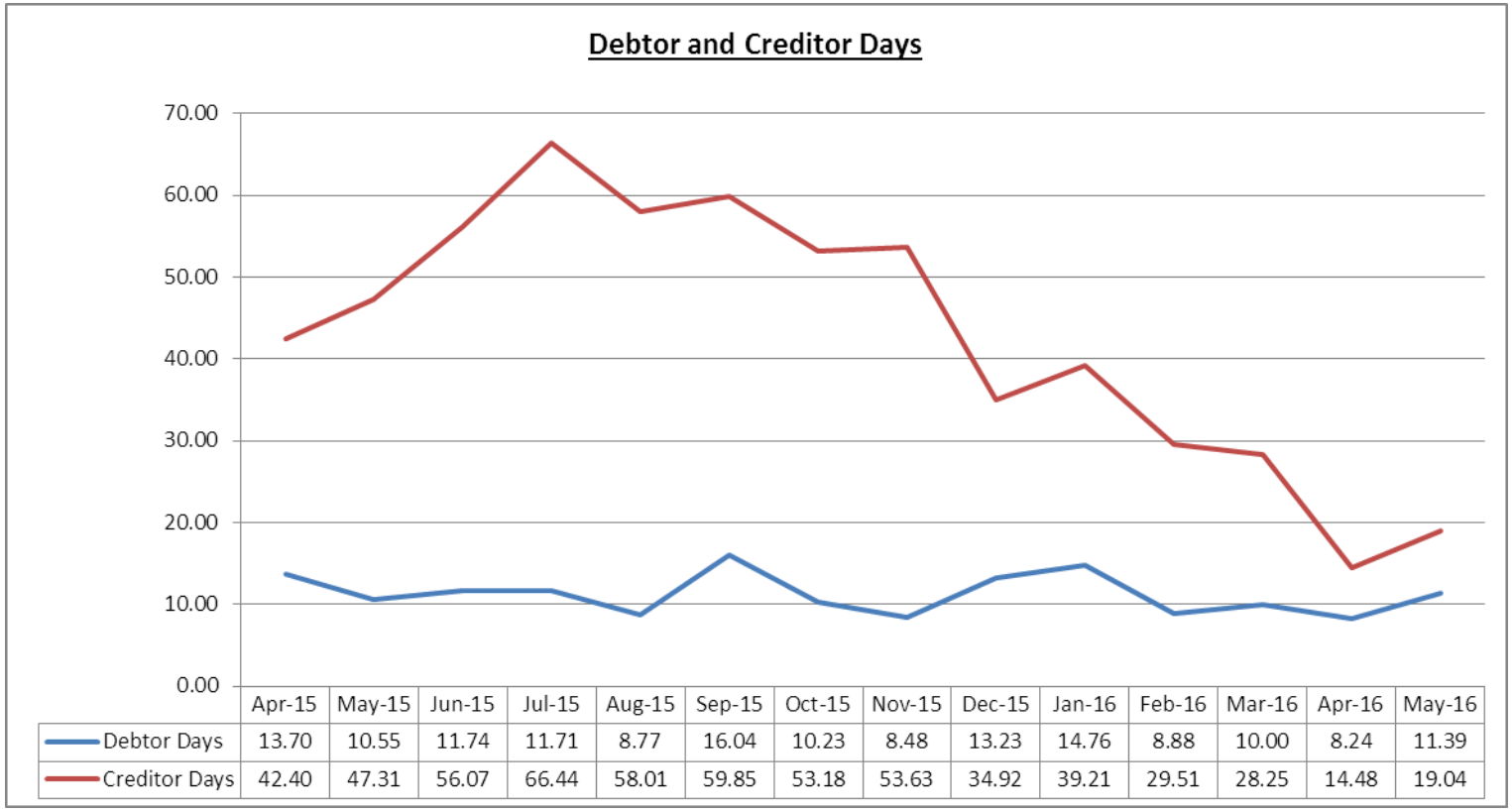
Summary	Apr £'000s	May £'000s
Not Due	£1,955	£2,175
Total Overdue	£573	£1,488
Total Oustanding	**£2,529**	**£3,663**
% age Overdue	22.68%	40.62%

Days Overdue		
0-30	£197	£1,442
31-60	£253	£45
61-90	£7	£6
91-120	£38	£5
120 +	£79	(£9)
Total Overdue	**£573**	**£1,488**



The level of outstanding creditors are significantly lower than experienced in 2015/16. The cash support from NHSI has allowed the Trust clear the older invoices and going forward to pay our suppliers within our payment terms.

6.5 Creditor and Debtor Days



	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16
Debtor Days	13.70	10.55	11.74	11.71	8.77	16.04	10.23	8.48	13.23	14.76	8.88	10.00	8.24	11.39
Creditor Days	42.40	47.31	56.07	66.44	58.01	59.85	53.18	53.63	34.92	39.21	29.51	28.25	14.48	19.04

7.0 Summary of Cash Position

7.1 Cash Flow Statement

	31 March 2016 Actual	As at 31st May 2016		
		Plan	Actual	Variance
	£'000	£'000	£'000	£'000
Cash flow from operating activities				
Surplus/(deficit) from operations	**(41,362)**	**(4,558)**	**(4,112)**	446
Depreciation, Impairment & Other	19,398	1,740	1,509	(231)
Operating cash flows	**(21,964)**	**(2,818)**	**(2,603)**	**215**
Movement in Working Capital (incl Capital Accurals)	(10,821)	616	(1,483)	(2,099)
Net cash inflow/(outflow) from operating activities	**(32,785)**	**(2,202)**	**(4,086)**	**(1,884)**
Cash flows from investing activities				
Capital expenditure	(14,906)	(2,186)	(1,621)	565
Proceeds on disposals	942	350	-	(350)
Interest received	42	6	8	2
Net cash inflow/(outflow) from investing activities	**(13,922)**	**(1,830)**	**(1,613)**	**217**
Net cash inflow/(outflow) before financing	**(46,707)**	**(4,032)**	**(5,699)**	**(1,667)**
Cash flows from financing activities				
Repayment of borrowings	(2,485)	(642)	(742)	(100)
Interest paid on borrowings	(693)	(95)	(95)	-
PDC dividends paid	(6,036)	-	-	-
PDC received	25	-	-	-
Planned term support requirement	46,352	4,500	6,397	1,897
Net cash inflow/(outflow) from financing activities	**37,163**	**3,763**	**5,560**	**1,797**
Net increase/(decrease) in cash	**(9,544)**	**(269)**	**(139)**	**130**
Opening cash	11,713	2,169	2,169	-
Closing cash	**2,169**	**1,900**	**2,030**	**130**

7.2 Cash Flow Reconciliation to I&E

	31 March 2016 Actual	As at 31st May 2016		
		Plan	Actual	Variance
	£'000	£'000	£'000	£'000
Reconciliation of I&E to Cashflow				
Surplus (Deficit) from Operations	**(41,362)**	**(4,558)**	**(4,112)**	**446**
Non-Operating income				
Interest Income	42	4	8	4
Gain/(loss) on asset disposals	17	-	-	-
Non-Operating income	**59**	**4**	**8**	**4**
Non-Operating expenses				
Interest Expense	(773)	(312)	(233)	79
PDC dividend expense	(4,666)	(530)	(530)	-
Finance Costs	**(5,439)**	**(842)**	**(763)**	**79**
Surplus (Deficit) before Tax	**(46,742)**	**(5,396)**	**(4,867)**	**529**

7.3 2016-17 Cash Flow Forecast

	Apr-16 £'000	May-16 £'000	Jun-16 £'000	Jul-16 £'000	Aug-16 £'000	Sep-16 £'000	Oct-16 £'000	Nov-16 £'000	Dec-16 £'000	Jan-17 £'000	Feb-17 £'000	Mar-17 £'000	Total 2016-17 £'000
Receipts													
Clinical and Contract Income	29,930	25,800	28,385	27,876	28,376	28,126	28,626	28,376	28,376	28,376	28,376	32,376	**343,000**
Sustainability & Transformation Funding	-	-	-	-	2,950	-	2,950	-	-	2,950	-	2,950	**11,800**
Other Income	1,100	1,598	497	1,582	1,582	1,582	1,582	1,582	1,582	1,582	1,582	1,582	**17,434**
Loans	4,397	2,000	1,237	1,000	2,000	1,500	2,950	2,950	2,950	2,950	2,950	2,200	**29,084**
Charitable Fund		-	-	1,400	-	500	250	250	-	-	-	-	**2,400**
Total Receipts	**35,428**	**29,398**	**30,119**	**31,858**	**34,908**	**31,708**	**36,358**	**33,158**	**32,908**	**35,858**	**32,908**	**39,108**	**403,717**
Payments													
Salary Costs	(18,085)	(18,414)	(18,418)	(18,420)	(18,420)	(18,420)	(18,420)	(18,420)	(18,420)	(18,420)	(18,420)	(18,420)	**(220,697)**
Suppliers	(16,023)	(11,891)	(11,841)	(13,960)	(16,047)	(12,346)	(17,226)	(14,617)	(14,502)	(17,437)	(14,036)	(17,881)	**(177,807)**
Capital	-	-	-	-	-	-	-	-	-	-	-	-	**-**
PDC	-	-	-	-	-	(220)	-	-	-	-	-	(1,590)	**(1,810)**
Loan Repayment	(642)	(100)	-	-	(271)	(113)	(642)	(100)	-	-	(271)	(613)	**(2,753)**
Other Payments	(86)	(9)	(0)	-	(170)	(609)	(70)	(7)	-	-	(182)	(602)	**(1,734)**
	(34,835)	**(30,413)**	**(30,259)**	**(32,380)**	**(34,908)**	**(31,708)**	**(36,358)**	**(33,144)**	**(32,922)**	**(35,857)**	**(32,909)**	**(39,107)**	**(404,800)**
Cash Inflow \ (Outflow)	**592**	**(1,015)**	**(140)**	**(522)**	**0**	**(0)**	**0**	**14**	**(14)**	**1**	**(1)**	**1**	**(1,083)**

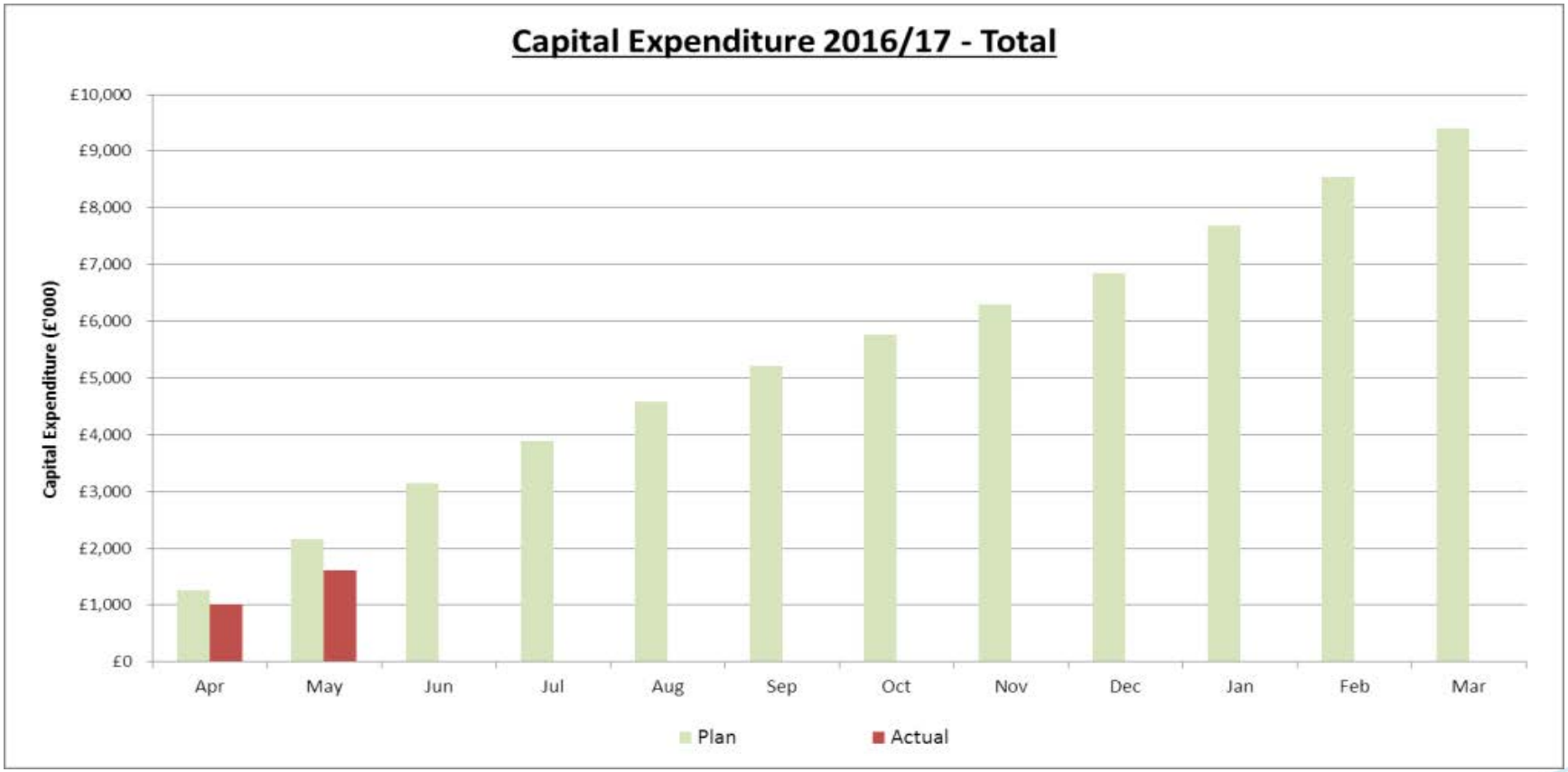
8.0 Capital Expenditure

8.1 Capital Expenditure

	Year to Date - May-16			
	Plan	Actual	Variance	Plan 2016/17
	£'000s	£'000s	£'000s	£'000s
Estate Investment Programme				
Fire Safety	£208	£294	(£86)	£1,300
Water Safety	£152	£1	£151	£670
Other	-	(£95)	£95	-
Capitalised Staff	£40	£45	(£5)	£250
Unallocated	£110	-	£110	£1,246
	£510	**£245**	**£264**	**£3,466**
Medical Equipment Replacement				
Surgical Care Group	£498	£161	£337	£1,629
Other	£14	£75	(£60)	£47
Unallocated	-	-	-	£100
DSA 1	-	(£3)	£3	£391
Other	-	-	-	£700
Unallocated	-	-	-	£100
	£512	**£233**	**£279**	**£2,967**
IT Schemes				
PACS	-	-	-	-
I Hospital	£16	£44	(£28)	£127
Unallocated	-		-	-
Switchboard	£34	£22	£12	£275
Other	£3	£11	(£8)	£18
Unallocated	£73	-	£73	£604
	£126	**£77**	**£49**	**£1,025**
Other				
Other	-	£37	(£37)	-
Trust Capital Expenditure	**£1,147**	**£592**	**£555**	**£7,458**
Charitable Funds				
Ophthalmology	£1,020	£1,017	£3	£1,948
Other	-	£13	-	-
	£1,020	**£1,029**	**£3**	**£1,948**
Total Capital Expenditure	**£2,167**	**£1,622**	**£559**	**£9,406**

The Ophthalmology works are funded by the Charitable Fund and therefore have no impact on cash or Capital allocation for the Trust.

8.2 Capital Expenditure Graph



Doncaster and Bassetlaw Hospitals NHS
NHS Foundation Trust

Title	**Business Intelligence Report**		
Report to:	**Board of Directors**	Date:	**28.06.2016**
Author:	**David Purdue, Chief Operating officer** **Sewa Singh, Medical Director** **Richard Parker, Director of Nursing, Midwifery and Quality**		
For:	**Approval**		

Purpose of Paper: Executive Summary containing key messages and issues

The Business intelligence report highlights the key performance and quality targets required by the Trust to maintain Monitor compliance.
The report focuses on the 4 main performance area for Monitor Compliance
Cancer, measured on average quarterly performance
4hr Access, measured on average quarterly performance
18 weeks measured on monthly performance against active waiters, performance measured on the worst performing month in the quarter
C Diff target based on the Trusts agreed trajectory for the financial year.
The quality report focuses on the key indicators of infection control, mortality and gives specific focus into best practice tariffs, complaints and serious incidents.

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

Recommendation(s)

To approve

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

We always put the patient first

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

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

- *By ensuring that all parties have contributed to the planning and delivery of services*

Committed to quality and continuously improving patient experience

- *By delivering new ways of working across health and social care to ensure compliance withal quality indicators*

Always caring and compassionate

- *By ensuring staff are committed to working with partners to improve services.*

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

- *By being accountable for delivery of the efficient and effective services*

Encouraging and valuing our diverse staff and rewarding ability and innovation

- *By ensuring engagement in planning and delivery of services*

Related Strategic Objectives

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

Analysis of risks

- Resource – Key financial issues related to additional funding streams to support planning for surge capacity.
- Governance – The Trust needs to maintain compliance framework with monitor
- Equality and Diversity – No known issues or risks.
- PR and Communications – Need for continued appropriate communication to ensure ongoing performance
- Patient, Public and Member Involvement – Public attendance at System Resilience Groups
- Risk Assessment – The risks to the Trust's performance are very high 2015/16, at this stage especially in relation to 4hr access
- NHS Constitution - Rights and Pledges – No known issues or risks.

Board Assurance Framework

7	Risk of failing to address the effects of the medical agency cap, leading to gaps in medical rotas.	*4 x 5 = 20*
9	Failure to achieve compliance with performance and delivery aspects of Monitor Risk Assessment Framework, CQC and other regulatory standards, triggering regulatory action.	*4 x 4 = 16*
11	Failure to deliver accurate and timely performance information through CaMIS system.	*3 x 4 = 12*
13	Inability to recruit right staff and ensure staff have the right skills to meet operational needs.	*4 x 3 = 12*

Doncaster and Bassetlaw Hospitals NHS Foundation Trust

Doncaster and Bassetlaw Hospitals NHS Foundation Trust Board of Governors Meeting

Performance - May 2016 - (Month 2)

Sewa Singh	Medical Director
Richard Parker	Director of Nursing
David Purdue	Chief Operating Officer
Jeremy Cook	Interim Director Of Finance

Doncaster and Bassetlaw Hospitals NHS
NHS Foundation Trust

Executive Summary - Performance - Quarter 1 - 2016

The performance report is against operational delivery in Quarter 1 2016
Provide the safest, most effective care possible
Monitor governance compliance is rated against 3 National targets, 4hr Access, Referral to Treatment, which includes diagnostic waits and Cancer Targets. The targets are all monitored quarterly, both 4hr access and cancer are averaged over the quarter but referral to treatment is monitored each month of the quarter and must be achieved each month.
The business intelligence report also highlights key National and local targets which ensure care is being provided effectively and safely by the Trust.

