Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

The meeting of the Board of Directors

To be held on Tuesday 31 October 2017 at 9.00am in the Boardroom, Doncaster Royal Infirmary

AGENDA
Part I

		Enclosures
1.	Apologies for absence	(Verbal)
2.	Declarations of Interest	(Verbal)
3.	Actions from the previous meeting	Enclosure A
4.	Doncaster Growing Together Lee Tillman – Doncaster Council	Presentation

Reports for decision

5.	Enabling Strategies Richard Parker – Chief Executive Marie Purdue –Director of Strategy & Transformation • Patient Experience & Engagement Strategy • Communications & Engagement Stratgey • People & Organisational Development Strategy • Clinical Governance Strategy • Quality Improvement & Innovation (Qii) Strategy	Enclosure B
6.	Emeritus Status – Dr Bruce Bittiner Sewa Singh – Medical Director	Enclosure C

Reports for assurance

7.	Chairs Assurance Logs for Board Committees held 25 October 2017 Neil Rhodes – Chair of Finance and Performance Committee Linn Phipps – Chair of Quality and Effectiveness Committee	Enclosure D
8.	NHS Protect – Withdrawal Of Local Support For Counter Fraud Philippe Serna – Chair of Audit and Non-clinical Risk Committee	Enclosure E
9.	Finance Report as at 30 September 2017 Jon Sargeant – Director of Finance	Enclosure F
10.	Performance Report – Month 6 2017/18 Led by David Purdue – Chief Operating Officer	Enclosure G

11. Winter Planning — Enclosure H
David Purdue – Chief Operating Officer

12. Missed Appointments Engagement Project — Presentation
David Purdue – Chief Operating Officer
Emma Challans – Deputy Chief Operating Officer

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

14. Bassetlaw Mortality – Fractured Neck of Femur — Enclosure J
Sewa Singh – Medical Director

15. Board Assurance Framework and Corporate Risk Register — Enclosure K
Matthew Kane – Trust Board Secretary

Reports for information

16. Chair and NEDs' Report — Enclosure L
Suzy Brain England – Chair

17. Chief Executive's Report & Q2 Objectives — Enclosure M
Richard Parker –Chief Executive

18. Minutes of Finance and Performance Committee, 19 September 2017 — Enclosure N
Neil Rhodes – Chair of Finance and Performance Committee

19. Minutes of Quality and Effectiveness Committees, 19 and 26 September 2017 — Enclosure O
Linn Phipps – Chair of Quality and Effectiveness Committee

20. Minutes of Charitable Funds Committee, 25 July 2017 — Enclosure P
John Parker – Chair of Charitable Funds Committe

21. Minutes of Management Board, 11 September 2017 — Enclosure Q
Richard Parker – Chief Executive

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

Minutes

23. To approve the minutes of the previous meeting held 26 September 2017 — Enclosure S

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

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

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

Date: 28 November 2017
Time: 9.00am
Venue: Boardroom, Bassetlaw Hospital

27. Withdrawal of Press and Public

Board to resolve: That representatives of the press and other members of the public be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest.

Suzy Brain England
Chair of the Board

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Action Notes

Meeting: Board of Directors

Date of meeting: 26 September 2017

Location: Boardroom, BH

Attendees: SBE, RP, KB, MH, DP, SS, AA, LP, JP, NR, MM, JS

Apologies: PS

No.	Minute No	Action	Responsibility	Target Date	Update
1.	**17/01/13**	Director of Education to share the Teaching Hospital phase two development plan at a future Board.	**MK**	**Following discussions at QEC**	To be arranged. Target date changed from September.
2.	**17/04/32**	Timetable six month review of CIPs.	**JS**	**November 2017**	Action not yet due.
3.	**17/04/54**	Invite NEDs to future quality summit.	**MH**	**November 2017**	Quality Summit for A5 being planned. Target date changed from October.

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No.	Minute No	Action	Responsibility	Target Date	Update
4.	**17/05/30**	Once the Emergency Planning Officer had considered the existing business continuity plans, a presentation would be brought to Board and the plans would be tested by internal audit.	**DP**	**November 2017**	Examination of plans ongoing. Target date updated.
5.	**17/05/51**	Work on complaints and the DNA working group would be brought to Board through the Finance and Performance Committee following quarter two.	**DP**	**October 2017**	Complete. On Board agenda though deferred from F&P.
6.	**17/06/34**	Board to meet with care group directors regarding EEPs.	**MK**	**November 2017**	To be arranged. Target date updated.
7.	**17/08/53**	Medical Director to report back on HSMR performance at Bassetlaw.	**SS**	**October 2017**	Complete. On agenda.

Date of next meeting: 31 October 2017
Action notes prepared by: M Kane
Circulation: SBE, AA, NR, KB, DJ, MH, MM, DP, JS, SS, JP, RP, LP, PS

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Title	**Strategy & Transformation Update**		
Report to	**Board of Directors**	**Date**	**31st October 2017**
Author	**Marie Purdue, Acting Director of Strategy & Improvement**		
Purpose			Tick one as appropriate
	Decision		
	Assurance		
	Information		√

Executive summary containing key messages and issues
The purpose of this paper is to ensure that Board has sight of the development and updating of the enabling strategies which support the implementation of the Strategic Direction 2017-2022.
Key questions posed by the report
Are the Board assured that the strategies align to the Strategic Direction 2017-2022?
How this report contributes to the delivery of the strategic objectives
This report identifies progress with the enabling strategies required to support the implementation of the strategy.
How this report impacts on current risks or highlights new risks
The main risk is that we will not have a credible and supported plan to deliver the transformation required at local, or system level, to ensure we can sustain high quality services in line with our revised Strategic Direction.
Recommendation(s) and next steps
The Board of Directors is asked to **note** the content of this report and advise on any additional actions which may be required.

1 Introduction

The purpose of this paper is to ensure that the Board of Directors considers the development and updating of the enabling strategies which support the implementation of the Strategic Direction 2017-2022.

2 Strategies Presented to Quality & Effectiveness Committee

The following strategies were reviewed at the September Quality & Effectiveness Committee (QEC):

- Patient Experience & Engagement
- People & Organisational Development
- Quality Improvement & Innovation
- Clinical Governance & Assurance Strategy
- Communications & Engagement Strategy

Minor amendments have been made by the Executive owners in line with the QEC feedback; the revised versions are included at Appendix 1 for information

Following this Board meeting, the strategies will be formatted by the Communications Team to ensure standardisation and an example of the final format is illustrated by the Patient Experience & Engagement Strategy.

3 Remaining Strategy Updates

The following strategies are being finalised following discussion at Finance & Performance Committee Meeting:

- Clinical Services
- Information Management & Technology
- Estates & Facilities
- Finance & Commercial

The Research & Development Strategy is not due for review until next year and good progress is being made with the objectives. This will be reviewed in 2018.

4 Next Steps

Communication and implementation of the strategies will be implemented and progress on key milestones will be monitored by the Executive owner and reviewed by QEC and F&P on a schedule identified by the Committees.

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Patient Experience & Engagement Strategy

We Care

Introduction

At Doncaster & Bassetlaw Teaching Hospitals NHS Foundation Trust, we are committed to improving the experience of our patients, families and carers. This means we want to work in partnership with our staff and patients to seek opportunities to improve the quality of care that we provide. We are constantly learning from the feedback that we receive and want to actively listen to our patients to understand what matters to them. We also recognise that sometimes we don't always get it right. In situations like this we pledge to our patients, families and carers that we will work with you to understand where care has not met your expectations and in doing so promise that this will not affect ongoing or future care that you may receive.

Our key principles to deliver this strategy are:

- To listen to our patients, families & carers
- To put things right if they go wrong
- To use feedback to learn and share lessons whilst identifying opportunities for quality improvement
- To work in partnership with our patients, families and carers in co-designing services
- To establish standards of best practice identified using for example the Always Events® toolkit

This strategy is aligned to the following Trust enabling strategies that outline how we will achieve our Strategic Vision.

- Clinical Governance
- Quality Improvement & Innovation
- People & Organisational Development
- Research & Development
- Communications & Engagement
- Information & Digital

Patient Experience & Engagement is the golden thread throughout each enabling strategy with each describing how patient experience will be enhanced.

With the required components of 'quality' widely accepted as being the combination of safe, effective care and a positive experience for patients, the Patient Experience & Engagement strategy sets out the Trust's intention to ensure the best possible experience of person centred care for all patients. The strategy describes how staff will understand their responsibility in ensuring each patient not only receives excellent clinical care, but that it is delivered in a manner that treats them as an individual, recognises their needs and cares for them with empathy and compassion. The strategy outlines how this will be achieved, how progress will be monitored and within the implementation plan describes a structured approach to involving and engaging patients and working with stakeholders in the development and improvement of service delivery.
This embodies our trust values of ***We Care.***

- **W**e always put the patient first
- **E**veryone counts – we treat each other with courtesy, honesty, respect and dignity
- **C**ommitted to quality and continuously improving patient experience
- **A**lways caring and compassionate
- **R**esponsible and accountable for our actions – taking pride in our work
- **E**ncouraging and valuing our diverse staff and rewarding ability and innovation.

Executive Summary

“It’s not just about what is the matter?” but “what matters to you?”

Doncaster & Bassetlaw Teaching Hospitals NHS Foundation Trust (DBTH) is extremely proud of the excellent improvements in the quality of care we continue to provide to our patients. This strategy complements a number of other enabling strategies to deliver the ***Strategic Vision 2017-2022*** and provides national and local context in conjunction with evidence based research whilst supporting our commitment to ensuring that our patients, families and carers have a positive experience in our care. Patients tell us that clinical effectiveness and safety is important, but their experience of care matters to them just as much. In order to make informed decisions and choices about their care they want to feel listened to and supported. They want to receive efficient person centred care that meets their personal needs and expectations.

With increasing evidence that positive patient experience leads to positive clinical outcomes and good quality and financial performance, this strategy is instrumental in detailing how the Trust will undertake future patient engagement activity to inform the best possible patient experience.

Experience of care, clinical effectiveness and patient safety together make the three key components of quality in the NHS. Good care is linked to positive outcomes for the patient and is also associated with high levels of staff satisfaction (NHS England 2017). In order for patient experience to improve, we need staff who are motivated and involved with making improvements happen. Evidence suggests that if staff feel valued, trusted and listened to by their leaders, they will be motivated to provide enhanced quality care for patients, families & carers whilst respecting and valuing each other. As an organisation we will ensure that we undertake activities throughout the year where we engage with staff via a number of methods including national and local surveys, drop in listening events and open communication forums including the use of social media to reach as many staff as possible. The feedback provided by staff will be used to inform action plans to ensure we provide a positive work culture where staff feel valued, involved and empowered. This is further detailed in the Communications & Engagement and the People & Organisational Development strategies.

We want to listen to our patients, families and carers to understand what is important to them, to value their ideas and feedback and to learn when care doesn’t meet expectations. We want to work in partnership with our communities when reviewing services and let the ‘expert by experience’ be instrumental in redesigning and shaping future services. By undertaking engagement activities we intend to gather a wealth of knowledge and information to inform the future development of this strategy. This will be achieved through partnership working with our stakeholders, local Healthwatch and voluntary/advocacy services. These activities will feature as informal drop in sessions, social media campaigns, listening events and roadshows in addition to targeted patient group activities and surveys in alignment with our key priorities. In line with our Information & Digital Strategy we will harness the use of information technology in existing and new ways to support how we collect and use feedback and how we communicate with our patients, families and carers.

The Patient Experience & Engagement Committee (PEEC) will monitor progress and performance against this strategy and provide assurance to the Clinical Governance Committee and the Quality & Effectiveness Committee (QEC). Each Care Group will be expected to present patient experience and engagement feedback to PEEC as part of the annual plan. By sharing best practice and lessons learned we can deliver a cohesive approach to improving services and further enhancing patient experience collectively.

The Trust expects that all staff will embrace this strategy and demonstrate the key principles through the care and service that is delivered, whilst demonstrating trust values in all that we do. By creating a culture of continuous improvement that strives to deliver excellent, quality, patient driven services we are able to achieve our ambition.

Where are we now?

Delivering harm free care and improving patient experience continues to be the Trust's focus over the coming years and this is reflected in the Trust Quality Accounts in relation to patient experience as detailed in the following key priorities:

1. Reduce the number of formal complaints
2. Demonstrate increased Patient Engagement activities in each Care Group
3. Reduce the number of complaints relating to staff attitude and behaviour

Whilst we seek to reduce the number of formal complaints, we actively welcome feedback relating to concerns and complaints. Over the coming years, by developing strategies to improve patient engagement and listening activities we will strengthen the patients and public voice in how we prioritise quality improvement initiatives for the future. This will also direct our commitment to delivering person centered care in collaboration with developing our workforce. This is described in more detail in the *Where do we want to be?* section.

"A person-centred approach puts people, families and communities at the heart of health, care and wellbeing. It means people feeling able to speak about what is important to them and the workforce listening and developing an understanding of *what matters to people*. It means working in a system in which people and staff feel in control, valued, motivated and supported" (Health Education England 2017).

At present the Trust undertakes various surveys to obtain patient, family, carer and staff feedback focused on our patient population (children and young people, adults and women and their partners accessing maternity services), these include:

- Picker National Inpatient Survey
- Picker Emergency Department Survey
- Picker Children & Young People's Inpatient & Day Case Survey
- Friends & Family Test (FFT)
- Paediatric survey
- End of Life Care survey
- Quality Assurance Tool- patient feedback & staff survey
- Staff survey
- Care Opinion

This data will be triangulated to enable thematic analysis to identify key areas for improvement and to celebrate best practice based on the feedback received. As a consequence action plans are developed and implemented by the responsible Care Group and exception reported to the Patient Experience & Engagement Committee.

Governors

We value the support and commitment from our Governors, including those who are active members of the Patient Experience & Engagement Committee. We will seek through attendance at Governor meetings to increase Governor sponsorship of wards and departments and increase Governor engagement in undertaking assessments of our wards using the Ward Quality Assessment Tool (WQAT) and support PLACE assessments. We will also seek feedback from Governors attending public engagements.

Where are we now?

The Trust's current membership strategy is to improve the quality and quantity of member engagement with a focus on underrepresented groups rather than increasing the overall membership numbers. We work to engage with our members, and support Governors to seek the views of members, in a number of ways, including:

- Continuing to communicate directly with individual members and keeping them informed regarding governors activities via the member magazine, Foundations for Health.
- Inviting feedback from members through the Foundation Trust Office.
- Holding member events on the topics that our members are interested in, and seeking their feedback on the services discussed.
- Governor attendance at local community events, targeting events at schools and colleges in order to recruit and engage with young people.
- Continuing to regularly inform the membership of the Trust's plans and activities through the member magazine, Foundations for Health.

Patient Stories

As we strive to improve patient experience we are constantly learning from a range of feedback, both positive and negative that we receive. Our ambition is to enhance this further by sharing patient stories on a regular basis to enhance the training and education our new and existing staff members receive in delivering compassionate care. We have recently worked in collaboration with a patient's family to produce a film which details the patients journey and highlights the importance of care with compassion, asking '***What kind of health professional would you like to be?'***

Patient Experience Team (PET)

Our Patient Experience Team (PET) provides an accessible service to patients and their families and carers. They strive to support our patients in first line resolution of concerns and complaints and work in collaboration with our Care Groups and Corporate Directorates if this is unachievable. Insert image of PET

Patient Experience & Engagement Committee (PEEC)

The Patient Experience & Engagement Committee (PEEC) meets on a monthly basis and works to an annual plan which includes presentations by each Care Group of engagement activity as well as analysis of patient experience data and feedback. Membership of the committee in addition to DBTH staff includes Healthwatch representatives from Doncaster and Nottinghamshire along with Clinical Commissioning Group (CCG) staff and two public governors. The committee is chaired by our Director of Nursing, Midwifery & Quality and reports to the Clinical Governance Committee.

John's Campaign

We have also demonstrated our commitment to patient experience in delivering new ways of working in relation to supporting carers and enhancing communication with our patients. This has been through the implementation of John's Campaign which supports open access for the carers of our patients with dementia "*Behind its simple statement of purpose lies the belief that carers should not just be allowed but should be welcomed, and that a collaboration between the patients and all connected with them is crucial to their health and their well-being*. " John's Campaign (2014).

This is Me

The introduction of our 'This is Me' document has enabled patients and their families and carers to provide clear information that is important to them at the time of receiving care in our hospitals. It provides valuable information to allow our healthcare teams to understand patient needs more effectively, particularly at times when our patients are at their most vulnerable. Insert image of 'This is me' document & John's campaign logo.

Me & My Plan- End of Life Care

The Me and My Plan project is using a specially designed folder, filled in by each patient, to tie together community and hospital care. The folder forms a hand held record of the patient's care choices and preferences and can be taken to appointments or brought in with the patient if they are admitted for inpatient care in a hospital or hospice. The Me and My Plan folders have been produced in collaboration with and endorsed by NHS Rotherham Doncaster and South Humber and the initial pilot was funded by Doncaster Clinical Commissioning Group. We strive to deliver the highest quality of end of life care to all of our patients, whatever their care setting and we can only achieve this by working together across boundaries to deliver services that our patients and their families deserve. We need to focus on dying well as well as living well.

Where do we want to be?

Our ambition is to continue on our improvement journey and to collaborate with our patients, families and carers as part of the process through engagement activities that will shape future service delivery. In addition to our existing engagement activities we want to broaden our approach to make it easier for our patient's voice to be heard.

Listening Activities

- Develop a range of drop in, listening events and roadshows in partnership with our local stakeholders including local Healthwatch and voluntary/advocacy services to take place bi-annually. The focus of these will be based on thematic outcomes from patient feedback and will also assist service redesign across the organisation, PLACE based and Accountable Care System. This is reflected in the Communications & Engagement Strategy

Use of Technology

- In line with the Information & Digital Strategy we will use technology and social media to reach a wider population as part of our engagement activities.
- Develop apps to enable feedback to be provided and responded to in a more timely manner.
- Utilise technology to aid in the analysis of feedback, which can identifying themes and trends in greater detail

Experts by Experience

- Utilising the range of opportunities to engage with patients, build a bank of patients, families and carers as 'experts by experience' to contribute to service improvement and redesign as outlined in the Trust Quality Improvement & Innovation Strategy.

Patient Experience Team

- Change the focus of our Patient Experience Team from a reactive to a proactive service that seeks out evidence of patient experience, identifying and analysing themes to inform our future improvement priorities.
- Work closely with Care Groups to identify lessons learned and share that learning across the organisation through the Patient Experience & Engagement Committee, a monthly corporate bulletin and at least annual Patient Experience learning event to supplement bespoke ward/departmental training.

Butterfly Volunteers

The physical, emotional and spiritual stress of a terminal illness and death places great strain on families and carers. Butterfly volunteers will help by providing practical non-medical services so as to enhance optimal care in the final days of life. Just sitting quietly in a room and being there can be a great comfort. Our Butterfly volunteers will provide temporary respite to relatives and carers who often try to maintain a bedside vigil through fear of their loved one dying alone.

Patient Environment Group

The Patient Environment Group will be instrumental in driving improvement following the annual Patient Led Assessments of the Care Environment (PLACE) assessment to identify areas of work to address poor patient experience regarding the hospital environment. Membership of the group will be represented by Estates & Facilities, clinical staff and a patient assessor who will represent the perspective of the patient, family and carer. The group will meet bi-monthly and work to an agreed action plan to implement improvements and monitor progress reporting into the Patient Experience & Engagement Committee.

Where do we want to be?

ReSPECT is a process that creates personalised recommendations for a person's clinical care in a future emergency in which they are unable to make or express choices. It provides health and care professionals responding to that emergency with a summary of recommendations to help them to make immediate decisions about that person's care and treatment. *"The ReSPECT process is all about thinking ahead with patients about realistic care options in a truly person-centred way. Ultimately the process aims to help people understand the care and treatment options that may be available to them in a medical emergency and enables them to make health professionals aware of their preferences"* ReSPECT (2107).

PRASE- Patient Reporting and Action for a Safe Environment

PRASE is a system for collecting patient feedback about how safe they feel whilst in hospital. It is designed to help staff identify things that are working well, and areas needing improvement. Feedback is collected using a patient safety questionnaire and a reporting tool (PMOS-30 and PIRT). With the help of PRASE hospital volunteers, patient feedback is collected using electronic mobile devices. Once enough information has been collected, a ward report is produced and guidance is provided to help make action plans and monitor their successes (Improvement Academy 2017). This will form part of our Patient Safety Improvement activities and will initially be piloted in one area with a scale up plan following analysis of the initial feedback. The Information & Digital Strategy further supports our ambition to use technology in gathering information and feedback to improve patient experience.

Where do we want to be?

Always Events ® toolkit

NHS England (2016) in collaboration with the Institute for Healthcare Improvement has developed a toolkit for health care teams to implement to improve patient experience through partnership working with patients, their families and carers. In principle, implementation of the toolkit will support DBTH to:

"strengthen the voice of those using health service, their carers and families and our staff- enabling a pro-active shift from a sole focus on "what is the matter?" to also include an inquiry into "what matters to you?"

Through engagement activities we will seek to determine the aspects of patient and family experience that matter the most and as such should always occur when accessing our services. The implementation of Always Events ® in pilot sites has enabled health care teams to develop clear practices or behaviours that:

- Provide a foundation for partnering with patients, their care partners, and service users
- Ensure optimal patient experience and improved outcomes
- Serve as a unifying force for all that demonstrates an ongoing commitment to person and family-centered care
- Add meaning to the work of care team staff

The implementation of Always Events ® through the annual work plan of the Patient Experience & Engagement Committee will facilitate monitoring and compliance of Care Group activity and promote shared learning and best practice across our services

#hello my name is…

In addition to enhancing our engagement activities we also want to improve our communication with our patients, families and carers and we will be launching the #hello my name is campaign to promote person centred compassionate care.

> In my mind #hellomynameis is the first rung on the ladder to providing truly person-centred, compassionate care
>
> Kate Granger founder of #hello my name is

Strategic Objectives	
Patients	We will work with patients, their families and carers in co-designing and developing accessible, high quality and responsive services that provide a positive patient experience.
People	We are committed to actively listening to our patients, their families and cares and welcome all feedback to improve the quality and provide a positive experience of care.
Performance	We welcome feedback to ensure our services are high performing and our Patient Experience Team will be proactive in making access even easier.
Partners	We will work with our partners to improve patient experience, listen to feedback and increase our engagement activities across our communities, using information technology tools where appropriate to do so.
Prevention	We will work with patients and their families and carers in seeking early resolution to concerns and complaints, will actively listen and when things go wrong we will ensure that lessons learned are shared to improve patient experience.

SWOT analysis

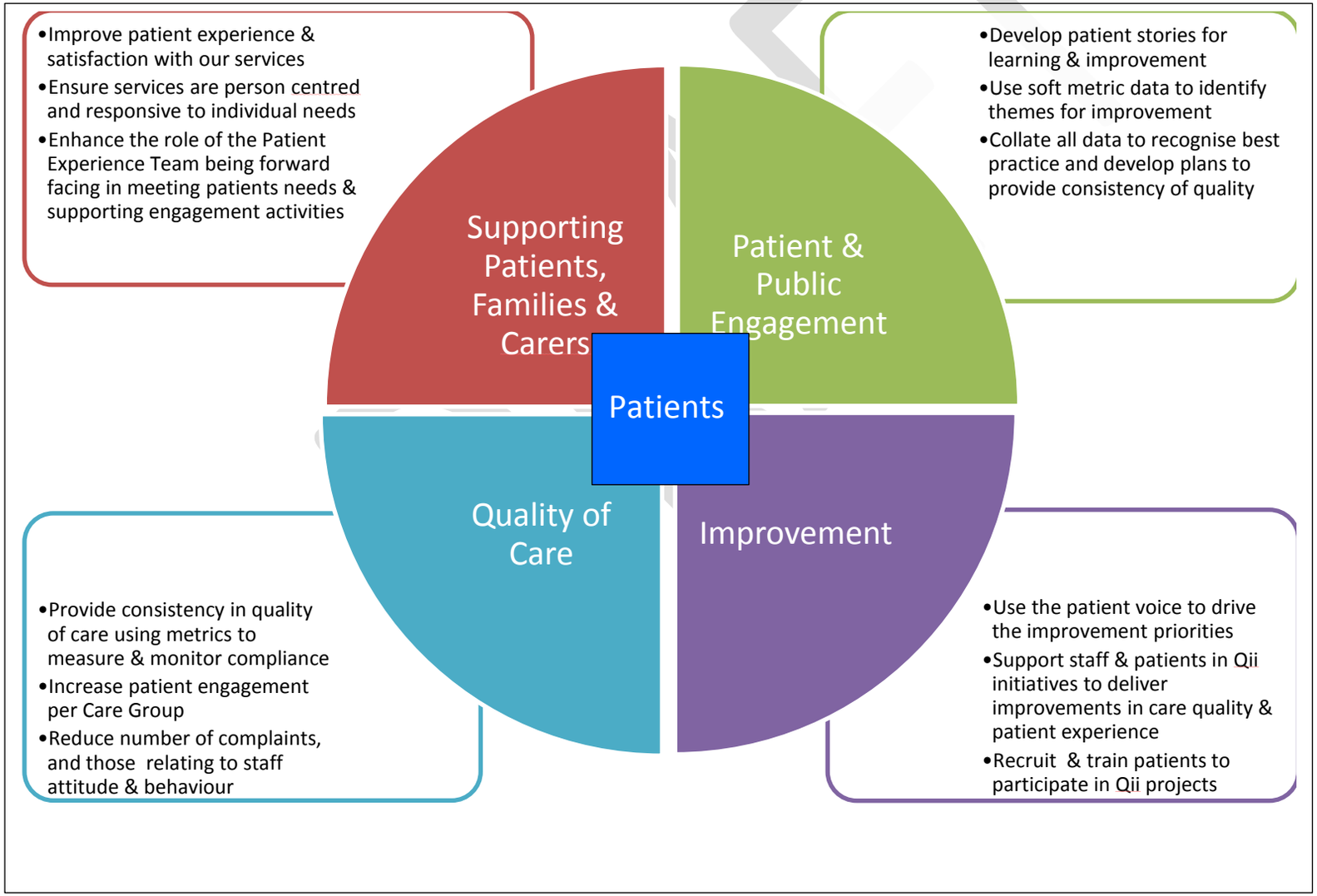
Strengths	**Weaknesses**
• Established Patient Experience & Engagement Committee (PEEC) with Governor and partner organisation involvement. • Use of patient stories (Gina's story, Carol's story) • Clear leadership and oversight through the newly developed post of Head of Patient Safety & Experience	• Limited shared learning from feedback. • Limited Patient Experience Team resource across all sites.
Opportunities	**Threats**
• Increase Care Group engagement at PEEC to share best practice and lessons learned and link directly to Clinical Governance Strategy and objectives. • Develop the Patient Experience Team. • Triangulate patient experience and staff feedback collaborating with People & Organisational Development in aligning key priorities outlined in both strategies. • Patient Experience Day to link patient and staff experience. • Explore IT options for seeking patient feedback from a wider group of patients, families and carers as outlined in the Information & Digital Strategy.	• Increase in formal complaints. • Increase in complaints related to communication and staff attitude & behaviour. • Patient harm. • Poor staff morale.

Objectives and Goals

How we will demonstrate our values and behaviours to improving patient experience

We always put the patient first	• We will work with our patients and families to understand what is important to them • We will actively engage patients and families in improving patient experience
Everyone counts	• We listen to others ideas as well as putting forward our views in a positive way
Committed to Quality	• We use evidence and best practice for improvement • By listening to our patients, families & carers we will improve the quality of care we deliver
Always caring and compassionate	• We will treat patients with care and compassion. • We will listen and respect the patients, families and carers voice recognising them as 'experts by experience'
Responsible and accountable	• We will strive to provide the best experience for our patients, families & carers • We will measure our performance against agreed quality metrics whilst learning from feedback
Encouraging and valuing our diverse staff	• We will listen to our staff and learn from experience whilst sharing best practice and quality improvement.

Objectives and Goals



Person centred interventions to reduced patient harms and improve patient experience

Use 'This is Me' **Say** 'Hello My Name is...' **Ask** 'What Matters to You?'	**#endPJparalysis** Prevent Deconditioning by Early Mobilisation	**#last1000days** Value patients time	**John's Campaign** Encourage family participation
Good Hydration and Nutrition Social dining and china cups	**Remove urinary catheters and other devices if appropriate** Promote scheduled toileting	**Good Wound Care** Minimise tissue pressure and friction	**Advanced Care Planning** Me and My Plan
Enhanced Care Plan Low bed assessment Safety sides assessment	**Reduce Polypharmacy** Good Pain Control	**Eyes, Ears, Teeth** Look after vision, dentures and hearing aids	**Check and Treat Postural Hypotension**
Provide Healthy Sleep Environment Consider sleep diary	**Orientation strategies dementia friendly environment** Patient engagement activities	**#Red2Green** Achieving reliable care	**Early Multi-disciplinary team involvement** Consider MCA and DOLS Consider CGA

Accountability and Timescales

Objectives	Challenges	Actions	Outcomes
1. Thematic analysis of patient, family & carer feedback to inform priorities for improvement.	Objectivity in coding and understanding what matters from the patient family & carer perspective.	PET to collate all data received and code themes for analysis.	Improvement/engagement plans agreed by PEEC to undertake over next 12 months. With Care group accountability monitoring through annual work plan.
2. Reduce the number of complaints related to staff attitude and behaviour.	Engagement with all staff groups	Individual & corporate educational activities provided through the PET & POD with Care Group's through 2017/18 to endorse Trust values, challenge unacceptable behaviours and embed best practice.	PET to undertake an organisational review of the last 12 months of data to identify key themes to agree a targeted action plan through PEEC.
3. Review the effect of enhancing & implementing : • Listening Activities • Use of technology • Experts by experience • Patient Experience Team • Butterfly Volunteers • Patient Environment Group • ReSPECT • PRASE • Always Events® toolkit • #hellomynameis campaign	Prioritisation of resources to enable improvement in the required timescale.	Individual Care Group feedback will reflect the effect of the implementation and inform future annual work plan.	Quarterly report feedback to PEEC.

Evaluation and Monitoring

Monitoring of performance and compliance will be undertaken by the Patient Experience & Engagement Committee (PEEC) through a programme of activities outlined in the strategy action plan. A composite indicator/balanced scorecard including hard and soft metrics (national & local) will be developed to provide monthly surveillance of performance in relation to Patient Experience & Engagement. Care Group's will attend to:

- Discuss performance and quality metrics regarding patient feedback including complaints, concerns and compliments, identifying themes and trends
- Demonstrate patient engagement activities
- Share good practice and patient outcomes including patient stories
- Feedback from patient surveys and present action plans/outcomes
- Share learning from both positive and negative patient experiences- when things go wrong, how do we put them right?
- Present planned projects for improvement that require PEEC support
- Describe Qii work that has been undertaken in the Care Group that directly links to patient experience and engagement and the outcomes of this work
- Provide evidence of how patient experience and engagement outcomes have been shared within the Care Group and across the Trust
- Demonstrate how Patient Experience & Staff Satisfaction correlate in their Care Group

All activity will be presented in the form of a report to the Quality & Effectiveness Committee on a quarterly basis, and will be reported annually in our Quality accounts.

Process Measures

- The number of unresolved and overdue complaints
- The number of complaints where communication is a factor
- The number of complaints where staff attitude and behaviour are a factor
- Compliance with cohort sampling of patient surveys
- Positivity of patient surveys

Learning Measures

- A review of Care Group activities with an appreciative learning approach on what went well and what could have been improved
- A review of the Patient Experience and Engagement Strategy by a range of stakeholders on learning what we are doing well, what we could do better, what is having the best outcomes
- Review of qualitative and quantitative feedback about patient experience and engagement across the organisation with a summary of what is going well and lessons learned

Outcome Measures

- Achievement of agreed patient experience and engagement action plans each year
- Analysis of patient survey results and actions undertaken to address/improve

References & Bibliography

Health Education England. (2017). Person-Centred Approaches: Empowering people in their lives and communities to enable an upgrade in prevention, wellbeing, health, care and support. A core skills education and training framework.
http://www.skillsforhealth.org.uk/news/latest-news/item/576-new-framework-to-promote-person-centred-approaches-in-healthcare?utm_source=Skills+for+Health+Mailing+list&utm_campaign=d646e6bc62-PCC+stakeholder&utm_medium=email&utm_term=0_c0a03bf296-d646e6bc62-2578549

#Hello my name is. (2013)
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DBTH Communications and engagement strategy 2017 - 2022

July 2017

Executive summary

The Communications & Engagement Strategy is one of the ten key strategies underpinning the delivery of the Trust's Strategic Direction 2017 – 2022 and is interlinked with the other nine. It recognises the value that good communications and engagement can add by enabling an organisation to achieve its objectives and to continuously improve its performance.

The Trust is a very different place from a few years ago and, like the rest of the NHS, is operating in a very different world. This strategy reflects the commitment that the Board places on communicating and engaging in an open, honest, transparent and meaningful way with staff, stakeholders and partners in the delivery of our strategic direction, so that the people who need, use and work in the health and care service delivered by DBTH feel informed and involved in their provision, now and in the future.

Background

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

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

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

Thanks to our identified savings, and a one-off support payment from NHS Improvement for our strong performance against our financial plan, we have started this planning period in a better position than expected. Like many other NHS organisations we will continue to face

significant changes and challenges, and in order to meet these, we have developed our strategic direction in anticipation to ensure we work effectively both internally and with partners to develop solutions.

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

This is thanks to established strong relationships with neighbouring trusts and clinical commissioning groups, and is built on the foundations of a proven history of working together to improve health and care for our population.

The role of communications and engagement

The importance of a communicating organisation

Organisations in all sectors now recognise that listening to, involving and learning from staff and consumers improves performance and the quality of the services or products being provided. We live in a 24/7 multi-channel world where news can reach millions in an instant and people are constantly plugged into both social and traditional media. Word of mouth is more influential than ever (good or bad) and everyone's word counts with people increasingly less inclined to establish 'real' form 'fake' news.

The NHS has recognised the importance of communications and engagement. Ipsos MORI research found better-performing NHS trusts committed more resources to communication and were more likely to have communications teams that were influential in decision-making. The landmark NHS policy paper, 'The Communicating Organisation' (17 Dec 2009), encouraged all trusts to place importance on communicating and engagement with 'stakeholders' (i.e. people and groups with an interest in the trust and what it does).

The NHS Constitution states that staff and patients have a right to be kept informed and to be engaged with the NHS. As set out in the Patient Experience and Engagement strategy, patients tell us that clinical effectiveness and safety is important, but their experience of care matters to them just as much. In order to make informed decisions and choices about their care they need to receive the right information and feel listened to and supported. They want to receive efficient person centred care that meets their personal needs and expectations, which can only be done through effective communications and engagement.

The argument for communications and staff engagement

Ruck & Welch (2012) suggest that the psychological state that links employees to their organisation are influenced by organisational level internal communication therefore engagement and internal communications cannot work in silos. Effective internal communication is described by Sedej and Justinek (2013) as creating an environment in

which all employees contribute towards achieving the organisation's vision and not just about producing and disseminating information to employees.

As many of our employees are members of the local community, they themselves, their families and friends are the consumers of the services we provide. It is therefore arguably more important than ever that our staff are recognised as the trusted source of news, and feel empowered to dispel myths and 'fake news'. Staff therefore have to feel informed, engaged and empowered as ambassadors for the organisation they work for.

There are many definitions of engagement however employee engagement essentially describes what happens when people act and think in a positive way about the work they do, the people they work with and the organisation they work in. From the health service perspective the following definition is most relatable:

"Employee engagement describes the involvement of people at all levels in positive two-way dialogue and action to deliver the highest quality patient care and create great places to work – where people find their work meaningful and are willing to work together for patients, their colleagues and the future success of their organisation" (Huggett et al, 2008)

In addition to the reputational benefits brought about by employee engagement there is compelling evidence that employee engagement in healthcare has significant benefits for organisations, staff and patients, notably:

- It improves patient care outcomes and experiences West and Dawson (2012) put forward compelling evidence that organisations with a strong culture of employee engagement report lower patient mortality rates and lower infection rates, as well as higher patient satisfaction scores and suggest it is when organisations care for their staff, staff can fulfil their roles of caring for their patients.
- It helps to deliver continued improvements and programmes of change – The King's Fund Report (2012) proposes that engaged staff are likely to exert more influence over the use of standard processes, teamwork and the degree to which there is a culture of improvement
- It helps connect clinicians with the organisation as well as the professional agenda and take on leadership roles
- It can improve sickness absence. Gallup's 2006 study found that engagement levels can be predictors for sickness absences with more highly engaged employees takin 3.8 days sickness less per year when compared to disengaged employees.

Staff engagement cannot be achieved through internal communications alone. There are a range of influential factors including reward, recognition and leadership contributing to staff engagement levels, all of which are set out in the People and Organisational Development (POD) strategy. This strategy compliments and supports the POD strategy in its delivery of improved staff engagement.

Where we are now – factors shaping the strategy

Background and recent developments

There have been major advances in the way the Trust communicates and engages over the past 18 months. The changes began in October 2015 as the changing financial picture was communicated and a period of Turnaround followed. New channels of communications and engagement were introduced to ensure that as an organisation we were communicating in an open, transparent and honest way, engaging inclusively with all stakeholders. The addition channels included:

- Setting up a staff recovery team – A staff forum/council for the organisation with representation from different sites and disciplines. This group provided a forum of new ideas, experiences and opinions to contribute to financial turnaround. The group also acted as a 'sounding board' for some of the work stream projects to understand the wider impact on a variety of staff groups. The informal meetings took place on a quarterly basis.
- Introducing corporate closed social media groups for staff – Whilst some closed staff groups were already established the all DBTH staff closed group was initially introduced as an extension to the recovery team. Now more than 1,500 members of staff are signed up to the group, enabling us to reach staff groups traditionally less accessible by traditional e-communications
- Dedicated columns in local press – Columns spaces were negotiated with local press in order to provide regular updates on the financial position. This has now enabled regular, Trust led content on a regular basis.
- Introduced content specific newsletters - Including *turnaround news*, monthly *in the news* updates and the newly established *Risky business*.

A list of all communications and channels is provided in **Appendix A**

Continuous improvements have also been made over this time period with established communications channels including:

- An increase in followers/ fans and levels of engagement with audiences through our social media channels, often reaching more people than the circulation of local newspapers
- The 'Buzz' weekly bulletin design has been refreshed. Now available via the trust website in order for staff to access it more easily. We know from metrics that approximately 4,000 members of staff read the bulletin on a weekly basis
- More than 700 members of Trust staff engaged with the strategic direction offering their feedback and suggestions on the vision and objectives, as well as their bugbears and bright ideas, through an integrated range of communications and engagement channels, including email, social media, face-to-face meetings and postcards, delivered to frontline areas to be completed and returned through internal post.

STRENGTHS	WEAKNESSES
• Good news to share – continuing quality and patient safety improvements • Achievements of staff and services • CQC – good in caring and well-led • Strong Board support for a communicating organisation with a focus on internal and external engagement, with a willingness to listen • Well established communications tools and techniques* • A developed and established communications team with a wide range of skills to implement a variety of techniques • The team delivers regional wide communications and engagement within the community for NHS England screening programmes, helping to strengthen community relationships • Strong relationships with communications and engagement colleagues on a 'place' and ACS level • A new website and intranet to communicate and engage externally and internally	• Communication from senior leaders is seen as poor (2016 Staff survey) • Staff motivation is low (2016 Staff survey) • Low rates of staff who feel able to contribute their ideas, or who feel involved in decision making (2016 Staff survey) • No established forums specifically for staff engagement • Increasing service challenges – requiring a focus on reactive/ crisis media with limited specialist resources • Lack of understanding in the organisation about getting communications/ engagement right at the start often resulting in a reactive responses (more resource intensive) • Lack of employee confidence in communications and engagement abilities, often leaving to corporate messaging.
OPPORTUNITIES	**THREATS**
• The clear new strategic vision enables us to tell the story of the future and increased opportunities to highlight research and development on the back of the recent achievement of Teaching Hospital status • Social media channel developments – If progress continues we will be increasingly our own content creators, relying less on traditional media • To link communications and engagement more closely with delivery, providing communications tools to enable behavior change • To work with partner communication teams to strengthen place based health and care messaging • Emerging Patient Experience strategy and Qii strategy will enable development of culture of co-creation with patients and carers • Emerging People and Organisation Development strategy presents leadership opportunities emphasizing the importance of staff engagement	• Confusing picture for people to understand future health and care with individual providers, place plans and Accountable Care System communications • The public perception of any health reforms • Technology advancing quicker than current resources can respond • Possible impact on communications and engagement resources as demand for communications and engagement becomes increasingly real-time due to technological advances

Strategy aims

Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust's strategic vision is:

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

The five key objectives to deliver the vision are:

- **PATIENTS: We will work** with patients to continue to develop accessible, high quality and responsive services.
- **PEOPLE**: As a Teaching Hospital **we are** committed to continuously developing the skills, innovation and leadership of our staff to provide high quality, efficient and effective care.
- **PERFORMANCE: We will** ensure our services are high performing, developing and enhancing elective care facilities at Bassetlaw Hospital and Montagu Hospital and ensuring the appropriate capacity for increasing specialist and emergency care at Doncaster Royal Infirmary
- **PARTNERSHIP: We will** increase partnership working to benefit people and communities.
- **PREVENTION: We will** support the development of enhanced community based services, prevention and self-care.

The vision and objectives address the local and national health and care reforms and the challenges currently faced by the NHS including increasing public demand and expectation, limited skilled staff and limited financial resources.

The transformation needed in order to achieve the vision is significant and will require increased levels of engagement from our patients, staff and stakeholders; communications and engagement has never been more important in the delivery of everything we do. As such communications and engagement form integral parts of all of the supporting strategies and are explicitly included in the following three supporting strategies:

1. **Patient Experience and Engagement strategy** – The strategy describes how patient feedback should inform service change and shape improvements and highlights opportunities for patients to become more involved in service development through co-creation.

2. **People and Organisational Development strategy** – The strategy describes how to develop staff reliance and engagement through leadership, talent management, learning and development, recognition and reward.

3. **Quality Improvement and Innovation strategy** – The strategy describes how in order to deliver transformation we need to develop a culture of quality improvement and innovation, giving frontline teams the autonomy to experiment, discover and apply new and improved ways of delivering care.

Set against this context the vision of the communications and engagement strategy is:

We will engage with our patients, staff, partners and the public to communicate DBTH's strategic direction, embedding an inclusive, open and honest approach to supporting the delivery of the vision and objectives

This will be achieved through the following communication objectives, developed in line with the overall organisational objectives:

- **<u>PATIENTS</u>: Proactively manage our excellent reputation in delivering high quality care to patients and local communities, providing assurance about any drivers for change at a Trust**

What this involves:

- Providing clarity and reassurance to our communities and stakeholders about the future of services and health care provision, promoting the new strategic direction
    - Launching a new, high quality website
    - Promoting positive news stories through our own media channels, local, regional and national media
    - Promoting Teaching Hospital developments and research opportunities for patients
    - Delivering high quality community news channels including Foundations for Health, DBTH what's in the news, partnership bulletin and governor bulletin
    - Delivering interactive social media channels increasing engagement and reach and responding to feedback

- **<u>PEOPLE</u>: We will create a culture of involving people**

What this involves:

- Working with services and external partners (such as Healthwatch) to gather feedback and information from our patients and visitors to learn from what we are being told, implementing changes to aid continuous service improvements
    - Working with colleagues in patient experience to evaluate, maintain and develop methods of collating and responding to feedback
    - Increase the use of social media as a tool for engagement and feedback, including open forums for public, patients and others to provide feedback
    - Raising the profile of how involving people is instrumental in making improvements to services, with a focus on a 'you said, we did' approach

- Providing opportunities for good communications throughout the organisation providing all employees with the opportunity to have their voice heard to influence decisions supporting improvements

- Evaluating and developing current opportunities for staff to have their voice heard, including Chief Executive listening events, Ask the boss and social media platforms. There will be a focus on improving the Staff Brief process to understand and monitor the flow of information both down and up the organisation.
- Developing and expanding on new opportunities including the staff experience group and the Closed staff Facebook groups
- Supporting POD colleagues to ensure staff survey results are understood at a local level, supporting engagement and the implementation of action plans to address the issues raised in the survey
- Promoting the new Quality Improvement and Innovation team, making QII accessible and something for all staff to be involved with.

- **<u>PERFORMANCE</u>: We will support effective communications and engagement by all within the Trust in order to support performance delivery**

What this involves:

- Embedding communications and engagement as a fundamental aspect of any service development, quality improvement, transformation and change programme.
  - Communicating openly and honestly about performance delivery and drivers for change
  - Deliver internal/ external media training to key spokespeople for the Trust where identified
  - Ensure adherence to policies including the media policy and the social media policy embracing staff as ambassadors in place of trying to control communications

- Support the POD strategy to retain staff and attract new staff to the organisation to support performance delivery
  - Develop new intranet to support staff to access benefits information
  - Develop new website to promote recruitment opportunities
  - Create a suite of recruitment materials and collateral to support
  - Promoting DBTH's USP including new Teaching Hospital status, development opportunities and health and wellbeing support

- Creating a culture of managers who are engaging and involve their staff by supporting them to help their employees to make sense of their role, identifying new opportunities for growth and development
  - Develop a new intranet as a better resource for employees and managers
  - Provide line managers with guidelines and examples of best practice leadership, engagement and team working

- Provide line managers with the necessary guidelines and documents in order to 'make it more simple' to be a line manager

- **<u>Partnership</u> : We will work with local and regional colleagues to support place and ACS communications and engagement**

What this involves:

- Working with ACS and place communications and engagement colleagues to inform, challenge and support communications and engagement plans
    - Attending ACS and place communications and engagement meetings, ensuring DBTH has a representative voice
    - Ensuring staff and communities have a voice in any proposed developments by promoting engagement opportunities
    - Ensure messages are communicated across Doncaster and Bassetlaw
    - Support the development and delivery of new communication and engagement opportunities including workshops aimed at specific target audiences

- **<u>Prevention</u> : We will inspire others to take care of their own health and wellbeing**

What this involves:

- Working with internal colleagues in Health and Wellbeing to support the delivery of staff health and wellbeing agenda
    - Develop and deliver a communications and engagement strategy for the health and wellbeing CQUIN and a communications and engagement plan for the flu campaign
    - Use engagement channels for insight to help establish a valuable health and wellbeing offering from the trust
- Provide the public and patients with high quality, accessible resources to help them maintain their own health and wellbeing.
    - Launch the newly developed Trust website as a resource for patients and public
    - Promote key public health messages with staff and communities in Doncaster and Bassetlaw to positively impact on their health and wellbeing
    - Delivering Screening communications and awareness campaigns for NHS England in South Yorkshire and Bassetlaw
    - Developing and improving the process for creating, storing and printing high quality patient information

How we will demonstrate our values and behaviours to improving communications and engagement

We always put the patient first	• We will work with our patients and families to understand what is important

	to them, providing opportunities to feedback and inform service change
Everyone counts	• We will provide timely, informative communications, accessible to all of our audiences • We will actively listen and act upon what people are telling us
Committed to Quality	• We will be innovative and flexible; making sure we use all new technologies and opportunities to ensure we are using the right methods to get the right messages to the right people in the right way
Always caring and compassionate	• We will engage in real dialogue and a two way process, providing timely and appropriate opportunities for a patient/ carer/ staff voice
Responsible and accountable	• We will be open, honest and transparent, communicating with control and consistency • We will be efficient and cost effective; making the best use of resources by using learning, insight and existing information
Encouraging and valuing our diverse staff	• We will provide a range of communications and engagement opportunities to accommodate our diverse staff groups, including those who don't have regular access to IT • We will ensure communications will be clear and concise; easy to understand by all

Accountability and timescales

Objective	Actions	Outcomes
Provide clear, accessible information about	• Launch a new, high quality, sustainable website through an Open Source product (17/18)	- Increased patient/ visitor engagement with an increase in

our services, now and in the future through a range of communication channels	• Continuously develop the site to provide key information about services including, contact details, how to get there, expectations of treatment and aftercare (18/19)	website visits from 30k per week to 35k (17/18) to 40k (18/19) - Changes and developments on the site completed at no cost
	• Improve 'traditional' media coverage in local, regional and national news titles • Develop relationships with local journalists (17/18)	- Increase coverage from 20 pieces to 24 per month (17/18) to 28 (18/19) - Improve positive: negative coverage ratio to 4:1 - Increased number of journalist interviews and meetings
	• Develop and improve our presence on social media channels, providing our own, reliable, news content. • Set up presence on emerging social media platforms and develop our voice • Increase our number of followers in order to increase the reach of our news stories to more than the local traditional newspapers • Create 'people' news stories, providing staff and patient success stories	- Increase Facebook fans from 3,797 to 4,000 (17/18) to 4,500 (18/90). Increase Twitter followers from 2,961 to 3,200 (17/18) t0 3,500 (18/19) - Increase in positive engagement (comments and posts)

Improve opportunities for good internal communications throughout the organisation providing all employees with the opportunity to have their voice heard	• Review current existing channels (17/18)
	• Develop the current staff brief process to ensure:
	  ○ More people attend
	  ○ Information is disseminated to teams
	  ○ Questions and/or issues are raised back up the channels
	• Improve the use of social media as an internal communications channel
		-Attendance at staff briefs increase by 50% (17/18)
		-A mechanism is in place to monitor staff brief dissemination
		- 50% of the organisation acknowledge receiving staff brief (18/19)
		-Increase closed staff group Facebook followers from 1554 to 1850 (17/18) to 2000 (18/19)

Create systems to support effective communications and engagement by all within the Trust in order to support performance	• Launch a new, high quality intranet, developed by staff, providing a platform for engagement and support (17/18) • Work with teams to develop current, relevant, supportive content • Use analytics to understand engagement with content and develop content further accordingly (18/19)	- engagement workshops to capture staff views delivered (approx. 200 views) -intranet delivered -positive evaluation of new intranet
Create and deliver inspiring campaigns for others to take care of their own health and wellbeing	• Deliver innovative campaigns to raise the awareness of screening across South Yorkshire and Bassetlaw in line with the NHS England contracts. Focus on cervical and breast screening in 17/18 • Deliver monthly staff and public facing health and wellbeing campaigns through a range of communications channels	-4 pieces of positive coverage per month -Attendance at 4 community events to raise the profile - Increased uptake of screening and self-referrals (evaluated per campaign area at specific times) -12 health and wellbeing campaigns delivered
Work with local and regional colleagues to support place and ACS communications and engagement	• Ensuring staff and communities have a voice in any proposed developments by promoting engagement opportunities • Ensure messages are communicated across Doncaster and Bassetlaw	- Presence of Doncaster and Bassetlaw voice - staff and communities in development of plans and engagement opportunities

Evaluation and monitoring

Evaluation will play an important part in our communications and engagement activity, evidencing whether we have successfully achieved our objectives. Monitoring of performance and compliance will be undertaken by the Quality and Effectiveness Committee (QEC).

We will constantly monitor the following activity to ensure we are reaching our audiences effectively:

- How we are perceived by our patients, community, staff and wider stakeholders

We will do this through:

  - Patient surveys
  - Followers, feedback and engagement via social media channels

    - Measure of media coverage, positive and negative
- How we engage with stakeholders and our communities delivering our strategic direction

We will do this through:

    - Feedback from stakeholders via corporate communication channels
    - Website statistics
- How we engage and involve our staff

We will do this through:

    - Staff Survey results
    - Feedback from staff via internal communication channels, including closed social media groups and the staff experience group
- How we deliver and evaluate our communications and engagement activity
    - Communications audits
    - Anecdotal feedback from stakeholders via a range of channels

References & Bibliography

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Ruck & Welch (2012)
Sedej and Justinek (2013)
Huggett et al (2008)
The King's Fund Report (2012)

Appendices

Appendix A – List of communications channels

Internal communication channels

- Staff brief - Delivered by the Chief executive the Thursday following the Board meetings held each month on the Tuesday. All staff brief should have a staff brief delivered to them by their line manager (all documentation is also available on the intranet).
- DBH Buzz weekly staff bulletin (email)
- Urgent emails to all staff
- The intranet
- Hospital notice boards and desktop displays in communal areas
- Information screens across the hospital
- Closed staff Facebook group
- The Staff experience Group
- Monthly and annual STAR awards

External communications channels

- Local, regional and national media
- MP brief (monthly brief to MPs based on the core content from the staff brief)
- Governor brief (monthly brief to Governors based on the core content from the staff brief)
- Partner brief (monthly brief to partners based on the core content from the staff brief)

- GP e-bulletin (contribute to the joint NHS Doncaster regular email updates to local GPs)
- DBTH in the news e bulletin
- Foundations for Health for staff, members and the public (magazine)
- Doncaster & Bassetlaw Teaching Hospitals Facebook page: www.facebook.com/pages/Doncaster-and-Bassetlaw-Hospitals-NHS-Foundation-Trust/511585218938624
- DBTH Twitter @DBH_NHSFT
- DBTH website www.dbth.nhs.uk
- DBTH you tube channel www.youtube.com/user/DBHHospitalsNHS
- DBTH Instagram account
- DBTH Snapchat account
- Patient Opinion and NHS Choices

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

People & Organisational Development Strategy 2017-2022

We Care

Executive Summary

The People and Organisational Development strategy has been developed in consultation with partners, stakeholders, staff and governors. With the achievement of Teaching Hospital status the major focus of the strategy is workforce - ensuring our staff have a positive experience as part of Team DBTH, enhancing recruitment, retention, training and development. This is a fundamental part of the *DBTH Strategic Vision: Stronger Together* and therefore one of our 5 strategic objectives states:

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

Local and national workforce initiatives and strategies such as 'Developing People – Improving Care', and the Accountable Care System's emerging workforce framework have influenced the development of the strategy. Key areas of focus include workforce productivity, planning and development to ensure we have the right workforce to deliver our strategic vision and objectives. To achieve this we continue to explore opportunities to be innovative in our recruitment strategy and maximise local recruitment and training.

We recognise the importance of staff having a positive experience and feeling supported by their managers so we will refresh our leadership strategy and talent management plan to identify staff at all levels that have the potential to develop. Our refreshed strategy will also include more effective use of our workforce systems to provide effective tools for managing teams and services.

As part of the South Yorkshire and Bassetlaw Accountable Care System we actively contribute to the Local Workforce Action Board framework: Developing and Enabling our Workforce

The foreword of the above framework states:

"Our health and care workforce is vital in delivering efficient, safe and high-quality services to our citizens. We recognise that the knowledge, expertise, hard work and professionalism of our staff is at the heart of the services we provide. As South Yorkshire and Bassetlaw develops into an accountable care system aligning with "place level" accountable care partnerships (ACPs), developing and enabling our workforce must be at the forefront of our thinking and planning. We know we must:

- Tackle well known 'supply' and shortage issues in some professions by careful planning, joined up recruitment and designing alternative models of care with emphasis upon enablement and self-care
- Encourage employers to work innovatively together on things like recruitment and to avoid competing for scarce skills
- Continue to invest, at all levels, in professional and personal development for our workforce of over 48,000 staff
- Review our employment models to make sure they enable rather than prevent employee flexibility

- Build capacity and capability in social, primary and community care to be sustainable and to respond to the "Care Closer to Home" agenda, recognising the contribution these services make to the cost effectiveness of the wider system
- Focus upon retaining our existing staff within our health and care community – retention, retention, retention
- Ensure our staff are well led and managed, motivated and that we look after their health and well-being
- Enable leadership to deliver organisational development including cultural / behaviour change necessary for organisational collaboration to flourish
- Acknowledge the important role that independent and voluntary care organisations play in supporting sustainability of public services

We have a vibrant and resilient workforce that has remained dedicated to maintaining high standards of care through a very difficult financial period and beyond. Our workforce has been engaged to shape the strategic vision and re-visit our values. We recognise that to deliver our vision we need to invest in the people in the organisation at all levels to make sure we have the leadership and skills necessary for delivering care now, and into the future. Building on our recent Teaching Hospital status we will continue to develop our education, research and leadership offer. Making our organisation a good place to work improves the recruitment and retention of existing staff. We offer flexible working within the context of service demands and are supporting the development of new roles to meet service needs and to address workforce challenges.

What will be different?

We will have a workforce that 'is in the right place, at the right time, with the right skills'

ACS Workforce framework

People will be feeling more and more positive about the culture of the Trust and this will continue to have a sustained impact on improvements to patient outcomes. All our basic processes and policies will be working well at every level. Workforce planning will be well used and understood, using tools supplemented by quality people data which in turn will allow for the proactive planning of recruitment campaigns, engagement activities and improvement plans. Managers will be showing their improved capability and be working across the system, the organisation and within their areas to develop and manage their staff. Engagement will be higher than ever. People will recommend this Trust as a place to work and receive care as a matter of course and our vacancy and absence rates will be low and falling.

Where are we now?

Background

The People and Organisational Development strategy has been developed in consultation with partners, stakeholders, staff and governors. With the achievement of Teaching Hospital status the major focus of the strategy is workforce - ensuring our staff have a positive experience as part of Team DBTH, enhancing recruitment, retention, training and development. This is a fundamental part of the *DBTH Strategic Vision: Stronger Together* and therefore one of our 5 strategic objectives states:

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

Local and national workforce initiatives and strategies such as 'Developing People – Improving Care', and the Accountable Care System's emerging workforce framework have influenced the development of the strategy. Key areas of focus include workforce productivity, planning and development to ensure we have the right workforce to deliver our strategic vision and objectives. To achieve this we continue to explore opportunities to be innovative in our recruitment strategy and maximise local recruitment and training.

We recognise the importance of staff having a positive experience and feeling supported by their managers so we will refresh our leadership strategy and talent management plan to identify staff at all levels that have the potential to develop. Our refreshed strategy will also include more effective use of our workforce systems to provide effective tools for managing teams and services.

Developing People – Improving Care – This framework is sponsored by the main national organisations with NHS responsibilities and aims to 'equip and encourage people working across the NHS to deliver continuous improvement in local health and care systems and gain pride and joy from their work' by developing improvement and leadership capabilities amongst staff. Why is this important – evidence and experience from high performing health and care systems shows that having these capabilities enables teams to continuously improvement population health, patient care and value for money.

The framework identifies the critical capabilities as:

- System leadership skills- to help leaders build trusting relationships, agree shared system goals and collaborate across organisational and professional boundaries
- Improvement skills for staff at all levels (refer to the Quality Improvement and Innovation Strategy)
- Compassionate, inclusive leadership skills for leaders at all levels.
    - Compassionate leadership – paying close attention to the people you lead, responding empathetically, taking thoughtful and appropriate action
    - Inclusive leadership – progressing equality, valuing diversity and challenging power imbalances
- Talent management to create a future diverse leadership pipeline

It calls on us to build improvement skills amongst all our people; to develop current and future leaders with the compassionate, inclusive leadership qualities, improvement leadership skills and systems leadership

strengths as well as the specific management skills needed to meet today's challenges; and to manage talent to fill future leadership pipelines with diverse and appropriately developed people

The publication of 'Next steps on the NHS Five Year Forward View' March 2017 included a chapter entitled 'Strengthening our Workforce' to ensure we have 'the Right Workforce, in the Right Place with the Right Skills'. Whilst it celebrated the various achievements in the last three years it also provides a focus for the coming years such as improving productivity and growing the frontline workforce:

- Improve productivity – removing any inefficiencies in the various people processes, reduction in agency spend
- Grow our frontline workforce – more and improved training, enabling more recruitment and better retention, improved flexibilities which might include employment models which enables cross boundary and cross sector working

Reference is also made to the following key priorities:

- New professional roles
- Health and wellbeing/resilience
- Being a more inclusive employer
- Partnership working with staff side organisations
- Leadership and improvement capabilities
- Local Workforce Action Boards in support of Accountable Care Systems

South Yorkshire and Bassetlaw Accountable Care System – Local Workforce Action Board
Developing and Enabling our Workforce

As part of the South Yorkshire and Bassetlaw Accountable Care System we actively contributed to the Local Workforce Action Board: Developing and Enabling our Workforce. The foreword of the above framework states:

"Our health and care workforce is vital in delivering efficient, safe and high-quality services to our citizens. We recognise that the knowledge, expertise, hard work and professionalism of our staff is at the heart of the services we provide. As South Yorkshire and Bassetlaw develops into an accountable care system aligning with "place level" accountable care partnerships (ACPs), developing and enabling our workforce must be at the forefront of our thinking and planning. We know we must:

- Tackle well known 'supply' and shortage issues in some professions by careful planning, joined up recruitment and designing alternative models of care with emphasis upon enablement and self-care
- Encourage employers to work innovatively together on things like recruitment and to avoid competing for scarce skills
- Continue to invest, at all levels, in professional and personal development for our workforce of over 48,000 staff
- Review our employment models to make sure they enable rather than prevent employee flexibility
- Build capacity and capability in social, primary and community care to be sustainable and to respond to the "Care Closer to Home" agenda, recognising the contribution these services make to the cost effectiveness of the wider system
- Focus upon retaining our existing staff within our health and care community – retention, retention, retention

- Ensure our staff are well led and managed, motivated and that we look after their health and well-being
- Enable leadership to deliver organisational development including cultural / behaviour change necessary for organisational collaboration to flourish
- Acknowledge the important role that independent and voluntary care organisations play in supporting sustainability of public services

Our Trust values are aligned with those within the NHS Constitution having been originally developed and reviewed by our staff and recently confirmed through the engagement exercise undertaken in support of the development of the Trust's strategic direction as being ones we can all continue to sign up to. The People & OD function will demonstrate these values by:

	Values into Action
We always put the patient first	• We will work with our staff and students to understand what is important to them • We will actively engage staff and students in improving their experience and in turn patient experience
Everyone counts	• Our staff are empowered to suggest ideas and make changes • We listen to others ideas as well as putting forward our views in a positive way
Committed to Quality	• We use evidence and best practice for improvement • By listening to our staff we will improve the quality of their experience at work and in turn the care we deliver • We actively encourage our students to provide us with feedback on the service we provide
Always caring and compassionate	• We will ensure training and education embeds care and compassion for patients and staff in our workforce • POD will ensure our teams epitomise caring and compassion in our everyday work with staff and managers.
Responsible and accountable	• We will strive to provide the best experience for our staff and students • We will measure our performance against agreed metrics, both qualitative and quantitative
Encouraging and valuing our diverse staff	• We will listen to our staff and through engagement develop a culture of trust and respect whilst recognising the importance of their health and wellbeing • We will embrace the diversity of our workforce, maximising opportunities to engage with staff with protected characteristics and to support their development

The previous P&OD strategy was developed in 2012 and was aligned with the Trust's Strategic Direction through to 2017. We have reviewed progress against the previous strategy; to determine which elements of the strategy need to be carried forward and how the Trust's refreshed Strategic Direction has influenced the priorities for the People & Organisational Development strategy.