4hr Access
The target is based on the number of patients who are treated within 4hrs of arrival into the emergency department and set 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. The Trust does not count any GP admissions areas within its target.
The rules on reporting changed in month and any breaches which occur after midnight are now classed on the day they breached rather than on the day of arrival.
Performance
Trust April 95.1%, May 93.12%
Q1 94.25%

April acheived the Target
April attendances were 13,550. A total of 669 patients failed to be treated within 4hrs.
DRI achieved 93.32%, if MMH were included Doncaster achieved 94.55%. 522 patients failed to be treated within 4hrs.
Bassetlaw achieved 96.3%, 146 patients failed to be treated within 4hrs.

May attendances were 14,758, which is 975 more attendances than in May 2015. A total of 1015 patients failed to be treated within 4hrs.

Ambulance attendances to both main sites have seen an increase in May, DRI by 12.6% and BDGH by 10.2%. Overall since Aoril there has been an 8% increase in attendances

DRI achieved 90.2%, if MMH were included Doncaster achieved 91.85%. 849 patients failed to be treated within 4hrs. 60% of the breaches were as a result of internal ED delays. Bed delays increased by 41, caused mainly by an increase in aconversion rate from 21 %to 25.6%
BDGH acheived 96.2%, 166 patients failed to be treated in 4hrs. 83% of the breaches were as a result of ED waits

Key Issues
Availbility of medical staff following the introduction of the NHSI cap, Memorandum of Understanding now agreed with the working together Trusts for consistency in applying the rules.
Increases in activity and acuity, 12% increase in ambulance attendances
Reduced bed availability
As part of the Urgent Care Network, work continues to agree escalation processes to ensure that drift from boundary localities does not adversely affect performance.

Ambulance handover targets improved in April. New system of recording to be commenced at Bassetlaw

Referral to Treatment
The target is now measured against incomplete pathways only at 92**%.** Fines for RTT have been lifted for 2016/17.

The data validation exercise was completed throughout March and the Trust was able to effectively validate the number of pathways agreed with NHS improvement.

April, 92.9%, May, 93.1%
3 specialities failed the target;
General Surgery,
ENT
Urology
Trauma and Orthopaedics is now compliant with the target for the first time in 3 years.

1 patient waited over 52 weeks for his surgery, in April, the patient was offered 11 dates during the year but due to moving to 3 different prisons he was unable to attend. His treatment was completed in early May.

The Trust is working as part of the SDIP, to ensure demand and capacity plans are in line with expected RTT performance.
Urology referrals continue to rise and internal capacity is being re- assessed, especially in relation to follow up pathways.

Diagnostic waits
April 99.17%, May 99.5% against the target of 99%
The numbers waiting over 6 weeks was 59 In April and 37 in May, the target was achieved in all tests.

Cancer Performance

All cancer targets have been achieved in March and for Quarter 4
New guidance for Cancer Breach Allocation has been produced and the agreement that day 38 will be the key date for inter hospital transfer for tertiary referrals.

April Performance

	Local	**National**	**Numbers not seen**
TWW	93.1%	93%	51, predominantly patient choice, 9 due to capacity issues
31 day	99.3%	97.4%	1, Pt transferred between 2 specialities
62 day	86.6%	82.7%	10 , 8 shared care breaches

Stroke
The Stroke pathways have been reviewed against the income related to Best practice Tariff and the Trust is now receiving the correct income. Of the 48 discharged strokes in the month, 36 received the highest income stream with all patients receiving elements of best practice performance.
In the latest SSNAP audit results, DBHFT has acheived A ratings across the indicators,.

Cancelled Operations
Cancelled operations performance, is those patients cancelled on the day of the procedure and is split into theatre and non-theatre cancellations.
Theatre cancellations were impacted mainly in the month due to staff availability. Cancellations due to bed availability remained at 11 across both sites.

Out-Patient Productivity
Hospital cancellations increased this month mainly due to the junior doctor industrial action.
The new call centre and patient change office is now in place along with the agreed protocols for clinic cancellations, which will allow for improved working and utilisation of lists.

David Purdue Chief Operating Officer May 2016

At a Glance -May 2016 (Month 2)

Page		Indicator	Standard (Local, National Or Monitor)		Current Month	Month Actual	Data Quality RAG Rating
4-5	Monitor Compliance Framework	31 day wait for second or subsequent treatment: surgery	94.0%	M	Apr-16	100.0%	
		31 day wait for second or subsequent treatment: anti cancer drug treatments	98.0%	M		100.0%	
		31 day wait for second or subsequent treatment: radiotherapy	94.0%	M		100.0%	
		62 day wait for first treatment from urgent GP referral to treatment	85.0%	M		86.6%	
		62 day wait for first treatment from consultant screening service referral	90.0%	M		93.3%	
		31 day wait for diagnosis to first treatment- all cancers	96.0%	M		99.3%	
		Two week wait from referral to date first seen: all urgent cancer referrals (cancer suspected)	93.0%	M		93.1%	
		Two week wait from referral to date first seen: symptomatic breast patients (cancer not initially suspected)	93.0%	M		93.4%	
6-7		A&E: Maximum waiting time of four hours from arrival / admission / transfer / discharge (Trust)	95.0%	M	May-16	93.1%	
8-9		Maximum time of 18 weeks from point of referral to treatment- incomplete pathway	92.0%	M	May-16	93.1%	
		% of Patients waiting less than 6 weeks from referral for a diagnostics test	99.0%	N		99.5%	
6-7	A&E Performance Indicators	Total time in A&E: 4 hours (95th percentile) HH:MM	04:00	N	May-16	05:22	
		A&E Admitted patients total time in A&E (95th percentile) HH:MM	04:00	N		09:07	
		A&E Non-admitted patients total time in A&E (95th percentile) HH:MM	04:00	N		03:58	
		A&E: Time to treatment decision (median) HH:MM	01:00	N		01:00	
		A&E unplanned re-attendance rate %	5.0%	N		0.4%	
		A&E: Left without being seen %	5.0%	N		3.7%	
		Ambulance Handovers Breaches -Number waited over 15 & Under 30 Minutes		N	Apr-16	680	
		Ambulance Handovers Breaches-Number waited over 30 & under 60 Minutes				75	
		Ambulance Handovers Breaches -Number waited over 60 Minutes				11	
10-12	Stroke	Proportion of patients admitted to an acute Stroke unit within 4 hours of arrival	90.0%	N	Mar-16	65.0%	
		Proportion of Stroke patients scanned within one hour of arrival at hospital	50.0%	N		47.5%	
		Proportion of Stroke patients scanned within 24 hours of arrival at hospital	100.0%	N		97.5%	
		Proportion of high-risk TIA patients investigated and treated within 24 hours of first contact with a health professional	60.0%	N		81.5%	
13	Theatres & Outpatients	Cancelled Operations	0.8%	N	May-16	1.2%	
		Cancelled Operations-28 Day Standard	0	N		2	
		Out Patients: DNA Rate		L		8.7%	
		Out Patients: Hospital Cancellation Rate		L		17.4%	
		Total Number of DNAs		L		Data Unavailable	
		Total Number of DNW		L			
		Did Not Wait Rate		L			
	Effectiv e	Emergency Readmissions within 30 days (PbR Methodology)		L	Mar-16	5.8%	

Page		Indicator	Current Month	Month Actual (TRUST)	Month Actual (DRI)	Month Actual (BDGH)
17	Fractured Neck of Femur	% of patients achieving Best Practice Tariff Criteria	May-16	63.7%	57.5%	80.0%
		Best Practice Criteria				
		36 hours to surgery Performance		67.2%	60.0%	86.7%
		72 hours to geriatrician assessment Performance		94.5%	92.5%	100.0%
		% of patients who underwent an MDT assessment		100.0%	100.0%	100.0%
		% of patients who underwent a falls assessment		100.0%	100.0%	100.0%
		% of patients receiving a bone protection medication assessment		100.0%	100.0%	100.0%
		Mortality-Deaths within 30 days of procedure		9.09%	5.00%	0.00%

Page		Indicator	Standard (Local, National Or Monitor)		Current Month	Month Actual	Data Quality RAG Rating
19	Safe	Infection Control C.Diff	4 Per Month for Qtr 2 - 45 full year	M	May-16	4	
		Infection Control MRSA	0	L	May-16	0	
16		HSMR (rolling 12 Months)	100	N	Feb-16	93.75	
		Never Events	0	L	May-16	0	
		VTE	95.0%	N	Apr-16	95.1%	
19		Pressure Ulcers	12 Per Month 144 full Year	L	May-16	3	
		Falls that result in a serious Fracture	2 Per Month 23 full Year	L		0	
		Catheter UTI	Snap shot audit			0.12%	

Page		Indicator	Current Month		Rag Rating
20	Complaints & Claims	Complaints received	May-16	557	
		Concerns Received		889	
		Complaints Performance		35.90%	
		Clinical Negligence Scheme for Trusts (CNST)		2	
		Liabilities to Third Parties Scheme (LTPS)		4	
		Total number of open and active claims with the NHSLA (as at 31 May 2015)		218 (CNST)	
				55 (LTPS)	
		Claims per 1000 occupied bed days		0.44	

Doncaster and Bassetlaw Hospitals NHS
NHS Foundation Trust

Title	**Strategy and Improvement Report**		
Report to:	**Board of Governors**	Date:	**30 June 2016**
Author:	**Dawn Jarvis – Director of Strategy and Improvement**		
For:	**Noting**		

Purpose of Paper: Executive Summary containing key messages and issues

This paper provides updates on three things:-

1. **CIP Programme 16/17 progress**
2. **Recovery and Financial sustainability plans**
3. **Strategic planning and process led by the Directorate of Strategy and Improvement**

Recommendation(s)

The Committee is asked to **NOTE** the progress reported.

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

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

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

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

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

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

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

Related Strategic Objectives

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

Analysis of risks

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

Board Assurance Framework

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

1. Introduction

1.1. This paper seeks to provide cumulative results at M2 of our 16/17 Cost Improvement Programme (CIP), and an update on a) progress on preparing our two year recovery plan and our 3-5 year financial sustainability plan, draft which was sent separately to Board members last week and b) our strategic planning process.

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

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

Our plan was to deliver CIPs to the value of £11m with an internal stretch target of £13m. The cumulative original plan to M2 was £1011k, with an additional stretch to £1228k. Cumulative delivery to M2 was £1281k which is £270k ahead of the original plan and £53k ahead of the stretch plan.

2.2. All work to reduce and control cost is within one of the 12 work streams, and they are subject to fortnightly challenge meetings and in May we began the first formal Programme Board, chaired by the Chief Executive. The highlight report for the June meeting, which took place on 13 June 2016, is attached at annex 2. This is supported by a Steering Group which met for the first time on 24 May 2016 and includes internal and external stakeholders.

2.3. A second round of Grip and Control meetings are currently being undertaken. This has proved slightly more difficult given the lateness of inputting budgetary information into the system, so only actual expenditure can be challenged rather than variance to budget, but we will do a review to pick up any variance issues. There have been one or two issues with attendance at the meetings which are being challenged. In addition we still need to sign off ALL the CIP proposals in the next month, there are some areas which have still not yet signed off their CIPs.

3. Recovery Plans – timetable, content and sign off

3.1. We have agreed with NHS Improvement the following timetable for delivery of the various stages of plans; this needs to take account of the fast paced work on the South Yorkshire and Bassetlaw Sustainability and Transformation Plan (STP), which is to provide its first report by the end of June 2016.

Date	Submission	Status
27 May 2016	Initial draft of short term recovery plan – to demonstrate direction of travel and to seek initial informal feedback/comments from NHSI	Delivered on time – feedback awaited – circulated separately
26 August 2016	Formal submission of two year recovery plan (FY16/17 and FY17/18) – NHSI will review and provide formal feedback on this version. Should demonstrate that engagement with local partners has taken place.	on plan
26 October 2016	First draft of five year plan – again to demonstrate the direction of travel, flesh out the likely content and provide	on plan

	detail of the work streams and governance arrangements that the longer term plan is likely to follow.	
December 2016 (actual date tbc)	Formal submission of the five year plan (FY16/17-FY20/21) – to demonstrate how this will fit in to STP; involve local partners in solution development and delivery; and how the trust will return to breakeven.	on plan

3.2. There are a number of interdependent plans in development across the STP footprint, our two localities, with our Working Together partners and within the Trust, all with different and sometimes competing timescales. In general the aim of all of them is similar, in that we are tasked as a health economy with delivering high quality care outcomes, maintaining national performance targets and controlling and reducing the cost of healthcare. It is likely that we will have much more detail on the activity we will undertake in this financial year and the next, the two year "Recovery Plan" will detail the CIPS for both years and the ground work which will have to take place to deliver transformational change, which tackles the underlying reasons for our deficit which will happen more in year two and beyond.

3.3. These plans will also need to detail the pace of change within DBH and how far that can go to deliver us back to breakeven, and what can only be achieved in partnership with other providers and commissioners.

3.4. Board of Directors has agreed to have item on each monthly Board Brief agenda to discuss and agree content and Board meetings from June onwards will need to approve various levels of content. In addition, various levels of consultation internally and potentially externally will be undertaken alongside close working across the STP footprint to, where possible, move forward together on any decisions.

4. Strategic Development

4.1. The current Trust Strategic Direction "Looking Forward to our Future 2013 – 2017" would, despite any internal or external drivers, shortly be due for revision and updating; this becomes more important given the serious financial issues faced by the Trust and by the arrival of need for a wider perspective driven by the Sustainability and Transformation Plans (STP) footprint developments across South Yorkshire and Bassetlaw. The current document can be found by following this link.
http://www.dbh.nhs.uk/Library/Corporate_pdf_Documents/Trust%20Strategy%20Direction%20May%2013.pdf

5. Developing a Framework

5.1 In order to support the delivery of a 3-5 year financial sustainability strategy, we need to recommit, refresh or recreate the Trust's Strategic Direction and the supporting strategies that have been created over the past three years as outlined in the NHS Improvement document via this link.
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/365697/Strategy_development_toolkit_MAIN_22102014.pdf

5.2 Some of those strategies will need to be created as they have not previously been in place but some will just need recommitting to. Please see the descriptive picture at annex 2 for an overview, but the suggested elements of the Strategic Framework are listed below:-

A. Refreshed 5 Year Strategic Direction - 2017-2022

The current Strategic Direction – Looking Forward to our Future 2013-2017 is due for review in 2017. It is proposed that this will become a high level direction setting document with an overview of our strategic intent and ambition, under each of the four pillars, plus a recommitment to our vision (which may change to be in line with the strategic intent), mission and values under the We Care mnemonic. As an output we need to develop a sustainable services strategy implemented through a range of interrelated, practical plans that are reviewed and refreshed annually.

B. 10 Potential Supporting Plans :-

- Quality Strategy
- Information Strategy
- Estates Strategy
- Clinical Strategy
- Commercial Strategy
- Research and Development Strategy
- People and Organisational Development Strategy
- Education Strategy
- Financial Strategy
- Governance Strategy

C. Annual Operational Delivery Plans

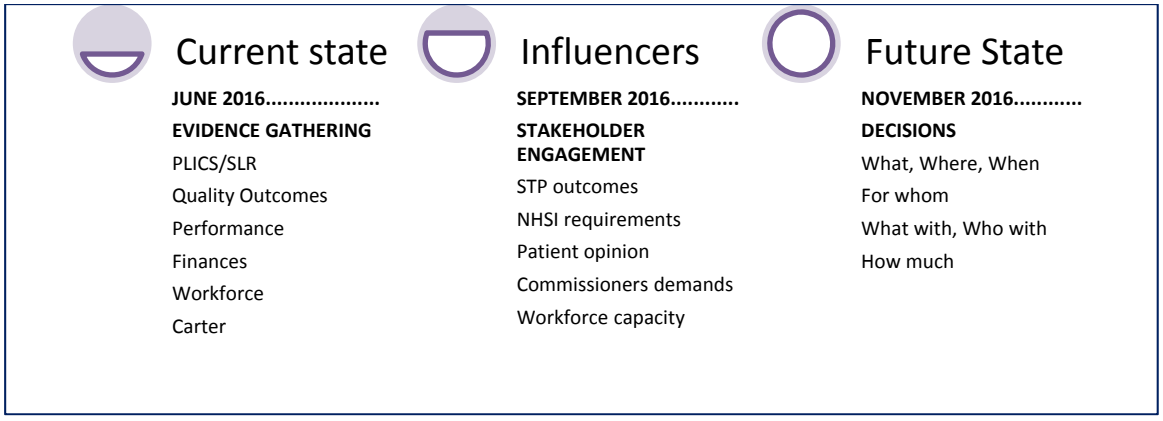
- annual high level deliverables
- supported by operational and financial plans

5 Year Strategic Direction	•2017-2022 •High level direction setting under each of the four pillars, plus vision, mission, values
10 Supporting Plans	•each giving more detail on specific ambitions for each are has specific timescales and outcomes
3-5 Year Financial Sustainability Strategy	• a commentary on all 10 plans majoring on financial sustainability but pulliing together or signalling where developments in the other areas will achieve financial sustainability
2 Year Recovery Plan	•CIPs 16/17 •CIPs 17/18 •leading into 3-5 year plan above
1 Year Operational Delivery Plans	•annual high level deliverables •supported by operational and financial plans

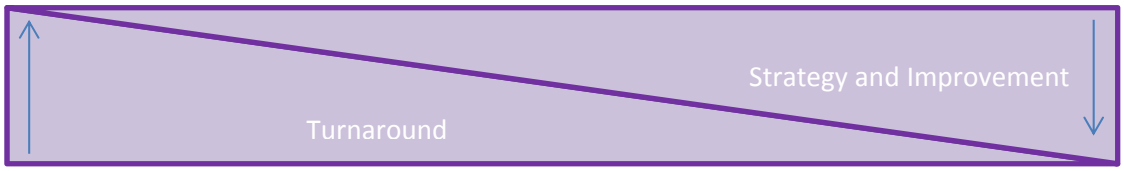
7. Process to delivery of the Strategic Framework

7.1 The Trust isn't in financial deficit to the degree it is due to misreporting issue, there are longer term underlying reasons for the gap between income and expenditure that won't be fixed by in year CIPs. While tactical and operational responses and in year savings can be made each year going forward, without some major changes to ways of working, clinical service and partnership or collaboration, longer term financial sustainability is unlikely to be achieved. Therefore in order to deliver more than in year CIPS, and consider some complex and difficult decisions, in a short space of time (STP plans and 3-5 Year Financial Sustainability Plan dates in 2016) it is important we put in place a robust and evidence based process.

7.2 Much discussion has been had about what we could do, what the landscape could look like, and this is, for the most part based around sound knowledge and understanding. However, before we embark on the process of suggesting any changes to the way we work across DBH or with partners, we are suggesting a process as outlined below. This will ensure our assertions can be backed up with evidence, rigour of thinking, and a good level of planning.



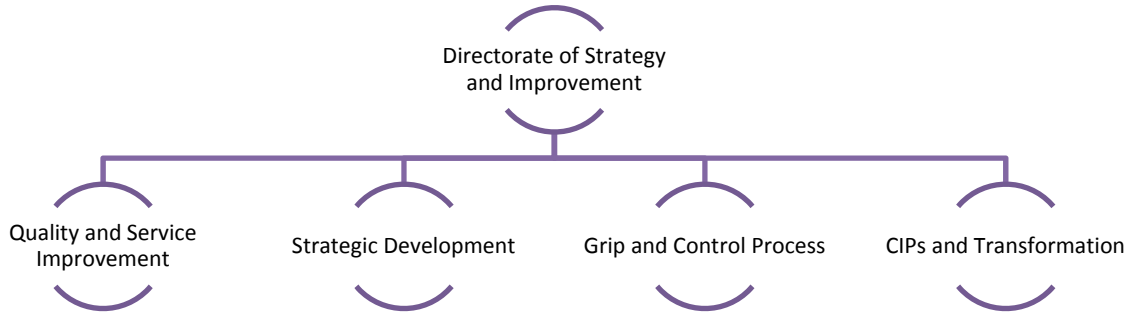
7.3 The Directorate of Strategy and Improvement is responsible for driving the process of Turnaround, and this has up to this point, been the predominant role of the team and where the effort has been almost completely placed. While this continues to be important, we must now begin the shift to drive the process for Strategic Development too.



Jan 16 ---------- June 16 ---------- April 17 ---------- 2019/20 ----------

7.4 Originally we had set out one of the CIP work streams to be about site and service development, however this is clearly not a CIP work stream in the savings sense of the word, and therefore we have agreed to remove this as a work stream with the usual SRO role etc and to rebadge this as a function within the Directorate of Strategy and Improvement. For some time to come we will need a focus on CIP/Turnaround/Grip

and Control, but as we move through this year these functions need to be joined by both Strategy AND Improvement as described below. A more permanent Strategy and Improvement Structure will be recommended to Management Board on 4 July 2016.



7.5 The Directorate of Strategy and Improvement is currently engaged in sourcing the data required to understand the current position. Assuming the Board is in favour of the general direction described in this paper, a commission will be issued to all Care Groups and Corporate Directorates updating them of the process and timeline and asking them for information about their services, and to secure senior leads for the 10 Supporting Strategies (though all will be led or overseen by an Executive Director or Director). This will formally begin the process internally; following on quickly from that will be an outline of the process we will follow to commissioners and other stakeholders.

8. Summary

In summary, we continue to make good progress but we have a challenging set of savings to achieve in 16/17 along with plans for 17/18 and beyond to develop and deliver. Resources, while sufficient at the moment, are under constant review and are supplemented by the support of selected external consultants independently procured or procured by the NHS Improvement's Financial Improvement Programme. For Turnaround and CIPs, there is active management of the work streams with leads and SROs held regularly to account for progress and delivery. The financial values are built into Executive Directors' objectives which helps to ensure a high level of visibility and scrutiny that supports outputs, which achieve the savings while preserving or enhancing the quality and performance of the services we deliver. For the development of the Strategic Framework, the Board is asked to endorse the general direction and for updates on specific deliverables, once a timeline has been created it will be provided in the update for the Board on a monthly basis.

Executive Summary – DBH Improvement Programme 16/17

The Plan and Forecast for Month 2 - May 2016

The planned delivery for the Improvement Programme for FY16/17 is £11.0m, with an internal stretch target to £13.0m.
The forecast outturn for the Improvement Programme (FOT) is now £12.570m an increase since M1 of £155k from £12.415m.
The plan required delivery of £557k in M2 (May '16). Actual delivery in M1 was £673k, ahead of plan by £116k. YTD £1,011 plan, £1.281m actual, ahead of plan by £270k, and ahead of stretch by £53k

Priorities (since the last report) have included:

- Signing off of 6 out of 15 local CIP plans
- Ensuring delivery of the themes remain on track via accountability meetings
- Working up final stretch targets to £13.0m, detail of pipeline and 17/18
- BDGH & MMH "Get Well Soon" workshops, 2 meetings of "Recovery Team
- Closing down Phase 1 of Financial Improvement Programme, start Phase 2
- Recruiting to Work Stream (theatres/infrastructure) and PM posts
- QPIA continues with CCG (all signed off), and Steering Group (24.5.16)
- Second Programme Board taken place (13.6.16)
- Second round of Grip and Control Meetings taking place
- Delivering draft of 2 year recovery plan

Priorities for the next month will include :

- Signing off remaining 9 CIP plans
- Ensuring delivery of themes remain on track via accountability meetings
- On-boarding new PMO starters
- Continuing to identify remainder of stretch target to £13.0
- Continuing to drive plans for pipeline and 17/18
- Working on 2 and 3-5 year plans
- Building on the communications activity
- Submitting business case to NHSI and tendering for Medical Productivity consultancy support

Risks and Issues and mitigating actions (where required)

Several schemes ramp up in delivery terms in October, careful monitoring required on all critical paths to each ramp up.

Several roles becoming vacant across the programme, recruitment in hand but careful monitoring required to ensure all critical roles remain filled, along with succession planning.

Business case for Medical Productivity work stream not supported would present a significant risk to three work streams

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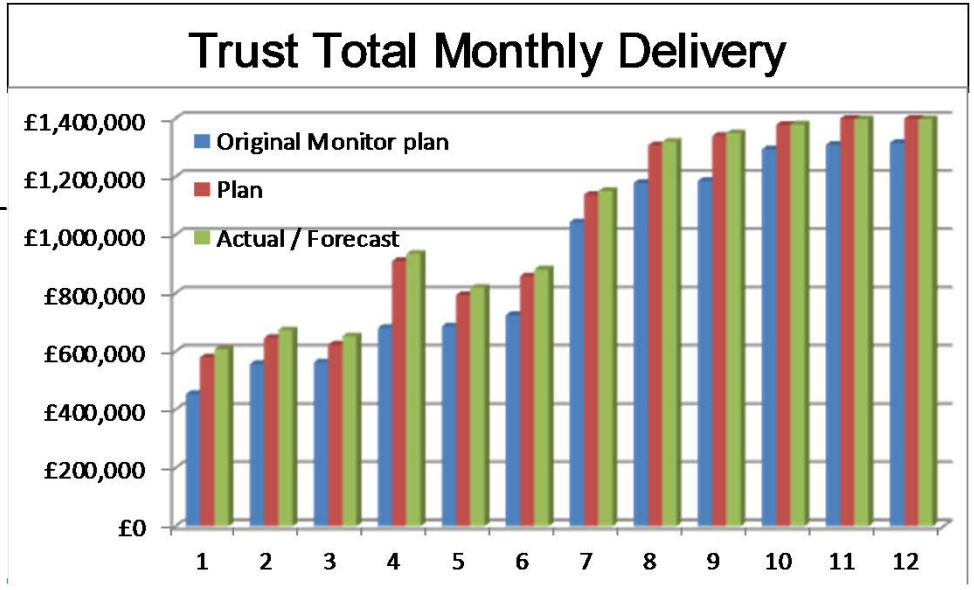
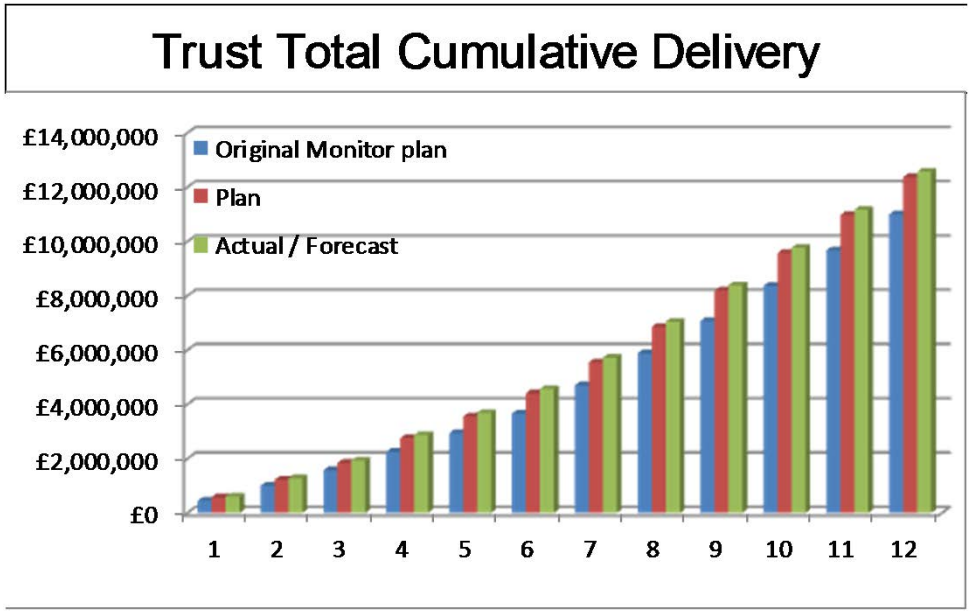
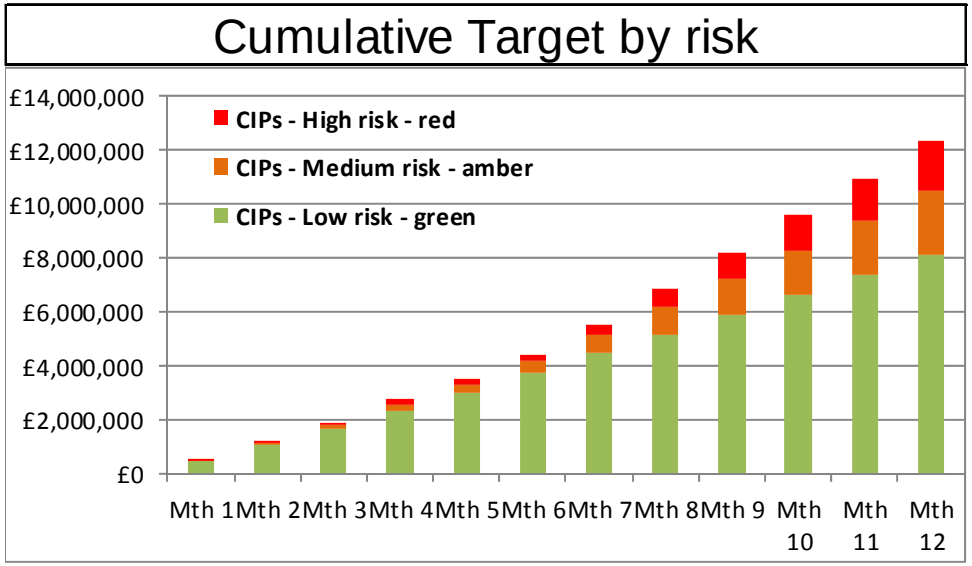


2016/17 Plan in Overview – total cumulative delivery and risk



Efficiencies Summary Information	Total Efficiency £000s	Proportion of total %
CIPs - High risk - red	1,900,391	15%
CIPs - Medium risk - amber	2,341,128	18%
CIPs - Low risk - green	8,138,539	63%
Total needed to be identified	619,943	5%
Total Efficiency	**13,000,000**	**100%**

Based on an original plan of £11m with an internal stretch to £13m, we are currently forecasting 92% of the £13m is made up of recurrent schemes and 63% of the schemes are low risk in terms of delivery This leaves a shortfall of £619,943k (5%) to be identified, and 15% at high risk for delivery.



2016/17 Plan in Overview – recurrence, category and development

Efficiencies Summary Information	Total Efficiency £000s	Proportion of total %
Recurrent schemes	11,899,963	92%
Non-recurrent schemes	480,093	4%
Total needed to be identified	619,944	5%
Total Efficiency	**13,000,000**	**100%**

Efficiencies Summary Information	Total Efficiency £000s	Proportion of total %
Pay	8,046,103	62%
Non pay	1,933,186	15%
Income	2,400,767	18%
Total needed to be identified	619,944	5%
Total Efficiency	**13,000,000**	**100%**

Based on an original plan of £11m with an internal stretch to £13m, we are currently forecasting 92% of the £13m is made up of recurrent schemes and 63% of the schemes are low risk in terms of delivery
This leaves a shortfall of £619,944k (5%) to be identified, and 15% at high risk for delivery.

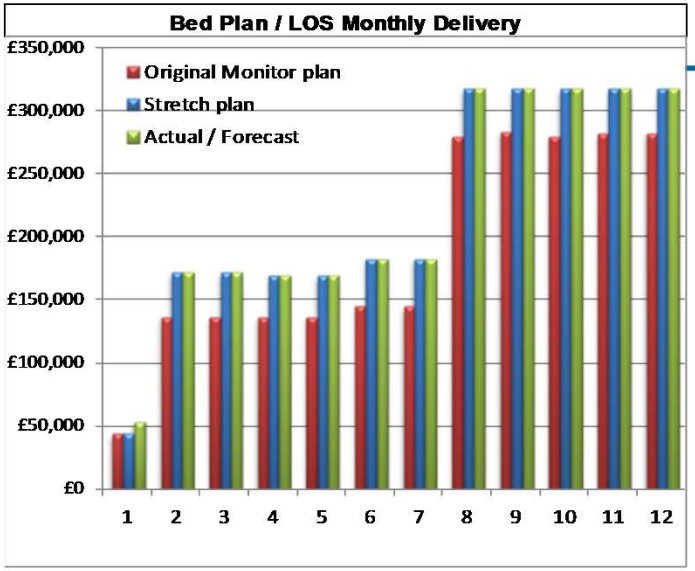
Efficiencies Summary Information	Total Efficiency £000s	Proportion of total %
CIPs - Fully developed	7,903,966	61%
CIPs - Plans in progress	2,790,526	21%
CIPs - Opportunity	1,110,365	9%
CIPs - Unidentified	575,200	4%
Total needed to be identified	619,944	5%
Total Efficiency	**13,000,000**	**100%**

Improvement Programme Forecast Out turn 2016/17

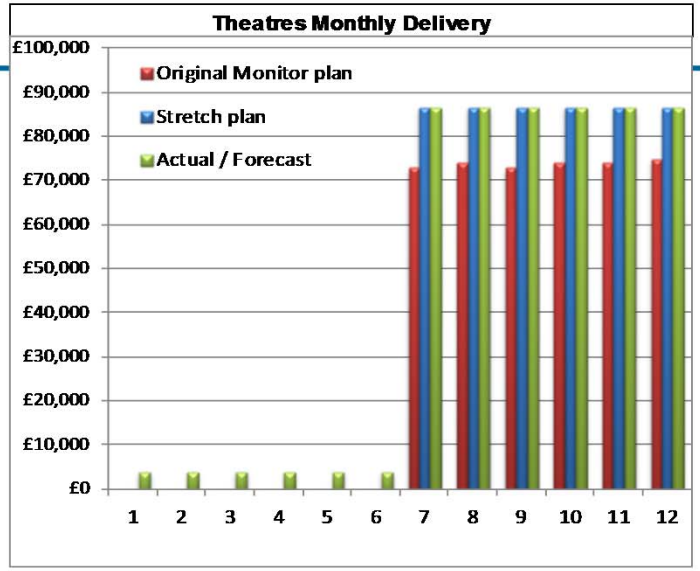
	Original Plan for the Year £'000	Stretch Plan for the Year £'000	Original Plan in Month £'000	Stretch Plan in Month £'000	Actual in Month £'000	Variance to Original in Month £'000	Variance to Stretch in Month £'000	Original Plan YTD £'000	Stretch Plan YTD £'000	Actual YTD £'000	Variance to Original YTD £'000	Variance to Stretch YTD £'000	Forecast CYE (16/17) £'000	Forecast FYE (Recurrent) £'000
Analysis by Workstream														
Theatres	443	520	0	0	4	4	4	0	0	8	8	8	544	1,039
Outpatient Productivity	287	259	10	20	15	5	-5	18	31	26	9	-5	254	287
Medical Productivity	413	441	0	0	0	0	0	0	0	0	0	0	441	966
Non Medical Clinical	261	261	0	0	5	5	5	0	0	10	10	10	285	1,188
Management & Corporate Services Review	761	987	57	69	64	6	-5	115	116	104	-10	-12	918	1,079
Bed Plan / LOS	2,293	2,683	137	172	172	35	0	181	217	226	45	9	2,692	3,816
Procurement	1,901	2,003	91	115	110	19	-5	182	298	295	114	-3	2,033	2,250
Clinical Admin Review	250	250	0	0	0	0	0	0	0	0	0	0	250	250
Infrastructure	531	894	0	26	65	65	39	0	44	111	111	66	1,119	1,599
Income	1,058	1,325	34	50	40	5	-10	63	135	125	62	-10	1,215	1,851
Care Group & Corporate - Local	1,578	1,779	125	115	106	-18	-9	249	230	213	-37	-18	1,761	1,604
Grip & Control	1,224	978	102	81	93	-9	12	204	155	163	-41	8	1,057	1,073
TOTAL	**11,000**	**12,380**	**557**	**647**	**673**	**116**	**26**	**1,011**	**1,228**	**1,281**	**270**	**53**	**12,570**	**17,004**
Rec	11,000	11,768	557	627	653	96	26	1,011	1,072	1,128	116	55	11,960	17,004
Non rec	0	612	0	20	20	20	0	0	155	153	153	-2	610	0
	11,000	**12,380**	**557**	**647**	**673**	**116**	**26**	**1,011**	**1,228**	**1,281**	**270**	**53**	**12,570**	**17,004**

Improvement Programme FY16/17

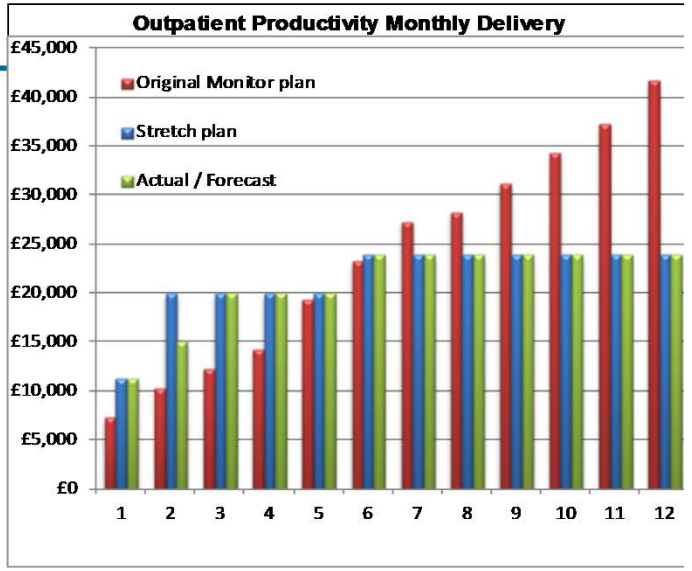
Doncaster and Bassetlaw Hospitals NHS
NHS Foundation Trust