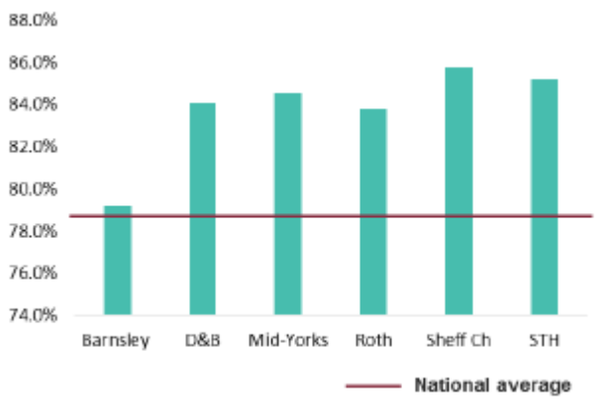
In determining the priorities for this strategy consideration has also been given to what the various workforce metrics are telling us.

Local Context

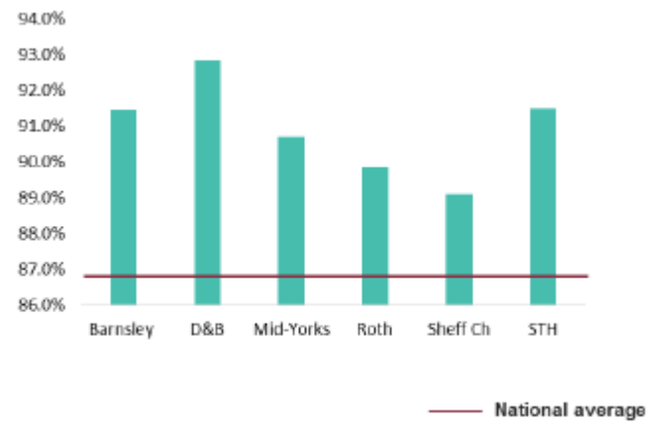
Stability Indices

The stability indices are positive for DBTH (stability index being the number of staff who were there at the start of the period and do not leave during the period). DBTH has the highest stability index for nursing staff in the area and we aim to retain this position.

Medical stability index over the period 2015/16 across the seven acute Trusts within the ACS



Nursing stability index over the period 2015/16 across the seven acute Trusts within the ACS (stability index being the number of staff who were there at the start of the period and do not leave during the period)



DBTH Workforce

Staff Group composition

	FTE	Headcount
Staff Group	**Aug-17**	
Add Prof Scientific and Technic	176.46	192.00
Additional Clinical Services	1,126.65	1,366.00
Administrative and Clerical	1,086.26	1,333.00
Allied Health Professionals	331.05	384.00
Estates and Ancillary	569.27	828.00
Healthcare Scientists	124.47	137.00
Medical and Dental	497.55	636.00
Nursing and Midwifery Registered	1,581.52	1,835.00
Grand Total	**5,493.23**	**6,711.00**

Nationally the official 'shortfall rate' for nurses and midwives is close to 10% (NHS Providers), locally we have a vacancy rate of around 4% but on the whole report upwards of 99% regularly in terms of planned versus actual ward staffing through the use of bank and agency staff and day to day assessment of the acuity of the patients. We recognise that we can no longer rely solely on overseas recruits due to tougher immigration and language rules and uncertainty surrounding the impact of Brexit.

Equality and diversity

We have a richly diverse workforce (see our workforce statistics below), with staff from across the globe working alongside those born and bred in South Yorkshire and Bassetlaw. Respect for each other's unique skills, experience and strengths is an integral element in effective team-working and our Fair Treatment for All policy sets out the standards we expect.

This includes equality of opportunity for job applicants, where we anonymise applications before shortlisting. We are a now recognised as Level 2 on the Disability Confident Scheme (replaced the Disability Two Ticks framework) focused on retention as well as recruitment. To support this work we have policies and guidelines in place to support the recruitment of people with disabilities. We also make reasonable adjustments to enable us to retain staff who become ill or develop disabilities with support from our Occupational Health Team.

Equality Information as at 31 December 2016

Gender	Headcount	Headcount %
Female (All staff)	5,512	82%
Male (All staff)	1,183	18%
Female (senior managers)	116	68%
Male (senior managers)	54	32%

Age	Headcount	Headcount %
16 - 20	45	0.67
21 - 25	485	7.24
26 - 30	697	10.41
31 - 35	712	10.63
36 - 40	667	9.96
41 - 45	835	12.47
46 - 50	971	14.50
51 - 55	1,059	15.82
56 - 60	801	11.96
61 - 65	351	5.24
66 - 70	61	0.91
71 & above	11	0.16

Ethnicity	Headcount	Headcount %
Any Other	45	0.67%
Asian	309	5.32%
Black	96	1.50%
Chinese	20	0.35%
Mixed	58	0.98%
White	6,102	88.79%
Not Disclosed	179	2.38%

Disability	Headcount	Headcount %
No	4,989	74.5
Yes	225	3.4
Not Disclosed	92	1.4
Unspecified	1,389	20.7

Sexual Orientation	Headcount	Headcount %
Bisexual	9	0.13
Gay	15	0.22
Heterosexual	2,574	38.45
Lesbian	15	0.22
Not Disclosed	3,174	47.41
Unspecified	908	13.56

Our Trust values set out in the strategic direction, embeds our desire to eliminate all forms of discrimination, promote equality of opportunity, value diversity and foster good relations. We are firmly committed to fair and equitable treatment for all and by truly valuing the diversity everyone brings, create the best possible services for our patients and working environment for our staff.

SWOT Analysis

Strengths	**Weaknesses**
Achieved Teaching Hospital status Extremely positive GMC and practice placement feedback Lower nursing and midwifery vacancy levels as compared with national average Health and wellbeing strategy First acute Trust to achieve 75% flu vaccine uptake Relatively low turnover of staff Nearly 50% of staff motivated to answer the staff survey in 2016 Approx. 700 members of staff had their say on the development of the overarching strategic direction During 2016/17 700 undergraduate health professionals; 520 medical students; 219 work experience students Trust involvement in training staff in new roles eg ACPs, tAPs, PAs, Apprentices Agency resourcing improvements Well established preceptorship programme for all health professionals Well established entry level programme combining the national care certificate	Drop in staff engagement scores and associated morale of staff as a consequence of turnaround Changes in people processes Vacancies amongst medical staff Vacancies in certain nursing areas, for example paediatrics, respiratory Volume of organisational change required Historic poor workforce planning processes Low confidence/ competence in the organisation to develop workforce models No established leadership/ talent management/ recognition offer Capacity of team to support the organisation Only worked with HEIs within SY region No clear career pathways for all staff groups Management of training pathways for new roles e.g. tACPs, tAPs
Opportunities	**Threats**
Teaching Hospital phase 2 Opportunity to streamline HR processes across the Accountable Care System Opportunity to innovate around workforce models Opportunity to involve staff in improvement initiatives Development of leadership capacity and capability Links with wider educational institutions across Place and ACS and beyond Opportunity to review the team structure to ensure alignment with strategic priorities Increase in placement availability to support pre-registration learners (local residents) Increased use of people related technology to reduce cost and improve control and governance Closer working relationships with our key stakeholders ACS wide collaboration (e.g. Holt collaborative bank; joint NHS P procurement)	Uncertainty around models of care could result in staff turnover Limitations on use of apprenticeship levy Infrastructure to become educational provider for apprenticeships Future models for back office functions across the ACS Introduction of self-funding (removal of bursary) at pre-registration level for nurses, AHPs etc New students on placement with us. Generation 'Z' expectations

Achievements against the 2013-2017 People & OD strategy

Detailed below is progress against actions identified within the previous strategy:

Engaged and involved staff who feel valued, safe, well treated and who trust their managers and leaders

- We introduced an Employee Assistance programme and developed a Health and Wellbeing strategy. We were successful in achieving the health and wellbeing CQUIN in 2016 and were the first acute Trust to achieve a 75% uptake of the flu vaccine in 2016.

- Achievement of the Nottinghamshire Council's Silver and Gold Awards for health and wellbeing

- We introduced a management skills modular programme and trained a number of coaches across the Trust.

Clear, consistent and fair people processes using internal and external contracts for best value

- We have introduced cohort recruitment for healthcare assistants, newly qualified nurses and service assistants.

- We are extending the use of the e-rostering software across teams who operate 24/7

- We introduced a new supplier of medical agency locums with improved visibility of fill rates

Well trained, educated, developed and skilled staff

- We have been awarded Teaching Hospital status in recognition of our long standing commitment to improving education and growing research

- We have revised our induction programme to include our values and behaviours in addition to providing core SET training for all staff

- We have made good progress towards the SET target of 90% and have aligned our SET training to the core skills framework which will enable us to passport our training and that of our partners across the ACS.

- We have seen improvements in the feedback from the GMC training survey and from our wider health professional student placements

In reviewing and refreshing the current P&OD strategy it is clear that much of its intent still applies; however as the Trust's strategic objectives have evolved so must the priorities for this P&OD strategy.

Where do we want to be?

Our Priorities to Achieve Our Objectives

As a Teaching Hospital we will continue on our journey to provide excellence both in education and research with the development of the Teaching Hospital plans. We will pursue the development of: 'academic directorates'; academic appointments; explicit inclusion of innovation and research within education and continued improvements in the quality and breadth of training placements and opportunities.

We recognise the importance of staff having a positive experience and feeling supported by their managers so we will refresh our leadership strategy and talent management plan to identify staff at all levels that have the potential to develop. Our refreshed strategy will also include more effective use of our workforce systems to provide effective tools for managing teams and services.

In recognition of our status as a Teaching Hospital we reflected on what that would mean for existing and future members of Team DBTH. We consulted staff about what the T in DBTH should represent and as result of that consultation added Thrive to our mantra.

‘Develop Belong Thrive Here’

As Team DBTH – we want all of us to feel:

- We can be the best we can be and **D**evelop our skills, qualifications, abilities, attitudes and behaviours for the good of the patients
- We are engaged and supported and that we are working together for the good of our patients, really feeling we **B**elong in team DBTH
- We have every opportunity to **T**hrive in the work we do and as we develop in our careers/work/placement experience at DBTH
- We trust in the way we do things and the people we work with and, if we are choosing a place to work and place to recommend others to work or receive care it would be **H**ere

In order to ensure the P&OD directorate is fit for purpose to deliver the People & OD strategy we are undertaking an OD diagnostic exercise which will enable us to develop and prioritise the various components of our directorate development plan in order to facilitate the delivery of this strategy across the Trust. We will continue to develop our HR Business Partner model and ensure that Care Groups and Directorates have the appropriate support so that they in turn can deliver their service and workforce plans. We will also utilise the Trust’s Qii (Quality Improvement & Innovation) methodology to improve our processes to ensure we are delivering efficient and effective services to the Trust.

We have a vibrant and resilient workforce that has remained dedicated to maintaining high standards of care through a very difficult financial period and beyond. Our workforce has been engaged to shape the strategic vision and re-visit our values. We recognise that to deliver our vision we need to invest in the people in the organisation at all levels to make sure we have the leadership and skills necessary for delivering care now, and into the future. Building on our recent Teaching Hospital status we will continue to develop our education, research and leadership offer. Making our organisation a good place to work improves the recruitment and retention of existing staff. We offer flexible working within the context of service demands and are supporting the development of new roles to meet service needs and to address workforce challenges.

Our priorities 2017-2022

The key focus of this strategy, to enable successful delivery of the strategic Direction 2017-22, is the support and development of the workforce at DBTH and the following section outlines how we will address our priorities to achieve this. Our priorities have been aligned to the Trust objectives.

People

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

- **Staff Engagement**

This staff engagement star developed by NHS Employers provides us with a clear focus on the areas which will make a difference to the experience of our staff and students and in turn our patients. It is based on the pledges contained within the NHS Constitution.

Our HR Business Partners and Education Leads will work alongside the Qii team in supporting Care Groups and Directorates to find the best ways to involve their staff and managers in shaping and delivering a positive experience for staff and patients. As a Trust we want to develop a culture in which all our staff are able to (and feel they are able to) thrive. We will continue to shape our HR Business Partner team and provide OD support across the Trust.

Through the trust-wide staff experience group and similar groups within Care Groups and Directorates we will understand how it feels to be part of Team DBTH and we will involve staff in shaping the improvements using

co-design methodology to make DBTH an even better place to work. In developing the Trust's strategy we sought feedback from staff about their bright ideas and bugbears.

We will involve our staff in developing proposals for service change and we will empower our staff to identify and make changes to improve patient experience. We will also work with colleagues within Communications to develop communications and engagement approaches for staff without easy access to electronic methods.

- **Delivering great management and leadership**

We will develop a leadership framework to capture the skills and behaviours expected of our leaders based on the framework 'Developing People – Improving Care'. Whilst we have developed a line manager modular programme to support the development of good line managers we must also identify our future leaders. We will develop/access Leadership development programmes to support our leadership teams and we will identify our future talent pool of great leaders and ensure they are able to access development opportunities. We must ensure that our appraisal process is fit for purpose in order that talent can be spotted but also so that supportive processes can be put in place where staff or managers are experiencing difficulties. We have a number of trained coaches across the Trust – we must therefore review our coaching offer.

We will ensure that people processes are effective and efficient – we will maximise the effective use of electronic systems to free up managerial and administrative capacity but we will also ensure that our HR policies and procedures are effective, efficient and person centred.

- **Promoting a healthy and safe work environment**

We will continue to implement the Trust's health and wellbeing strategy and associated action plan to ensure that staff have access to an effective occupational health and wellbeing service, that they can access advice on wellbeing with particular focus on mental resilience, physical and financial wellbeing. We will ensure that staff know what is available to support them in the workplace and outside of the workplace. We will continue to work with our partners to maximise our offer to staff.

We will support teams who might be in difficulty through the use of OD interventions and ensure we have the capacity and capability to support Care Groups and Directorates.

- **Ensuring every role counts**

We will continue to review our approach to recruitment to ensure we are selecting staff who support our vision and values. Through our appraisal system we will seek to ensure that staff feel valued and that they understand the impact they can have on the service we provide and on their colleagues.

The Board has stated its commitment to ensure that all staff regardless of their characteristic feels part of

Team DBTH and able to develop and in so doing approved an action plan for the period 2017-2019. We have formed a diversity forum which we will continue to develop and seek ways of involving a wider range of staff in the work of that forum.

Through our HR Business Partner and Education lead structure working in conjunction with the Qii team we will support our staff to grasp opportunities to deliver changes and improvements to the service and care they deliver.

- **Supporting personal development and training**

As a Teaching Hospital we will continue on our journey to provide excellence both in education and research with the development of the Teaching Hospital phase 2 plans (link to R&D strategy). This plan will pursue the development of 'academic directorates', academic appointments, explicit inclusion of innovation and research within education and continued improvements in the quality and breadth of training placements and opportunities.

Notwithstanding this development agenda we will continue to seek innovative methods to ensure our staff have access to Statutory and Essential training so that we can assure our regulators that we have a safe workforce and in turn provide staff with access to role specific training.
We will continue to expand the provision of apprenticeships as new frameworks come on stream – this will enable the Trust to develop clearer career pathways in place for various staff groups including those in supporting roles and managers. This will include the expansion of career pathways, for example clinical academics.

Patients – we will work with patients to continue to develop accessible, high quality and responsive services

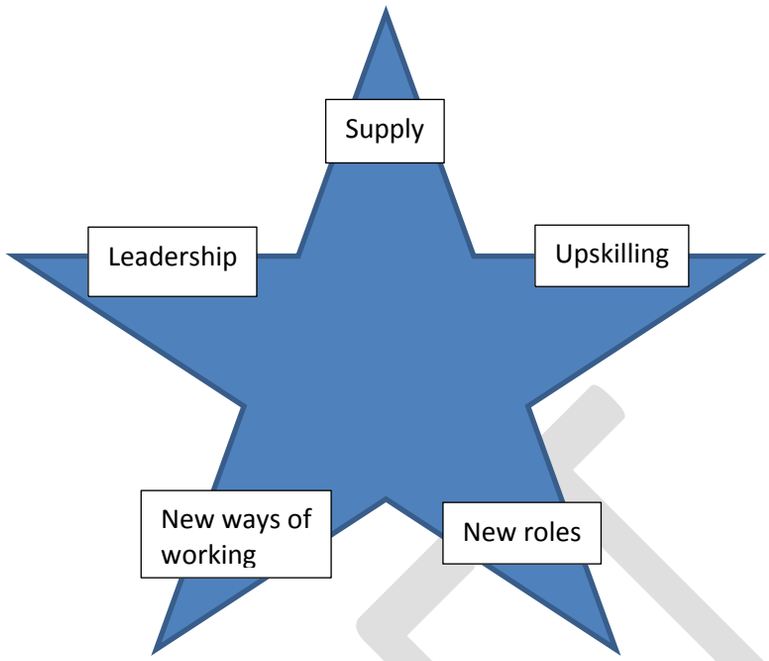
We will develop metrics to demonstrate the links between staff and patient experience. We will adopt a person centered approach throughout our directorate in developing our systems, processes and policies.

Performance - We will ensure our services are high performing; developing and enhancing elective care facilities at Bassetlaw Hospital and Montagu Hospital and ensure the appropriate capacity for increasing specialist and emergency care

- **Workforce Planning**

In order to ensure we have the right staff in place to deliver the agreed service models across each of our sites we will facilitate the development of workforce plans using the Calderdale framework and by taking account of how we implement that workforce plan. These workforce plans will link to the Trust's clinical strategy and other enabling strategies and identify how the Trust will reduce its paybill and reliance on agency workers.

Health Education England have developed a star approach (diagram below) to identify the various components of workforce planning and to assist their prioritization of bids. This enables us to structure our approach.



Source: Health Education England

Supply

We will maximise the use of the apprenticeship levy by identifying the effective use of apprenticeship frameworks as they are introduced including those at degree level and above. This will support the development of staff through career frameworks and enable us to 'grow our own' and support the development of existing staff. We will work with our Higher Education Institutions to offer opportunities for local people to be trained locally (placement of preference for pre-registration nurse training) and encourage them to take up employment with DBTH once they qualify. We will also undertake joint and innovative approaches to student recruitment with our Higher and Further Education providers. We will work in collaboration with our Place partners to offer employment opportunities to the local population, widening the participation of hard to reach groups but also to attract professionals to Doncaster and Bassetlaw. Where it is appropriate we will explore international recruitment. We will develop our USP to attract new recruits to the DBTH and ensure our onboarding processes are both efficient and welcoming.

Upskilling

We will exploit the use of the apprenticeship levy and funding and opportunities from Health Education England to provide development opportunities for our existing workforce. We will ensure that these opportunities are available for all staff groups. We will be a key partner in the South Yorkshire Region Excellence Centre supporting the development of Bands 1-4.

New roles

Through participation in the Accountable Care System's Local Workforce Action Board we will be a key partner in the Advanced Clinical Practice Faculty to maximise our access to ACPs and Physicians Associates. Through the use of the Calderdale framework we will determine the appropriate staffing models which will also include Assistant Practitioner and Nurse Associate roles.

New ways of working

Our HR Business partners will be trained in the use of the Calderdale framework and Quality Improvement and Innovation techniques to provide support to Care Groups and Directorates to consider how services might be provided by a different workforce, including the use of generic workers where appropriate potentially working across systems. We will work with our partners to develop flexible employment models to support staff working across organisations.

Leadership

We will develop our managers at all levels to ensure they feel equipped to lead their teams with care and compassion. We will maximise our access to regional and national programmes. We will equip our leaders to be system leaders.

- **Efficiency and effectiveness**

We will review our people processes and policies to ensure that we are able to maximise the use of technology and systems such as self-service within ESR (the HR/payroll system), electronic rostering and job planning, but also including the use of social media for staff engagement from recruitment to educational updates and streamlining systems and processes to free up managerial and administrative capacity. We will review workforce metrics to enable us to benchmark within the Trust but also across peer groups utilising the model hospital portal and NHSI's single oversight framework. As a directorate we will support the delivery of the Trust's Efficiency and Effectiveness Programme by ensuring appropriate mechanisms are in place for the effective use of the temporary workforce and identify improvements we can deliver both within the directorate and as a member of the HR community across the ACS.

Partners - We will increase partnership working to benefit people and communities

As a key partner within the Accountable Care System we will play a full role within the Local Workforce Action Board in support of the identified priorities:

- Primary Care Strategy
- South Yorkshire Regional Excellence Centre
- South Yorkshire Faculty of Advanced Practice
- HR process standardisation and streamlining

We will continue to work with our Local Authorities and other NHS organisations to commission and deliver training and education which will facilitate changes to care pathways. We will link with educational establishments to provide opportunities for work experience.

We will collaborate across the Accountable Care System to commission and support Advance Clinical Practice specifically local placement plans

We will work with colleagues to streamline HR systems and processes to facilitate movement of staff between organisations and to ensure that we have all adopted best practice in implementing systems such as electronic rostering, ESR, SET training.

We will collaborate with members of the ACS including the GP federation to review the delivery of support functions across Place and the ACS in particular training and education opportunities. We will provide support to Place initiatives such as Internships to ensure we can maximise local opportunities for local people.

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

We will promote and value the health and wellbeing of our staff by ensuring they have access to occupational health and wellbeing services and through our links with the communications team we will maximise the usage of technological solutions to ensure they know what opportunities are available for them to remain healthy or become healthier.

Through our involvement in Place initiatives we will support the wider health and wellbeing agenda for the community. We will also maximise the continued employment of staff with long term conditions and explore how staff off sick are able to return to work more quickly

What will be different?

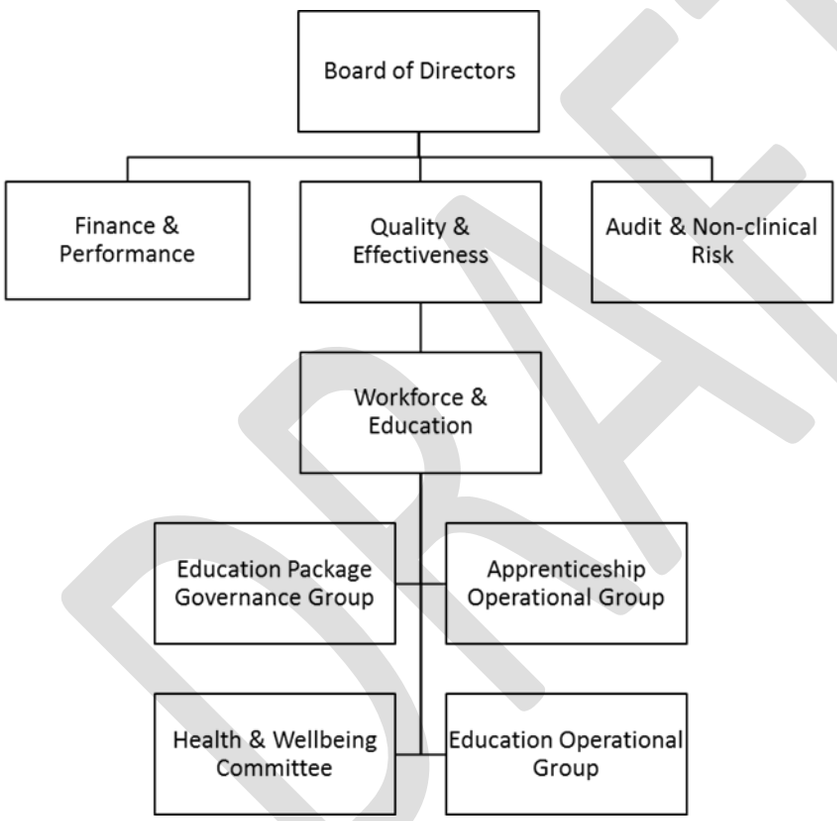
We will have a workforce that 'is in the right place, at the right time, with the right skills'

ACS Workforce framework

People will be feeling more and more positive about the culture of the Trust and this will continue to have a sustained impact on improvements to patient outcomes. All our basic processes and policies will be working well at every level. Workforce planning will be well used and understood, using tools supplemented by quality people data which in turn will allow for the proactive planning of recruitment campaigns, engagement activities and improvement plans. Managers will be showing their improved capability and be working across the system, the organisation and within their areas to develop and manage their staff. Engagement will be higher than ever. People will recommend this Trust as a place to work and receive care as a matter of course and our vacancy and absence rates will be low and falling.

Evaluation and Monitoring

Progress against the implementation plan will be reviewed by the Workforce and Education Committee reporting through to the Quality and Effectiveness Committee thereby providing assurance to the Board of Directors.



Communication and Engagement

This strategy has been developed through the involvement of the whole of the People & OD Directorate by reviewing the previous P&OD strategy, taking account of the revised strategic objectives and through the work of the HR Business Partners and Education leads with their respective Care Groups and Directorates. We have listened to the Care Group leadership teams to understand their priority areas and what matters to them and their staff. We have also heard from our staff, governors, Non-Executive Directors and staff side colleagues. This strategy will form the basis of the directorate workplan working in conjunction Care Group and Directorate leadership teams. Regular updates will be provided through various fora including the Partnership Forum.

References

Developing People – Improving Care: A national framework for action on improvement and leadership development in NHS-funded services

5 year forward view –next steps

Carter – model hospital portal

NHS Improvement – single oversight framework

Michael West – Developing Collective leadership for healthcare

NHS Employers website and associated toolkits

DBTH Strategic Direction and Clinical Strategy

Developing and Enabling our Workforce – LWAB ACS framework

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Clinical Governance Strategy 2017 - 2020

What is Clinical Governance?

Clinical Governance has been defined as:

"A framework through which NHS organisations are accountable for continually improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care can flourish"

(A First Class Service: Quality in the New NHS 1998)

Clinical governance is a combination of structures and processes, at and below board level, to lead on Trust-wide quality performance. We need to focus on experiences and learning, in order to improve clinical outcomes, improve the working environment, assess and, where possible, anticipate risk and also to eliminate or reduce risk or harm. This strategy must therefore address the following:

- The clinical governance arrangements and responsibilities
- The need to continuously improve performance in clinical governance issues through communication, education and training
- The creation of an environment which secures support and commitment towards patient safety and high quality patient care.

The aim of Clinical Governance is to provide the Board with assurance of effective and sustainable management of quality throughout the Trust. Quality drives the Trust's Strategic Direction and as such this strategy takes as its foundation the five domains used by the Care Quality Commission.

How Governance is applied in practice

To ensure our strategies link to our work streams and form the basis of practice throughout the organisation they are supported by policies, procedures, guidelines and the terms of reference within which the committees operate.

Executive Summary

This Strategy describes a clinical governance framework that fosters and embeds a culture of excellence in clinical practice to enable the delivery of safe, high quality care to patients that is evidenced by good outcomes along with positive patient feedback. This document should be read in conjunction with a number of supporting specialist strategies and policies.

Trust Strategies integral to clinical governance include:

- Clinical Service Strategy
- Information Management & Technology Strategy
- Patient Experience & Engagement Strategy
- Research and Development Strategy
- Quality Improvement & Innovation Strategy
- People & Organisational Development Strategy
- Estates & Facilities Strategy
- Finance & Commercial Strategy

This Clinical Governance Strategy outlines the plan for the continued development of clinical governance structures and process at Doncaster & Bassetlaw Teaching Hospitals NHS Foundation Trust (DBTH).

The strategy defines what “clinical governance” means for the Trust and establishes a vision of how we ensure this continues to be a priority, at all levels in the Trust. It also outlines how clinical governance is organised within the Trust as part of a whole-system approach to improving standards and protecting the public from unacceptable standards of care.

Where are we now?

Clinical Governance Committee Accountability Structure

Corporate Responsibility and Accountability for Clinical Governance

The Trust Board ("the Board")

The Board has overall responsibility for the activity, integrity and strategy of the Trust and has a statutory duty to ensure high standards of clinical governance.

The Chief Executive has overall accountability for Clinical Governance, delegating the executive responsibility to the Medical Director who is responsible for reporting to the Trust Board on the clinical governance agenda and ensuring that any supporting strategy documents are implemented and evaluated effectively. Other aspects of governance such as Financial, Information and Research form part of the relevant Executive Directors portfolios.

Quality & Effectiveness Committee (QEC)

The Quality and Effectiveness Committee consists of six members, appointed by the Board of Directors. Two public or patient governors, nominated by the Board of Governors, are invited to attend the committee, as observers.

QEC provides the Board of Directors ("the Board") with independent and objective review of clinical governance and clinical risk management with respect to:

- Strategic direction for clinical governance and clinical risk management for the Trust
- Prioritisation of clinical risk issues on a Trust-wide basis
- Clinical controls assurance systems, including information to governors
- Compliance with law, guidance and codes of conduct

Where are we now?

Clinical Governance Committee (CGC)
CGC is chaired by the Medical Director and the Director of Nursing, Midwifery & Quality acts as Vice Chair. The purpose of CGC is to operationalise the Clinical Governance Strategy and provide the Quality & Effectiveness Committee ("sub-committee of the Board") with assurance of a continuous and measurable improvement in quality and patient safety through the effectiveness of its clinical governance processes to:

- Promote safety and excellence in patient care
- Identify, prioritise and ensure management of risk arising from clinical care
- Ensure the effective and efficient use of resources through evidence-based clinical practice; and
- Protect the health and safety of trust employees

Care Group Responsibility and Accountability

Care Group Management Team
The Care Group Management teams are accountable for the delivery of the Clinical Governance agenda within their Care Groups. Care Group Management teams have the responsibility to ensure that the governance values are embedded within their Care Groups.