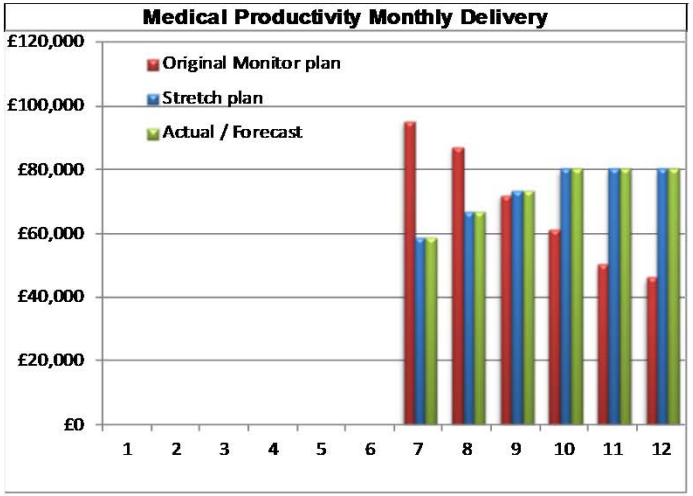
Bed Plan / LOS



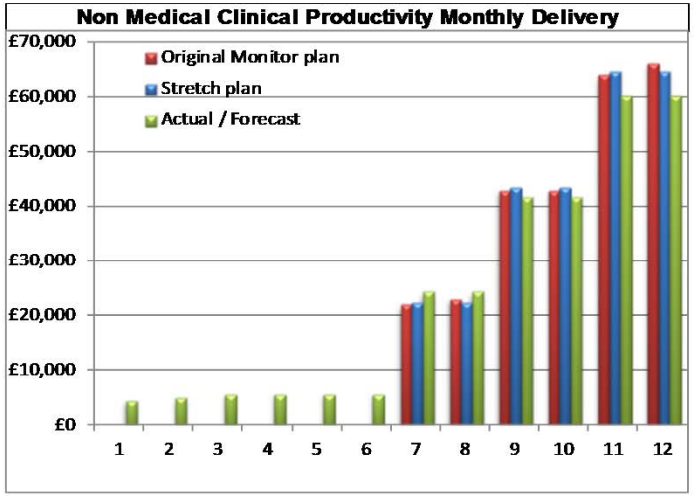
Theatres



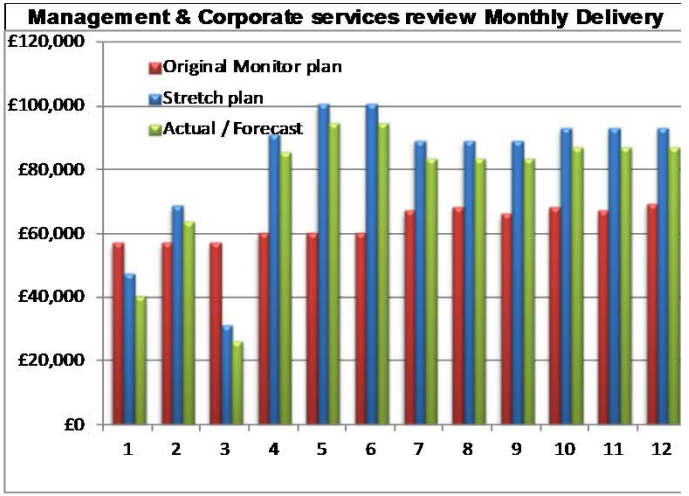
Outpatient Productivity



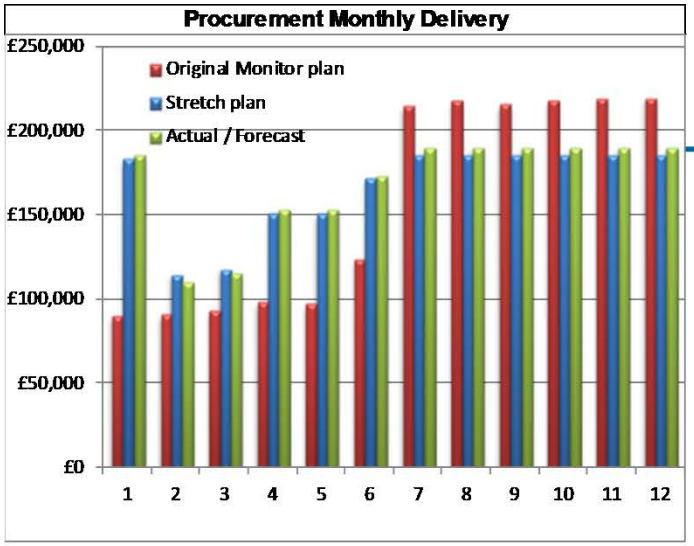
Medical Productivity Monthly Delivery

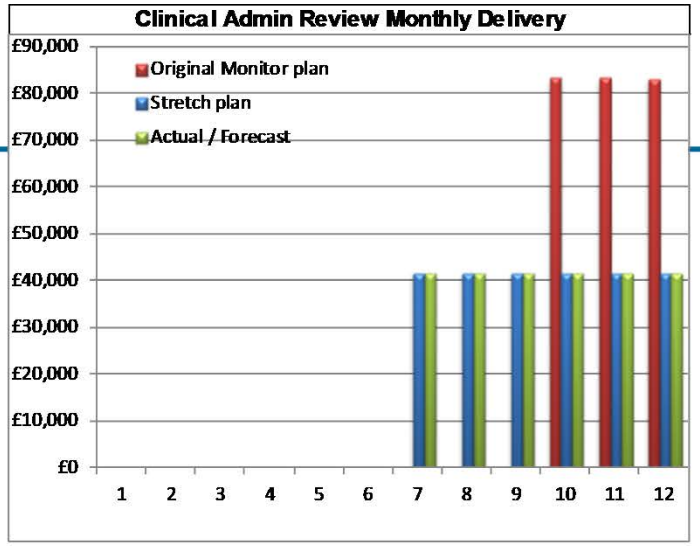


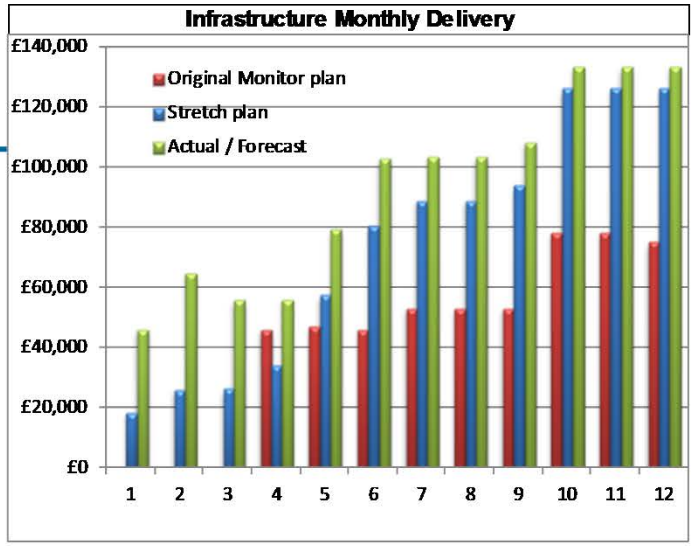
Non Medical Clinical Productivity Monthly Delivery



Management and Corporate services review



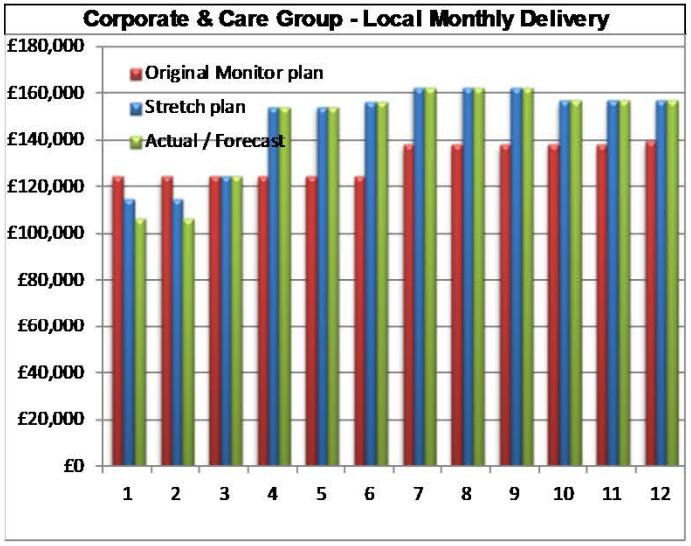


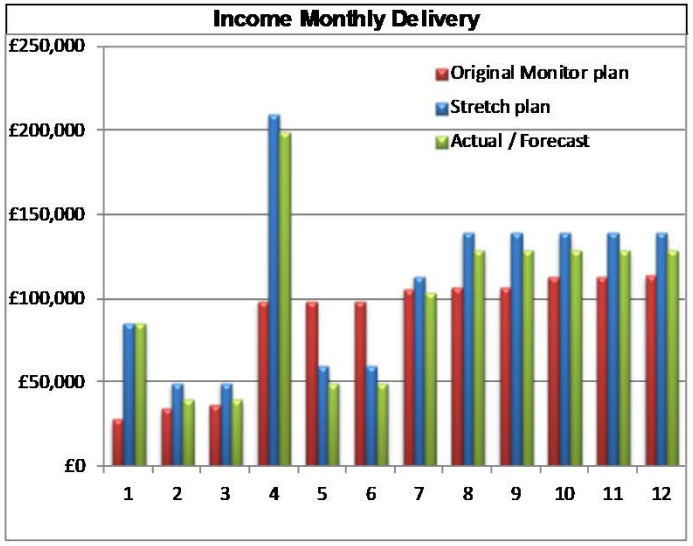


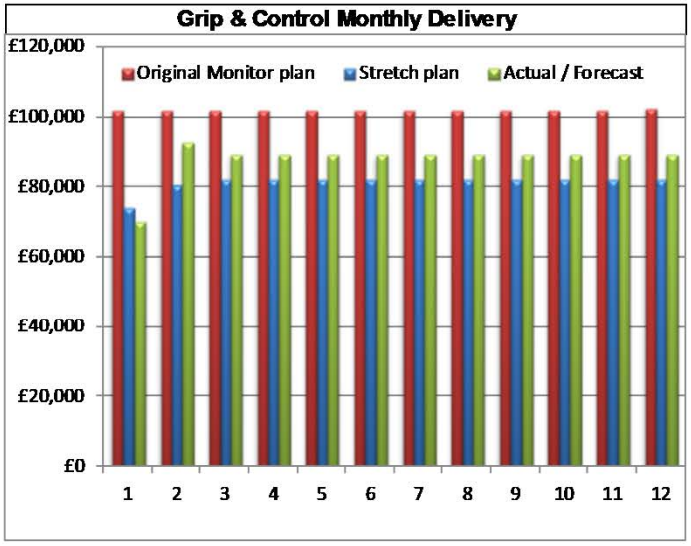
Procurement Monthly Delivery

Clinical Admin Review Monthly Delivery

Infrastructure Monthly Delivery







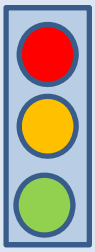
Corporate & Care Group - Local Monthly Delivery

Income Monthly Delivery

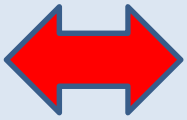
Grip & Control Monthly Delivery

Turnaround Programme - Highlight Report

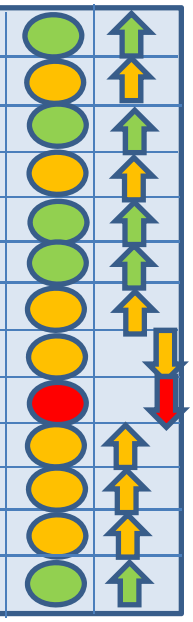
Status



Trend



Theatres	
Outpatient productivity	
Medical productivity	
Management and Corporate Directorates review	
Bed Plan / length of stay	
Procurement	
Clinical admin review	
Infrastructure	
Income	
Care Group / Corporate Directorate Schemes	
Grip and control	
Strategy	
Non-medical clinical	



Summary

- Financial savings for the Turnaround Programme are above planned target
- The majority of the work streams are making progress
- PMO is fully established, still a number of vacancies across the work streams to be filled

Key Risks

1) If savings are not fully quantified or correctly identified by each work stream, there is a risk that overall savings target will not be reached
2) If the programme doesn't maintain sufficient resources delivery of work streams will be in jeopardy
3) If engagement of staff and other stakeholders is not managed delivery of some work streams will be in jeopardy

Key Issue

1) Infrastructure work stream lead leaves in July
2) Infrastructure PM post still vacant
3) Catering specification delayed
4) Parking – Issue remains regarding understanding income gain from parking deductions/increases
5) Theatres adequate WSL discussions
6) Understanding ongoing support required for theatre timetabling when in BAU
7) CAMIS Issue to be resolved to allow best practice tariff to be gained for theatres
8) Clinical Admin Review to scope out savings
9) Slow progress within income work-stream; delay with Park Hill changes
10) LNC still not signed off SPA process
11) 17/18 plans for management review to be scoped

Doncaster and Bassetlaw Hospitals NHS
NHS Foundation Trust

Title	**15/16 Report on progress to deliver the People and Organisational Development Strategy including the Q4 update**		
Report to:	**Board of Governors**	Date:	**30 June 2016**
Author:	**Karen Barnard, Director of People & Organisational Development (P&OD) (Board update produced by Ruth Cooper whilst Acting Director)**		
For:	**To Note**		

Purpose of Paper: Executive Summary containing key messages and issues

This paper seeks to update Board of Governors on the progress made to deliver the P&OD Strategy in 2015/16, the annual KPIs, objective and targets with Q4 results included.

Recommendation(s)

The Board is asked to **NOTE** the content of the update and **COMMENT** on the progress towards the delivery of the P&OD Strategy

Overall we've made some positive progress in a number of areas during 2015/16, but through the second half of the year faced the challenge of the financial deficit emerging, which in some areas impacted on progress.

During 2014/15 improvement was supported by the vastly improved line of sight with regard to accountability of managers brought about by the restructure, and the resultant certainty of ownership for delivery, whether local or central. This set the tone for the future, but was dramatically reinforced as turnaround activity became well established towards the end of 2015/16, which adds more rigour and accountability to current processes. We could therefore expect to see that contributing to further progress of the P&OD Strategy in 2016/17.

P&OD produce data each month for the Care Groups/Corporate Directorates which gives them full staffing lists for their cohort and reports on all the KPIs at team and individual levels, and they usually receive these within the first two weeks of the month, reporting on the previous month. The timing of this will be reviewed going forward as incomplete sickness data is available due to the timing of payroll processes.

During the year we have also developed data at a high level so they can have an at a glance page of people information, which also gives the comparative picture of performance in other Care Groups/Directorates. This includes the KPIs we can monitor objectively for absence, vacancy rates, turnover, registration, roster, engagement and appraisals, with red, amber or green RAG rating for each KPI. It is apparent that this level of accountability drives improvement and acceptance of responsibility where improvements need to be made.

Despite financial turnaround challenges in the latter part of the year, there are many notable achievements to report and some points to note about internal and external influence that impact on progress:

1. Absence and wellbeing – we've invested a great deal of time and effort in raising the skills of managers to deal effectively with sickness absence; improve our occupational health and health and wellbeing service; and add more rigor to the way we hold managers accountable for action. It would therefore not be unrealistic to expect absence levels to rise in the short term. But despite that and

with the exception of a spike at the end of the year in March 2016, we've sustained levels of absence over 6 months and 12 months and maintained our best performance and lowest levels of absence over 28 days and Bradford factor scores of over 1000.

2. Casework – this shows a steady downturn in discipline and conduct dismissals, a sharp rise in capability dismissals, a big reduction in appeals and no employment tribunals with five potential ones being withdrawn due to good internal responses. This shows a heightening level of grip and competence by managers being well supported by the Casework and HR Business Partner teams
3. Staff survey and engagement – good improvement in response rates up to 44% in the 2015 survey with engagement rates rising to 3.77 (from 3.72 in 2014, 3.52 in 2012).
4. Vacancy rates –widened the focus this year onto all gaps across the Trust, which may translate into a vacancy and can now report the difference between budgeted for whole time equivalent (WTE) and fill rate where the end year cumulative position in 7.9%.
5. Appraisals and objective setting – improvement in the reporting levels up from 27% to a high of 81% in Q3 as recorded on ESR. This level of performance was further endorsed when 88% of staff responded in the 2015 staff survey confirming they had an appraisal in the last 12 months.
6. Turnover and staff in post – a rise of numbers of staff of around 200 (187 WTE 223 HC) and slightly over our turnover target.

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

We always put the patient first

- *By focusing on improving staff presence, well-being, engagement and skill level*

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

- *By having clear and transparent processes and policies and by living our values*

Committed to quality and continuously improving patient experience

- *By ensuring we are continuously improving against our KPIs and objectives*

Always caring and compassionate

- *By recruiting, retaining and engaging the right staff who demonstrate our values*

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

- *By having clear objectives and actions to improve our performance and quality*

Encouraging and valuing our diverse staff and rewarding ability and innovation

- *By ensuring the right people with the right skills are involved in delivering our progress*

Related Strategic Objectives

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

Analysis of risks

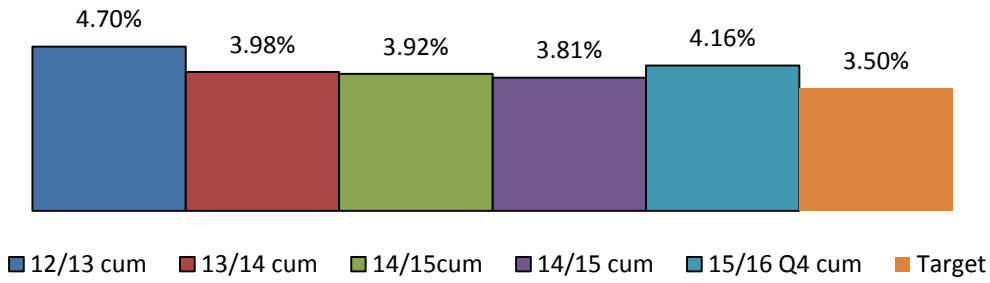
There are three Trust wide risks on the Corporate Risk Register and the Board Assurance Framework that will be directly improved or mitigated by the delivery of the P&OD Strategy through successful delivery will help to support the delivery or mitigation of most corporate risks.

Board Assurance Framework

7	Risk of failing to address the effects of the medical agency cap, leading to gaps in medical rotas	*4x5=20*
8	Failure to engage and communicate with staff and representatives in relation to immediate challenges and strategic development	*4x4=16*
13	Inability to recruit right staff and ensure staff have the right skills to meet operational needs	*4x3=12*

1. Absence and Wellbeing

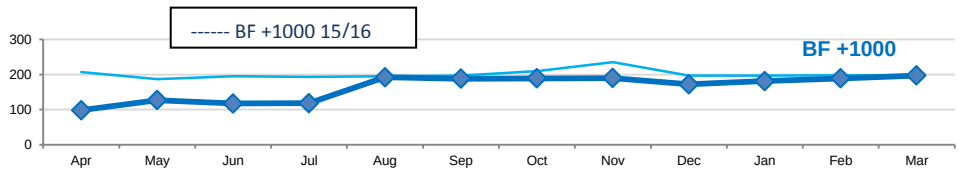
Corporate Objectives 15/16	Q1 15/16
Comprehensively implement and maintain processes and procedures to reduce and then maintain staff sickness to <3.5% measured as an annual position. Hold corporate directorate and care groups to account by escalating performance issues or failure to use corporate tools and processes designed to manage sickness.	Q4 annual
Develop a comprehensive BoD approved Strategy for Staff Health and Wellbeing by Q2 that will be supported by staff side, set measurable goals for improvement and will radically impact the health and wellbeing of our staff, helping us over time to become role models for healthy living	Q2
People and Organisational Development Strategy KPIs	
Staff sickness <3.5%	Q4 annual
Flu immunisation >81% - 63.6% outcome in December. Most NHS organisations saw a decline, many of around 20% we were just in the top 10% being 27th out of 270. In comparison with other local or benchmark organisations we did relatively well as follows:- Chesterfield – 76.6%; Barnsley – 66.1%; SCH – 46.6%; STH – 44.3%; MYorks 35.7%; TRT 55.4% York – 40.4%; WWL 50.4%; Salford 25.8%	Q3



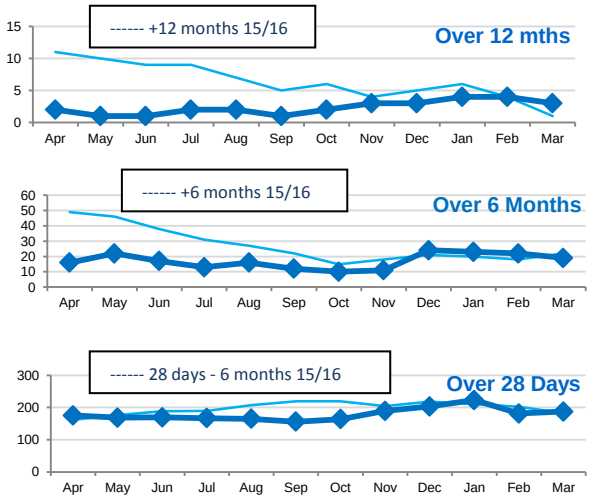
We have not yet met the cumulative target of 3.5%, but we saw a downward trajectory to 3.81% in 14/15. During 15/16 we've generally seen monthly absence well below 4% (and below Trust target in 4 separate months), but there has been a spike to 4.45% in March 2016. The national acute average to the 12 month period ending December 2015 is 4.5% and DBH sat towards the middle of that group just above average at 4.6%. Regionally we again sat in the middle of 15 other organisations with scores ranging from 3.8% to 6.4%.

We build in the 3.5% absence rate to our staffing plans but anything over this may affect care and costs if we directly backfill. Our cumulative annual absence of 4.16% represents 84,101.06 days lost. Using £112 per day average salary, this represents just under £9.5m.

Throughout the year a focus by Care Groups/Directorates on frequency of absence through the use of the Bradford Factor ($S^2xD=BF$ – S=spells, D=days lost, BF=Bradford Factor), shows a slight increase in cases with a score of 1000, but shows a more stable picture from August 2015 to March 2016 (from 192 cases to 197). While BFs take some time to show a reduction as there is a long tail time lag to them as we use a rolling absence period of a year. Although this is an increase in year, it is still lower than the 207 cases at the highest point in 14/15.



Monitoring the length of absences over the 12 month period has shown relatively few cases over 12 months duration (**from 2 cases to 3**); over 6 months duration (**from 16 cases to 19 - lowest point 10**) and over 28 days (from 175 to 187, with a spike in January 2016 of 223).



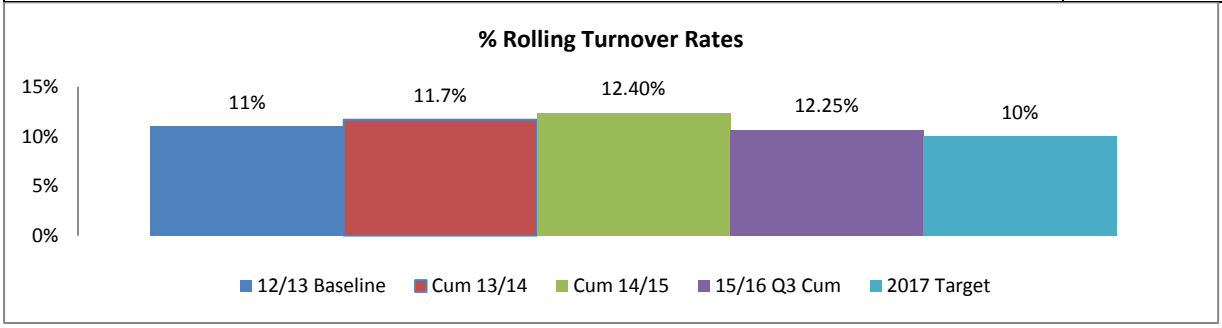
The strategy for Health & Wellbeing set out significant and comprehensive plans for delivery and was agreed by Board in September 2015. But plans for delivery suspended due to financial elements not able to be funded currently.

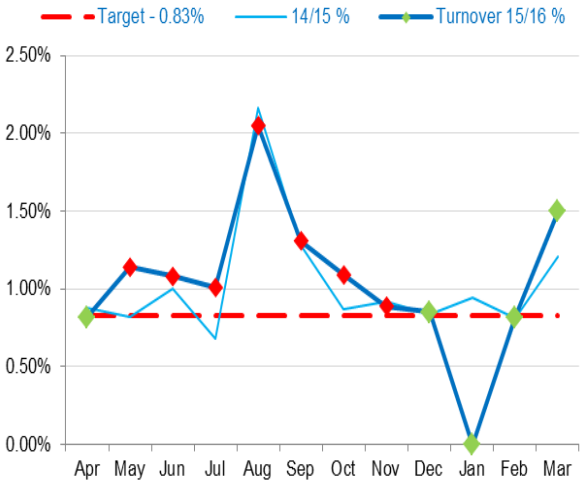
Outcomes 15/16

Solution	Status	Action	Target
Continue data sharing with Care Groups	B	Care Group Accountability meetings and wider Grip & Control discussions give an increasing focus on action	Ongoing through 2016
Repeat spells and/or long spells (Bradford Factor/BF) – over 1000	B	All staff with score over 1000 (or less depending on CG) will have a management plan, signed off by manager, HR and OH	Q4 annual
Management Action and Manager Training	B	Part of Management Skills Programme	Rolled out from 2015
Staff responsibility	B	"The Deal" communications included in induction and management skills programme	Jan 2015
Formal Action	B	Track speed of case work – section 6 shows increased action	Q4 annual
Flu Immunisation	B	Still a relatively good result in 2015, set against public nepotism of the value in flu immunisation over 61% for nursing and 65% for all staff	Dec 2015
Health prevention and Wellbeing	A	Significant plans for delivery agreed with Board in Sep 2015 - plans for delivery suspended due to financial elements not funded currently.	Review funding Sep 2016
Policies and tools	A	Revised sickness policy and development of motivational interviewing techniques in OH to support Health & Wellbeing	Q2
Training for Managers	A	Range of sickness absence and mentally healthy training being rolled out for managers	Q4 annual

2. Turnover, deployment and registration

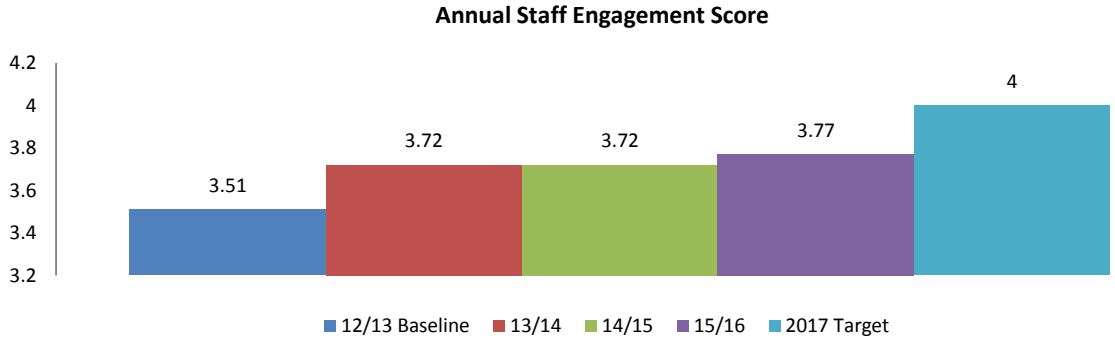
Corporate Objectives	Q1
N/A	
People and Organisational Development Strategy KIPs	
Voluntary turnover <10% annually	Q4 annual
Additional P&OD led projects	
E-roster roll out (DBH2020 project on embedding and handover to be a separate project)	Further roll out moving to CIP Programme
Deliver voluntary turnover levels by taking out areas for purposeful turnover from the statistics.	Q3
NHS Professionals Phase2	Moving to CIP Programme

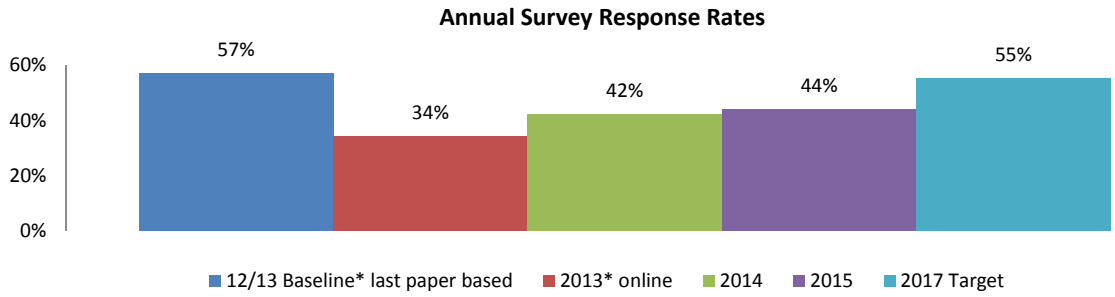


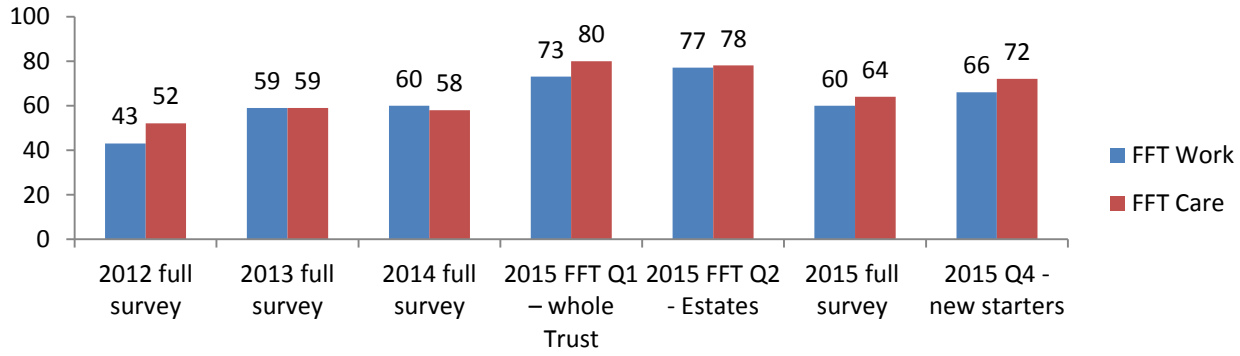


Staff Survey and Engagement

Corporate Objectives	Q1
Develop and agree a clearly defined and branded staff engagement programme to deliver P&OD Strategy, communication and engagement ambitions.	Q3
Implement the key actions arising from the Staff Survey 14/15 and quarterly Staff FFTs. Ensure each care group and corporate directorate has developed a local action plan by the end of Q1 to take forward local issues identified in the staff survey	Q1 & Q3
People and Organisational Development Strategy KPIs	**Q1**
Engagement scores at 4.00 by 2017	2017
Staff survey response rates at 55% in the annual staff survey by 2017 Our response rate for annual staff survey increased to 44% against an average of 38%	2017
Additional P&OD led projects	
Internet/Intranet Procurement and Implementation	Q2 & Q4
Quarterly Staff Friends and Family Test (FFT).	**Q1,2,3,4**







NHS organisations are mandated to complete an annual full staff survey and a quarterly Staff Friends and Family Test (FFT). We are one of a minority of Trusts carrying out a full census meaning in 2015 with a response rate of 44%, it represented a response from almost half of the organisation.

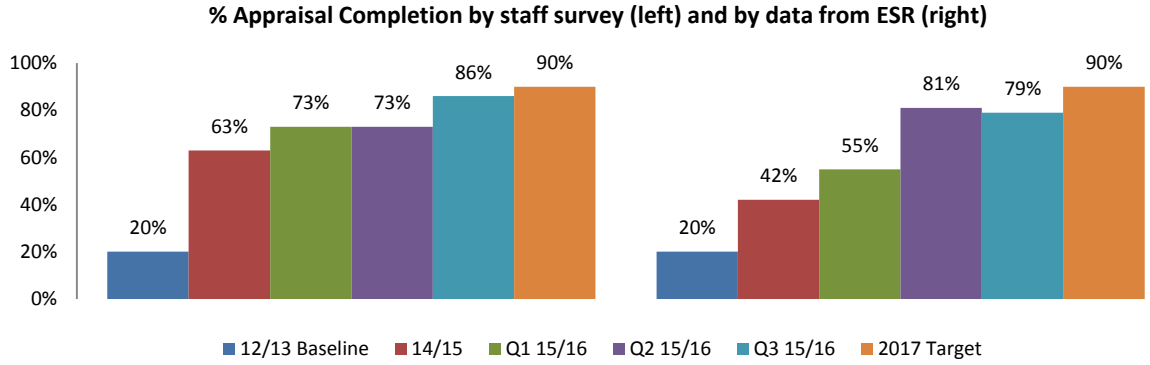
Our smaller FFT samples continue to provide excellent "recommend for work and care" which tend to be slightly higher than the results from our main annual survey, but they also show a generally positive picture, with a very significant rise in the number of people saying they'd had an appraisal in the last 12 months (from 64% in 2014 to 88% in 2015). There are some local variations across Care Groups/Directorates where P&OD will support development of action plans.

Outcomes 15/16

Solution	Status	Action	Target
Improve response rate	B	11 % increase needed to meet target in 2017	55%
Improving Staff FFT scores	B	73% (2014) place to work, FFT Q1 80% (2014) place for care, FFT Q1	Dec 2017 – 85% Dec 2017 – 85%
Annual action – 2, Appraisal rates	A	88% in staff survey - see page on appraisal for actions	85% overall
Values induction	B	Trust Welcome project delivered	Jan 2015 first new session
Values recruitment	B	All interviews, documents, assessments include DBH Values. Initial testing through service assistant cohort recruitment complete	Sep 2016
Values Skills	B	Management Skills Programme	Running from 2015
Long Serv. Awards	B		BAU Jan 2015
Local CG/Directorate action plans	A	Building on previous action plans, use 2015 survey results to review and refresh local actions	Q4 annual

4. Appraisals

Corporate Objectives	Q1
Ensure that at least 90% of staff are recorded on ESR by September 2015 as having had an appraisal in the last year through delivery of the first stage of a longer term project covering uptake, information and systems and quality assured content. The Director of People & OD will be responsible for the corporate systems and policy. Each executive director will be held individually accountable for the staff under his/her leadership as demonstrated by the September ESR report	80% by September 90% by Q4
People and Organisational Development Strategy KIPs	
Appraisal completion >90% by 2017	2017



Continued roll-out of project to ensure we have the right quantity and quality of appraisals completed for all staff across DBH. We began 14/15 reporting only 27% (20% in 2012) of staff logged as having an appraisal and are currently reporting 79% against a national standard of 85% and an internal target of 90%. In the 2014 full staff survey, 63% of staff said they had received an appraisal in the last year, with a rise to 73% in Q1 FFT. Early, unverified outcomes of the 2015 staff survey show this has risen to 86%, above the national average.

This is excellent progress, and our engagement with the project board continues to be high, with the project moving into phase two focusing on quality of conversations as well as quantity of appraisals.

Outcomes 15/16

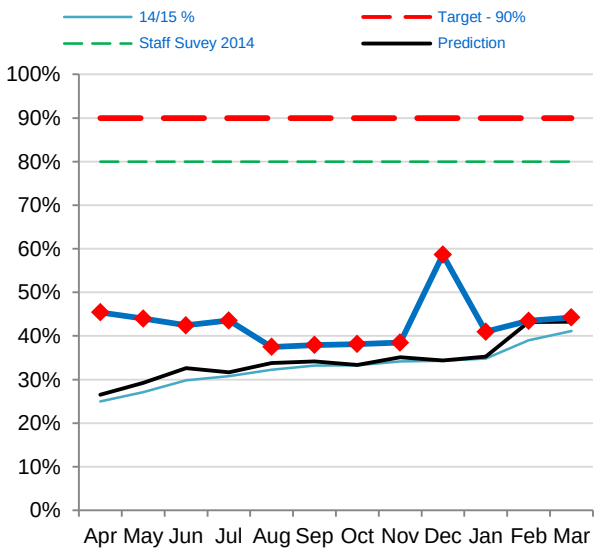
Solution	Status	Action	Target
Increase recording in ESR	B	Ended year on 79% (although Staff Survey reported 86%), but essential to maintain trajectory	85% by Q3 16/17
Appraisal Training	B	Revised module, with specific focus on values, behaviours and unconscious bias rolled out	April 2015
Tools and guidance	B	Full suite of tools launched	March 2016
Quality of appraisals	A	Tools and guidance developed and available now for managers to use. P&OD to measure sample at end year.	Q4

Training, education and development

Corporate Objectives	Q1
Deliver the Statutory and Essential to role (SET) training project to ensure that at least 90% of staff accesses the full programme appropriate to their role, including safeguarding training, by year end	Q4
Develop a clear understanding and forward programme covering the next three years with the University of Sheffield Medical School by Q3, describing how the two organisations will work together to increase student numbers and deliver excellent medical education at DBH	Q3
People and Organisational Development Strategy KPIs and deliverables	
SET training completed for >85% of staff by 2017	2017
Additional P&OD led projects	
Future Leaders – first pilot cohort working well with all 15 through first stages	Q3
Coaching – delivery in Q3 procured training provider dates for October	Q3
Training and Education Restructure – delivery in Q3	Q3
Management Skills Programme – Module 1, 2, 3 and 4 up and running over 200 attended	Q4

We have delayed the planned launch over the summer on our much simplified SET training programme. However we have been following the same pattern of action as with the appraisal project and this is already showing an increase in the internal Trust systems of recording as shown below we are currently at 44.25% (59% in Dec), although in the 2015 NHS Staff Survey 91% of staff said they had mandatory training in the last 12 months. The issues that led us to report such low rates are very similar to that of appraisal and the two are mutually supportive as the essentials of good people management. We are also making excellent progress in our work and relationship with Sheffield Medical School and Sheffield Hallam University.