Care Group Governance Team
The Trust has standardised terms of reference for Care Group and Specialty Clinical Governance Groups. Each Care Group, and the specialities within, is required to have monthly meetings to discuss and oversee all governance issues within the Care Group or Specialty. To ensure accountability, the Care Groups are required to report on progress against objectives to the Clinical Governance Committee on a six monthly basis. They are also required to submit minutes of their meetings to a shared drive which is accessible by members of the Clinical Governance Committee.

Care Groups are required to ensure there is sufficient clinical representation within the Clinical Governance Groups and attendance is monitored monthly. Poor attendance is managed by Care Group Directors and escalated to the Medical Director and Deputy Medical Director for Clinical Standards. A quarterly attendance monitoring report is submitted to the Quality & Effectiveness Committee by the Clinical Governance Committee.

Governance Roles within Care Groups
Each Care Group is required to appoint a Care Group Clinical Governance Lead who is responsible for the co-ordination of the governance agenda within the Care Group. The Care Group Clinical Governance Lead is responsible for chairing the Care Group Governance meeting and is a member of the Clinical Governance Committee.

The Care Group Director is responsible for ensuring there is a Clinical Governance Lead for each of the specialties within the Care Group and who in turn will be responsible for the co-ordination of the governance agenda within the Specialty. The Specialty Clinical Governance Lead is responsible for chairing the Specialty Governance meeting and is a member of the Care Group Governance Group.

Clinical Governance Assurance and Escalation framework
It is important that the Board is able to monitor the implementation of strategic objectives set out in its business plan. Assurance is provided through the committee structure.

The Clinical Governance structure described in this framework aligns quality, risk and performance and how each are monitored.

Within the clinical governance structure there are committees, sub committees and groups; each have delegated responsibility to deliver the Trust's strategic goals and objectives via compliance with performance and quality indicators and monitoring of associated risks.

There is inter-dependency between the committees, through sharing of minutes, standing agenda items for escalation and action logs.

A Summary of Where We Are Now – SWOT Analysis

STRENGTHS	WEAKNESSES
▪ Care Group Clinical Governance Leads in post ▪ Established Care Group Clinical Governance Teams ▪ Monthly Care Group Clinical Governance Meetings ▪ Established escalation processes from Care Groups to CGC ▪ Specialty Clinical Governance Leads in post ▪ Established Specialty Clinical Governance Teams	▪ Frequency of smaller Specialty Clinical Governance meetings ▪ Dedicated administrative support for Care Group and Specialty Clinical Governance Teams ▪ Review of Risk Registers ▪ Review of incidents ▪ Tracking of themes ▪ Closure of Serious Incident action plans ▪ Escalation process from Specialty to Care Group ▪ Under-reporting of incidents
OPPORTUNITIES	**THREATS**
▪ Robust clinical governance arrangements throughout the Care Group from senior management to ground floor ▪ Active management to reduce or eliminate risks ▪ Learning from incidents, complaints and claims to avoid occurrence	▪ Increase in incidents, complaints and claims ▪ Poor patient experience ▪ Poor staff morale ▪ Patient harm

Where do we want to be?

What do we want to achieve?

We want to ensure that patients can rely on consistently high quality care and experience when they use our services. By developing transparent and rigorous review and assurance processes, staff will be provided with the data and feedback they require to engage with continuous improvement.

These themes are underpinned by the Trust's vision and values

OUR VISION: As a *sustainable* Acute *Teaching* Hospitals Trust we will transform services so DBTH can maintain and improve high *quality* integrated care as a crucial, leading *partner* in health and social care across South Yorkshire and Bassetlaw

Our Values

Our values underpin the Department of Health's definition of clinical governance and will enable us to realise our vision:

- **W**e always put the patient first
- **E**veryone counts – we treat each other with courtesy, honesty, respect and dignity
- **C**ommitted to quality and continuously improving patient experience
- **A**lways caring and compassionate
- **R**esponsible and accountable for our actions – taking pride in our work
- **E**ncouraging and valuing our diverse staff and rewarding ability and innovation

Where do we want to be?

Our strategic objectives

Patients

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

People

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

Performance

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

Partners

We will increase partnership working to benefit people and communities.

Prevention

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

Objectives and Goals

Clinical Governance Objectives - 1

The principal aim is to maintain a robust framework for Clinical Governance with realistic goals that take into account the organisational context and strive for continual improvement.

The following objectives have been identified:

Strategy – clear direction and realistic goals

- Ensure the Clinical Governance and risk management framework continues to be fit for purpose at all levels
- Be compliant with the terms of Care Quality Commission registration, regulations, standards and inspection and with the Governance requirements of NHS Improvement
- Maintain and improve the Trust's assessments in relation to other external accreditations, internal audit, inspections and peer reviews
- Ensure care is effective and that audit processes develop
- Develop in partnership with others a governance framework to underpin the objectives for the *Working Together Partnership* (2013)

Capabilities and Culture – Leadership & Quality Focus

- Ensure that explicit and robust accountability arrangements are in place and effective at all levels of the Trust
- Increase the number of patient representative and special interest groups we engage with
- Work with our Care Groups on maintaining the improvements in clinical governance work streams. Further develop and embed local ward and department process and meetings so that clinical governance is 'everyone's business'

Processes and Structures – accountability, escalation and resolution

- Work with key stakeholders such as commissioners, staff, regulatory bodies, patients and the public to ensure engagement with, and accountability to, those who use our services
- Embed and develop defined, well understood processes for reviewing assurances and escalating and resolving quality and performance issues
- Regularly review the effectiveness of our committee structures and policy management system to ensure they are fit for purpose

Clinical Governance Objectives - 2

Measurement - monitoring improvements and intelligent information

- Monitor improvements through the further development of standards-based and outcome based indicators across the Trust, e.g. the use of clinical metrics outcome measures to inform our performance reports
- Ensure collation of intelligent information and data which is robust, well analysed and used effectively in the production of regular reports and identification of 'hot spots' to support decision-making and effective operation of the Trust at all levels
- Use of our clinical audit programme and quality improvement programme as drivers for improvement across all services.
- Develop Quality Reviews (based on the Keogh and new CQC inspection regime methodology)
- Promote and enhance our involvement in external audit/peer review/ benchmarking initiatives

Risk Management Objectives

A key component of Clinical Governance is robust risk management. To this end, the Trust has a clear process by which, risks are identified, quantified and managed.

The Trust is committed to providing high standards of patient-centred care in all settings. All services are required to focus on patient safety, experience, outcomes and quality of care whilst acting with responsibility within the financial and performance framework of the Trust.

There is a coordinated approach within the organisation to the management of risk outlined in our Risk Management Policy and associated policies and procedures and the aim is to achieve the following objectives:

- Adopt a seamless approach to the management of risk and integrate risk into the overall Clinical Governance arrangements
- Support the achievement of the Trust's visions and values, as set out in the Annual Plan
- Comply with national standards and guidance
- Have clearly defined roles and responsibilities for the management of risk
- Maintain a safe environment for patients, employees and visitors and improve quality of care and the patient experience
- Ensure that risks are continuously identified, assessed, reported and minimised.
- Support the Trust's Board Assurance Framework through ongoing review of local and corporate risk registers
- To use risk assessments and intelligent risk information, gathered from a variety of sources, to inform the overall business planning/investment process in the Trust, as well as other components of governance i.e. clinical effectiveness, audit and education and training
- Ensure the provision of a robust system for reporting and analysing of incidents, complaints and claims resulting in timely learning for all staff.
- Foster an open, honest and transparent culture that allows organisation wide learning
- Establish clear and effective communication that enables information sharing.
- Ensure that any concerns over sub-optimal decision-making or practice are identified quickly and dealt with in a proactive and supportive way
- Provide intelligent information and feedback at various levels of the organisation in order to assist decision making

Operational Objectives at Care Group level
Embedding governance values within Care Groups means:

Awareness

- All staff should know that robust risk management and quality improvement are key priorities for the Trust and understand how they can contribute to this agenda
- All staff should be aware of what CQC compliance is and the purpose of the CQC standards
- All staff should be aware of the key Trust policies and processes and should comply with them

Compliance

- Each Care Group should use the CQC standards and Key Quality Indicators, developed by the Clinical Governance Committee, to plan a programme of clinical governance work to ensure compliance and year on year improvements in the quality of patient care are achieved (and build this into their business plan)

Assurance

- Each Care Group management team should be 'assured' (i.e. by evidence collation, walkabouts, surveys, audits) of, and able to demonstrate, compliance with the standards and other relevant accreditation requirements

Sharing and learning

- Care Groups should share areas of good practice and learning across the Trust, both when things go well and when things could be improved

Leadership and drive for results

- Each Care Group needs to support the Trust goal of being a centre of excellence and choice by continually striving to improve and by ensuring the Trust can set itself apart by its high quality of care.

How do we achieve our Objectives?

Ensuring we are SAFE:

- Learning from incidents
- Learning from claims & Inquests
- Reducing and learning from mortality and morbidity
- Medicines management
- Safeguarding
- Reducing Healthcare acquired infections
- Demonstrating safe staffing levels
- Implementing handover practices (including patient transfer)
- Implementing patient identification practice standards

Ensuring we are EFFECTIVE:

- Full Trust-wide compliance with policies/guidelines
- Achieving Best Practice (NICE, Clinical Outcome Reviews)
- Monthly monitoring of HED metrics (outcomes)
- Real time CQC Insight tool
- NHSI Single Oversight Framework

Ensuring we are CARING:

- Learning from and resolving complaints and concerns
- Friends and family test scores and sample rates
- Application of the Duty of Candour
- Achieving protected meal times and nutritional support

Ensuring we are RESPONSIVE:

- Responding to complaints/concerns in thorough and timely manner
- Responding in a supportive and timely manner to matters escalated through the governance process
- Wide-spread dissemination of learning from incidents, complaints & claims
- Wide-spread dissemination of learning from external reviews

Ensuring we are WELL-LED:

- Training and development
- Risk identification and escalation
- Risk register management

As an organisation, DBTHs will also engage the wider health community and work in partnership with patients, commissioners, other providers, and other stakeholders to achieve the aims of this strategy. The foundation of the strategy will be to ensure the lessons from the Francis (201*3)* and Keogh *(2013)* reports are embedded in the organisational culture.

Accountability and Timescales

Objectives

Key Quality Indicators have been developed for Care Groups using Healthcare Evaluation Data (HED), CQUINs and Department of Health targets in terms of Mortality, Patient Safety Events, Infection Rates, Re-admission rates, Complaints & Friends & Family data.

Challenges

Constant pressures affecting Healthcare organisations namely; recruitment and retention of staff, ensuring compliance with policies & procedures, availability of resources

Actions

The Key Quality Indicators are monitored against set targets on a monthly basis by the Clinical Governance Committee and each of the measures are further analysed to identify gaps in individual Care Groups.

Specialty-specific measures have also been identified and included within the dashboard and Clinical Governance Leads are held to account for Care Group performance.

Outcomes

Improvement will be measured in achieving and maintaining the targets set year on year.

Evaluation and Monitoring

Each year, Clinical Governance Committee will review its work-plan and in 2017/18, we will

- Focus on maintaining and enhancing the safety and effectiveness of our services and our patients' experiences and ensure compliance with the new CQC regulations and NHS Improvements Governance and Well Led Framework requirements
- Make further improvements in the systems we have introduced for our policies management and ensure procedural documents are user friendly and updated in a timely manner
- Further develop standardised risk and quality reports for our Care Groups – so they know what they are doing well, what needs improvement and understand their accountability to continuously monitor and improve.
- Continue to adapt our systems and practices to meet the needs of regulatory and legislative changes and developments
- Use both internal and external learning and benchmarking to ensure continuous quality improvement

- Update the priorities and metrics in our Quality Metrics Dashboard year on year

    - Build on our clinical governance framework and further develop our assurance and escalation processes
    - Review the effectiveness of our clinical governance committee structure to ensure it remains efficient, effective and appropriate
    - Produce an annual Clinical Governance Report which details achievement against these objectives
    - Undertake a baseline analysis of clinical governance maturity at Care Group level and develop action plans based on the same

Communication and Engagement

This Strategy has been developed by the Clinical Governance Department with the support of the Trust's Clinical Governance Lead (Medical Director), the Deputy Medical Director for Clinical Standards and the Care Group Clinical Governance Lead for Children & Family Services.

The Strategy will be circulated to the Clinical Governance Committee at its meeting in September 2017, and circulated to all Specialty Clinical Governance Teams once approved.

References

A First Class Service: Quality in the New NHS (1998) – Department of Health

Review into the quality of care and treatment provided by 14 hospital trusts in England (2013) – Sir Bruce Keogh, KBE

Report of the Mid Staffordshire NHS Foundation Trust Inquiry (2013) – Robert Francis QC

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Quality Improvement & Innovation (Qii) Strategy

2017 - 2021

Qii Way

Quality improvement
is 'working together, using methods, tools, data measurement, curiosity and an open mindset to improve healthcare'

(Health Foundation, 2013)

Innovation
is 'the introduction and application of processes, products, treatments or procedures, new to the team, department, ward, pathway, organisation or system and intended to benefit patients, staff, the organisation or the wider society

(Kings Fund, 2017)

Creating the Conditions for Qii
'requires giving frontline teams the autonomy to experiment, discover and apply new and improved ways of delivering care'

(Kings Fund, 2017)

Outcomes from Qii
Chief executives of the majority of provider trusts rated 'outstanding' by the Care Quality Commission credit established quality improvement methods for improvement in their operational performance, staff satisfaction and quality outcomes.

(NHS Improvement, 2016)

	Qii Behaviours **Values into Action**
We always put the patient first	• I work with our patients and families to understand what is important to them • I actively engage patients and families in Qii
Everyone counts	• My team and I are empowered to suggest ideas and make changes. • I listen to others ideas as well as putting forward my views in a positive way
Committed to Quality	• I use evidence and best practice for improvement • Qii is everyone's role and I look for opportunities everyday to '*be better tomorrow than today'*
Always caring and compassionate	• I use a positive, strengths based approach. • In my team we recognise what is working well and build on this as well as constructively challenging and questioning with curiosity
Responsible and accountable	• I take ownership for what I can change in my practice, and regularly make improvements • My team has ownership of Qii and we work jointly to solve problems and identify our plans for Qii
Encouraging and valuing our diverse staff	• We will come together to improve care and I actively participate • I share ideas with other people, teams and organisations sharing best practice

Executive Summary

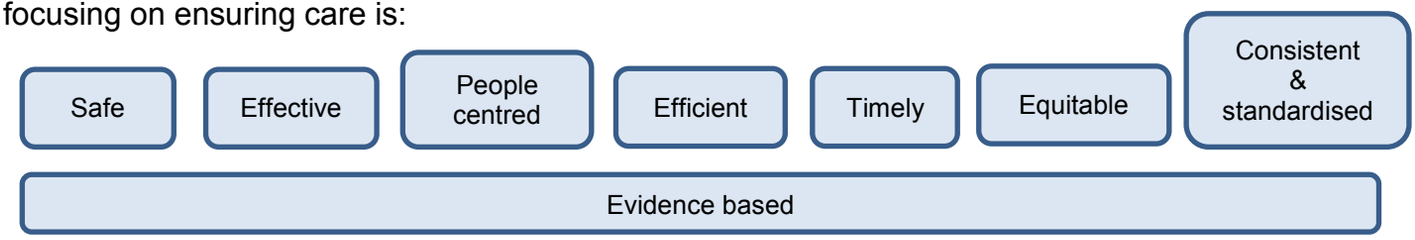
Providing the best possible care and outcomes for patients means continual improvement, and at DBTH we want to ***'do things better tomorrow than today'*** and deliver the ***'best care possible'.*** This Quality Improvement & Innovation (Qii) Strategy sets out our vision and our aims to embed Qii into our culture. It is an evolving strategy that will be regularly updated and reviewed (using Qii methodologies to do so) and we want to engage with as many staff as possible in its implementation and evaluation. It is an important enabling strategy and complements and works with all other corporate strategies.

We believe that all staff, along with our patients, carers, residents, governors, and partner organisations have all the ideas and experience to contribute ideas to improve the quality, safety, effectiveness and efficiency of our services, and to create solutions for the way we design and provide our future services. Working together on improving the quality of our services will help us to achieve our vision of:

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

We are moving from a period of successful financial turnaround where we needed significant focus on efficiency. Going forward we need to continue to improve our efficiency and meet the on-going financial challenges at the same time as developing sustainable transformation and longer term sustainability by working together on Qii.

This Qii strategy will support the vision of DBTH by bringing a systematic approach to tackling complex problems, with a focus on outcomes and by bringing staff and patients, and partners together to improve and redesign the way that care is provided. This will improve quality of care by focusing on ensuring care is:



(Based on Quality indicators, identified by Institute of Healthcare Improvement)

This strategy outlines our methodology and **WAY** for Qii, **WHAT** we will put in place in terms of the Qii infrastructure, the mechanisms, resources, and ways of working, our focus for Qii and **WHERE** Qii will be evident. The strategy also focuses on our desired culture of Qii and **HOW** we want Qii to feel within DBTH. This will be achieved through empowerment and engagement of **WHO**ever you are (staff, patients, volunteers, governors and partners) so everyone is involved and engaged in Qii

This strategy also includes what we expect to see as a result of Qii. A range of measures are included such as did we do what we said we would in the actions through to the impact this Qii strategy has on patient outcomes, and staff engagement. This will help us understand where we are on our Qii journey as we progress and how we are doing in achieving our vision for this strategy of:

'All patients will experience the best care possible by all staff and teams improving quality in their practice every day. Staff, patients, carers and partners work together to co-create ideas and plans for continuous improvement and innovation.

Where are we now?

Why do we need a strategy?	Our patients, carers and residents in Doncaster & Bassetlaw deserve the very best care that we can provide for them. Although we have lots of examples of excellent quality improvement practice by staff and teams we don't have an overall organisational approach, and up to now we have not set out our plans for how we want to work on improvement together. This strategy will do that by outlining the support we will provide to staff, as well as our approach across the organisation, and with our wider partners so we are working together on quality improvement as effectively as we can.

Aren't we improving quality already? **Do we really need to do anything differently?**	We have lots of excellent examples of staff working with patients, carers and partners to improve care everyday. We have improved significantly our patient safety measures such as reducing falls, and reducing hospital acquired infections. Many teams and Care Groups are working together to improve the quality of care in a planned way, to review services and how they are provided, and to identify innovative and new ways to provide effective and efficient care. We want to build on this. What we don't have is a 'DBHT Qii way' where we have a shared approach that we all understand and use. We want all staff to be confident and skilled in a range of Qii practical tools and approaches to use in their everyday work, and to be involved in quality improvement projects with others as we think this is the best way of maximizing quality improvement, and the spread of good practice. We want to develop our DBHT 'Qii way' including creating a culture where all staff are able to use their curiosity, creativity and enthusiasm to benefit patients.

Is this about efficiencies and reducing costs?	We are moving from a period of successful financial turnaround where we needed to focus predominately on efficiency. Going forward we need to continue to improve our efficiency and meet the on-going financial savings at the same time as developing sustainable transformation and longer term sustainability by working together on Qii. Quality improvement is our aim for this strategy. If we focus on what is important to our patients, carers, partners and staff then we can provide the highest quality care that is safe, effective, patient centered, efficient, timely, equitable, consistent and evidence based which will then be best value within the resources available, and sustainable.

What is our data telling us about quality improvement?	We have made significant improvements in quality of care such as those outlined in our Quality Account for 2017/18: • 18.75% improvement on our performance in 2015/16 for C.Diff infection • Reduction of 14% in repeated falls, falls with harm, as well as serious harm from falls. • Continued progress with our Hospital Standardised Mortality Ratio (HSMR), reducing by 4.54 points from 95.62 in 2015/16 to 91.08 in 2017/18. We have a relatively small number of staff trained in Qii approaches across the organisation and some who are champions in their areas. We have lots of activity in teams on improvement and innovation although we don't collect and report on this organisational so we don't really know how well we are doing, what the positive outcomes are or the opportunities for sharing and spread of this. We are currently rated 'Requires Improvement' by the Care Quality Commission (CQC) for our care although it is positive that 74% of services were assessed as 'Good', and no services or components of core pathways were identified as 'Inadequate', Our most recent staff survey results for 2016 highlight areas where staff feel less engaged such as lower rates of staff who feel able to contribute their ideas towards improvements at work of 63%, support from immediate managers at 3.61 (out of 5) and staff satisfaction with levels of responsibility and involvement 3.83. There is lots of evidence that higher staff engagement, and in particular involvement in decision making and being able to contribute ideas impacts on care quality, patient mortality, and patient satisfaction (Michael West)

A Summary of Where We Are Now – SWOT Analysis

STRENGTHS	WEAKNESSES
✓ Recent achievement of Teaching Hospital status ✓ Decision to invest in and develop Qii team ✓ Many examples of excellent quality improvement and innovation by staff and teams in DBTH ✓ Improved significantly patient safety measures such as reducing falls, and reducing hospital acquired infections, Hospital Standardised Mortality ratio (HMSR) ✓ Continued achievement of other quality indicators ✓ CQC – good in caring and well-led ✓ Willingness to listen and use feedback to improve quality and patient experience ✓ Open to new ways of doing things with clinical staff generally responsive to Qii ideas ✓ Developed and established R&D team ✓ Track record of working with strategic partners to develop services and improve pathways ✓ Some clinical staff trained in Qii who currently champion this work ✓ Positive senior level (Board) sponsorship and support	• No organisational approach to Qii and lack of co-ordination of activity and priorities means external funding opportunities may be missed. • Relatively small number of staff trained in Qii • Low rates of staff who feel able to contribute their ideas, or who feel involved in decision making (2016 Staff survey) • Systematic patient engagement in Qii less evident • On-going financial deficit will require ongoing efficiency drive • No current organisational wide mechanisms for Qii – will require prioritization and clear focus to manage capacity • Difficulties with recruitment of some clinical staff and pressures in clinical areas impacting on potential ability to fully engage in some Qii activity • Service capacity challenges – may mean some focus on reactive problem solving rather than longer term service change

OPPORTUNITIES	THREATS
✓ Re-fresh of strategic vision is an opportunity to place Qii centrally to enable delivery ✓ Programme of improvement programmes for operational efficiencies and Strategic Delivery Projects identified where Qii approach will enable sustainability and broader quality focus ✓ Well developed Qii infrastructure in region to draw on resources, training, and for networking ✓ Funding for innovation and improvement externally and nationally to support work, potentially linked to Teaching Hospital status ✓ Pathway re-design across Place and STP is an opportunity for collective Qii work ✓ CQC requires improvement in safe, effective and responsive –74% of areas were judged to be good. Opportunity to use Qii to support plans ✓ Further improve our Research, Development and Innovation profile ✓ Equipping all staff across Trust with understanding of Qii through skills training to embed approach in everyday activity ✓ Emerging Patient Experience strategy will enable development of culture of co-creation of Qii with patients and carers	• Balance of focus on Qii mechanisms and 'tools' – needs also to be on culture • Qii outcomes may take time to realize as this is not a 'quick fix' approach • Scale of Qii challenge will require ownership by clinicians and leaders as essential

<u>Won't this take time and be extra work?</u>

'Funny how we don't have enough time to improve, but we have plenty of time to perform work inefficiently and to resolve the same problems over and over.

Fire fighting can be fun but it is only putting the process back to where it was in the first place. It is not improvement of the process'.

(Deming, change management and quality improvement expert)

'Improvements in the quality of care do not occur by chance. They come from the intentional actions of staff equipped with the skills needed to bring about changes in care, directly and constantly supported by leaders at all levels.'

(Kings Fund, 2016)

Where do we want to be?

Vision for Qii

'All patients will experience the best care possible by all staff and teams improving quality in their practice every day. Staff, patients, carers and partners work together to co-create ideas and plans for continuous improvement and innovation.

Our vision for Qii will result in our patients and families experiencing improved care, and staff working in improved services which are:

Safe – We will continue to improve our progress in avoiding harm to patients. We will embed Qii approaches into quality governance work and processes to embed high impact improvements

Effective – We will provide services based on evidence, and use benchmarking and other data to review our performance. We will make improvements that impact positively on outcomes

People centred – We will work in equal partnership with patients / families to ensure care meets patients' needs and preferences. This principle will be at the centre of all Qii work

Efficient – We will reduce unnecessary waste in all areas to ensure we are as efficient as possible. We will systematically review capacity and demand, flow, and pathways to increase efficiency

Equitable – We will seek to understand any inequity in our services and care. We will make improvements to reduce / eliminate gaps in health outcomes between different social groups

Timely – We will reduce unnecessary waits and delays in our pathways, and in our services to ensure we improve our performance on required standards as well as internally identified expectations

Consistent & standardised – We will reduce unnecessary variation in the way we provide care and services. We will identify optimal pathways to enable us to deliver the best care consistently

Evidence based – We will use evidence, clinical best practice, national and local benchmarking, and intelligence / data to understand where we are and where we need to be, and to measurement progress

Targets and specific desired outcomes for improvements in these areas will be included in the Qii annual action plan, which will be updated and reported on regularly. This vision is equally applicable to staff working in support service and corporate roles who provide an internal service to other staff or other departments.

The Qii vision described above will enable the successful achievement of our Strategic Objectives:

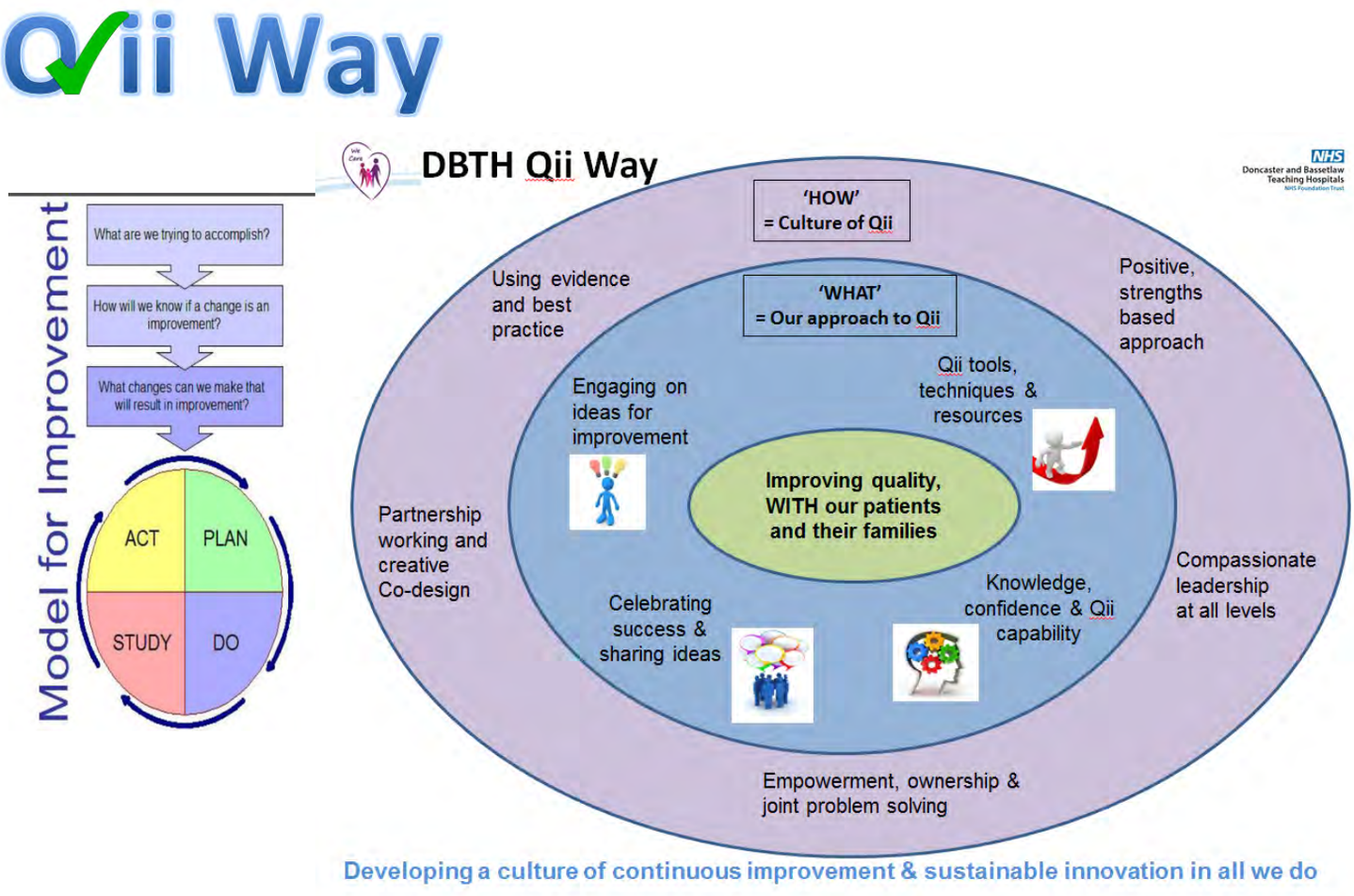
- We will work with patients to continue to develop accessible, high quality and responsive services.
- As a Teaching Hospital we are committed to continuously developing the skills, innovation and leadership of our staff to provide high quality, efficient and effective care.
- We will ensure our services are high performing, developing and enhancing elective care facilities at Bassetlaw Hospital and Montagu Hospital and ensuring the appropriate capacity for increasing specialist and emergency care at Doncaster Royal Infirmary.
- We will increase partnership working to benefit people and communities.
- We will support the development of enhanced community based services, prevention and self-care.

Qii Aims and Objectives

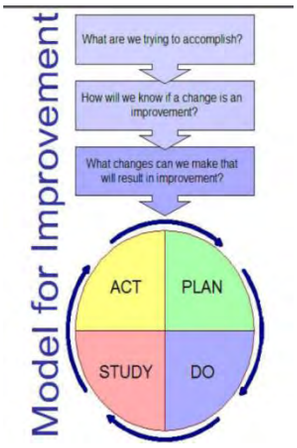
Qii Aims

To achieve our Qii vision our strategic approach to Qii will include:

1. **Our Model for Improvement = 'WAY'.** This is the methodology for the delivery of this strategy, as well as for how we approach Qii within DBTH.
2. **Our approach to Qii = 'WHAT'.** This is what we will put in place in terms of the Qii infrastructure; the mechanisms, resources, and ways of working across the organisation.
3. **Our focus for Qii = 'WHERE'.** This is the places that Qii will be evident.
4. **Our empowerment and engagement** = '**WHO'**. We want everyone (staff, students and trainees, patients, volunteers, governors and partners) to be involved and engaged in Qii
5. **Our culture of Qii = 'HOW'**. This is how we want Qii to 'feel' within DBTH through the way we go about working on quality improvement & innovation.



MODEL FOR IMPROVEMENT : WAY



A consistent approach to how we deliver improvements through a common Qii language and 'way of doing things' will enable the greatest Qii impact.