More widely in the education and development area we are making good progress across a number of development interventions with excellent attendance and engagement in coaching, Management Skills Programme and our innovative Future Leaders Programme.



SET Training rates drawn from Employee Staff Record system (ESR)

Outcomes 15/16

Solution	Status	Action	Target
Set booklet and e-learning package	B	Basic level SET compliance training accessed through one booklet	Nov 2015
Enhanced SET training	G	Development of next level of SET training	Q4 annual
Coaching	G	Training for 2nd cohort of coaches	Q3 16/17
Management Skills Programme	G	Continued roll-out of programme	Through 16/17

5. Vacancy Rates and Recruitment

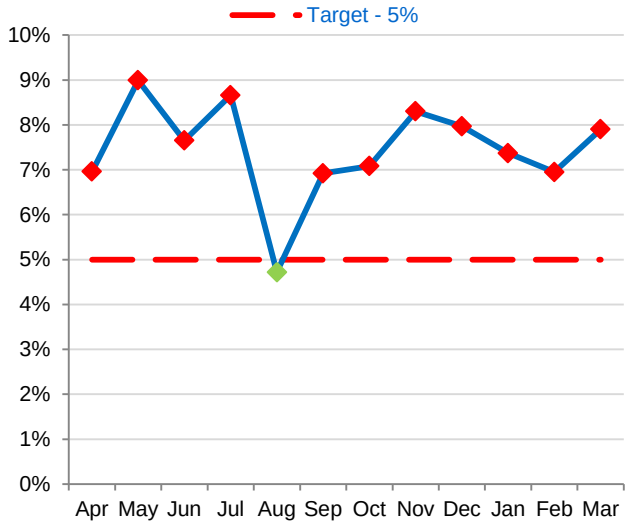
Corporate Objectives	Q1 15/16
To Produce a Workforce Planning Strategy for all professions and staff groups by Q2 15/16 with clear plans to deliver on over and under supply issues for each profession or staff group by Q4 15/16; the overall Trust wide strategy will be developed and delivered by the Director of P&OD, and each profession or staff groups' plans will in turn be led by the relevant Executive Director	Q2
People and Organisational Development Strategy KPIs	
Vacancy rates less than 5%	2017
Additional P&OD led projects	
Recruitment and Workforce Planning Project	Q4 & 2016
International Recruitment Project	Q3 & Q4

For this report we have widened the focus onto all gaps across the Trust, which may then translate into a vacancy.

Currently, we can report the difference between the budgeted for, whole time equivalent (WTE) in a Care Group or Corporate Directorate and the fill rate of those roles which the cumulative average for the year is 7.9%. We have two pieces of work underway though these are currently of a lower priority within Finance and Employee Services:

- one to align the budget data with people in post data e.g. staff on maternity leave who are not here but are being paid which may show as an oversupply issue; and
- a second, which is part of the Recruitment and Workforce Planning Project to report by staff group what gaps translate into actual vacancies that are or are not being recruited to and what stage that recruitment is at.

While I am satisfied that the reported % is currently an overestimation of our vacancy position it is likely to be some months before we can report a fully accurate position, as we have yet to remove examples like the maternity one or gaps where the choice has been made not to fill it, from the calculations.



Overall Trust gap % drawn from Employee Staff Record system (ESR)

6. Casework

Corporate Objectives 15/16	Q1
N/A	
People and Organisational Development Strategy KPIs	
N/A	
Additional P&OD led projects	
Employee Relations Casework review – suspended following loss of funding in Nov 2015. Paused until wider resource can be committed	Q4

Case Type	12/13	13/14	14/15	15/16	
Grievance (17/19/16)		2	9	1	Grievance Upheld
		12	7	5	Grievance Not Upheld
		3	3	4	Part/Informal
				6	Withdrawn
Conduct/Discipline (176/160/79)		66	73	30	No Action/Informal Action
		87	72	36	Formal Action not Dismissal
		23	15	8	Dismissal
				5	Resigned
Capability (26/67/190)		4	11	27	No Action/Informal Action
		18	33	135	Formal Action not Dismissal
		4	23	19	Dismissal
				9	Resigned
Harassment & Bullying (4/4/5)		4	3	5	No Action/Informal Action
		0	1	0	Formal Action not Dismissal
		3	0	0	Dismissal
Appeals # (21/9/7)		1	1	0	Appeal Successful
		20	9	5	Appeal Unsuccessful
				2	Withdrawn
Employment Tribunals # (4/0/6)		0	0	0	ET Successful for claimant
		4	0	1	ET Unsuccessful for claimant
		0	3	5	ET Withdrawn
Whistleblowing (0/1/2)		0	1	2	
Suspensions *&** (6/6/6)	16 paid 2 unpaid	6 paid	5 paid 1 unpaid	6 paid	Calculated as a cumulative total year to date – i.e., there are currently (15.01.16) just 4 ongoing suspensions and no alternatives to suspension.
Alternatives to Suspensions (8/7/3)		8 paid	7 paid	3 paid	2014/15 includes 1 individual who was initially suspended on full pay for two weeks and this was then commuted to alt. to suspension.
Capability - failure of sickness targets		5	2	160	
Ill Health Capability		3	23	25	
Capability - Performance		1	1	4	

No. of Appeals/ET cases concluded in period (case included only if also concluded in same period)

* These will be included in the above figures; ** With and without pay;

Annex 1 – P&OD Strategy KPI tracker 2012 – 2017

The DBH P&OD Strategy was launched in 13/14 to support the delivery of the Trust's Strategic Direction. This stated our aims under four key P&OD themes, supporting the Trust's Strategic Themes and planned by 2017 to deliver a range of positive changes across the Trust, with and for staff, which would improve the quality and consistency of care given to our patients.

The strategy agreed a set of Key Performance Indicators (KPIs), base lined in 12/13 for delivery by 2017; below is an overview of progress towards these KPIs and this report highlights progress towards delivery of objectives delegated to the Director of P&OD - fully delivered (black) and partially delivered (amber).

The review of the Trust Strategic Direction has been delayed slightly to take account of any modification on direction as a result of our financial turnaround. Given that the P&OD Strategy has a further full year to run to 2017, timely review and refresh needs to link to any modifications to Trust Strategic Direction. As we move to review our strategy across the Trust and welcome an new Director of People and Organisational Development in May 2016 the time is right to plan to deliver a reframed P&OD Strategy in 16/17 to ensure the focus shifts from operational stability to an organisation that is able to support and deliver turnaround and long term financial/operational and quality performance.

KPI	2017 Target	12/13	Q4 15/16	Cum. 15/16	Descriptor
Vacancies	5%*	9-12%	7.9%	7.19%	
Absence	3.5%**	4.7%	Jan 3.77% Feb 3.69% Mar 4.45%	4.16%	Cumulative YTD taken directly from eWin workforce data source
Turnover	<10%	11%	Q4 1.5		Rolling annual % **includes voluntary turnover** taken directly from eWin data source
Engagement	4.00	3.51	Annual only	3.77	An increase on previous year 3.72 Calculated by taking the scores for 9 questions (scored 1-5) and averaging them scoring 4 for 5 of the questions and 3 for 4 of the questions means (4x5)+(3x4)=32÷9=3.5 giving an engagement score of 3.5
Flu immunisation	>81%	80%	Annual only	64.7% - including 61% nursing	% of clinical, front line staff immunized, our denominator group as determined by NHS England is around 4700 results are a % of that figure. Other staff cannot count towards results
Staff Survey response rates	>55%***	57%	Annual only	44% (2015)	2% increase of staff responding – based on full annual on line survey since 2013.
Appraisal	>90%	20%	42% ESR	86% (2015)	23% increase in staff in staff survey saying they have had an appraisal in the last 12 months
Training	>85%	20%	41%	81% (2014)	1% increase in staff saying they have had training that has helped them do their job more effectively in the staff survey

*4.5% raised to 5% by Board of Directors following nurse staffing paper June 2014

**absence target is 3.5% not 3% as stated in the printed copy of P&OD Strategy

***reduced from 70% by Board of Directors following March 2015 Board paper on staff survey after reviewing performance of top decile Trusts.

Q4 2015 / 2016

KPI		Absence			Vacancy			Turnover			Registration			Engagement		Appraisal			Training		
Cumulative Q4 Trust / Target		%	4.45%	3.50%	%	7.19	5.00	%	12.25	A - 10.00% M - 0.83%	%	99.66%	99.80%	3.77 3.79	44.00 55.00	%	74.25	67.84	%	43.48%	44.25%
Months		Jan	Feb	Mar	Jan	Feb	Mar	Jan	Feb	Mar	Jan	Feb	Mar	Score	Response	Jan	Feb	Mar	Jan	Feb	Mar
Trust	%	3.77%	3.69%	4.45%	7.37	6.95	7.9		0.82	1.5	99.80%	99.66%	99.45%			75.98	74.25	67.84	40.97%	43.48.%	44.25%
Care Group	C&F	4.66%	4.05%	4.66%	4.15	2.66	3.49		0.55	0.83	100.00%	99.32%	99.77%	3.68	47.00	80.03	80.35	77.00	49.14%	48.01%	49.43%
	D&P	4.24%	3.87%	3.88%	5.62	7.43	6.48		0.77	1.33	100.00%	98.83%	97.65%	3.59	40.00	85.33	77.77	69.00	40.03%	39.26%	43.84%
	Em	3.55%	3.19%	4.27%	13.68	12.41	13.85		0.97	1.08	99.77%	100.00%	99.76%	3.79	42.00	73.82	71.47	62.66	41.13%	43.73%	44.21%
	M&F	2.37%	2.69%	3.77%	6.42	5.24	6.00		1.01	2.03	100.00%	100.00%	99.80%	3.84	50.00	76.39	81.49	74.89	56.75%	56.90%	59.12%
	Sp	3.72%	4.05%	5.35%	5.52	4.35	6.87		0.74	1.19	100.00%	100.00%	100.00%	3.95	49.00	66.77	66.72	62.31	50.26%	47.94%	49.64%
	Su	4.23%	3.76%	4.65%	1.88	2.19	-0.46		0.83	1.74	99.47%	99.74%	99.47%	3.79	41.00	71.72	70.47	62.16	44.53%	44.11%	45.24%
Corp Dir	CEO	8.42%	9.83%	9.38%	7.11%	1.16	13.86		0.00	0.00	100.00%	100.00%	97.96%	4.24	77.00	94.74	90.00	60.00	10.25%	34.15%	32.32%
	E&F	4.54%	4.94%	5.18%	16.50	16.43	16.88		0.45	1.47				3.65	24.00	80.25	74.22	69.92	17.24%	16.95%	17.46%
	Fi	2.83%	3.43%	5.84%	7.31	1.93	4.90		1.86	2.36	100.00%	100.00%	100.00%	3.66	67.00	78.77	76.81	77.50	61.07%	59.86%	69.63%
	MD	1.28%	0.00%	0.00%	-18.48	-18.48%	-18.48		0.00	0.00	100.00%	100.00%	100.00%			66.67	57.14	50.00	26.92%	22.22%	25.93%
	NS	3.71%	0.98%	2.13%	1.16	5.97	9.74		0.00	1.64	100.00%	100.00%	100.00%	3.99	75.00	54.69	53.23	50.85	54.31%	53.53%	55.58%
	P&OD	2.72%	3.84%	1.75%	7.89	6.74	4.84		0.91	3.59	90.91%	91.67%	92.31%	3.95	92.00	85.71	87.62	79.00	58.38%	66.26%	69.34%
	Pe	3.02%	5.01%	4.48%	4.44	6.29	6.30		0.00	1.46	100.00%	100.00%	100.00%	3.68	55.00	73.13	66.18	57.35	42.37%	39.96%	41.34%
	Strat & In	0.00%	0.00%	0.00%	-6.28	14.42	-4.42		0.00	0.00	100.00%	100.00%	100.00%			0.00	100.00	100.00	0.00%	50.00%	37.50%

Q3 2015 / 2016

KPI		Absence			Vacancy			Turnover			Registration			Engagement		Appraisal			Training		
Cumulative Q3 Trust / Target		%	3.89%	3.50%	%	7.47	5.00	%	10.67	A - 10.00% M - 0.83%	%	99.63%	99.00%	3.72 4.00	42.00 55.00	%	79.12	90.00	%	58.64%	90.00%
Months		Oct	Nov	Dec	Oct	Nov	Dec	Oct	Nov	Dec	Oct	Nov	Dec	Score	Response	Oct	Nov	Dec	Oct	Nov	Dec
Trust	%	3.08%	3.44%	3.79%	7.08	8.30	7.97	1.09	0.89	0.85	99.35%	99.83%	99.63%			81.79	81.47	79.12	38.15%	38.46%	58.64%
Care Group	C&F	3.03%	2.97%	3.08%	5.08	5.09	3.26	0.69	0.83	0.56	98.64%	100.00%	99.32%	3.84	33.54	86.20	85.24	81.70	45.79%	45.24%	45.82%
	D&P	3.11%	3.54%	4.87%	6.37	7.60	8.80	0.78	0.89	0.67	99.71%	99.71%	99.71%	3.49	37.96	86.83	88.19	86.57	34.93%	33.86%	38.70%
	Em	2.23%	2.60%	2.65%	15.73	17.66	15.85	0.50	0.87	0.99	99.52%	99.76%	100.00%	3.59	37.90	80.06	80.22	76.32	37.48%	39.08%	38.50%
	M&F	2.59%	3.06%	2.72%	5.22	9.14	5.49	1.03	0.92	0.72	99.25%	99.80%	99.41%	3.72	47.35	80.97	80.79	80.57	48.06%	48.96%	50.63%
	Sp	3.12%	3.53%	3.75%	5.17	4.96	7.53	0.89	0.88	0.44	99.02%	100.00%	100.00%	3.94	32.08	64.69	68.33	67.43	43.31%	43.92%	44.90%
	Su	2.62%	3.70%	4.26%	0.37	1.62	1.71	0.99	0.50	1.14	99.47%	99.74%	99.61%	3.72	43.00	78.70	75.90	73.01	38.01%	37.86%	39.31%
Corp Dir	CEO	4.85%	4.91%	5.16%	-2.35	4.03	0.04	8.70	4.55	0.00	100.00%	100.00%	100.00%	4.20	100.00	95.00	95.00	94.74	43.10%	41.67%	39.09%
	E&F	5.21%	4.87%	5.52%	15.11	15.30	16.67	0.78	0.78	0.90				3.67	33.11	88.66	88.42	87.57	18.54%	15.42%	18.34%
	Fi	1.87%	3.82%	3.17%	8.99	4.61	4.55	0.46	0.45	0.00	100.00%	100.00%	100.00%	3.79	68.94	92.31	88.83	83.56	52.17%	51.53%	58.48%
	MD	0.00%	0.00%	13.22%	-18.48	-40.22	25.00	0.00	0.00	0.00	100.00%	100.00%	100.00%	4.20	100.00	100.00	100.00	100.00	21.28%	25.64%	15.00%
	NS	3.21%	3.32%	4.87%	4.36	0.22	-0.69	0.00	0.00	3.08	100.00%	100.00%	100.00%	3.98	70.00	80.30	71.64	60.61	47.26%	49.86%	53.65%
	P&OD	5.59%	2.77%	2.92%	0.00	3.43	6.94	1.69	6.84	0.89	100.00%	100.00%	99.67%	3.97	90.54	98.18	97.22	89.72	51.63%	54.53%	57.10%
	Pe	5.04%	0.93%	3.78%	4.02	2.90	4.12	0.00	0.00	0.00	100.00%	100.00%	100.00%	3.75	46.34	91.38	91.53	89.61	34.90%	38.04%	39.94%

KPI		Absence			Vacancy			Turnover			Registration			Engagement		Appraisal			Training		
Cumulative Q2 Trust / Target		%	3.82%	3.50%	%	6.92	5.00	%	7.73	A - 10.00% M - 0.83%	%	99.58%	99.00%	3.72	42.00	%	80.85	90.00	%	37.93%	90.00%
														4.00	55.00						
Months		Jul	Aug	Sep	Jul	Aug	Sep	Jul	Aug	Sep	Jul	Aug	Sep	Score	Response	Jul	Aug	Sep	Jul	Aug	Sep
Trust	%	3.01%	3.71%	3.82%	8.66	4.72	6.92	1.01	2.05	1.31	99.57%	99.48%	99.58%			64.76	71.71	80.85	43.56%	37.50%	37.93%
Care Group	C&F	2.07%	4.57%	4.83%	7.80	4.66	6.65	0.85	4.08	0.56	99.78%	99.77%	98.41%	3.84	33.54	47.42	59.43	86.41	52.47%	48.20%	46.68%
	D&P	2.59%	2.60%	3.24%	10.86	7.41	6.47	0.79	2.01	1.00	100.00%	100.00%	100.00%	3.49	37.96	75.00	78.84	87.03	37.92%	30.10%	30.69%
	Em	2.45%	4.69%	4.25%	12.84	6.94	9.40	1.36	4.21	3.56	99.26%	99.50%	100.00%	3.59	37.90	48.60	61.30	77.00	40.77%	36.46%	37.91%
	M&F	2.76%	3.24%	2.59%	10.02	2.52	6.07	1.59	0.95	0.94	100.00%	98.98%	99.59%	3.72	47.35	74.85	73.34	77.56	52.74%	48.51%	48.33%
	Sp	3.39%	3.81%	4.36%	7.43	2.16	9.89	0.60	3.18	1.20	99.71%	100.00%	99.38%	3.94	32.08	52.09	51.18	55.87	49.19%	43.36%	42.70%
	Su	3.14%	3.65%	3.60%	1.22	-1.55	1.01	1.01	2.61	1.00	99.73%	99.33%	99.87%	3.72	43.00	66.79	77.72	81.27	44.71%	38.56%	38.84%
Corp Dir	CEO	3.01%	4.56%	4.73%	16.13	-24.20	-1.55	0.00	4.08	0.00	100.00%	100.00%	100.00%	4.20	100.00	65.22	66.67	100.00	49.64%	45.28%	43.81%
	E&F	5.26%	4.31%	5.23%	14.37	15.37	14.39	0.89	0.66	1.32	N/A			3.67	33.11	48.60	85.33	88.05	25.87%	16.17%	15.94%
	Fi	1.84%	2.08%	1.74%	6.28	10.76	8.96	0.94	1.89	1.42	100.00%	100.00%	100.00%	3.79	68.94	68.02	78.54	92.08	53.85%	48.07%	49.54%
	MD	0.00%	0.00%	0.00%	2.68	-18.48	-19.52	0.00	0.00	0.00	100.00%	100.00%	100.00%	4.20	100.00	100.00	85.71	85.71	33.33%	28.95%	31.58%
	NS	2.65%	3.65%	3.61%	6.12	7.93	0.49	0.00	0.00	0.00	100.00%	100.00%	100.00%	3.98	70.00	84.75	91.67	88.89	48.43%	40.26%	43.26%
	P&OD	3.27%	4.62%	5.74%	-3.83	-1.38	-2.29	0.00	1.66	0.84	100.00%	100.00%	100.00%	3.97	90.54	97.27	99.11	100.00	53.02%	45.21%	49.00%
	Pe	1.19%	3.73%	2.40%	7.95	3.75	-2.50	0.00	0.00	0.00	100.00%	100.00%	100.00%	3.75	46.34	57.89	69.49	86.21	39.13%	32.38%	31.64%