At the heart of our Qii Way we will use the recognised 'Model of Improvement' which is an easy to use, yet powerful structured cycle of improvement. It includes problem & issue definition, generating and testing ideas for improvement and innovation, measurement and learning, following by on-going assessment of impact. This will result in sustainable Qii change as we will be clear what we are trying to do, where we are and where we need to be and the difference our changes make. A practical toolkit designed to be used by individuals and teams will cover more detail of each step from where to start, what to consider, key questions, essential practical tools to apply.

OUR APPROACH TO QII : WHAT

	Aim	What this will look like
	**Engaging on ideas for Improvement & Innovation**	We want all teams and staff to be involved in improvement and innovation as part of their everyday work and for everyone to have 'a voice' so all ideas are heard

Objectives

- Establish organisational wide methods for actively encouraging and generating ideas, and for involving staff, patients, families, and key stakeholders in Qii using specific timed campaigns linked to organisational goals. This may include: 'Bright Ideas', 'Bugbears', 'Break the Rules' / 'If only we …..', Rapid Improvement Events, NHS Fab Change Week etc
- Diagnostic support will be provided to help teams identify improvement opportunities from local Qii champions and coaches as well as the Strategy & Qii team
- We want all managers and leaders to access development in engagement and Qii which will be included as part of the 'Management Passport' and other leadership programmes
- Develop approaches and increase patient engagement and involvement in Qii such as trialing experienced based design. Our vision and actions for this work are outlined further in the Patient Experience & Engagement Strategy.
- Support, guidance and coaching will be available from the Qii team to Care Groups, Corporate departments and teams about how to 'engage for ideas'
- Provision of external evidence, benchmarking, diagnostic tools and intelligence including horizon scanning of new approaches, knowledge services, literature reviews, new technology, etc will be provided to ensure opportunities for improvement are understood and considered
- A variety of 'Improvement and Innovation Spaces' will be established which will enable and encourage discussion, debate and sharing on potential ideas.
- Enhanced availability of relevant quality and efficiency metrics and intelligence for staff to identify areas for improvement
- Maximizing use of external funding to support Qii by ensuring all available funding streams utilized

	**Accessible and practical Qii tools, techniques & resources**	We want all staff to be able to access practical tools and resources to apply to achieve Qii outcomes

Objectives

- Create a collection of practical tools, techniques and resources on Qii for all staff
- Use a range of methods such as paper, on-line, apps, videos for maximum usefulness
- Resources will include topics such as identifying issues, generating and testing ideas, thinking creatively, measurement and learning
- Develop an accessible database of Qii projects across the organisation which is used by services to share Qii work and progress, and to identify opportunities for spread
- Ensure new resources, and tools made available nationally are reviewed, and an evaluation takes place of their potential use, and how best to evaluate implement
- Listen to staff about what is helpful, what is missing, what is needed and refine.
- Support, guidance, signposting available and seen as useful by services from the Qii team on where to start with Qii, the best tools to use, and to support questions
- To enable joined up approaches and resources between Qii, R&D, Clinical Audit, so enable staff to access the right support and resources, and choose the best path for their work

	**Developing Qii knowledge, confidence & capability**	We want all staff to have a practical understanding of Qii and confidence to use in their role.

Objectives

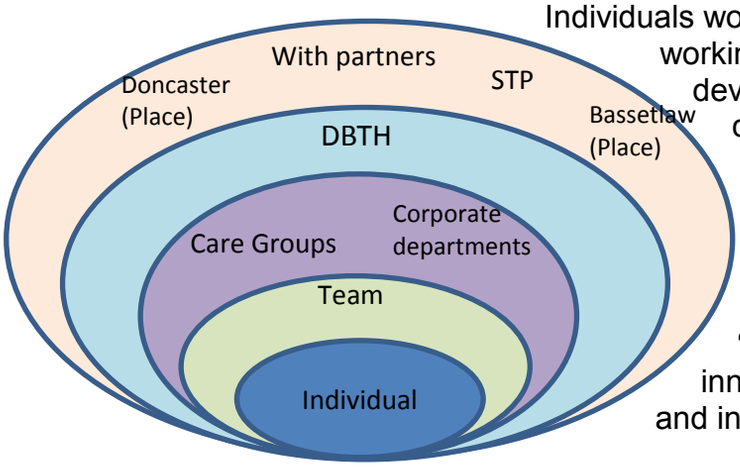
- All staff will gain a basic understanding of Qii through annual SET training
- A range of practical skills development opportunities and training will be at different levels of expertise – face to face, e-learning, video, regular ‘Qii tips’ in Buzz. This will enable all staff, in all roles, and at all levels to be actively involved in Qii. This includes students, trainees and junior doctors too who have a crucial role in bringing new knowledge and insights and contributing to Qii
- All managers and leaders will be confident and skilled in Qii which will be included as part of the ‘Management Passport’. ‘Compassionate Leaders for Improvement’ is a key objective
- Developing a ‘Qii faculty’ with a range of staff contributing to education, teaching and development. This will support the aspirations and vision of the People & OD Strategy.
- Develop Qii champions across the organisation, enthusiastic staff of any level and role who will support Qii. Aim of having at least one champion in each team.
- Enabling governors and patients / families skills input into Qii through opportunities to actively participate, and training and support where helpful
- Embed Qii skills by bespoke development for specific roles such as PMO team, HRBPs, finance business partners, business managers etc
- Develop coaches throughout DBTH who will support others, and provide advice, support, challenge and expertise. Aim of at least one Qii coach in each Care Group / Corporate team.
- Develop senior leader knowledge and confidence in Systems level Qii through bespoke internal development, as well as accessing NHSI programmes
- Qii team will provide coaching and mentoring, including developing a ‘Qii Coaching Circle’ and ‘Qii Champions Network’ to further develop skills as well as contributing to sharing ideas.

	**Celebrating Qii success and sharing ideas**	We want all teams to regularly discuss lessons innovation and improvement, and share their learning with others, internally and wider.

Objectives

- Reward and celebrate staff and teams who are actively engaged in quality improvement.
- Review Qii activity and success as part of the trust regular reporting processes including; Ward Quality Assurance Too (WQAT) and the DBTH Balanced Scorecard / Dashboard
- Establish ways of 'spreading' Qii across the organization:
  - Improvement 'portal' – information on Qii projects across the organisation
  - 'Pass-it on' forums
  - Qii annual conference
  - 'Qii Coaching Circle'
  - 'Qii Champions Network' inc 'virtual / technology
- Into DBTH - Use horizon scanning of external new approaches, technology, etc to spread good practice into relevant areas will be improved to enhance availability of relevant quality and efficiency metrics for staff to identify areas for improvement
- A variety of 'Improvement and Innovation Spaces' will be established which will enable and encourage discussion, debate and sharing on potential ideas.
- Out of DBTH – Increase proactive communications and media of Qii successes. Promote our success also across STP and with commissioners and other partners.

OUR FOCUS FOR QII : WHERE



Individuals working to improve what they do and teams working together on Qii to continually improve and develop their services is critical – all these changes add up to big improvement. Care Groups and corporate services will use Qii to deliver fundamentally improved new models of care for the future. This will involve working across service and organisational boundaries, as part of the 'Place Plans' and in the wider STP to innovate and improve care across pathways and integrate care for the benefit of patients.

Qii across the STP system on large scale transformation will increase in importance throughout the lifetime of this strategy. This systems approach to Qii will enable patient pathways to be improved in a strategic way and will ensure the complexities of improvement across multiple providers and partners

Qii will also involve collaboratively with a wider range of partners and such as the Academic Health Science Network (AHSN), Yorkshire & Humber Innovation Unit, NHS Improvement, the Yorkshire & Humber Innovation Champions Network with Medipex, and the Yorkshire & Humber Collaboration for Leadership in Applied Health Research and Care (CLAHRC).

OUR EMPOWERMENT AND ENGAGEMENT: WHO

We want everyone to be involved and engaged in Qii. This includes:

- **Staff** – all staff, in all roles, and at all levels being actively involved in Qii. Qii is a key part of all of our everyday roles, and something we can all contribute to, lead and champion.
- **Students and Trainees –** will all have opportunity to learn about Qii when on placement by actively contributing to and leading Qii work. We value the perspective that student nurses, student therapists, preceptors and trainee junior doctors bring with new knowledge and insights from other environments, and will enable them to fully contribute to Qii and work with other team members.
- **Patients, families and carers** – We will engage patients, families and carers in identifying areas for improvement, actively seeking feedback and input, and involve in quality improvement projects
- **Volunteers** – We want our volunteers to be able to get involved in Qii as part of the teams they work in
- **Governors** – Have a crucial role in supporting Qii to improve care
- **Partners** – We will work with colleagues in a wide range of partner organisations to improve quality together. This will include working together on Qii as part of our 'Place Plans' in Doncaster & Bassetlaw as well as part of the South Yorkshire & Bassetlaw STP.

OUR CULTURE OF QII: HOW

Culture of Qii	We will embed our DBTH values as part of our Qii approach to develop a culture of continuous improvement and innovation.

Objectives

- Board level and very senior leaders role model Qii values and behaviors, and these expectations will be included as part of objectives, and feedback
- All leaders supported to, and expected to model innovation, improvement and compassionate inclusive leadership.
- All Directors and senior leaders (Heads of Nursing, General managers, Corporate Leads) to act as a Qii coach / sponsor for at least one Qii project outside of their team per year
- Evaluation tools accessible and used to understand Qii culture development areas
- All Care Groups and Corporate services to develop their own local Qii strategic plans and priorities as part of the usual business planning to embed into 'business as usual'. To identify how they will approach and lead Qii in their services
- All staff will have the opportunity to be actively involved in Qii, including students, trainees and junior doctors on placement. This will enable improvements in patient care.
- Gain regular feedback from staff survey as well as Qii 'temperature checks' on Qii culture. To improve staff views of engagement, inclusion and involvement in all areas
- Embed Qii into all organisational processes and ways of working with visible examples in:
    - appraisal objectives for leaders,
    - meetings and action plans using 'Qii approaches',
    - Qii as part of Quality assessment process including the Ward Quality Assurance Too (WQAT) and the DBTH Balanced Scorecard / Dashboard
    - Qii approach to workforce redesign using the Calderdale framework as a key supporting tool

'Not only do these methods [Qii] deliver results in terms of quality and value for money, they also have tremendous power to engage, energise and motivate staff by recognising their individual and collective strengths and trusting them to work with patients and communities to make health and care systems better.'

(Developing People, Improving Care, 2016)

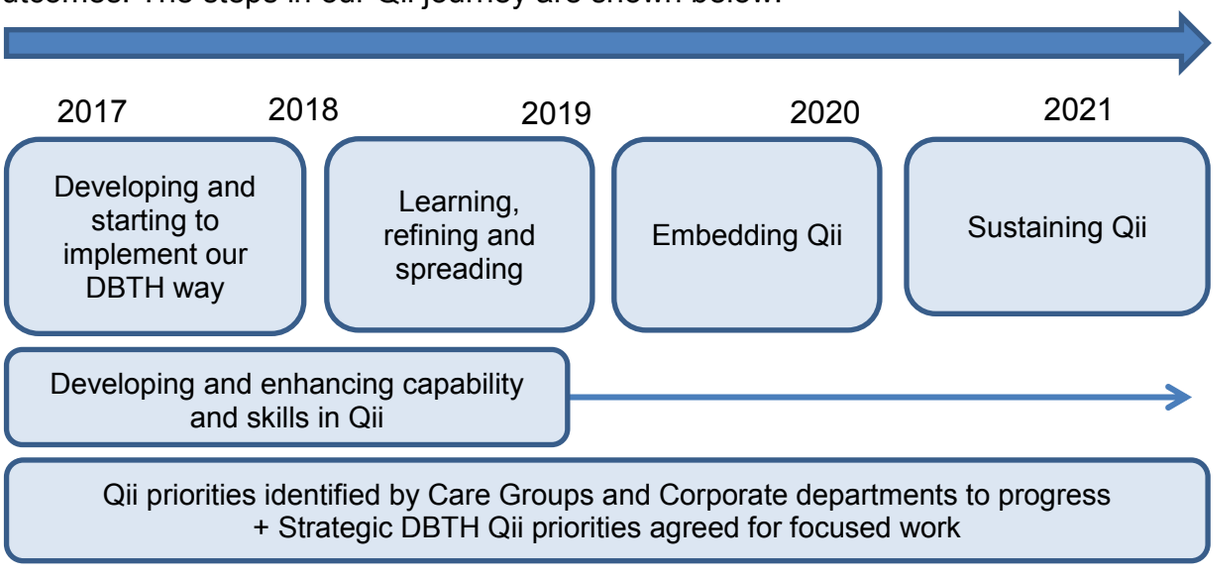
Priorities: Way, What, Where, Who & How?

Qii Priorities

'Evidence about successful Qii indicates that it is not necessarily the method or approach used that predicts success, but rather it is the way in which the change is introduced'

(Health Foundation. 2011)

Our Qii strategy is a long term organisational development programme of cultural change. We will use the 'model for improvement' to ensure our Qii progress continues to evolve and develop as we learn about what we are doing well, what we could do better, and test out what is having the best outcomes. The steps in our Qii journey are shown below:



Each year we will develop a specific Qii plan for that year, which sets out what we want to achieve, clear actions on what we will do and when, and the expected outcomes. In future years we will also look back on what has been achieved in previous years – what we achieved, what went well and what didn't go so well, and what we have learnt that will help us adapt and grow on our journey going forward.

Qii Goals for 2017/18

In our first year of the strategy we will focus on goals in 3 areas:

- Developing & starting to implement our 'Qii Way'
- Developing & enhancing capacity & Skills in Qii
- Identifying and delivering on Qii priorities identified by Care Groups & Corporate departments, and strategic Qii priorities identified corporately

A detailed action plan for 2017/18 has been developed, which also summarizes key areas of focus for 2018/19 and 2019/20.

Evaluation and Monitoring

Each year we will develop a specific Qii plan for that year, which sets out what we want to achieve, clear actions on what we will do and when, and the expected outcomes. In future years we will also look back on what has been achieved in previous years – what we achieved, what went well and what didn't go so well, and what we have learnt that will help us adapt and grow on our journey going forward. This measurable improvement plan will result in an annual report each year which will be shared at the 'Qii Conference / Sharing Event' to ensure successes and learning from working with teams across the organisation is highlighted.

Evaluation and monitoring of this strategy will be coordinated by the Qii team, which is part of the Strategy & Improvement Directorate, working closely in partnership with Care groups and Corporate teams. There will be regular discussion on evaluating together the impact of the DBTH Qii Way, and reports on progress through the Care Group accountability structures.

A '**Qii strategy huddle'** will be established that will include a wide range of staff from across the organisation to support translating the strategy into action. The group will informally review progress of the strategy, test out ideas for upcoming actions, gain feedback on impact, and help identify key successes and learning for reporting into formal meetings.

Governance

Progress will be formally reported quarterly highlighting what has been achieved from the agreed action plans, and the impact against a range of measures (see below) including, where relevant, the expected ambitions. Progress will be reported via the Quality & Effectiveness Committee.

Process Measures

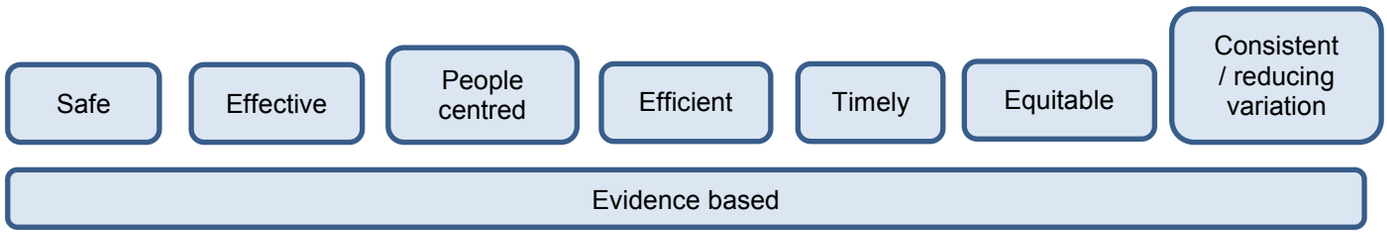
- Achievement of agreed Qii action plans each year
- The number of individuals coached and supported with quality, innovation and service improvement work
- The number of active Qii projects in each acre Group, and Corporate service , and the number of completed Qii projects, to understand spread and impact
- Numbers of individuals who have completed Qii training, by professional background, Care Group etc., to understand knowledge spread
- The number of trained Qii champions and Qii coaches within the organisation, and the Qii projects they have supported

Learning Measures

- A review of Qii projects against objectives – with an appreciative learning approach review on what went well and what could have been improved
- Review of the Qii strategy by a range of stakeholders on learning: what we are doing well, what we could do better, what is having the best outcomes
- Review of qualitative and quantitative feedback about Qii across the organisation with a summary of what is going well and lessons learned

Outcome Measures

Through using the 'Model for Improvement' each individual QI programme will have specific measures of the improvements being made to quality (using the various components of quality shown below), and the outcomes achieved. Case studies of a sample of these will be reported regularly.



Impact

This Qii strategy, along with other strategies and specific quality governance work will contribute to the organisation's efforts overall to deliver improvement against the elements of quality shown above. The impact of the Qii strategy will therefore be wide:

'Healthy, flourishing and engaged staff are essential to drive continuous improvement and deliver quality and value. There is strong evidence this impacts positively on outcomes for patients'.

Kings Fund, (2017) & West (2002)

'Where leaders model a commitment to high-quality and compassionate care, this has a profound effect on: clinical effectiveness, patient safety, patient experience, the efficiency with which resources are used, the health, wellbeing and engagement of staff and the extent of innovation within the health care system'

Kings Fund, (2017)

This Qii Strategy has strong links with the People & OD Strategy and the Patient Experience & Engagement Strategy, and will collectively support the development and improvement of staff engagement, leadership behaviours, and patient outcomes.

The staff survey, along with regular 'temperature checks' will provide an understanding of the outcome of Qii cultural work, along wide the staff engagement workstreams. Cultural evaluation measures re-used over time, specifically for Qii and more broadly for leadership behaviours will be used to understand the outcomes and impact of our work. Board self assessment of our Qii culture will be completed regularly to understand senior perceptions and vision.

Communication and Engagement

This strategy has been developed in a number of stages:

Strategy : Development

- Engagement has taken place with the senior leaders from all Care Groups, and leaders from Corporate departments on the vision for Qii, and what success would look like. Key messages were collated and incorporated into the initial draft of the strategy
- Discussion and engagement has also taken place with a wide range of clinicians to gain their input
- Trust Strategy sessions have taken place with Care Groups via their leadership meetings structures with the Qii strategy as a component, and feedback sought

Strategy : Engagement & Involvement plans

- The Qii strategy and evolving action plan will be shared with staff side to gain feedback, and to identify on-going staff-side engagement with its implementation
- A 'Qii strategy huddle' will be established including a wide range of staff from across the organisation interested in Qii, to informally review progress of the strategy, test out ideas for upcoming actions, gain feedback on impact, and help identify key successes and learning for reporting into formal meetings.
- Development sessions for Governors will also take place to identify opportunities for Governors active involvement and on-going engagement with Qii

Strategy : Communication

This final version of the strategy will be communicated to all staff, along with the Trust Strategic Vision.

Strategy : On-going engagement and communication

On-going updates on the action plan and key objectives with progress will be communicated through staff briefing and Buzz on a regular basis

The '**Qii strategy huddle'** will informally review progress of the strategy, test out ideas for upcoming actions, gain feedback on impact, and help identify key successes and learning for reporting into formal meetings.

Progress will be formally reported quarterly highlighting what has been achieved from the agreed action plans, and the impact against a range of measures. Progress will be reported via the Quality & Effectiveness Committee.

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Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Board of Directors Meeting : 31st October 2017

Granting of Emeritus Consultant Status

Background

It has been traditional that Consultants retiring from NHS hospital appointments request, and may be offered, some form of Honorary Emeritus status. Historically, the Trust has taken the view that it would wish retiring Consultants to maintain their contact with hospitals and their colleagues locally, and where requested, would consider offering Honorary Emeritus status, with its associated rights of access to the library and postgraduate meetings.

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

Proposal

Dr Bittiner worked in the Trust for a period of 25 years as a Consultant Dermatologist and held the role of Specialty Clinical Governance Lead for Dermatology for a period prior to the organisational re-structure in 2014, and continued to support the clinical governance team thereafter.

The Board of Directors is asked to grant Emeritus Consultant Status to **Dr Bruce Bittiner**, Consultant Dermatologist at Doncaster & Bassetlaw Teaching Hospitals NHS Foundation Trust.

Sewa Singh
Medical Director/Responsible Officer

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Title	**Finance & Performance Committee – Chair's Log**		
Report to	**Board of Directors**	**Date**	**31 October 2017**
Author	**Neil Rhodes, Chair of Finance & Performance Committee**		
Purpose			Tick one as appropriate
	Decision		
	Assurance		X
	Information		

Executive summary containing key messages and issues

Overview

Again, a very full meeting, which despite a good pace ran from 9.15 to 1.30. The energy and commitment of attendees was appreciated. We opened by noting and congratulating the Doncaster Procurement Team on being shortlisted for 'Procurement Team of the Year', based upon a raft of impressive achievements.

In future meetings we will rotate the order of items, focussing alternately on Performance and Workforce Management issues in the first session and Finance in the second, in one meeting and reversing the order in the following meeting.

We will continue to consider risk alongside agenda items, but only formally review the risk register every second or third meeting, timing this by agreement with the Chair of Audit to allow that committee to consider F+P risks between times.

Assurance area – Performance

The Board meeting will receive a separate performance report which will give a more granular appreciation of the picture. In broad terms Trust performance had no sufficiently exceptional issues to merit particular highlighting to the Board in this log.

The new style performance report, with embedded charts and greater analysis continues to develop and prove its worth. The 'At-a glance' chart continues to develop, with direction of travel indicators added and commentary against national and similar hospital comparators.

Assurance area – Workforce Management

The second comprehensive workforce management report was received and considered by the committee. It addressed:

- The profile of vacant posts
- Agency spend
- Staff sickness
- Appraisals and SET

Good progress was evident across the broad range of areas covered, however the principal item to draw to Board attention is the positive and encouraging movement in Agency spend, with the significant increases of recent months being halted and reversed. Spend in the reporting period was £718k compared with £1138k the previous month. Even allowing for some over accrual (£100k) that had proven unnecessary, this is a really positive step. The Committee will follow progress closely in future months. More detail is available in the financial report to the Board.

Assurance area – Overall Financial Picture

F&P spent most of the morning considering the overall financial picture and closing the financial gap. Additionally, we received a presentation from BDO in relation to the support we are in the process of contracting from them.

In essence, the mid-year stock take gave us a picture that strongly indicates under-performing CIPs and other cost pressures, without swift action, will result in us missing our control total by circa £3.2m this financial year. This will put at risk £2 – 2.5m of STF funding that could mean a £5.2 – 5.7m distance from that control total. We explored the reasons for this in detail.

BDO presented their analysis of our position, which had been shared with the Board Chair and Committee Chair within the past two weeks, whilst in development. They had positive messages about recent changes to reassert grip and control, but also shared hard to hear but important to hear commentary about processes, controls and culture.

They proposed the employment of an interim, external Efficiency Director, a repurposing and renaming of our existing PMO, beefing it up. BDO would come into the organisation to both work as part of a blended team (to ensure transfer of skills to Trust staff) around grip and control and also to provide targeted support around specific schemes.

BDO assert that with this support achievement of the control total is still viable. They propose a scale of fees (details available through the Director of Finance), contingent upon delivery of the control total.

As we have discussed in last month's Board meeting, time was of the essence and executive action supported by the Chair, has seen BDO engaged on those terms, currently working at risk whilst NHSi approval is in train. F&P were in agreement with this course of action, which

offers the most realistic prospect of hitting our control total at this time and delivering efficiency savings that would continue in subsequent years. We also saw it as important that BDO's fees were linked to delivery.

We will retain a sharp focus on progress.

Assurance area – Strategy Formulation

The Committee considered four strategies at the meeting.

- People and OD
- Clinical Sites
- Digital
- Estates and Facilities

Helpfully, all had been circulated prior to the full meeting papers, which enabled members to have a better chance of reading and commenting on what were significant and bulky documents.

The Committee felt all documents would now merit full Board consideration, and despite making comments have asked that they move forward.

Although recognising that drafting by committee is not a good way to frame strategy, detailed comments were shared with the relevant executives. In broad terms there was a request that the Executive Summary section should give the reader a strong sense of the principal elements of the plan moving forward, in plain English that an interested but non-expert reader can grasp. This will be particularly helpful when they are shared with our Governors and via websites. The executive summaries did vary significantly in relation to style and content. Additionally, some strategies at times lacked a clear sense of priority in relation to the activity planned. However, a massive amount of work has patently gone into the creation of these strategic plans and the Committee was keen to acknowledge this.

Particular scrutiny was given to the IT Strategy, which appeared to lay out a five year plan of schemes, although the authorisation for the commissioning of the schemes and the funding to deliver them was far from apparent. A more in-depth consideration of this area would be helpful at an executive level.

F&P considered two months ago an early draft of the Finance Strategy. Now that cognisance can be taken of the wider raft of strategies this will be finalised and presented at next month's F&P.

Key questions posed by the report
• Is the Board assured in respect of the key areas considered in this report?
How this report contributes to the delivery of the strategic objectives
N/A

How this report impacts on current risks or highlights new risks
N/A
Recommendation(s) and next steps
That Board receives the report for assurance.

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Title	**QEC Assurance Report**		
Report to	**Board of Directors**	**Date**	**31 October 2017**
Author	**Linn Phipps, Chair of Quality and Effectiveness Committee**		
Purpose			Tick one as appropriate
	Decision		
	Assurance		x
	Information		

Executive summary containing key messages and issues

Escalation

No items for escalation to QEC or to the Board.

Extraordinary QEC Meeting 26 9 17 to review a range of enabling strategies:

All strategies were endorsed subject to further revision to adopt consistently the good practices identified at the meeting (Minutes appendix) i.e.:

- Possible summary document/strategy on a page to highlight key priorities
- SWOT
- Cross referencing to DBH values and to supporting the new 5Ps
- Where appropriate link to ACS
- Consistent presentation & terminology – thinking Audience
- Sections on Governance (how it will work), KPIs, monitoring & evaluation
- Cross reference to Action Plans rather than including them
- Clearly setting out interdependencies
- Aim not to exceed c 15 pages.

Meeting 26 10 17 - process

We welcomed an additional Governor as well as our two usual Governor Members.

The scope and structure of Assurance reports (and data reports) agreed at QEC meeting 22.8.17 (minutes, Appendix 1) is :
1. What is the data telling us (where are we now)? How are we triangulating data to give a richer picture of what is happening (e.g.staff and quality data)?
2. What are our good practices and achievements?
3. What are the causes for concern (what are the problem issues, "the red areas"?)
4. Where there are concerns, are we assured on having action plans to address these/ improve and to monitor these?
5. What assurances are there on progress with mitigatory actions on the causes of concern, and on next steps?
6. What is the future trajectory, better or worse?

Two of our Assurance reports adopted this approach, which was felt to work well in providing assurance, and we aim for the remainder of reports to adopt it for the December meeting. Please see Appendices 1 and 2 (NB these are the Cover sheets only!). It was agreed that the section headings would be used flexibly and could be used for the Cover paper or the Main Paper.

ToR: noted that the agreement for PEEC to continue to report to CGC needs to be reflected in the ToR.

Meeting outputs and outcomes

Strategic thematic discussions

(1) QEC considered two linked items – a first "deep dive" **interrogation of a key risk** "How we communicate service changes to the public"; and the **Enabling Strategy "Clinical Site Strategy"**. The key risk interrogation used the framework of a Risk Review Template - a set of questions to probe assurance - which Linn had devised several years ago in the NHS. A key aspect which emerged was the critical role of staff in communicating with patents and their communities – and therefore of securing the hearts and minds of staff around changes. It was agreed that the title of the risk be amended, along the lines of "Failure to improve staff morale".

It was requested that a number of the good practices, identified in the September QEC, be built into a revised Clinical Site Strategy.

(2) QEC held the 1st part of a two-phased approach to reviewing **how we are assured on Research & Development (R&D)**. This initial debate focussed on determining the questions we need to address in the 2nd stage – presentation to December QEC. It was agreed that the assurance questions to be addressed are of different types, covering objectives & focus, process, and outcomes. Here are a couple of the questions agreed, by way of example:

- How assured are we that the Governance Tree for R&D is clear and effective?
- How assured are we that our R&D is generating better care, better outcomes, and better patient experience?

(3) Finally, QEC gave initial consideration to the **Quality Metrics** we should review, so as to provide Assurance to the Board, and how this relates to the Quality metrics reviewed by the Board, and by CGC, PEEC, WEC etc. The Medical Director described the work he and his team have been undertaking to develop a "live" Quality Dashboard, located on the Trust's B Drive, to incorporate quality metrics from CQC Insights and on workforce and patient experience. It was agreed that the Executives would review this to determine whether additional – and especially non-clinical - metrics would be required, and how the Quality Dashboard would relate to the composite measure/Balanced Scorecard for patient experience which we are developing, as well as to the Single Oversight Framework. Also agreed that there would be a presentation on the Quality Dashboard at December QEC.
Consideration would be given to NED and Governor access to the B Drive.

Quality and Care

QEC considered a range of Assurance reports on:

- Clinical Governance
- Readiness for CQC Inspection
- Nursing Workforce & Quality Metrics
- Patient Experience

And for each report probed current issues and risks, variability of performance, actions/follow-up plans and mitigations.
The Clinical Governance Assurance Report had helpfully drawn particular attention to the areas where there are concerns, with a commentary on each and an assurance on action plans.
Alan Armstrong sought further assurance of learning from complaints resulting in tangible improvements.
The QEC was assured on progress and no items are escalated to the Board. Fuller detail will be provided through the Minutes.

Leadership & improvement capability

Workforce and Education Assurance report

The substantial effort to align workstreams, and to develop meaningful KPIs was noted. It was agreed that the next QEC would undertake a Risk Interrogation of Failure to improve staff morale, as well as review learning from current work to triangulate staff and patient experience.

Governance & Risk

RCOG Action Plan – Maternity Services

The previous QEC had requested an update focussed on that dozen of the recommendations on which least progress had been made hitherto. It was noted that approximately half of these have now been completed.

In response to a question from the Chair about timescales for planned the DBH 6-monthly survey on "soft" issues, the Medical Director confirmed that the baseline would be in November, with follow-up surveys from March-April 2018.

Alan Armstrong asked about how we are assured on progress with outcomes such as teamwork, which transcend the shorter-term recommendations for actions.

Agreed action – see Future Items

'Exception reporting"
It was agreed that Matt and Linn would work together to create a definition.

Board Assurance Framework / CRR
Updates were noted as well as the planned risk review at December QEC.