Q1 2015 / 2016

KPI		Absence			Vacancy			Turnover			Registration			Engagement		Appraisal			Training		
Cumulative Q1 Trust / Target		%	4.03%	3.50	%	7.65	5.00	%	3.29	0.83	%	99.72	99.00	3.72	42.00	%	54.99	90.00	%	42.45	90.00
														4.00	55.00						
Months		Apr	May	Jun	Apr	May	Jun	Apr	May	Jun	Apr	May	Jun	Score	Response	Apr	May	Jun	Apr	May	Jun
Trust		4.25	4.07	3.95	6.96	8.99	7.65	0.82	1.14	1.08	99.86	99.79	99.72			45.42	46.34	54.99	45.40	43.99	42.45
Care Group	C&F	3.83	4.56	3.76	4.55	6.54	6.30	1.39	0.56	0.99	100.00	100.00	100.00	3.84	33.54	32.70	32.42	32.78	54.06	52.82	51.83
	D&P	3.87	3.46	3.32	8.74	10.42	10.88	0.68	1.24	0.68	100.00	99.71	100.00	3.49	37.96	68.76	66.67	71.00	42.80	40.31	37.45
	Em	5.26	4.47	4.46	10.71	11.48	10.39	0.23	1.16	1.17	99.77	99.77	99.77	3.59	37.90	31.81	31.12	38.43	41.52	41.21	40.35
	M&F	5.25	3.85	4.23	5.63	12.17	4.58	1.57	1.59	0.96	100.00	100.00	99.79	3.72	47.35	63.41	62.65	70.75	52.00	51.92	51.22
	Sp	3.89	3.10	3.60	0.13	6.57	6.98	0.59	0.45	1.80	100.00	100.00	100.00	3.94	32.08	35.83	39.85	41.07	49.95	48.18	47.54
	Su	3.35	4.26	3.85	1.54	2.92	4.83	0.44	1.40	1.05	99.73	99.45	99.18	3.72	43.00	44.30	49.23	55.88	45.72	44.54	43.15
Corp Dir	CEO	4.33	4.13	4.39	-5.37	13.92	-34.89	0.00	0.00	0.00	85.71	100.00	100.00	4.20	100.00	65.22	63.64	66.67	45.70	43.71	46.76
	E&F	5.22	5.56	5.20	13.56	14.85	14.34	1.10	1.43	0.88	N/A			3.67	33.11	47.60	45.13	63.74	31.45	28.91	25.62
	Fi	4.36	3.88	2.82	6.73	7.64	8.55	0.00	0.48	0.47	100.00	100.00	100.00	3.79	68.94	21.08	22.82	57.71	54.65	53.00	48.81
	MD	0.00	0.55	0.00	-8.54	-8.54	-32.93	0.00	0.00	0.00	100.00	100.00	100.00	4.20	100.00	33.33	33.33	50.00	29.27	24.44	28.89
	NS	3.50	2.71	1.89	1.77	3.05	-9.23	0.00	1.55	6.30	100.00	100.00	100.00	3.98	70.00	32.26	35.94	43.33	53.50	48.81	48.43
	P&OD	1.70	3.39	3.91	4.32	2.45	-3.49	0.00	1.70	0.00	100.00	100.00	100.00	3.97	90.54	31.03	57.89	96.36	58.42	52.56	50.66
	Pe	3.05	1.03	2.16	5.59	7.85	6.23	0.00	0.00	3.57	100.00	100.00	100.00	3.75	46.34	7.27	8.93	47.17	36.19	38.63	38.56

Board of Governors Meeting – Thursday 30 June 2016

Appointment of Trust Chair

1. Purpose

The purpose of this paper is to seek the Board of Governors' approval for the appointment of Suzy Brain England OBE as a Non-executive Director for a term of office of three years commencing 1 January 2017.

2. Background

The appointment of Non-executive Directors is defined in the Constitution, which provides that the Board of Governors shall appoint the Chair and Non-Executive Directors at a general meeting. Monitor's *Code of Governance* also states that the Governors are responsible for the appointment and removal of the Chair and Non-executive Directors.

3. Appointments & Remuneration Committee

The Board of Governors has delegated the task of conducting the selection process and recommending candidates for appointment to its Appointments and Remuneration Committee.

The committee has been convened six times during the appointment process, including conducting shortlisting and interviews. An open recruitment process was carried out, and the post was put out to open advertisement. Five shortlisted candidates were interviewed on the 20th and 27th June 2016 and following these interviews the panel resolved unanimously to recommend Suzy Brain England to the Board of Governors for appointment.

Geraldine Broderick, as Senior Independent Director, led the Appointments and Remuneration Committee in undertaking the process. Sue Symington, Chair of York Teaching Hospitals NHS Foundation Trust, acted as external advisor to the interview panel.

The main interview panel consisted of the Senior Independent Director, external advisor, and four governors from the Appointments and Remuneration Committee. A second interview panel, consisting of three non-executive directors and three other governors, also fed into the decision making process.

Prior to the interviews, all candidates met with the Chief Executive, Board Advisor and executive directors, and feedback from these meetings was submitted to the panel to support the decision making process.

In recommending Suzy Brain England for appointment, the committee has given due consideration to:

- The need to ensure an appropriate balance of skills and experience on the board.
- Compliance with the Code of Governance and other guidance where appropriate.
- The phasing of appointments, and the need to ensure ongoing refreshing of the board.
- The strategic director of the Trust over the coming years.
- The skills and attributes required, given the context the Trust is currently operating within.

4. Eligibility & Appointment of the Chair

Suzy Brain England is eligible to be a member of the Trust's public constituency and is therefore eligible for appointment. A brief summary of Suzy Brain England's curriculum vitae is attached as an appendix to this report for governors' information (see appendix).

If the Board of Governors approves this appointment, each of the Non-Executive Directors of the Board would have the following terms of office:

Name	**End of term of office**	**Years served at end of term**
Alan Armstrong	30 September 2016	3
Chris Scholey (Chair) – retiring at end of current term	*31 December 2016*	*8*
David Crowe	31 March 2017	8
Martin McAreavey	28 February 2018	3
John Parker	31 March 2018	8
Philippe Serna	30 June 2018	3
Suzy Brain England (Chair)	31 December 2019	3
Vacant seat (appointment process during summer 2016)		

5. Recommendation

The Board of Governors is invited to CONSIDER and if thought fit RESOLVE that, in accordance with the provisions of the Constitution of the Doncaster and Bassetlaw Hospitals NHS Foundation Trust, Suzy Brain England be appointed as Trust Chair for a term of office of three years commencing 1 January 2017.

Geraldine Broderick
Senior Independent Director

Mike Addenbrooke
Vice-Chair

APPENDIX

Suzy Brain England OBE: Candidate Background and Career Summary

Suzy Brain England is a Chartered Director with extensive experience in Chair and non-executive director roles. She is currently a non-executive director at Barnsley Hospital NHS Foundation Trust, where she chairs the Audit and Risk Committee, and she has previously been Acting Chair at Mid Yorkshire Hospitals.

In addition to non-executive roles, she has also held a number of executive positions, including Chief Executive of the Talent Foundation and Earth Centre. Suzy was awarded an OBE in the Queen's Birthday Honours in 2009 following her work as Chair of the Standards Committee for the Department or Work and Pensions.

Executive roles:

Position	Organisation	Dates
Chief Executive Officer	The Talent Foundation	July–Oct 2003
CEO	The Earth Centre	2001 - 2003
Director	Central London Training & Enterprise Council	1998 – 2001
Managing Director	Library Services UK	1994 - 1997
Managing Director	Morley Books	1990 - 1994

Recent non-executive roles:

Position	Organisation	Dates
Chair, then Regional Director	Institute of Directors, Yorkshire	2013 - 2014
Non-executive Director	Barnsley Hospital NHS Foundation Trust	2012 - present
Chair	Derwent Living Housing Association	2010 - present
Chair	VOICE UK	2011 - 2012
Acting Chair, Midlands	Community Health Partnerships	2010 - 2011
Non-executive Director	Avanta	2008 - 2014
Chair	Berneslai Homes	2007 - 2014
Non-executive Director (and Acting Chair)	Mid Yorkshire Hospitals NHS Trust	2005 - 2009
Non-executive Director	Melton Mowbray Building Society	1997 - 2007

Doncaster and Bassetlaw Hospitals NHS
NHS Foundation Trust

Title	**Decision to Tender the Trust's External Audit Function**		
Report to:	**Board of Governors**	Date:	**30 June 2016**
Author:	**Jeremy Cook (Interim Director of Finance)** **Andrew Thomas (Interim Associate Director of Finance)**		
For:	**Approval**		

Purpose of Paper: Executive Summary containing key messages and issues

The purpose of this paper is to outline the considerations regarding the termination and retendering of the Trust's External Audit service.

The appointment of the Trust's external Auditors is a power assigned to the Board of Governors.

Recommendation(s)

The BoG is asked agree to the following :

1. Terminate the appointment of the current External Auditors (PWC).
2. Commence the tendering process for the appointment of a replacement.
3. Agree to the process for this outlined in the attached paper.

Should the BoG agree to the above a recommendation for the appointment of a new External Auditor will be brought to the next session of the BoG (21st September 2016). However the ultimate decision will still reside with the BoG at that meeting.

DECISION TO TENDER THE TRUST'S EXTERNAL AUDITOR FUNCTION

1. Background

1.1. PWC are the current providers of external audit services to the Trust. This work largely involves the auditing of and subsequent opinion on the Trust's annual accounts and report.

1.2. PWC were appointed for a three year period commencing with the 2014/15 financial year. Therefore the current contract has one year left to run i.e. the audit of the 2016/17 accounts.

1.3. The Trust reported a surplus for 2014/15 of £1.6m. These financial statements were approved by the External Auditors with an unqualified opinion given.

1.4. Subsequent events and investigation have revealed that the above accounts were significantly intentionally misstated. These have subsequently been restated to show a deficit of £14.8m i.e. a reduction of £16.4m. PWC have subsequently audited these restated accounts at no additional charge.

1.5. Given the issues outlined above the Trust has considered whether the services of PWC should be retained for another year and, if not, what is the mechanism and possible legal ramifications of not going so.

2. Current Contract

2.1 The current contract with PWC commenced for the 2014/15 accounting period and was to run for three years i.e. to cover the audit of the 2016/17 accounts.

2.2 The tendering process was undertaken under a standard government 'framework agreement'. This mechanism serves to minimize the often onerous EU procurement regulations and impose standard terms and conditions.

2.3 Despite the formal contractual agreement the PWC and Trust management have agreed and signed a 'Letter of Engagement' each year outlining any changes to contractual terms and conditions for that year. In particular changes limiting liability to £1m was agreed for 2014/15.

2.4 Despite the annual agreement outlined in 2.3 above the Trust's legal advisors have confirmed that the contract is for a fixed three year period with opportunities to subsequent extend i.e. the agreement of variations to Terms & Conditions on an annual basis does not imply a rolling annual contract.

3. Grounds for Termination

3.1 The contract permits termination where there "has been a material failure by the contractor to perform services". This term is not defined in the contract but a court

would generally be looking for evidence that any such breach have had a serious effect on the benefits the Trust would have derived from the services provided.

3.2 To trigger such a contract breach the trust would need to show that PWC has failed to carry out its duties in a manner such that "the exercise of that degree of skill, diligence and foresight which would reasonably and ordinarily be expected from a skilled and experience service provider".

3.3 It is therefore not sufficient to merely show that PWC did not identify misrepresentations in the Trust's accounts but that they failed to do so where other reputable audit firms would have.

4. Legal Advice Obtained

4.1 Trust management has, via correspondence and a series of teleconferences, obtained legal advice from the trust's solicitors Capsticks LLP. Key elements of these are outlined below with elements within parenthesis (" ") representing direct quotes.

4.2 "While the trust is clearly concerned at the circumstances that allowed a large deficit to build up without its knowledge and considers that PWC may not have performed its role as external auditor to the required standard, there is little clear evidence, on the information we have reviewed, that there has been a breach of a duty of care or a material breach of the contract"

4.3 However Capsticks LLP recommend an alternative approach will be to engage with PWC given their inevitable understandable concerns about their involvement and performance in the circumstances.ie

- Publicity about a failure to pick up > £10m deficit will cause reputational damage

- Should the Trust initiate performance management action this will could affect PWC's other contracts with NHS bodies under the same overarching framework agreement

- Audit services are regulated services. PWC will be keen to avoid any potential for the relevant Recognised Supervisory Bodies to become involved. Even if the outcome would ultimately be the exoneration of the partnership.

4.4 "……..Our view is that potentially the most effective route ahead for the Trust would be to meet with PWC to agree next steps, including for example, a mutual agreement that arrangements would conclude following the work to be done on the restated 2014/15 accounts and 2015/16 accounts"

4.5 Trust management has subsequently initiated discussions with PWC who have informally indicated that they would be prepared to reach an amicable agreement to terminate the contract early.

5. Implication of Removal

5.1 Should the Board of Governors agree to remove PWC the Trust will be without an External Auditor. However this is perfectly acceptable at this stage of the financial year given that work on the audit of the annual accounts does not normally commence until the last quarter of the year in question.

5.2 The Trust would then need to commence a process to tender for a replacement. Details of this proposed process are outlined below.

6. Tendering Process for Replacement

6.1 The power to appoint the Trust's External Auditors resides with the Board of Governors. Therefore it is the intention that a recommendation will be brought to the next meeting (21st September 2016) for consideration.

6.2 Given the need to assess a number of detailed, often lengthy bid documents, it is proposed that a small assessment group is set up to undertake the detailed work and make a recommendation to the Board of Governors. This will be made up of:

- A Governor representative
- A Non-Executive Director representative (Chair of the Audit and Non-Clinical Risk Committee)
- A Trust Management representative (Director of Finance or designated deputy)

6.3 The criteria used to evaluate the various bids combine price and quality assessments as follows:

Evaluation criteria	Weighting
Pricing	30%
Quality	70%
Total	**100%**

Of the 70% quality the following weightings will be applied:

Quality Breakdown	Weighting
Technical Ability	35%
Relevant Experience	30%
Key Performance Indicators	20%
Implementation/Contract Delivery	5%
Management of Team	5%
Client Relationship	5%
Total	**100%**

6.4 The proposed timeline for this work will be as follows:

Event	Date
ITT issued	**25/Jul/2016**
Deadline for receipt of Tenders	**10/Aug/2016**
Evaluation of Tenders	**17/Aug/2016 to 24/Aug/2016**
Shortlist invited to Present	**25/Aug/2016**
Presentation to Panel	**29/Aug/2016 to 9/Sept//2016**
Recommendation to Board of Governors	**21/Sept/2016**
Notification of contract award decision	**23/Sept/2016**
Standstill period	**26/Sept/2016 to 7/Oct/2016**
Contract award	**10/Oct/2016**
Contract work starts	**1/Nov/2016**

7. Recommendations

7.1 It is recommended that the Board of Governors agree to remove PWC by mutual agreement as the Trust's external auditors.

7.2 It is recommended that the Board of Governors instruct the Trust's management to undertake a tendering process to appoint a new external auditor based on the process outlined above.

Non-executive Directors – Draft Objectives 2016/17

Board of Governors Meeting – 30 June 2016

1. Background

Monitor's *Code of Governance* provides that the Board of Governors should take the lead in agreeing the framework for the appraisal of the Non-executive Directors and Chair. For this reason, the Board of Governors is invited to approve the annual objectives of the Non-executive Directors for the coming year (draft objectives for the Chair have not yet been developed).

The attached draft objectives for 2016/17 have been drafted in consultation with the non-executives as part of the annual appraisal process.

2. Recommendation

The Board of Governors is invited to consider and, if thought fit, APPROVE the objectives listed in this paper.

Chris Scholey
Chair

Alan Armstrong

1.	Demonstrate a high quality of contributions at Board and sub-committee meetings.
2.	Demonstrate independence and rigour: • Probe effectively to test assumptions • Challenge the Executive directors • Take a properly independent attitude to Board decisions • Able to resist pressure from others • Follow up and ensure satisfactory resolution in relation to matters about which they have expressed concern
3.	As an active member of the CGOC: • Gain assurance that systems and processes are in place to deliver high levels of Clinical Governance, and that these are embedded, fully implemented and continuously improved. • Gain assurance that a culture of excellent clinical governance is in place and widely understood, and that delegated authority is implemented fully and appropriately
4.	Chair the Fred and Ann Green Legacy Advisory Group.
5.	Chair the Training & Education sub-committee.
6.	Support the turnaround and cost improvement activity working with the Director of Strategy and Improvement to ensure maximum impact of CIP plan and consequent continuous improvement activity.
7.	Maintain and develop knowledge of the Trust's business and dialogue with staff, and ensure visibility through regular visits to wards and departments.
8.	Challenge and review headcount planning and activity, including fte, part time,agency and locum staff to ensure maximum effect of total payroll cost reduction on the Trusts financial performance.
9.	Keep up to date with latest developments regarding corporate governance, regulatory framework, financial reporting and industry conditions/drivers.
10.	Support executives to ensure effective processes, relationships and structures are in place to enable governors to hold Non-executive Directors to account for the performance of the board.