Identification of new risks: none – re-wording of some risks to be examined.

Governor questions
How planned hours are calculated for metrics, why planned hours are similar for wards with different numbers of beds, how to report views on ward layouts, where are we not following NICE guidelines, how to balance seeking strategic assurance with actualities/ detailed patient experience, where to report concerns about an individual ward and an individual patient's treatment.

Meeting reflections – what have we learnt?

- The structure designed for our Assurance Report had worked well for Assurance Reports
- The Risk Review Template had proved a useful framework for probing Assurance
- The "so what" question is often helpful in helping us to fine-tune what aspects of assurance we need to challenge
- Our metrics need to have a balance of leading as well as lagging indicators
- Seek to balance strategic assurance with actualities/ detailed patient experience

Future discussion items identified for Work plan

- BIR (Quality section) scope and QEC role in providing assurance to the Board eg patient experience, metrics – further work
- Presentation on new Quality Dashboard
- Use of NQB metrics
- R&D – presentation on assurance questions, at December QEC
- Risk interrogation – Failure to improve staff morale
- Presentation – learning from triangulation of staff and patient experience
- CQC/progress on maternity (RCOG report) – assurance on progressing the longer-term and "soft" changes such as teamwork and cultural change, and embedding good practices
- What we mean by "Effectiveness"

Key questions posed by the report
N/A
How this report contributes to the delivery of the strategic objectives
N/A
How this report impacts on current risks or highlights new risks
N/A
Recommendation(s) and next steps
The Board receives the report for assurance.

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Title	**Nursing Workforce and Quality Metrics Assurance Report**		
Report to	**Quality and Effectiveness Committee**	**Date**	**24 October 2017**
Author	**Moira Hardy, Acting Director of Nursing, Midwifery & Quality** **Rick Dickinson, Acting Deputy Director of Nursing, Midwifery & Quality**		
Purpose			Tick one as appropriate
	Decision		
	Assurance		✔
	Information		

Executive summary containing key messages and issues

This paper updates the committee on key issues relating to the Nursing Workforce, using information from the UNIFY return for September 2017 planned and actual hours:

What is the data telling us?

The workforce data submitted to UNIFY demonstrates the overall planned versus actual hours worked to be 99% for September 2017. However, within this overall picture, planned versus actual hours range from 83% to 118%. The rationale for this range is described at section 2a.

Care Hours Per Patient Day (CHPPD) for September 2017 is similar to recent months at 7.56. This is a slight decrease from the previous month, but largely consistent with the previous six months. The benchmarking data from Model Hospital illustrates a slightly lower overall rate than national and peer groups, with a lower registered staff rate and higher HCA rate.

The agency usage rate was 2% in September and remains under the 3% cap rate.

The majority of ward managers have been able to take their balance of clinical and administrative time, as have the Matrons and Heads of Nursing.

Workforce information and Quality and Safety profile meeting requirements of NHS England (NHSE), relating to Hard Truths demonstrates that two wards were Red for Quality. These are A5 and the Respiratory Unit and the reasons for each ward being rated red are detailed at section 2c.

Are there causes for concern?
The Respiratory Unit's workforce data shows a 10% deficit of planned versus actual. This is due to vacancies and a shortfall of back fill through temporary staffing routes.

A5 has been rated Red for Quality for the second month. A quality summit has not yet been undertaken due to the availability of Non-Executive Director colleagues. This needs to be progressed as a matter of urgency as does the Quality Summit for the Respiratory Unit.

Where there are concerns, how are we triangulating data to give a richer picture of what is happening (e.g. staff and quality data)

The data at appendix 1 provides both workforce and quality data by ward. The workforce data for Ward A5 shows a surplus of staff at 108%, whilst the workforce data for the Respiratory Unit, as described above, shows a 10% deficit in staffing at both RN and HCA due to vacancies and a shortfall in temporary staffing. The quality summit is the opportunity to further triangulate data to provide a richer picture of the concerns and to put an action plan in place.

What assurances are there on mitigations of the causes of concern?

New registrants have commenced in post during October and this will help to alleviate some of the workforce issues on the respiratory unit, although there will remain Registered nurse vacancies.

The quality summits for both Ward A5 and the Respiratory Unit will take place to identify any mitigations in relation to the quality assessment

What is the future trajectory, better or worse?

There is the potential for the Respiratory unit to remain in deficit for staffing in October as the new registrants may not have their NMC registration immediately and will also require a period of supernumery time to orientate to the ward and their new role. In addition there will still be Registered Nurse vacancies in this area. With regard to quality as some of the quality metrics are cumulative; there is the potential for the Respiratory unit to also remain red for quality.

Key questions posed by the report

- Does the triangulation of staffing and quality data provide the assurance on the adequacy of resources balanced with quality improvement potential?

How this report contributes to the delivery of the strategic objectives

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

How this report impacts on current risks or highlights new risks

Risks associated to the inability to recruit to establishment and develop staff to provide harm free care, delivered with compassion and of appropriate quality.

Risk associated with not meeting regulatory and commissioner requirement.

The risks identified have been mitigated by the use of temporary staffing to provide planned versus actual hours worked at 99% in September. Despite the use of temporary staff to maintain safe staffing levels the Trust has remained below this with 2% registered nurse usage, so within the 3% agency cap. The main risk in relation to staffing continues to be the recruitment to Registered nurse and midwifery vacancies and opportunities to recruit are

actively being explored.
Recommendation(s) and next steps
The Quality and Effectiveness Committee is asked to confirm that it is sufficiently assured taking into account the identified actions or identify areas which require further assurance.

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Title	**Patient Experience & Complaints Quarterly Report Q2 2017/18**		
Report to	**Quality & Effectiveness Committee**	**Date**	**24th October 2017**
Author	**Moira Hardy-Acting Director of Nursing Midwifery & Quality** **Lisette Caygill-Acting Deputy Director of Quality & Governance**		
Purpose			Tick one as appropriate
	Decision		
	Assurance		✓
	Information		

Executive summary containing key messages and issues

This report provides the Quality & Effectiveness Committee with data relating to Quarter 2 performance using the information available from Datix and the learning points from the Patient Experience & Engagement Committee. It aligns key priorities and outcomes that are measured through patient feedback, and outlines our intentions to implement and monitor performance against the Patient Experience & Engagement Strategy.

What is the data telling us?

The Trust wide trend in complaints and concerns shows normal variation as does the trend by Care Group with the exception of Children & Families Care Group where there have been two statistically significant increases in complaints in September 2016 and March 2017. This is now returning to normal variation.

The top three themes identified from complaints are i)staff attitude and behaviour, ii) communication and jointly iii) treatment and iii) admission/transfer/discharge procedure/sleeperout

Two of the objectives set in the Quality Account for 2017/18 has been to reduce communication complaints and complaints in relation to staff attitude and behaviour by 10%. This has been achieved for Q2.

Are there causes for concern?

Complaints reply performance compliance to timescale is sub-optimal. This is being addressed through robust weekly Care Group engagement meetings to agree/review timescales and improve communication and documentation of progress for monitoring of compliance and escalation purposes.

Duty of Candour compliance requires improvement. This has been presented at a multi-professional lecture and is being overseen by the Patient Safety Leads. In addition, Datix has been updated to ease recording of the three touch points to demonstrate compliance.

Where there are concerns, how are we triangulating data to give a richer picture of what is happening (e.g. staff and quality data)
Of the three wards flagging red on the quality metrics in September, only one (Respiratory Unit) had a higher complaints rate against trajectory in conjunction with low staffing. In future the Patient Experience & Engagement dashboard will help to triangulate this data.

What assurances are there on mitigations of the causes of concern?
Weekly complaints meetings, taking forward actions for PEE strategy
Medical Imagining have a higher incidence of complaints in relation to staff attitude and behaviour and bespoke training is being planned for the department to be delivered by PE team

What is the future trajectory, better or worse?
To remain within normal variation
Improve complaint reply performance
Improve Duty of Candour compliance

Key questions posed by the report
Does the current report information and the planned steps described provide the relevant information to enable the committee to seek assurance on the quality of patient experience and engagement provided by the Trust?
How this report contributes to the delivery of the strategic objectives
This report contributes by detailing our performance in complaints handling which directly impacts on patient experience. This is in addition to outlining organisational learning and illustrating how the implementation of the Patient Experience & Engagement Strategy will be measured and monitored for effectiveness.
How this report impacts on current risks or highlights new risks
The report provides some mitigation against reputational risk from poor patient experience. This is evidenced by demonstrating improved response and positivity from FFT locally and nationally and >95% performance in ward based patient satisfaction surveys.
Recommendation(s) and next steps
The Patient Experience & Engagement Strategy will be launched and performance measured against objectives. This will be embedded and monitored through the Patient Experience & Engagement Committee.

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Title	**NHS Protect – Withdrawal Of Local Support For Counter Fraud**		
Report to	**Board**	**Date**	**31 October 2017**
Author	**Mark Bishop, NHS Accredited Local Counter Fraud Specialist (LCFS)**		
Purpose			Tick one as appropriate
	Decision		
	Assurance		✓
	Information		

Executive summary containing key messages and issues

In February 2016, NHS Protect (formerly known as the NHS Counter Fraud and Security Management Service (NHS CFSMS)) announced fundamental changes to its service delivery.

In essence NHS Protect announced they would be withdrawing from direct operational support during the FY 2016/17 to NHS organisations and their incumbent LCFSs, to a model of standard setting, bench marking and assurance which will enable local corrective action.

The onus for compliance is being placed firmly on Trust's and to some extent the Chair of a relevant Audit Committee to oversee anti-crime activity.

The key changes included:

- The local Area Anti-fraud services provided by NHS Protect being phased out and no longer provided from 1 April 2017.
- The application of the decision that Boards now have sufficient knowledge of anti-crime procedures without the need of support by NHS Protect.
- The withdrawal of services for advice and guidance in Counter Fraud matters to the Trust.
- The withdrawal of training and support to anti-crime specialists.
- The cessation of NHS Protect's local review of investigation files.

In February 2017, NHS Protect expanded on their drawdown by outlining the following:

- The DH had agreed that NHS Protect will be dissolved and become a Special Health Authority known as the NHS Counter Fraud Authority (NHSCFA).

- The NHSCFA will only be charged with the prevention, detection and investigation of fraud, bribery and corruption across the NHS;
- They will ensure NHS boards take full responsibility for local counter fraud risk, and that this work is monitored and improvements delivered;
- The Intelligence Unit will take on the FIRST case management functions for the receipt, allocation and closure of Information Reports (fraud referrals) and investigation cases;
- A Crime Reduction Unit is being established to design fraud prevention solutions and develop guidance for local specialists and NHS organisations on countering fraud;
- NHSCFA will retain the National Investigation Service (NIS), including its financial investigation and forensic computing capability for the investigation of National cases;
- They will no longer deliver the Accredited Security Management Specialist (ASMS) training course;
- From 1st April 2017, not be tasked with the security management remit.

In March 2017, the Chair of the ANCR wrote a letter to the Managing Director of NHS Protect to seek clarification of their intentions and to seek assurance regarding the future. The resultant response only served to reaffirm the points outlined above and that from April 2017 the Trust would have complete responsibility for ensuring compliance with the relevant anti-crime standards and ensuring a suitable and sufficient anti-crime provision existed.

Given that the withdrawal of support by NHS Protect to LCFSs commenced during 2016, to date no particular problems have been encountered at a local level as a consequence of this.

Key questions posed by the report

Is the Trust's Counter Fraud arrangements suitable and sufficient to cope with future demands post the cessation of NHS Protect support?

How this report contributes to the delivery of the strategic objectives

By ensuring that appropriate mechanisms are in place to address potential risks to service delivery and quality.

How this report impacts on current risks or highlights new risks

Fraud is a standing risk in the Corporate Risk Register and remains on the BAF. Due to the current robust internal arrangements and by having a dedicated counter fraud service in place there is fundamentally no change to or additional risks identified.

Recommendation(s) and next steps

The ANCR already have clear oversight of the Counter Fraud activity within the Trust. The Director of Finance is the direct reporting line of the LCFS and regular update meetings already take place.

Quarterly written reports on counter fraud activity are presented to the ANCR along with an annual report prepared by the LCFS. All activity is programmed to accord with the requirements of NHS Standards for Providers, which forms the basis of the standard setting and compliance checks currently carried out by NHS Protect and soon to also be a requirement of the NHSCFA.

The current model of counter fraud provision is through a specialist counter fraud collaboration between DBTH, Northern Lincolnshire and Goole NHS Foundation Trust (NLaG) and United Lincolnshire Hospitals NHS Trust (ULHT), known as 'Counter Fraud Plus' (CFP), which has recently entered its fifth year of operation at DBTH.

CFP continues to provide an effective proactive service across the three organisations as well having strength in depth where reactive services are required with established links to many law enforcement agencies. Regular monthly CFP team meetings are held to ensure that an effective and professional service is provided to the three organisations. This service includes a full time LCFS dedicated to DBTH with resilience and additional expertise provided from within CFP. This model of service is robust, has been tested by NHS Protect and is able to absorb changes brought about by the withdrawal of local support from within NHS Protect.

Provided the Trust remains committed to countering fraud in the NHS and continues to deploy appropriate resources then there should be no change to the current fraud risk profile.

Members are therefore asked to assure themselves of the current counter fraud arrangements and to acknowledge that fundamentally there will be no change to the day to day service.

This report does not specifically deal with the issues of Security Management, but notes that the changes in this arena can impact upon anti-crime work.

LOCAL COUNTER FRAUD SPECIALIST REPORT TO THE BOARD

CHANGES TO NHS PROTECT SERVICE DELIVERY MODEL AND THE CREATION OF THE NHS COUNTER FRAUD AUTHORITY

Month Issued: **September 2017**

Issued To: **Board**

Author: **Mark Bishop**

NHS PROTECT – CHANGES TO SERVICE DELIVERY

Outline: On the 25th February 2016, NHS Protect announced by way of the issue of circular C/G/13/2015-16 significant changes to the delivery and support of anti-crime at a local level.

Since November 2014, NHS Protect has been subject to a review of its functions and services. That review concluded that the primary responsibility for all local anti-crime work (covering both economic and non-economic crime) should remain with the boards of local NHS organisations.

The Review: The review identified that a single expert intelligence-led organisation (NHS Protect) should limit its functions to providing a centralised capacity at a national level for investigations into complex crime matters and to have oversight of and monitor anti-crime work across the NHS. This will included the definition of anti-crime standards and assessment of performance against them, as well as the provision of comparative data and resources to drive improvement in anti-crime work.

The review went further to identify that the support work undertaken by NHS Protect, such as training for anti-crime specialists and local support services, had been successful. However, it now concluded that NHS Protect should no longer provide these services, as boards of local NHS organisations should now have the necessary knowledge and capacity to deal with the crime threats that they face. The review opined that if these services continued, there was a risk that NHS boards would not properly take ownership of local anti-crime risks.

As a result NHS Protect's service delivery model was identified to change from direct operational support to standard setting, bench marking and assurance to enable local corrective action.

Since the review outcome was initially explained in the first circular, a succession of circulars has followed. For ease of brevity attached at Appendix 1 to this report is a copy of the initiating circular and all subsequent circulars issued to date. These documents are relatively self-explanatory and set out the changes that have occurred and are still to occur since April 2016.

In February 2017, the review took another significant step in that it was announced that NHS Protect would be dissolved and be replaced with a new Special Health Authority to be known as the NHS Counter Fraud Authority (NHSCFA). The NHSCFA was established in shadow from April 2017 with an initial inception date of 3rd July 2017. This has currently been delayed to be on an as yet unspecified date in 2017/18. Notably, from 1st April 2017, NHS Protect has no remit to provide security management functions and this element has been completely sacrificed in the new structure.

Key Changes: In short, there has been little or no engagement at Trust level throughout the process and the changes that are taking place have been decided at a DH level. With the NHSCFA about to go live the key changes are:

- NHS Protect will no longer provide Local Support and Development Services for Local Counter Fraud Specialists and NHS Trusts. (CPD to be sourced separately).
- Ensure NHS boards take full responsibility for local counter fraud risk, and that this work is monitored and improvements delivered.
- Establish a Crime Reduction Unit to design fraud prevention solutions and develop guidance for local specialists and NHS organisations on countering fraud.
- Develop its national intelligence function leading on counter fraud matters across the NHS.
- Continuance of the National Investigation Service (NIS), including its financial investigation and forensic computing capability. NIS will retain functions that support the pursuit of sanctions against those who commit fraud against the NHS.
- Criminal proceedings will still be progressed through the Specialist Fraud Division of the Crown Prosecution Service (CPS). NHS Protect has in place a memorandum of understanding with CPS for the prosecution of NHS fraud. This will continue as part of the NHSCFA. NIS will check local prosecution files to ensure that necessary documents are in place in accordance with CPS's national file standards before onward transmission via FIRST.
- No longer deliver the Accredited Counter Fraud Specialist (ACFS) training course (to be sourced privately)
- Through the enhanced intelligence and analysis function, the authority will form the evidence base upon which standards and a compliance regime can be developed to identify where crime reduction action is most needed to drive improvements locally.
- From 1st April 2017, NHS Protect will not be tasked with the security management remit and will no longer provide Local Support and Development Services, the primary responsibility for security management work will remain with the boards of local NHS organisations.
- No longer deliver the Accredited Security Management Specialist (ASMS) training course (to be sourced privately)

Outcomes: On a day to day basis there will be no obvious change to the provision of services provided by the current Counter Fraud provider 'Counter Fraud Plus (CFP)' as this is a collaborative service between DBHFT, Northern Lincolnshire and Goole NHS Foundation Trust (NLaGFT) and United Lincolnshire Hospitals NHS Trust (ULHT).

CFP continues to provide an effective service across the three organisations as well as maintaining a good support mechanism within the team. Key elements of fraud risk management include:

- Provision of non-limited counter fraud service;
- Agreement of an Annual Counter Fraud Operational Plan with the Director of Finance (DoF) and ratified by the ANCR (underpinned by a local fraud risk assessment);
- Regular update meetings with the DoF;
- Provision of quarterly update reports and an Annual report to the ANCR;
- Conduct of an Annual Fraud survey;
- Monitoring and reporting of compliance with the NHS Standards for Providers and relevant elements of the NHS Standards for Commissioners;

Conclusion. The dynamics of CFP provide DBTH with adequate counter fraud resilience in a cost effective model that meets the requirements of the NHS Provider Standards upon which the Trust is annually assessed. Provided that this arrangement continues then any shortfall in support by NHS Protect and more latterly the NHSCFA will be managed by CFP.

In respect of dissolution of support for the Security Management functions then this is a potential area of risk the board may need to consider.

Protect

Circular

Circular reference	C/G/13/2015-16
Publication date	25 February 2016
Subject	**Outcomes of the review of NHS Protect's functions and services**
Who should read	Local Counter Fraud Specialists Directors of Finance Local Security Management Specialists Security Management Directors
Action	For information only
Relevant documents and standards	None

Contents

Summary

This circular provides an update on the outcomes of a review of NHS Protect's functions and services.

Background

Since November 2014 NHS Protect has been subject to a review of its functions and services. That review has now come to an end, and its conclusions are set out below.

Outcomes of the review of NHS Protect

The review concluded that the primary responsibility for all local anti-crime work (covering both economic and non-economic crime) should remain with the boards of local NHS organisations.

There remains a need for a single expert intelligence-led organisation - NHS Protect - to provide centralised capacity at a national level for investigations into complex crime matters and to have oversight of and monitor anti-crime work across the NHS. This will include the definition of anti-crime standards and assessment of performance against them, as well as the provision of comparative data and resources to drive improvement in anti-crime work.

It was identified that the support work currently undertaken by NHS Protect, such as training for anti-crime specialists and local support services, had been successful. The review concluded that NHS Protect should no longer provide these services, as boards of local NHS organisations should now have the necessary knowledge and capacity to deal with the crime threats that they face. If these services continued, there is a risk that NHS boards would not properly take ownership of local anti-crime risks.

As a result NHS Protect's service delivery model will now change from direct operational support to standard setting, bench marking and assurance which will enable local corrective action.

In 2016-17 NHS Protect will undergo a transition, and it is anticipated that it will move to an operating model that no longer includes the direct provision of support services, so it can deliver its agreed new remit and strategic direction. Until this time NHS Protect will continue to provide the full range of support functions that it provides at present. When more information becomes available, this will be shared with all users of our services.

Contact details

If you have any queries about the content of this circular then please email transition@nhsprotect.gsi.gov.uk

NHS

Protect

Circular

Circular reference	F/G/04/2016-17
Publication date	9 June 2016
Subject	**Changes in Accredited Counter Fraud Specialist training delivery**
Who should read	Local Counter Fraud Specialists Directors of Finance
	This circular will also be of interest to chairs of audit committees.
Action	For information only
Relevant documents and standards	NHS Protect fraud, bribery and corruption standards for providers (and standards for commissioners), Standard 1.2 - available in the Anti-crime standards section of our website.

Contents

Summary

This circular informs health bodies in England and Wales that NHS Protect will stop delivering Accredited Counter Fraud Specialist (ACFS) training from April 2017. The ACFS qualification is still relevant to the role of the Local Counter Fraud Specialist and is the required standard for those working in the sector as per Standard 1.2 of NHS Protect's fraud, bribery and corruption standards for providers (and standards for commissioners).

Background

The recent review of NHS Protect's functions and services, which was completed in early 2016, concluded that NHS Protect should withdraw from the direct delivery of the foundation level Counter Fraud Specialist training course, and from all associated additional learning that it previously provided to anti-fraud specialists working in the NHS.

Withdrawal of NHS Protect from ACFS training delivery

NHS Protect has been working to withdraw from direct delivery of ACFS training while minimising the impact on availability of the core qualification to those who are nominated to work in the sector in line with NHS anti-fraud standards.

This qualification has been accredited by the Counter Fraud Professional Accreditation Board (CFPAB) since 1999, and there are a number of provider organisations represented on this board delivering the qualification to both the public and private sector.

NHS Protect cannot recommend one provider over another; however all of the recognised organisations delivering the ACFS qualification are listed on the CFPAB web page at http://www.port.ac.uk/centre-for-counter-fraud-studies/counter-fraud-professional-accreditation-board/

NHS Protect will continue to recognise organisations that deliver the course as described above as meeting the criteria for meeting our standards.

The exact details are still to be worked out, but access to FIRST and an LCFS number would still be administered in the same way as now for those who complete the ACFS course. The only difference is that the NHS organisation would provide the details of the individual and the certificate number from CFPAB.

Currently NHS Protect provide assurance to CFPAB that those working within the NHS have access to continuing professional development (CPD) and comply with CPD requirements. These requirements are already set as part of the CFPAB standard for investigators. It is expected that individual investigators will have to comply with the CPD requirements set by the board and that they may subsequently be measured on them as part of NHS Protect's quality assurance process.

As a consequence of these changes, NHS Protect will no longer be delivering the ACFS course. All places on existing courses are now fully taken, and no further provision will be available. NHS bodies seeking the qualification for their nominated staff should therefore use the providers listed at the link above.

Contact details

Any enquiries about this document should be directed to the Training enquiries e-mail inbox: Training@nhsprotect.gsi.gov.uk

NHS

Protect

Circular

Circular reference	C/G/06/2016-17
Publication date	28/09/2016
Subject	**The quality assurance process: Post assessment final report and follow up actions**
Who should read	Local Counter Fraud Specialists Local Security Management Specialists Directors of Finance Security Management Directors
	This circular will also be of interest to: • CCG chief officers • CCG contract managers • audit committee chairs
Action	For information only.
Relevant documents and standards	• Security management standards for providers 2016-17 • Security management standards for commissioners 2016-17 • Fraud, bribery and corruption standards for providers 2016-17 • Fraud, bribery and corruption standards for commissioners 2016-17

Contents

Summary

This circular discusses the role of audit committee chairs of NHS providers and CCG chief officers in ensuring that there are proper anti-crime arrangements in place at NHS provider organisations.

Background

NHS Protect delivers a service focused on the protection of NHS resources from crime. The aim of our anti-crime work is to protect health and care staff and resources from activities that would otherwise undermine their effectiveness and their ability to meet the needs of patients and professionals. Ultimately this helps NHS Protect to lead the fight against crime affecting the NHS and the wider health group, protecting vital resources intended for patient care.

NHS Protect produces a set of anti-crime standards and has a quality assurance assessment process which establishes that providers are complying with them. The assessment process focusses annually on a number of providers and its output is a final report on the anti-crime activity against the standards. Providers that are assessed are required to produce an action plan based on the recommendations resulting from the assessment process and deliver against these.

The final reports will support and assist the coordinating CCGs in monitoring progress against the action plan within their providers, in line with the requirements of the NHS Standard Contract and the standards.

Action required

Service Condition 24 of the NHS Standard Contract 2016-17 requires providers to put in place and maintain appropriate anti-crime activity. Service Condition 24 also places obligations on commissioners in relation to the review of anti-crime arrangements in the providers from whom services are commissioned.

The chair of the audit committee should, using the action plan and final report, ensure that the process of compliance with the NHS Standard Contract, the corresponding standards and any action plans arising from assessment are followed internally. Particular attention should be given to the standards for commissioners which relate to the monitoring of providers' anti-fraud, bribery and corruption arrangements (these are highlighted using a shaded background in the standards for commissioners document). This information should be shared with NHS Protect and the coordinating commissioner.

In cases where the action plan is not delivered in a timely manner, NHS Protect will expect the corresponding coordinating commissioner to fulfil their contractual

obligation in relation to the review of anti-crime arrangements in the providers from whom services are commissioned.

Where there is persistent non compliance on the part of provider organisations, NHS Protect will escalate as necessary to address the identified risks arising from the assessment process.

Contact details

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NHS

Protect

Circular

Circular reference	C/G/07/2016-17
Publication date	26 October 2016
Subject	**Update on the review of NHS Protect's functions and services**
Who should read	Local Counter Fraud Specialists Directors of Finance Local Security Management Specialists Security Management Directors
Action	For information only
Relevant documents and standards	None

Contents

Summary

This circular provides an update on NHS Protect following the last circular on the review of the organisation's functions and services.

Background

Since November 2014 NHS Protect has been subject to a review of its functions and services by the Department of Health (DH), the conclusions of which were communicated to you in February of this year (see circular C/G/13/2015-16).

As a result of the review outcome and the impact of the comprehensive spending review, NHS Protect has been required to change the way in which its services are delivered in the future. An outline of this and our new and improved operating model is provided for you below.

NHS Protect's new operating model

The DH review concluded that during 2016-17 NHS Protect needed to undergo a transition and identify the functions required to deliver its agreed new remit and strategic direction.

A programme of work is under way to change NHS Protect's service delivery model from direct operational support to standard setting, bench marking and assurance which will enable local corrective action. As part of our new remit we will:

- provide a single central expert anti-crime organisation at a national level
- provide intelligence-led crime prevention/reduction work
- maintain oversight of and monitor anti-crime work across the NHS
- define and set anti-crime standards and assess performance against them
- assess, bench mark and assure the performance of local anti-crime delivery against those standards
- provide anti-crime management information to the NHS to drive improvement
- drive improvement to the quality and consistency of outputs of local anti-crime provision
- provide a central investigation capacity for complex fraud cases that local NHS organisations are not able to pursue

Discussions are currently taking place about the ongoing provision of security management work (beyond the direct operational support functions that will no longer be provided). Further information on this will be provided in due course.

We will continue our transition activity over the next three months and aim to implement our new structure in shadow form in January 2017, with a view to starting to deliver our new operating model and services after that.

As a result, from December 2016 NHS Protect will be scaling back on a number of services it currently provides, and it will no longer provide them from 1 April 2017. The services involved are as follows:

- direct provision of operational support services, including Area Security Management Specialist, Area Anti Fraud Specialist and Legal Protection Unit services. The primary responsibility for all local anti-crime work (covering both economic and non-economic crime) will need to remain with the boards of local NHS organisations.
- direct delivery of accredited counter fraud specialist training; information about this was provided in a circular in June 2016 (Circular F/G/04/2016-17)
- direct delivery of accredited security management specialist training. This function will be passing to the private sector under the auspices of the Professional Accreditation Board (PAB) for Security Management Specialists. NHS Protect will continue to provide a consultancy service to the PAB to ensure that the continuing delivery of this qualification by the private sector meets all of the criteria to allow local boards to fulfill their responsibilities in meeting the anti-crime standards.

NHS Protect will continue to provide access to a range of manuals, toolkits and guidance materials for anti-crime specialists on our digital platforms. In addition to this, during this transitional period we will put in place a central point of contact so that where necessary anti-crime specialists can contact NHS Protect and be signposted to the information they require. We will notify you of the contact details in due course.

The Q&A annex below aims to address some of the questions you may have as a result of the implementation of NHS Protect's new structure.

Contact details

If you have any queries about the content of this circular, please email transition@nhsprotect.gsi.gov.uk.

Annex

Update on the review of NHS Protect's functions and services - Q&As

Question	Answer
What will happen to Local Counter Fraud Specialist (LCFS) and Local Security Management Specialist (LSMS) regional meetings?	NHS Protect will no longer organise regional LCFS or LSMS meetings. However, it may be that local specialists decide to organise their own regional meetings and there may be occasions when NHS Protect representatives are invited to them to provide updates.
How will LCFSs and LSMSs access information and guidance documents in the future?	Information will continue to be made available on NHS Protect's extranet. A new extranet will be released shortly and this service will be enhanced over time to provide a wider range of materials for LCFSs, LSMSs, Directors of Finance (DOFs), Security Management Directors (SMDs) and others. As part of the ongoing development of our digital platforms (including our extranet), we are looking into the possibility of extending access to other audiences. More details to be provided in due course.
What information will be available to DoFs & SMDs?	A new welcome pack has been developed providing information on NHS Protect for DoFs and SMDs. This is available on NHS Protect's website. Further guidance is also being developed and it will be made available on NHS Protect's extranet next year. This will range from information on investigations procedures to crime prevention and detection resources.
Will there be a single point of contact at NHS Protect for queries?	Yes, arrangements are being made to provide a single point of contact at NHS Protect for queries. More information about this will be made available in due course.
What will happen to the nomination process for LCFSs and LSMSs?	NHS Protect's nominations process for local specialists will continue. You can find more details in the new welcome pack and in an updated versions of our nominations guidance, both of which are available on NHS Protect's website.