Geraldine Broderick

1.	Demonstrate a high quality of contributions at Board and sub-committee meetings.
2.	Demonstrate independence and rigour: • Probe effectively to test assumptions • Challenge the Executive directors • Take a properly independent attitude to Board decisions • Able to resist pressure from others • Follow up and ensure satisfactory resolution in relation to matters about which they have expressed concern • Contribute to strategy development
3.	As an active member of the CGOC: • Gain assurance that systems and processes are in place to deliver high levels of Clinical Governance, and that these are embedded, fully implemented and continuously improved. • Gain assurance that a culture of excellent clinical governance is in place and widely understood, and that delegated authority is implemented fully and appropriately
4.	As Senior Independent Director ensure that whistleblowing policy is reviewed to take account of current best practice, widely communicated and that you are available as required, in light of the recent financial misreporting and KPMG findings.
5.	Continue to work with the Director of Nursing to ensure complaint metrics remain appropriate and gain continuing assurance that complaints are resolved in a timely and effective manner.
6.	Work with the relevant Executives to ensure that quality information is appropriate for the Board and is easy to read and understand. Continue to attend Patient Experience Committee.
7.	Maintain and develop knowledge of the Trust's business and dialogue with staff, and ensure visibility through regular visits to wards and departments.
8.	Keep up to date with latest developments regarding corporate governance, regulatory framework, financial reporting and industry conditions/drivers.
9.	Support executives to ensure effective processes, relationships and structures are in place to enable governors to hold Non-executive Directors to account for the performance of the board.

David Crowe

1.	Demonstrate a high quality of contributions at Board and sub-committee meetings.
2.	Demonstrate independence and rigour: • Probe effectively to test assumptions • Challenge the Executive directors • Take a properly independent attitude to Board decisions • Able to resist pressure from others • Follow up and ensure satisfactory resolution in relation to matters about which they have expressed concern • Contribute to strategy development.
3.	To act as a 'critical friend' to the new Director of People and OD providing both support and input as well as ensuring that she appreciates the key concerns and issues from the NEDs.
4.	To ensure that all appropriate actions are being undertaken to ensure that as significant reduction as possible can be made as quickly as possible in our claims levels in order to reduce the ongoing cost to the organisation. Gain assurance that the organisation is correctly managing electronic/paper communications to ensure that claims don't result from poor communications.
5.	As an active member of the ANCRC: • Contribute to risk management and assurance • Contribute to ensuring that the Trust maintains an appropriate financial regime.
6.	As a member of the FinOC and ANCRC, provide a link between the two committees. Contribute to the assurance processes and, with the Chair of the ANCRC, work to ensure that there is minimum overlap between the two committees.
7.	Maintain and develop knowledge of the Trust's business and dialogue with staff, and ensure visibility through regular visits to wards and departments.
8.	Keep up to date with latest developments regarding corporate governance, regulatory framework, financial reporting and industry conditions/drivers.
9.	Support executives to ensure effective processes, relationships and structures are in place to enable governors to hold Non-executive Directors to account for the performance of the board.

Martin McAreavey

1.	Demonstrate a high quality of contributions at Board and sub-committee meetings.
2.	Demonstrate independence and rigour: • Probe effectively to test assumptions • Challenge the Executive directors • Take a properly independent attitude to Board decisions • Able to resist pressure from others • Follow up and ensure satisfactory resolution in relation to matters about which they have expressed concern • Contribute to strategy development
3.	As an Chair of the CGOC: • Develop a clear understanding of the clinical governance and regulatory framework within which the Trust operates. • Gain assurance that systems and processes are in place to deliver high levels of Clinical Governance, and that these are embedded, fully implemented and continuously improved. • Gain assurance that a culture of excellent clinical governance is in place and widely understood, and that delegated authority is implemented fully and appropriately
4.	As an active member of the ANCRC: • Contribute to risk management and assurance • Contribute to ensuring that the Trust maintains an appropriate financial regime. • Widen his understanding of the NHS/Trust finances.
5.	Support the Director of Education in moving DBH towards teaching hospital status, with a target of obtaining Teaching Hospital status before the end of 2016.
6.	Contribute to strategy development.
7.	Keep up to date with latest developments regarding corporate governance, regulatory framework, financial reporting and industry conditions/drivers.
8.	Support executives to ensure effective processes, relationships and structures are in place to enable governors to hold Non-Executive Directors to account for the performance of the board.

John Parker

1.	Demonstrate a high quality of contributions at Board and sub-committee meetings.
2.	Demonstrate independence and rigour: • Probe effectively to test assumptions • Challenge the Executive directors • Take a properly independent attitude to Board decisions • Able to resist pressure from others • Follow up and ensure satisfactory resolution in relation to matters about which they have expressed concern • Contribute to strategy development
3.	As Chair of the Financial Oversight Committee provide the Trust Board with a means of independent and objective review of the reported financial position and progress delivering the turnaround and cost improvement programmes.
4.	As Deputy Chair, support the Chair and act as Chair when the Chair is unavailable.
5.	Develop greater visibility within the Trust through dialogue with staff, regular visits to wards and departments.
6.	Act as a critical friend to the Finance, Facilities, Procurement, Fraud and Security teams and provide a link between these teams and the Board. Maintain a visible presence within these teams.
7.	Contribute to strategy development.
8.	Keep up to date with latest developments regarding corporate governance, regulatory framework, financial reporting and industry conditions/drivers.
9.	Support executives to ensure effective processes, relationships and structures are in place to enable governors to hold Non-executive Directors to account for the performance of the board.

Philippe Serna

1.	Demonstrate a high quality of contributions at Board and sub-committee meetings.
2.	Demonstrate independence and rigour: • Probe effectively to test assumptions • Challenge the Executive directors • Take a properly independent attitude to Board decisions • Able to resist pressure from others • Follow up and ensure satisfactory resolution in relation to matters about which they have expressed concern • Contribute to strategy development
3.	As Chair of the ANCRC, provide the Trust Board with a means of independent and objective review of internal controls and risk management arrangements relating to: • Financial Controls • The financial information used by the trust • Non clinical controls assurance systems, including information governance • Non clinical risk management arrangements • Compliance with law, guidance and codes of conduct • Advise / assist the Finance Director with the redesign of the Management Reporting Pack sent to Board. • Oversee the transition of internal audit suppliers focusing on continuity and quality improvement / service levels. • Advise / assist Governors as required with their review of External Audit performance and any consequent decisions that they take.
4.	Maintain and develop knowledge of the Trust's business and dialogue with staff, focusing on finance related staff, in particular Care Group Accountants (meetings with each to be completed by April 2017).
5.	Keep up to date with latest developments regarding corporate governance, regulatory framework, financial reporting and industry conditions/drivers.
6.	Support executives to ensure effective processes, relationships and structures are in place to enable governors to hold Non-executive Directors to account for the performance of the board.

Meeting of the Agenda Planning Sub-committee of the Board of Governors held on 19 May 2016 at 10 am in the Boardroom, DRI

Present:	Chris Scholey	Chairman
	Mike Addenbrooke	Public Governor
	Bev Marshall	Public Governor
	John Plant	Public Governor
	Pat Ricketts	Public Governor
	Clive Tattley	Partner Governor
	George Webb	Public Governor
	Maureen Young	Public Governor
In attendance:	Maria Dixon	Head of Corporate Affairs

Action

Apologies for absence

16/05/1 Apologies had been received from Susan Overend.

Minutes of the meeting held on 4 March 2016

16/05/2 The minutes of the meeting held on 4 March 2016 were APPROVED as an accurate record.

Matters arising

16/05/3 Chris Scholey updated the committee on the current financial position and changes since the last meeting. The Trust had agreed a plan to achieve the control total set by NHS Improvement (formerly Monitor). Month 1 performance had been positive, and it was hoped that Q1 performance would be better than plan. The Trust had also met the A&E target for April.

16/05/4 The Trust was participating in the Financial Improvement Programme, which involved NHSI procuring consultancy support for Trust in turnaround. KPMG had been identified as the preferred bidder for the work. The financial envelope for the work was £2m, but it was anticipated that the cost would be much lower due to the fact that the Trust already had a turnaround director and turnaround programme in place.

16/05/5 Bev Marshall noted that management consultants could identify possible savings, but the Board would need to implement them and might decide not to do so because of the knock-on effect on other areas.

16/05/6 NHS Improvement had also appointed a Board Advisor, Chris Mellor, who was providing advisory services to the Trust.

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16/05/7 Matthew Kane had been appointed as the new Trust Board Secretary, and would commence in post on 4 July 2016.

16/05/8 Chris Scholey summarized the position in relation to emergency surgery at Bassetlaw Hospital, noting that a small number of patients (1 or 2 per day) were affected and those patients were now coming to DRI.

16/05/9 Maureen Young asked whether patients were having to wait longer for surgery. Chris Scholey advised that this was not the case, as the surgical team at DRI were able to prepare while the patient was transferred.

16/05/10 Chris Scholey noted that John Mann MP had written to all governors requesting that they attend a public meeting he would organize regarding the changes. This was discussed and it was suggested that John Mann be invited to a Board of Governors meeting.

Review of previous Board of Governors meeting

16/05/11 Chris Scholey advised that he did not feel that the DRI Lecture Theatre had been an appropriate venue and alternative options for future meetings were discussed.

16/05/12 It was agreed to hold the next meeting in the Bassetlaw Lecture Theatre, and to arrange for sound equipment to be used to ensure all attendees could hear. The September meeting, along with the Annual Members Meeting, would be held in the Ivanhoe Centre in Conisbrough.

Draft Board of Governors Agenda: 30 June 2016

The following reports were agreed for inclusion on the agenda:

16/05/13 Standing Items - The usual standing items, including Chairman's Report and Correspondence, and matters arising from Board of Directors minutes, were agreed.

16/05/14 Executive Reports

- Chief Executive's Report (to include summary of position following KPMG report and Monitor intervention)
- Finance Report
- Business Intelligence Report (summary version, with executive commentary)
- People and OD Report
- Strategy and Improvement Report

16/05/15 The question of whether the Board of Governors should receive an update on the impact of agency caps was discussed and it was agreed that this should be on the agenda for the September timeout. **DP Sept**

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16/05/16 Governance & Statutory Compliance

- Chair appointment
- External Auditors
- NED Objectives 2016/17

16/05/17 It was noted that PwC had been invited to attend the June timeout to report on the 2014/15 and 2015/16 audits. It was agreed that legal advice regarding the external auditors' appointment would be sought prior to the Board of Governors meeting.

16/05/18 Governor/Member matters

- Feedback from members
- Minutes of the sub-committees
- Governor reports from committees and other activities

16/05/19 George Webb asked whether the attendance issues at the Health and Care of Young People committee had been resolved, and Maureen Young confirmed that the committee was now up to full membership.

Any Other Business

16/05/20 John Plant highlighted that he had not yet been informed as to whether a share of surplus generated from ophthalmology development could be used to repay Fred and Ann Green Legacy funds. He advised that he would raise this at the next Fred and Ann Green Legacy Advisory Group meeting, and would escalate to the Board of Governors if the matter was not resolved.

Date & Time of Next Meeting

16/05/21 10am, 9 August 2016
Boardroom, DRI

DRAFT

Communications, Engagement and Membership Sub-committee
Minutes of meeting held at 10 am on 7 June 2016
in the Kilton Room, Bassetlaw Hospital

Present:	David Cuckson	Public Governor (nominated Chair)
	Philip Beavers	Public Governor
	George Webb	Public Governor
In attendance:	Emma Bodley	Head of Communications & Engagement
	Maria Dixon	Head of Corporate Affairs
	Alison Parker	Communications & Marketing Assistant

Action

Apologies for Absence

16/06/1 Apologies were received from Susan Overend and Dev Das.

Minutes of the previous meeting

16/06/2 The minutes of the meeting held on 9 February 2016 were APPROVED.

Matters Arising

16/06/3 16/02/25 – Maria Dixon confirmed that, following recruitment, the team would be fully staffed as of 13 June 2016.

16/06/4 16/02/26 – Maria Dixon reported that a message had gone out to staff, but that she was aware that staff governors sometimes found it difficult to commit to committees due to lack of available time. It was agreed to invite Clive Tattley to join the committee. **MD**

16/06/5 16/02/27 - David Cuckson had not attended the last Patient Experience meeting and would bring the issue up at the next meeting.

Impact of recent changes to member communications

16/06/6 Maria Dixon summarised the response to the recent letter to members advising that only one hard copy of the member magazine would be sent out per year, with the remainder being electronic only. The Foundation Trust office had received hundreds of responses from members providing their email addresses, and the vast majority of comments had been positive.

16/06/7 Going forwards, the Trust would mail out one magazine to all members in August in year, along with an invitation to the Annual Members Meeting. All other issues would be sent out electronically and 5000 copies distributed throughout the hospital. This could be done without any cost to the Trust, as the printing of 5000 copies could be funded by advertising.

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16/06/8 The question of whether the Trust should move from producing 3 issues a year to 4 per year was discussed. Philip Beavers asked whether the resource was available to support the production of 4 issues. Emma Bodley confirmed that there was.

16/06/9 It was AGREED to move to producing 4 issues of the member magazine per year, in February, May, August and November. The committee meeting schedule would be amended to ensure there was a meeting prior to each issue. **EB** **AL**

16/06/10 George Webb asked whether partner organisations were informed when the magazine was produced, and Emma Bodley confirmed that they were. The question of how the magazine should be promoted was discussed, and it was agreed that it should be publicised via Facebook, Twitter and other social media. **EB**

16/06/11 David Cuckson expressed concern regarding whether not sending out magazine would decrease the visibility of the members and governors, and noted that this should be kept under review. It was AGREED to review any further impact from the changes at the next meeting.

Membership Demographic and Churn Report

16/06/12 Maria Dixon presented the membership report, highlighting that the primary area in which the membership was unrepresentative of the local population remained age, with young people underrepresented.

16/06/13 Maria Dixon drew attention to the churn report, noting the gradual decrease in membership numbers. Most of the decrease was attributable to deceased members and members moving away without providing a forwarding address.

16/06/14 Philip Beavers asked whether the Trust's membership was typical, compared to other trusts, and whether there was a benefit to having a larger membership. Maria Dixon confirmed that the Trust's membership was fairly typical, as a percentage of the population served. She advised that there was no direct benefit to having a large membership but that the membership provided a way for the Trust for communicate and engage with patients and the community.

16/06/15 Emma Bodley highlighted that, with increasing use of social media, there were now more ways to communicate with the public than via the membership. The Trust used Facebook, Twitter and other social media, and posts often generated responses and 'likes'.

16/06/16 Philip Beavers noted that younger people, who were underrepresented in the membership, were more likely to use social media.

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16/06/17 George Webb asked whether it was primarily staff who engaged with the Trust on social media, and Emma Bodley advised that it was a mixture of staff and public. Some patients provided feedback via social media.

16/06/18 Maria Dixon noted that previously, one of the main benefits of membership was the ability to receive information from the Trust. Now that information was far more widely available, and more people were using the internet and social media, this wasn't a significant benefit for members any more. Membership was therefore less attractive.

16/06/19 George Webb noted that with the development of Sustainability and Transformation Plans and financial pressure across the health sector, services in some areas could be under threat. This would be likely to motivate people to join their local trust.

16/06/20 Ways to increase the membership were discussed, and it was agreed that membership should be promoted via social media. The patient opt-in which had previously been used to increase the membership was not thought to be a good option, as many of those who were signed up were not aware of how they had become members. **EB**

16/06/21 Philip Beavers asked why there was a need to increase the membership, given the cost associated with servicing the membership and the financial challenges the Trust was facing. Maria Dixon noted that Monitor was no longer focusing on trusts growing their memberships, as it had been in the past.

16/06/22 Alison Parker stated that when the Trust needed to consult with patients and the local community, it now had ways of going out to the wider public as well as the membership.

16/06/23 This was discussed, it was suggested that the committee's focus should shift away from member communication and recruitment and instead focus on communication and engagement with patients and the local community in the wider sense. This would be a significant shift in the committee's work, but would reflect the changing environment.

16/06/24 It was AGREED to highlight this at the next Board of Governors meeting, in order to seek the views of other governors, and to bring a revised terms of reference to the next committee meeting for consideration. **DC** **AL/MD**

Member event 2016

16/06/25 Maria Dixon reported that a member event had not yet been held this year, and asked whether the committee wished to consider holding one, and if so on what topic.

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16/06/26 Emma Bodley asked whether the new strategy and the STP would be a good topic, and George Webb noted that the position was changing rapidly and there would also be separate consultations regarding proposed changes.

16/06/27 George Webb highlighted the need to ensure that the public were kept up to date regarding the Trust's financial position, and the turnaround programme. Emma Bodley acknowledged this and undertook to ensure the website was up to date. **EB**

16/06/28 Philip Beavers asked what sort of topics were usually covered at members events. Maria Dixon advised that they had previously been on health topics, aimed at patients or those caring for relatives with a specific condition. Recent topics had included eye health, dementia, arthritis and cardiology services.

16/06/29 It was AGREE to put this on the agenda for the next meeting, when more members would be present. The next meeting would be held in September, in order to fit with a November publication date for the member magazine. **AL**

Foundations for Health

16/06/30 Review of last issue – The committee felt that the April issue had been good, with more readable colours than some other recent issues.

16/06/31 Editorial panel – August 2016 issue – The committee discussed potential content for the magazine and AGREED to include the following:

16/06/32
(i) A membership promotion item at page 2. **AP / EB**
(ii) An article on the Sustainability and Transformation programme.
(iii) The 'History Matters' article was to continue, as this was felt to be very interesting.
(iv) An article by Chris Scholey, reflecting on his time at the Trust.
(v) Who's the Governor – George Webb, Susan Overend and Philip Beavers nominated to be covered in the next few issues.
(vi) A feature on volunteers week, and the work undertaken by volunteers.
(vii) A short article introducing Matthew Kane.
(viii) The recent governor election results.
(ix) A double page feature on the finance position and turnaround work.

16/06/33 Maria Dixon undertook to check which issue normally contained the governor map. She noted that there had been a number of significant errors on the last map, and this would be addressed next time it was published. **MD**

[Post meeting note – It was confirmed that the governor map was published once per year in the November issue of the magazine]

Any Other Business

16/06/34 Volunteers Week - George Webb noted that the recent NHS Providers email regarding Volunteers Week had arrived too late for governors to do anything, and undertook to feed back to NHS Providers regarding this. **GW**

Date of Next Meeting

16/06/35 September 2016 - exact date, time and venue to be confirmed. **AL**

DRAFT