Question	Answer
When will all the existing guidance produced by NHS Protect be updated and available?	NHS Protect is undertaking an ongoing programme of work to ensure that existing information is updated, maintained and made available via NHS Protect's extranet. Work will be prioritised as appropriate and further information on this will be made available in due course.
What are the new arrangements for opening and closing FIRST cases?	In future, all FIRST entries will be managed by Local Information Management Officers instead of Area Anti-Fraud Specialists. However, existing arrangements for opening and closing FIRST cases will remain the same.
Will LCFS managers be able to view LCFS cases allocated to their staff in the future?	LCFS managers will continue to have access to LCFS cases allocated to their staff. Arrangements already exist for the manager to be nominated as a support LCFS; this will not change. Nominations will be directed to an officer in NHS Protect's Business Support Unit tasked with keeping the nominations up to date.
When will the new procedure for submitting an initial LCFS case for prosecution be published?	NHS Protect is transitioning to a new structure and when this is in place new procedures for submitting LCFS cases for prosecution will be circulated.
What support will be provided to an LCFS when a prosecution cases progresses to court?	NHS Protect will no longer be able to support LCFSs with this. When a case has been checked and sent to the Crown Prosecution Service (CPS), future liaison about the case and its progression to court will be between the LCFS and the CPS. NHS Protect will not be involved in that process.
Who will advance warnings be sent to in the future?	The advance warning process is under review but it will remain the same until alternative arrangements are put in place.
How will LSMSs and LCFSs raise a request for an NHS Protect alert?	Information will need to be submitted to the Information and Intelligence Unit. Further details will be provided in due course.
How will LSMSs be able to raise requests for assistance or information on possible emerging crime trends?	NHS Protect will no longer be able to provide operational assistance to LSMSs. Where there is a need to share information with the health sector on emerging crime trends relating to security management work, NHS Protect will inform LSMSs through the issue of circulars.

Question	Answer
What will happen to the Security Incident Reporting System (SIRS) and the reporting of security-related crime incidents?	The SIRS system will remain available to report any security related crime incidents to a central point where that might be required. NHS Protect will continue to host SIRS unless directed otherwise.
Will paralegal advice still be available to LSMSs?	NHS Protect will no longer be able to support LSMSs with this. However, information will be made available on NHS Protect's extranet, including resources on crime management and effective investigations.
How will newly appointed security specialist access the LSMS courses?	A new Professional Accreditation Board (PAB) for Security Management Specialists is currently being formed. Once this has been created, details of training providers who will offer LSMS courses will be available from them. Further details will be issued on this in due course.
How will the LSMS/LCFS courses be delivered and how much will they cost?	External providers will now be responsible for deciding the format and costs of training courses. More information will be made available in due course.
How will LSMSs and LCFSs be able to identify and access appropriate CPD opportunities?	Identification and access to continuing professional development for anti-crime specialists is the responsibility of local health bodies.
How do I access support and advice when my organisation is selected for a quality assurance assessment?	The standards for providers and commissioners contain a section on the quality assurance programme and this provides details about the assessment process. The standards documents also set out the expectations of both parties involved in the assessment. There is also considerable advance communication before a quality assurance assessment from the Senior Quality and Compliance Inspector. Where organisations require further information, they should contact the Senior Quality and Compliance Inspector who is conducting the assessment. You can also email either fraudqa@nhsprotect.gsi.gov.uk or securitymanagementqa@nhsprotect.gsi.gov.uk

Question	Answer
How will I receive support from NHS Protect following a quality assurance assessment on-site visit?	Organisations that have been assessed can expect to receive a final report with recommendations, as appropriate, within 4 weeks of the on-site visit. The report will be copied to the audit committee chair. A viable action plan must be produced by the organisation within a further 4 weeks and NHS Protect will share this with the co-ordinating commissioner and monitor that the final report recommendations are implemented.
How will Anti-Social Behaviour Injunctions (ASBIs) be applied for in the future if NHS Protect is no longer supporting this?	Anti-Social Behaviour Injunctions (ASBIs) can be applied for through the local authority and/or the police. Information and guidance on this will be made available on NHS Protect's extranet.

NHS Protect

Circular

Circular reference	C/G/15/2016-17
Publication date	3 February 2017
Subject	**NHS Protect organisational update**
Who should read	Local Counter Fraud Specialists Directors of Finance Local Security Management Specialists Security Management Directors
Action	For information only
Relevant documents and standards	n/a

Contents

the receipt, allocation and closure of Information Reports (fraud referrals) and investigation cases; this includes cases requiring submission to the Tactical Tasking and Coordination Group for consideration of investigation by the authority.

- ensure NHS boards take full responsibility for local counter fraud risk, and that this work is monitored and improvements delivered. As a result, Local Support and Development functions as they exist currently will be discontinued from 1 April 2017. Although local Area Anti-fraud support and advice services will no longer be provided, a Crime Reduction Unit is being established to design fraud prevention solutions and develop guidance for local specialists and NHS organisations on countering fraud. This will be available via an enhanced website and extranet, including the development of an online library of resources. A dedicated email inbox will also be set up for anyone with questions or requiring guidance and information.
- continue to retain its National Investigation Service (NIS), including its financial investigation and forensic computing capability. NIS will retain functions that support the pursuit of sanctions against those who commit fraud against the NHS. Criminal proceedings will still be progressed through the Specialist Fraud Division of the Crown Prosecution Service (CPS). NHS Protect has in place a memorandum of understanding with CPS for the prosecution of NHS fraud. This will continue as part of the authority. NIS will check local prosecution files to ensure that necessary documents are in place in accordance with CPS's national file standards before onward transmission via FIRST. A dedicated email inbox will also be set up in due course for the submission of CFS13 forms.
- enable the delivery of the work above via its Business Support function which includes the development of bespoke IT support systems; information technology services; and organisational development, media and engagement functions.
- no longer deliver the Accredited Security Management Specialist (ASMS) training course. Standard 1.3 in both commissioner and provider standards requires that 'The organisation employs or contracts a qualified, accredited and nominated security specialist(s) to oversee and undertake the delivery of the full range of security management work.' NHS Protect has passed its training material and the delivery of the course to the private sector who are currently preparing for delivery from April 2017 onwards. Currently listed applicants for the course held by NHS Protect will be offered the chance to complete the on-line learning part of the course through NHS Protect until 31 March 2017 and the opportunity to have their contact details passed to the Professional Accreditation Board who hold records of accredited providers. Thereafter this will no longer be available to new applicants, who should seek

to gain accreditation through the providers directly. Contact details for these providers will be shared with you in due course.

- not be tasked with the security management remit. From 1 April, as previously advised, NHS Protect will no longer provide Local Support and Development Services, the primary responsibility for security management work remaining with the boards of local NHS organisations. As the detailed work to progress the creation of a special health authority is undertaken, discussions about national oversight for security management will be ongoing. Further information will be provided in due course when this becomes available. A dedicated email inbox will be set up for anyone with questions or requiring guidance and information.

Contact details

If you have any queries about the content of this circular, please email transition@nhsprotect.gsi.gov.uk

NHS Protect

Circular

Circular reference	F/G/16/2016-17
Publication date	24 March 2017
Subject	**New arrangements following NHS Protect review**
Who should read	Local Counter Fraud Specialists Directors of Finance
Action	For information only
Relevant documents and standards	n/a

Contents

Summary

This circular provides an update on the new arrangements in NHS Protect following the recent review of the organisation's functions and services. It also provides an update on the creation of a new special health authority following the information circulated to you in February 2017 (please see circular C/G/15/2016-17).

Background

The role of NHS Protect is changing and work is under way to create a new special health authority to tackle fraud, bribery and corruption in the NHS and the wider health group. The new organisation will be called the NHS Counter Fraud Authority (NHSCFA) and it will exist in shadow form from 1 April 2017. The transfer of staff and the creation of the NHSCFA will take place during the first quarter of 2017-18, with the new organisation being launched on 3 July 2017. At this point NHS Protect will cease to exist.

As you will be aware, the services provided by NHS Protect's Local Support and Development Services (LSDS) team will cease on 31 March 2017. As a result, any communication with this team via the Area Anti Fraud Specialist (AAFS) role will also cease on this date. The LSDS team and the AAFS role will no longer exist after 31 March.

Counter fraud guidance

NHS Protect's new extranet has been rolled out and it contains a wide range of information and resources for local specialists and NHS organisations on countering fraud. This includes the NHS anti-fraud manual, guidance documents and templates. Local Counter Fraud Specialists (LCFSs) looking for information should refer to NHS Protect's extranet and public website.

From 1 April 2017, all queries related to the documents on NHS Protect's extranet and website should be directed to the Crime Reduction unit at crimereduction@nhsprotect.gsi.gov.uk.

Information reports and investigation cases on FIRST

From 1 April 2017 all fraud allegations placed on FIRST will be controlled by information management officers. They will consist of one Senior Information Officer (SIMO) and three Information Management Officers (IMOs). The SIMO will be Patrick Kelly, formerly the AAFS for the Eastern and South Eastern regions, supported by three former AAFS Support officers. Their role is to process the allegations on FIRST and consider any data requests received from LCFSs. Unlike under the previous arrangements, they will not be offering any advice on how to

progress an investigation. This will be the responsibility of the LCFS and their managers.

Where initial enquiries are being progressed from information reports, all communication between the LCFS and the SIMO/IMO will be conducted via FIRST. Where enquiries are being progressed on an investigation case in FIRST, communications with the SIMO/IMO will initially be through a dedicated email account, IMO@nhsprotect.gsi.gov.uk. Development work is underway to enable FIRST to replace this mailbox.

NHS providers and commissioners are required, under the standard contract and by NHS England respectively, to comply with NHS anti-fraud, bribery and corruption standards. The arrangements outlined in this circular relate specifically to standards 4.1 and 4.2 and whether these are being complied with. Users are reminded of their obligations in relation to compliance with these standards. Keeping information reports and cases up to date comprehensively and in a timely manner is essential if these standards are to be met.

In order to assist with this, we are developing the information reports on FIRST. Two new tabs will be added to aid compliance. The Information Progress tab will mirror the case progress logs to report the enquiries undertaken. This should greatly enhance the intelligence picture and help managers to properly monitor progress. The updates within this field must be made in a timely and comprehensive manner. The Sanctions tab will enable the LCFS to record disciplinary sanctions where the LCFS and the Director of Finance/CFO consider that it is not proportionate to pursue an investigation but where there is a disciplinary investigation.

LCFS investigations

LCFSs are also reminded of the need to constantly review and update information reports and cases, with particular reference to paragraph 5.3.2 of the NHS anti-fraud manual. The responsibility and accountability for investigations conducted locally by NHS organisations rests with those organisations and their LCFS.

In essence, if no update has been recorded within 3 months, information reports and cases will be closed, at your risk, by the IMOs. The Quality and Compliance Unit will provide Directors of Finance/CFOs with regular reports of the activity on investigations relating to their health body, and information reports and instances of non-compliance in relation to the standards will be highlighted. Cases of continued non-compliance will be referred to the audit committee, co-ordinating commissioners, NHS England and ultimately the Department of Health.

From 1 April 2017, NHS Protect will act as a gateway for initial file submissions to the Crown Prosecution Service (CPS) in relation to LCFS investigations. The

National Investigation Service within NHS Protect will review case material to ensure that the submission to CPS meets the requirements of the National File Standard and will ensure the safe and secure transmission of material for CPS consideration. Thereafter, it is expected that CPS will liaise directly with the LCFS, and not via NHS Protect. From 1 April, appropriate investigations should be identified by direct email to the following address: CPSfile@nhsprotect.gsi.gov.uk

NHS Protect will continue to provide access to its trained and accredited Financial Investigators for appropriate LCFS cases. Where the circumstances of an investigation suggest that financial investigation might be appropriate, an initial request should be made to the following address: david.hall@nhsprotect.gsi.gov.uk. A Financial Investigator will subsequently liaise directly with the LCFS to discuss potential support.

NHS Protect will also continue to provide access to its Forensic Computing Unit (FCU) for appropriate LCFS cases. Where the circumstances of an investigation suggest that FCU support and assistance might be appropriate, an initial request should be made to the following address: Forensics@nhsprotect.gsi.gov.uk. A Forensic Computing Specialist will subsequently liaise directly with the LCFS to discuss potential support.

Contact details

If you have any queries about the content of this circular, please email crimereduction@nhsprotect.gsi.gov.uk

NHS Protect

Circular

Circular reference	F/G/01/2017-18
Publication date	28 June 2017
Subject	**Update on the creation of the NHS Counter Fraud Authority**
Who should read	Directors of Finance Local Counter Fraud Specialists
Action	For information only
Relevant documents and standards	n/a

Contents

Summary

This circular provides an update on the creation of the NHS Counter Fraud Authority, a new special health authority which began in shadow form in April 2017.

Background

As announced by the Department of Health in March, a new organisation is being created to tackle fraud, bribery and corruption within the health service in England. This will be known as the NHS Counter Fraud Authority (NHSCFA).

It will provide a clear focus for both the prevention and investigation of fraud and will work with key stakeholders to tackle fraud, bribery and corruption within the health service.

Update on the creation of the NHS Counter Fraud Authority

The NHSCFA began in shadow form in April 2017 and it will be established as an independent special health authority in the autumn. This was originally planned for July, but work to create the new organisation was delayed as a result of the general election. This work includes legislation requiring parliamentary approval as well as preparations around the functioning of the new organisation. We are currently awaiting confirmation of a specific launch date, as soon as we have more information we will share it with you.

NHS Protect is still in operation and will continue to function until the NHSCFA is established. We have recently implemented a number of changes in our structure and operating model as a result of a review of the organisation; these were described in previous circulars (see circulars C/G/15/2016-17 and F/G/16/2016-17, both available on NHS Protect's extranet).

Contact details

If you have any queries about the content of this circular, please email transition@nhsprotect.gsi.gov.uk.

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Title	**Financial Performance – September 2017**		
Report to	**Board of Directors**	**Date**	**31 October 2017**
Author	**Jon Sargeant - Director of Finance**		

Purpose		Tick one as appropriate
	Decision	
	Assurance	
	Information	X

Executive summary containing key messages and issues
The month 6 position for 2017/18 is a deficit of £13,006k, which is £673k ahead of the planned year to date deficit of £13,679k. However it must be noted that this reported position includes £419k of STF income relating to 2016/17 that cannot be counted towards the Trust's control total as well as £258k of variance relating to donated asset income, which again is discounted from the control total. The restated position which will be used by NHS Improvement to monitor the Trust's financial performance, is a deficit of £13,483k which is £4k better than our control total target to date. During September, expenditure reduced from previous run rate levels, largely driven by a reduction in medical agency spend. However, the income position was significantly worse than expected, causing a significant pressure on the Trust bottom line.
Key questions posed by the report
Are the Board assured by actions taken to bring the financial position back in line with plan?
How this report contributes to the delivery of the strategic objectives
Relevant strategic objectives; • Provide the safest, most effective care possible • Control and reduce the cost of healthcare • Focus on innovation for improvement • Develop responsibly, delivering the right services with the right staff

How this report impacts on current risks or highlights new risks
Update on risk relating to delivery of 2017/18 financial plan.
Recommendation(s) and next steps
The Board is asked to note the month 6 2017/18 financial position of £13.4 million deficit, £8k favourable to plan after removal of the 16/17 STF funding and any variance related to donated asset income.

FINANCIAL PERFORMANCE

P6 September 2017

31st October 2017

DONCASTER AND BASSETLAW TEACHING HOSPITALS NHS FOUNDATION TRUST

FINANCE SCORECARD SEPTEMBER 2017

1. Income and Expenditure vs. Forecast

Performance Indicator	Monthly Performance Actual £'000	Monthly Performance Variance £'000		YTD Performance Actual £'000	YTD Performance Variance £'000		Annual Plan £'000	Forecast £'000
I&E Perf Exc Impairments	164	(1,378)	F	13,006	(673)	F	16,489	16,070
Income	(30,212)	209	A	(182,699)	(2,820)	F	(361,442)	(361,442)
STF Incentive	(770)	0	F	(4,041)	0		(11,547)	(11,547)
STF Adjustment 16/17	0	0		(419)	(419)	F	0	(419)
Donated Asset Income	(58)	(58)		(58)	(250)	F		
Operating Expenditure	30,070	(1,609)	F	193,711	2,354	A	376,642	376,642
Pay	21,412	233	A	130,134	3,146	A	253,999	253,999
Non Pay	8,658	(1,842)	F	63,576	(793)	F	122,643	122,643
I&E Perf Exc 16/17 STF and Donated Asset Income	**583**	**(1,320)**	**F**	**13,483**	**(4)**	**F**	**16,489**	**16,489**

F = Favourable A = Adverse

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

2. CIPs

Performance Indicator	Monthly Performance Actual £'000	Monthly Performance Variance £'000		YTD Performance Actual £'000	YTD Performance Variance £'000		Annual Plan £'000	Forecast £'000
Employee Expenses	198	(755)	A	1,222	(2,666)	A	11,675	
Drugs	5	(3)		19	3	F	65	
Clinical Supplies	44	(50)	A	266	(273)	A	1,156	
Non Clinical Supplies	0	(1)		0	(3)	A	10	
Non Pay Operating Expenses	71	(8)	A	216	(165)	A	1,224	
Income	91	60	F	169	(16)	A	369	
Total	**409**	**(758)**	**A**	**1,892**	**(3,119)**	**A**	**14,500**	

3. Statement of Financial Position

All figures £m	Opening Balance 01.04.17	Current Balance 30.09.17	Movement in year
Non Current Assets	**196,907**	**193,883**	**(3,024)**
Current Assets	33,612	61,919	28,307
Current Liabilities	(31,967)	(66,024)	(34,057)
Non Current liabilities	(79,348)	(83,576)	(4,228)
Total Assets Employed	**119,204**	**106,201**	**(13,003)**
Total Tax Payers Equity	**119,204**	**106,201**	**(13,003)**

4. Other

Performance Indicator	Monthly Performance Plan £'000	Monthly Performance Actual £'000	YTD Performance Plan £'000	YTD Performance Actual £'000	Annual Plan £'000	Forecast £'000
Cash Balance	1,900	8,667	1,900	8,667	1,900	1,900
Capital Expenditure	635	300	2,038	1,247	6,481	7,842

5. Workforce

	Funded WTE	Actual WTE		Bank WTE	Agency WTE		Total in Post WTE	Under / (over)
Current Month	6,032	5,613		177	179		5,969	63
Previous Month	6,031	5,618		197	214		6,029	2
Movement	(1)	5	0	20	35	0	60	61

1. Context/Background

The month 6 position for 2017/18 is a deficit of £13,006k, which is £673k ahead of the planned year to date deficit of £13,679k. However it must be noted that this reported position includes £419k of STF income relating to 2016/17 that cannot be counted towards the Trust's control total as well as £258k of variance relating to donated asset income, which again is discounted from the control total. The restated position which will be used by NHS Improvement to monitor the Trust's financial performance, is a deficit of £13,483k which is £4k better than our control total target to date.

During September, expenditure reduced from previous run rate levels, largely driven by a reduction in medical agency spend. However, the income position was significantly worse than expected, causing a significant pressure on the Trust bottom line.

To alleviate the pressure caused by the year to date Care Group expenditure and the month 6 income performance, there has been a review of reserves and prior year accruals being held. This has resulted in £1.3m of recurrent reserves being released into the position during Month 6. No reserves relating to month 7 to 12 position have been released. In addition, £0.7m of prior year accruals have been released into the I&E position. This release relates to specific accruals that have been investigated and found to be no longer required, either due to the initial accrual being overstated, or to the payment already having been made in the 17/18 position.

The Trust has forecast its year end position and this work indicated that without remedial action the Trust would miss its control total by £3.2m a recovery plan including external support from BDO (that is paid for on delivery of results) closes this gap. The impact of the poor income performance this month does make this recovery more risky if the income is not recovered in future months.

2. Executive Summary

Subjective Code	In Month Budget	In Month Actual	In Month Variance	YTD Budget	YTD Actual	YTD Variance	Previous YTD Budget	Previous YTD Actual	Previous YTD Variance	Annual Budget	Forecast
1. Income	-31,191	-30,982	209	-183,920	-187,159	-3,239	-188,493	-187,359	1,134	-372,989	-373,408
2. Costs	31,679	30,070	-1,609	191,357	193,711	2,354	193,847	189,087	-4,760	376,642	376,642
3.Capital Charges	1,054	1,076	21	6,242	6,455	212	7,088	6,943	-145	12,836	12,836
Total Position Before Impairments	**1,542**	**164**	**-1,378**	**13,679**	**13,006**	**-673**	**12,442**	**8,670**	**-3,771**	**16,489**	**16,070**
4.Impairments	0	0	0	0	0	0	0	0	0	0	0
Total Position After Impairments	**1,542**	**164**	**-1,378**	**13,679**	**13,006**	**-673**	**12,442**	**8,670**	**-3,771**	**16,489**	**16,070**
Remove STF relating to 16/17	0	0	0	0	419	419	0	0	0	0	419
Remove variance relating to Donated Asset Income		58	58	-192	58	250					
Position to compare to control total	**1,542**	**222**	**-1,320**	**13,487**	**13,483**	**-4**	**12,442**	**8,670**	**-3,771**	**16,489**	**16,489**

I&E position	In Month Plan	In Month Actual	In Month Variance	2017/18 Plan
Position before STF	2,312	934	-1,378	28,036
STF funding	-770	-770	0	-11,547
STF funding relating to 16/17	0	0	0	0
Reported position	1,542	164	-1,378	16,489

During September, income has been £209k worse than plan (£583k worse than forecast), this is due to an under-performance on clinical income (excluding Non PbR drugs) of £662k. The main areas of under-performance in month are elective activity which is £469k behind in month, outpatient first activity and the Outpatient Cap which is also continuing at previous levels giving a YTD impact of £979k. During September, Care Group expenditure was £1.5m higher than budgeted levels. This overspend includes £187k of pay costs where agency premium costs are over and above funded levels and £758k of undelivered CIP savings. Care Group overspend in Month 6 was £266k lower than the average of the previous five months.

The cumulative income position at the end of Month 6 is £3,239k favourable.

Income Group	Annual Budget	In Month Budget	In Month Actual	In Month Variance	YTD Budget	YTD Actual	YTD Variance
Commissioner Income	-302,250	-25,243	-24,581	662	-150,477	-151,779	-1,303
Drugs	-22,601	-2,055	-2,204	-150	-11,065	-12,208	-1,144
STF	-11,547	-770	-770	0	-4,041	-4,460	-419
Trading Income	-36,590	-3,124	-3,427	-303	-18,338	-18,711	-374
Grand Total	**-372,989**	**-31,191**	**-30,982**	**209**	**-183,920**	**-187,159**	**-3,239**

The expenditure position in September was £1,609k higher than budgeted levels, after underspend of £3,142k within reserves.

Subjective Code	In Month Budget	In Month Actual	In Month Variance	YTD Budget	YTD Actual	YTD Variance	Previous YTD Budget	Previous YTD Actual	Previous YTD Variance	Annual Budget	Forecast
1. Pay	21,179	21,412	233	126,988	130,134	3,146	127,319	125,504	-1,815	253,999	253,999
2. Non-Pay	10,219	11,519	1,300	58,722	65,973	7,251	63,107	61,637	-1,470	113,569	113,569
3. Reserves	281	-2,860	-3,142	5,646	-2,397	-8,043	3,422	1,946	-1,476	9,074	9,074
Total Expenditure Position	**31,679**	**30,070**	**-1,609**	**191,357**	**193,710**	**2,354**	**193,847**	**189,087**	**-4,760**	**376,642**	**376,642**

The below table summarises the Month 6 position compared to the Month 6 forecast;

	M6 Forecast	M6 actuals	Variance	
Clinical Income	-28,595	-27,555	1,040	Elective, Outpatient and Maternity income all below expected levels in September.
Non Clinical Income	-2,970	-3,427	-457	£272k of donated asset income received in Month 6, plus Education income received with expenditure offset.
Total Income	**-31,564**	**-30,982**	**583**	
Substantive pay	20,243	20,356	114	Includes £39k of backdated CEA payments with associated budget transferred. (Previously included in reserves forecast)
Agency pay	1,502	1,055	-446	
Remove recharge pay	-246	-248	-1	
Total Pay	**21,498**	**21,164**	**-334**	
Non Pay	10,574	11,034	460	£481k of increase relates to the Apprenticeship Levy which has been moved from reserves with associated funding.
Efficiency	-130	0	130	Delivered efficiency included within the Pay and Non Pay positions
Recharges and Reserves	740	-2,126	-2,865	
Non Pay	**11,184**	**8,909**	**-2,275**	
EBITDA	**1,118**	**-909**	**-2,027**	
Financing Costs	1,079	1,076	-3	
Bottom line	**2,196**	**167**	**-2,030**	

3. Conclusion

Lower income than expected has caused a significant pressure within the Month 6 position. In particular, elective activity was £0.5m lower than forecast. Improvements in the pay expenditure run rate have partially offset some of the loss in income, but a year to date release of reserves and a review of prior year accruals has been required to ensure delivery of the Q2 control total.

- For the second month running there has been a significant movement from the expected position (this income based) that was unexpected but predictable, there is clearly a lack visibility of operational issues and the impact on financial performance. This has made the delivery of the Financial Plan, despite the additional actions taken to date more risky.
- The position, if recurrent, in terms of Orthopaedic workload this will further impact the Trusts performance and ability to meet its financial target
- The movement on Agency spend is pleasing but it remains to be seen if the overall reduction will be sustainable.

- BDO have been commissioned to support CIP delivery by the Trust in year and add vigour and speed to the strengthening of grip and control processes.
- Further focus on CIP from the BDO work and CEO led meetings is starting to create momentum, but also highlighting a number of schemes that have stalled and need further work before savings will be released.
- The Doncaster CCG has a significant overspend and the assumptions between the Trust and the CCG on the trading between both organisation. This is a gap of circa £2.5m at least.
- The forecast and recovery plans included support have been reviewed at and are supported by the Finance and Performance Committee.

£1.3m of Month 1-6 reserves have been released in the month 6 position, these were due to be released as part of the forecast year end position. £0.7m of additional prior year accruals have also been released in the September position.

4. Recommendations

The Board is asked to note the month 6 2017/18 financial position of £13.4 million deficit, the actions taken to bring the plan in line and risks identified.

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Title	**Performance Report**		
Report to	**Board of Governors**	**Date**	**26 October 2017**
Author	**David Purdue, Chief Operating Officer** **Sewa Singh, Medical Director** **Moira Hardy, Acting Director of Nursing, Midwifery and Quality** **Karen Barnard, Director of People and Organisational Development**		

Purpose		Tick one as appropriate
	Decision	
	Assurance	x
	Information	

Executive summary containing key messages and issues

This report highlights the key performance and quality targets required by the Trust to maintain NHSI compliance.

The report focuses on the 3 main performance area for NHSi 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

The report also highlights the ongoing work with Care Groups and external partners to improve patient outcomes.

The report also focuses on vacancy levels, agency spend and usage, sickness rates, appraisals and SET training.

Key questions posed by the report
Is the Trust maintaining performance against agreed trajectories with NHSi? Is the Trust providing a quality service for the patients? Are Governors assured by the actions being taken to maintain a quality service?
How this report contributes to the delivery of the strategic objectives
This report supports all elements of the strategic direction by identifying areas of good practice and areas where the Trust requires improvements to meet our expectations.
How this report impacts on current risks or highlights new risks
The corporate risks supported by this report are related to NHSi single oversight framework, especially in line with quality, patient experience, performance and workforce.
Recommendation(s) and next steps
That the report be noted.

Performance report

The performance report is against operational delivery in July, August and September 2017

Provide the safest, most effective care possible

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

The report also highlights key local targets which ensure care is being provided effectively and safely by the Trust.

Referral to Treatment

The Referral to Treatment Target, active waiters below 18 weeks set at 92%, is the target which is causing the most significant issues for the Trust.

Though performing above the National average, the Trust position for quarter 2 is at 89.5%. The key issues relate to 4 significant specialities which have high numbers of patients above 18 weeks caused due to a shortfall in Trust capacity.

The 4 specialities with the largest capacity gaps are

- Ophthalmology
- ENT
- General Surgery
- Orthopaedics

Trajectories are set for these specialities which are reliant on external support and additional sessions to bring performance back to the required standard.

NHSI are aware of the current capacity shortfalls and the expected timescales for performance to meet the target.

1 patient is waiting over 52 weeks due to their choice.

The diagnostic target failed September at 98.12% with a combination of audiology and nerve conduction delays. The issues relate to locum workforce and inability to recruit in audiology. The care group are required to develop a workforce plan for their October accountability meeting.

Key to performance is the need to be maintaining contracted activity and ensuring the cancelled clinics and new to follow up ratios are within the ratios set by the CCG.

Work continues to reduce both short notice hospital driven changes and cancellations and to reduce DNA rates. These pieces of work are monitored through the planned care stream of the patient pathway transformation project.

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.

September Performance

Trust 93.72%, including GP attendances 94.3%

Quarter 2 93.49%, NHSI trajectory for Q2 93.1%, STF achieved

15.5% of patients were transferred to the urgent care centre at DRI. The streaming pathway for Bassetlaw will be in place by 1st. October 2017

The key issues for breaches remains internal ED waits to see or be reviewed by a doctor. Potential improvements are expected after successful recruitment to the consultant tier and a review of rotas to increase the time on the shop floor of the consultants.

The DBTH remains in the top third of Trusts nationally on average 34th out of 138

The quality metrics for 4hr access remain above the required standards.

National additional reporting requirements have been mandating by NHSI to ensure the Boards visibility on the pressures in the wider system, these are:

Monday ED attendance and admissions as a comparison to the remainder of the week

Discharge rates at a weekend in comparison to the week days

Metric	DRI	BDGH	Further Information
Total Discharges Weekday	57175	17818	
Average Discharges Weekday	1466	457	
Total Discharges Weekend	13113	3047	18.7% of all of DRI discharges take place at a weekend and 14.6% at BDGH
Average Discharges Weekend	336	78	
Total Monday Attendances ED	11410	5813	
Average Monday Attendances ED	293	149	If the rest of the week was at the same level as Mondays then we would see an extra 500 patients a week at DRI and an extra 400 patients at BDGH
Total Tues - Sunday Attendances ED	62017	30757	A&E attendances on a Monday at DRI account for 15.5% of weekly activity rising to 15.9% at BDGH
Average Tues - Sunday Attendances ED	1590	789	
Total Elective Admissions Weekday	29154	8851	
Average Elective Admissions Weekday	748	227	
Total Elective Admissions Weekend	4662	510	
Average Elective Admissions Weekend	120	13	
Total Non-Elective Admissions Weekday	27853	8142	
Average Non-Elective Admissions Weekday	714	209	
Total Non-Elective Admissions Weekend	8621	2703	
Average Non-Elective Admissions Weekend	221	69	
Total Non-Elective (GP) Admissions Monday	1115	146	
Average Non-Elective (GP) Admissions Monday	29	4	
Total Non-Elective (GP) Admissions Weekday	5616	759	Non Elective Admissions information on a weekday the GP admissions account for 20.2% of all Emergency Admissions at DRI but only 9.3% at BDGH.
Average Non-Elective (GP) Admissions Weekday	144	19	
Total Non-Elective (GP) Admissions Weekend	942	72	When we move into the weekend this drops to 10.9% at DRI and 2.7% at BDGH
Average Non-Elective (GP) Admissions Weekend	24	2	

Cancer Performance

August 62 day performance 85.7%

Performance achieved in month. The key pathway remains urology. Additional monies have been agreed to invest in High Value pathways which includes urology.

A 10 high impact intervention plan has been completed nationally to address the national performance shortfall against 62 day target.

Day 38 transfers are now being measured as part of the work to improve 62 day performance for the wider Accountable Care System

Stroke Performance

Stroke performance against direct access in 4hrs maintained the improved position at 73.9%.

CT within 1hr was achieved at 60.9%.

SNAPP performance improved to A rating and continues to be the best performance in the region.

David Purdue Chief Operating Officer, October 2017

Cancer Performance

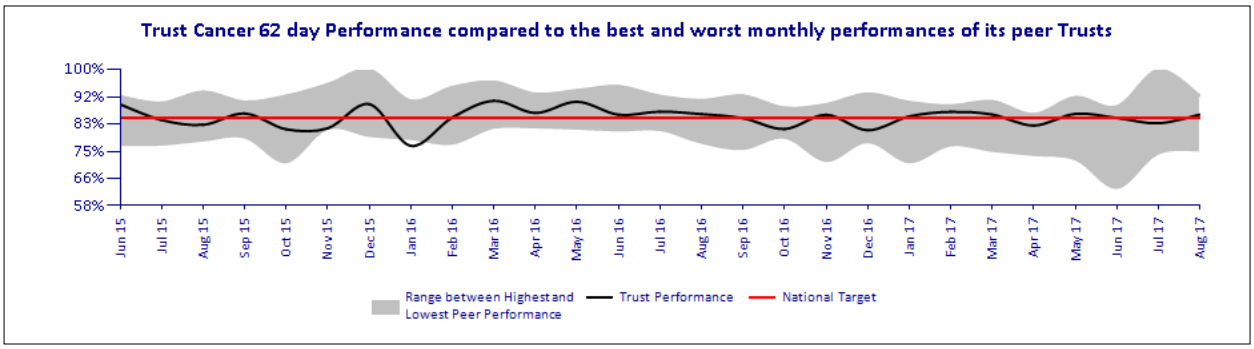
Cancer performance against National standards is monitored quarterly. The following information relates to Trust performance in August.

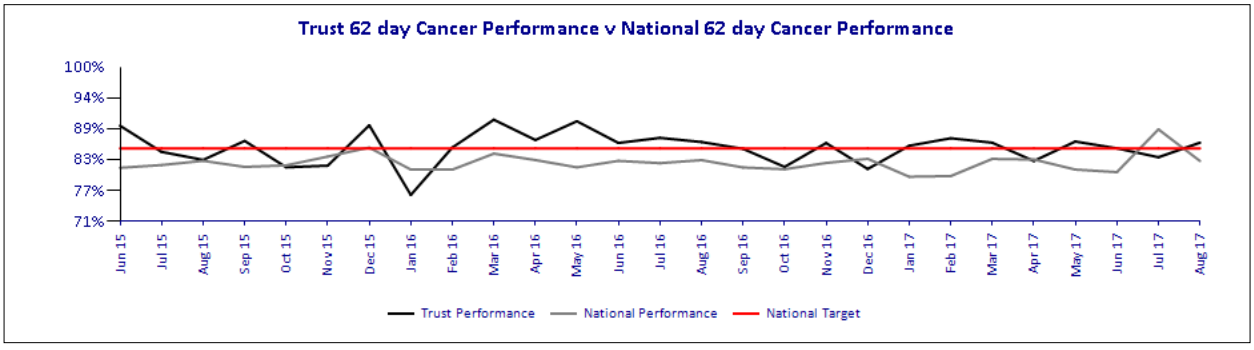
62 day Cancer performance

62 day performance nationally has failed for the past 3 years and is not achieving for the SYB ACS. A National 8 high impact intervention plan has been shared which DBTH has responded to. Cancer performance is monitored locally through the Cancer alliance.

The 62 day target was achieved by the Trust in August at 85.7% against the National target of 85%. The key issue remains in urology, due to the number of patients requiring treatment. The main cancer is within the prostrate pathway and the key issues are mainly related to the start of the pathway and the need for diagnostic tests. We have been successful in securing funding for Quarter 3 and Quarter 4 for diagnostic capacity (MRI) and for administrative MDT support. There is in addition, the opportunity for the Trust to bid for additional funding.

The graphs below compare 62 day performance at Doncaster and Bassetlaw with National performance.





Two Week Wait Performance

The August position for two week wait is 88.1% and is not compliant with the national target, however the breast symptomatic target was achieved in August at 93.4%.

	2ww	Non 2ww Symptomatic Breast Referrals	31 Day - Classic	31Day Sub - Surgery	31 Day Sub - Drugs	31 Day Sub - Palliative	62 Day - Classic	62 Day Screening	62 Day Consultant Upgrades
Operational Std	93%	93%	96%	94%	98%	94%	85%	90%	TBA
Breast	97.4%	93.4%	100%	100%	100%		100%	100%	
Gynaecology	84%		87.5%				58.3%		100%
Haematology	100%		100%				100%		100%
Head & Neck	94.9%		100%				50%		
Lower GI	86.6%		100%	100%			94.7%	50%	100%
Lung	100%		100%			100%	80%		78.6%
Other			100%	100%		100%	100%		
Skin	74.3%		93.8%	100%			100%		
Upper GI	84%		100%				86.7%		100%
Urological	85.4%		97.7%	100%		100%	59.4%		100%

The Cancer two week wait booking team has now been relocated within the central booking office to allow for increased flexibility in capacity planning. Fewer issues regarding booking have been escalated both internally, and from the CCGs.

Patient choice continues to be a key reason for patients not being seen within 2 weeks. Patients who choose to be seen outside of 2 weeks are contacted by nurse specialists to ask why they do not wish to attend. The cancer management team meets regularly with the CCGs to review the information given in primary care which supports the 2 week wait position.

All 2 week wait referrals are now received through the Electronic Referral System (ERS) and the Trust is required to have 80% of all referrals through this pathway by the end of March 2018. In August, 50.87% of referrals were received via ERS.

The table below shows the number of patients and the reasons for not meeting the required target.

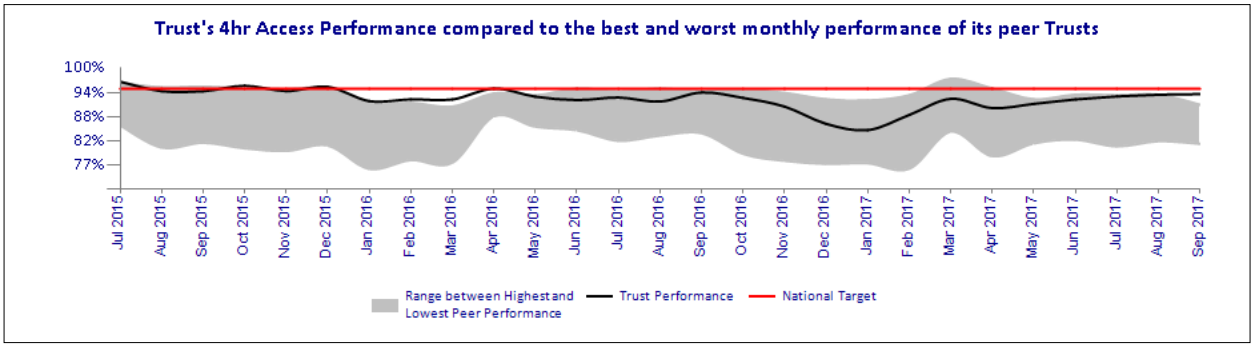
CWT Standard	Tumour Group	Performance against CWT standard	High Level View
Two Week Wait	Gynae	84%	15 breaches – 6 patient choice, 4 administrative delays, 6 capacity related
	Lower GI	86.6%	2 breaches – 12 patient choice, 4 capacity, 6 hospital cancellations
	Skin	74.3%	45 breaches – 16 patient choice, 22 capacity, 4 hospital cancellation, 3 administrative delay
	Upper GI	84%	23 breaches – 5 patient choice, 8 capacity, 1 hospital cancellation, 9 administrative delay
	Urology	85.4%	19 breaches – 7 patient choice, 11 capacity, 1 hospital cancellation
31 day	Gynae	87.5%	1 pathway – patient choice
	Skin	93.8%	1 pathway – delay to treatment planning date
62 day	Gynae	58.3%	4 patients – local pathway , 3 shared care . Local pathway – medical reason for delay - shared care – additional tests required to give definite treatment plan
	Head & Neck	50%	2 patients – both shared care - both complex pathway
	Lung	80%	1 patient – shared care - administrative delay WPH
	Urology	59.4%	10 patients – 8 shared pathway & 2 local pathways . All linked to capacity issues - opd capacity local and inreach, imaging delays
62 day Screening	Lower GI	50%	2 patients – both local care – 1 patient choice , 1 medical reason for diagnostic delay (High BP)
62 day Consultant Upgrade	Lung	78.6%	2 patients – both shared care – 1 out-patient capacity inadequate WPH, 1 treatment delayed for medical reasons

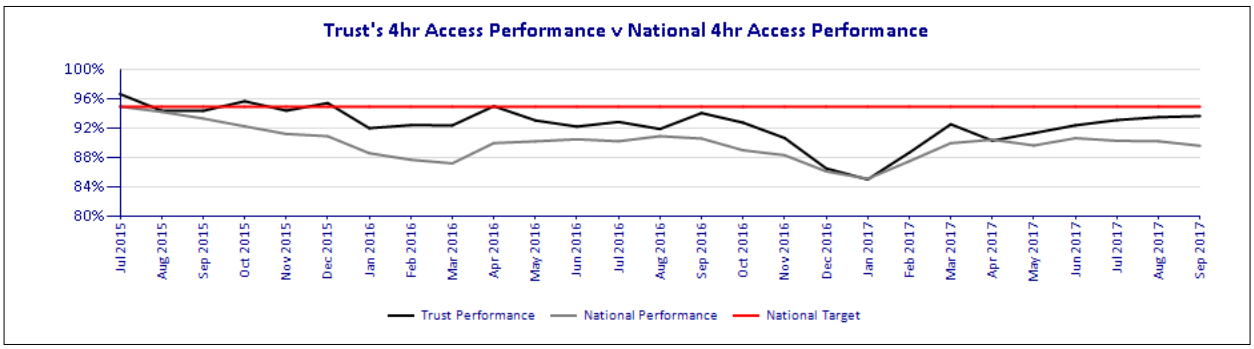
4hr Access Target

The Trust achieved 93.72% in September against the 95% 4hr access target.
The Trust requirement for NHSi STF in Quarter 2 was achieved at 93.5% against a target of 93.1%.
Nationally the Trust remained within the top 35 Trusts. September performance maintains the year to date performance at 92.46%

Type 1 performance was not achieved on the DRI site - 91.6% DRI, but achieved on the Bassetlaw site at 95.53%

The graphs below compare 4 hour access performance at Doncaster and Bassetlaw with National performance





In September, 861 patients failed to be treated in 4hrs, with a total of 13817 patients attending ED. 17 less patients breached in September compared to August.

The main breach reason was wait to see ED doctor/ ED review which accounted for 532 of the 861 breaches. 78 breaches were due to bed pressures. 176 breaches were classed as unavoidable due to the patient's clinical condition. The ED waits have predominantly occurred after 18.00hrs following spikes in activity between 17.00-19.00hrs. Medical staffing rotas have been changed to allow for increased staffing out of hours and the consultant in charge is responsible for ensuring that the department is controlled when they hand over to the on call Consultant at 19.00hrs. The Consultant rotas are being reviewed to extend shop floor cover until 00.00hrs.

The Trust action plan to achieve the 4hr Access Target is monitored weekly through the internal 4hr access meeting and monthly via the A&E Delivery Board. The Trust is reviewing the latest NHSi/DoH guidance in relation to 4hr access:-

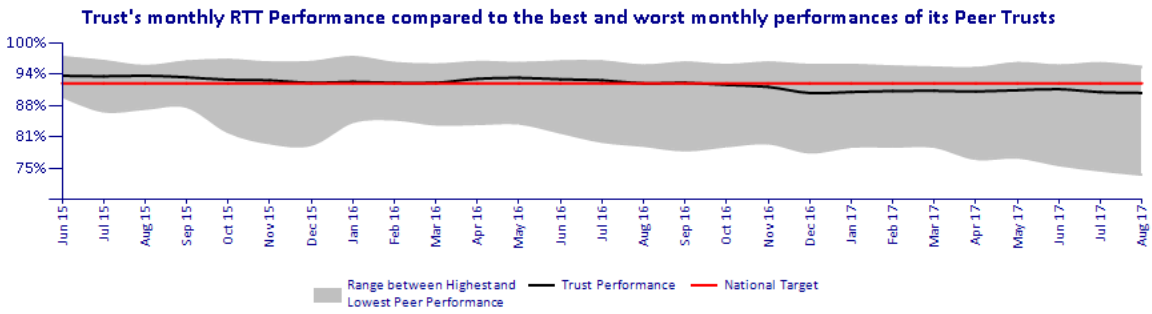
- Monday attendances/admissions including GP admissions compared to Tues-Sunday
- Weekend discharge rates compared to Mon-Friday
- Review of counting of all attendances outside of ED

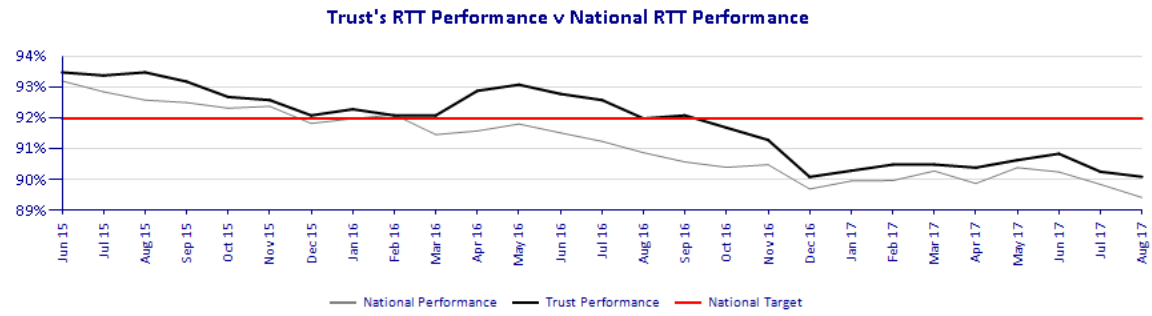
The System Perfect initiative concluded on the 12th of September and key learning is being reviewed to support winter planning. These include additional support for social care to provide a bridge to care providers, community provider in-reach into ED and increased 7 day integrated discharge planning.

All quality targets have been achieved in September.

Referral to Treatment (RTT)

Incomplete pathways for September ended at 89.5%.





There is 1 ongoing 52wk pathway. The patients chosen date for treatment is October 2017.

Specialties failed to meet 92% in September

- General Surgery
- Urology
- ENT
- Ophthalmology
- Trauma and Orthopaedics
- Cardiology

Weekly PTL meetings take place with Care Groups where Delivery Plans are discussed to bring performance levels back in line with commissioned activity and meeting RTT. Management of

the key areas takes place through fortnightly advanced performance meetings with Ophthalmology, General Surgery, ENT and Orthopaedics.

Trajectories are set for each service with timescales to achieve 92% in line with commissioned activity.

Ophthalmology

- Outsourcing action plan agreed with care group due to capacity gap in medical tier. Successful in recruitment to, expand middle grade tier by 3. This is in support of a long term realistic workforce model for the service.
- Plan to hold a joint workshop for primary and secondary care clinical teams, facilitated by an independent clinical lead. Purpose is to review and agree future service model for Doncaster.

ENT

- Key issue for month 6 – cancelled activity due to bed availability
- Additional capacity agreed with care group for ENT resultant in 'super weekends' and planned additional clinic slots up to March 2018
- Increase theatre activity from January 2018 to support waiting list reduction
- New Clinical Lead of ENT to be agreed with COO/CGD

General Surgery

- Key issue with operating capacity due to theatre availability.
- Cleansing of PTL in train and review of all patient pathways by Clinical Lead/Business Manager
- Enhanced support from the DQ Team to support management and review of patients awaiting tests/follow up
- Additional operating sessions in place from October and mitigations to improve theatre utilisation

Specialties

- Urology RTT Recovery Plan meeting monthly trajectories and led by Consultant Clinical Lead
- Cardiology position to be pulled back to +92% from October onwards

Trauma and Orthopaedics

- Key issues, reduced activity due to introduction of new Consultant rota from early September 2017
- RTT Trajectory plan submitted by Care Group to recover lost activity
- Increased outsourcing capacity to mitigate further loss
- Service placed in advanced monitoring chaired by the COO

Referral Management Plans

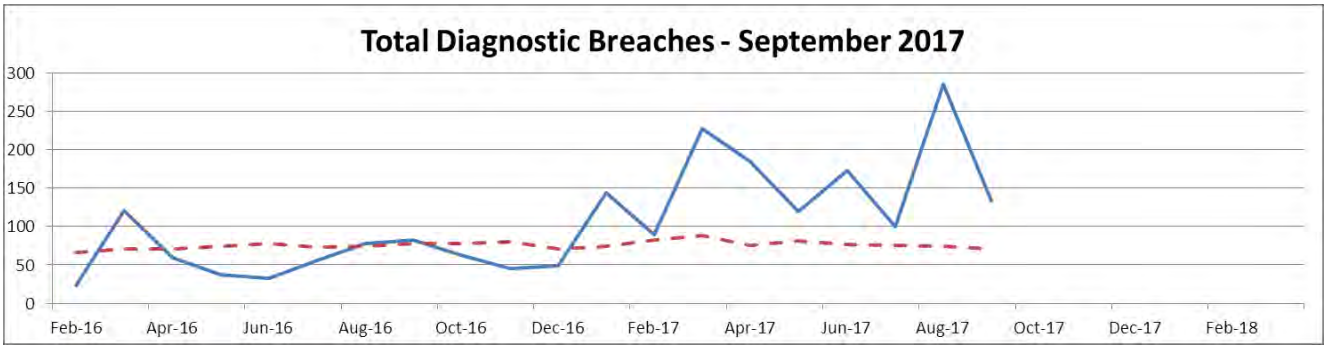
- Collaboration with CCG on referral management and support in managing demand: Contract for no growth in referrals, with the exception of urology with a planned increase and dermatology with a planned decrease.
- Planned Care Programme Board manages the process of demand management. Overall GP referrals are down. Deep Dive to understand rise in consultant to consultant referrals.
- Trust level RTT recovery plan to meet 92% by Q4 2017/18. To be discussed through Strategic Contracting meeting.

Clinical Admin: Right First Time Initiative

- Key to improving the performance is ensuring pathways are generated correctly the first time. Right First Time task and finish group set up and aligned to the clinical admin improvement workstream.
- Targeted training in care groups based on data quality issues and increase in 52wk breaches
- New SOP agreed in the management of data quality escalations and sign off of pathway amendments
-

Diagnostics

Diagnostic performance for September: 98.12%. Although below the 99% standard, this is a significant improvement on August's position of 96.17%.



The key issues are capacity in Audiology and Nerve Conduction.

A deep dive into Audiology capacity is being undertaken by the Care Group General Manager and a recovery plan will be reviewed in the bi-weekly advanced monitoring meetings. Two locums commenced 10/04 to improve the position.

Additional Endoscopy capacity has been secured through external supplier to mitigate patient breaches.

Nerve conduction studies being undertaken and reported dependent on STH capacity.

Stroke

Performance in July

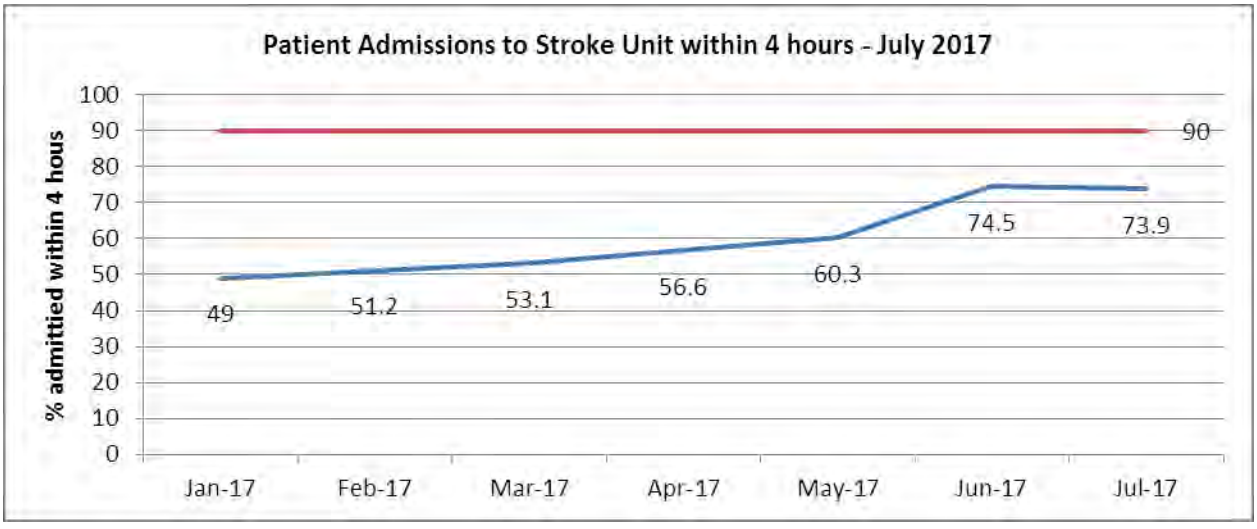
Performance against the scan within 1 hour standard continues to be maintained above 48% (60.9% at Trust level) as does the percentage for admissions within 4 hours (73.9% at Trust level).

Overall, the Bassetlaw patients did not encounter the usual level of pathway issues and were all scanned within 1 hour and admitted to the Stroke Unit within 4 hours of their clock start. There appear to have been pathway delays in ED for patients at DRI, with patients waiting for scans, and 2 patients had to wait for beds to be available on Ward 16.

Direct admissions within 4hrs, target 90%

	CCG			
Direct Admission within 4 Hours	Bassetlaw	Doncaster	Other	**Total**
Yes	8	23	3	**34**
No	0	10	2	**12**
Grand Total	**8**	**33**	**5**	**46**
Performance	100.0%	69.7%	60.0%	**73.9%**

Category	Sub Category	Total
Organisational	Beds	2
	Pathway	4
	Staff Availability	
Clinical	Patient Presentation	5
	Patient Needs	1
Patient Choice	Declined	
Awaiting further validation		



Scan within 1hr, target 48%

	CCG			
Scan 1 hr	Bassetlaw	Doncaster	Other	**Total**
Yes	8	17	3	**28**
No	0	16	2	**18**
Grand Total	**8**	**33**	**5**	**46**
Performance	100.0%	51.5%	60.0%	**60.9%**

Category	Sub Category	Total
Organisational	Scanner	
	Pathway	12
	Staff Availability	1
Clinical	Criteria	1
	Patient Needs	1
	Patient Presentation	3
Patient Choice	Declined	
Awaiting further validation		

Yorkshire and The Humber SSNAP Performance Tables (April - July 2017)

The table below shows the Trust's performance in Quarter 1 compared with other Trusts in the region. The arrows indicate a change from the results of the previous Quarter. The Trust's overall rating increased to A rating for the quarter.

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	158	150	C	A	A	C
Bradford Teaching Hospitals NHS Foundation Trust	Bradford Royal Infirmary	175	176	D	A	C↓	D
Calderdale and Huddersfield NHS Foundation Trust	Calderdale Royal Hospital	192	227	B	A	A	B
Chesterfield Royal Hospital NHS Foundation Trust	Chesterfield Royal	164	166	C	A	B	C
Doncaster and Bassetlaw Hospitals NHS Foundation Trust	**Doncaster Royal Infirmary**	219	210	A↑	A	A	A↑
Harrogate and District NHS Foundation Trust	Harrogate District Hospital	83	83	D	B↓	B	C↑
Hull and East Yorkshire Hospitals NHS Trust	Hull Royal Infirmary	283	266	B↑	A	B	B
Leeds Teaching Hospitals NHS Trust	Leeds General Infirmary	304	286	B↑	A↑↑	A	B
Mid Yorkshire Hospitals NHS Trust	Pinderfields Hospital	271	263	B↑	A	A	B↑
Northern Lincolnshire and Goole Hospitals NHS Foundation Trust	Scunthorpe General Hospital	178	185	B	A	A	B
Rotherham NHS Foundation Trust	Rotherham Hospital	167	177	C	A	A	C
Sheffield Teaching Hospitals NHS Foundation Trust	Royal Hallamshire Hospital	307	308	C	A	B	B
York Teaching Hospital NHS Foundation Trust	York Hospital	292	299	C↓	A	A	C↓

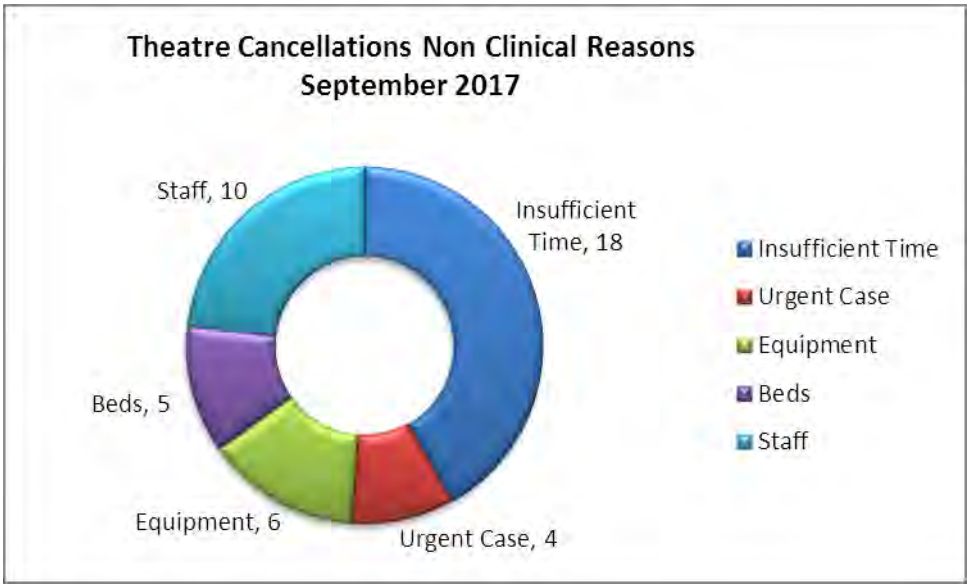
Cancelled Operations

In September, 1% of Trust operations were cancelled. This demonstrates a further slight improvement on performance from the previous month with 50 patients cancelled out of 4987.

Indicator	Standard	Aug-16		Qtr 1 2017-18	Jun-17	Jul-17	Aug-17	Sept-17
Cancelled Operations (Total)	0.8%	1.1%		1.1%	1.0%	1.3%	1.1%	1.0%
Cancelled Operations (Theatre)		0.8%		0.9%	1.0%	0.8%	1.0%	0.98%
Cancelled Operations (Non Theatre)		0.2%		0.2%	0.1%	0.4%	0.1%	0.02%
Cancelled Operations-28 Day Standard	0	3		5	1	2	0	1

Out of these overall cancellations, 43 operations were cancelled for non-clinical reasons: 32 at Doncaster, 3 at Bassetlaw and 3 at Mexborough Montagu. 1 patient was cancelled on the day of admission and waited over the 28 day standard for their surgery to be rearranged.

The reasons for the non-clinical cancellations are displayed in the graph below:



Ambulance Handover Times within 15 minutes

The table below shows the ambulance handover times for Doncaster and Bassetlaw, and for both YAS and EMAS.

AMBULANCE HANDOVER TIMES - AUGUST 2017

Hospital	% Handovers in 15 minutes (Target 100%)	Average Handover Time
YAS AMBULANCE HANDOVER TIME		
BARNSLEY DISTRICT GENERAL	72.1%	00:12:24
BRADFORD ROYAL INFIRMARY	81.8%	00:10:46
DONCASTER ROYAL INFIRMARY	**83.5%**	**00:09:07**
NORTHERN GENERAL HOSPITAL	60.2%	00:16:08
ROTHERHAM DISTRICT GENERAL HOSPITAL	71.7%	00:14:10
YAS	73.9%	
EMAS AMBULANCE HANDOVER TIME		
BASSETLAW	**65.0%**	**00:13:15**
KINGSMILL	57.0%	00:14:37
EMAS	40.0%	00:14:40

DNA and CNA Rates

Indicator	Aug-16	Qtr 1 2017-18	Jul-17	Aug-17	Sept-17
Outpatients: DNA Rate Total (Refreshed Each Month)	9.42%	9.51%	9.57%	9.23%	9.49%
Outpatients: DNA Rate First (Refreshed Each Month)	9.69%	10.12%	10.19%	10.11%	10.14%
Outpatients: DNA Rate Follow Up (Refreshed Each Month)	9.30%	9.22%	9.27%	8.84%	9.19%
Outpatients: Hospital cancellation Rate (Refreshed Each Month)	6.93%	5.80%	7.29%	6.04%	7.69%
Outpatients: Patient cancellation Rate (Refreshed Each Month)	9.80%	10.14%	10.71%	10.33%	11.13%
Outpatients: Patient died cancellation Rate (Refreshed Each Month)	0.24%	0.00%	0.00%	0.00%	0.00%

In September, the overall DNA rate across the Trust was 9.49%. Although there was a slight increase in both the new and follow up non-attendance rates, this rate still falls within expected levels and is lower than non-attendance in Quarter 1 of this year.

Cancelled appointments by the hospital and by patients were also higher in September.

Work is commencing across the Trust to develop new ways of communicating better with patients regarding their outpatient appointments. A collaborative piece of work has started supported by Healthwatch, Doncaster to understand why patients miss appointments. Public engagement is to commence from end of October and will run up to end of December 2017.

Non-attendance is being further analysed at specialty level to highlight those areas with the highest DNA rates. A focused piece of work is being undertaken to improve attendance within these specialties.

At a Glance -September 2017 (Month 6)

Page		Indicator	Standard (Local, National Or Monitor)		Current Month	Month Actual	Data Quality RAG Rating
2	Monitor Compliance Framework	31 day wait for second or subsequent treatment: surgery	94.0%	M	August	100.0%	
		31 day wait for second or subsequent treatment: anti cancer drug treatments	98.0%	M		100.0%	
		31 day wait for second or subsequent treatment: radiotherapy	94.0%	M		100.0%	
		62 day wait for first treatment from urgent GP referral to treatment	85.0%	M		85.7%	
		62 day wait for first treatment from consultant screening service referral	90.0%	M		86.7%	
		31 day wait for diagnosis to first treatment- all cancers	96.0%	M		98.6%	
		Two week wait from referral to date first seen: all urgent cancer referrals (cancer suspected)	93.0%	M		88.1%	
		Two week wait from referral to date first seen: symptomatic breast patients (cancer not initially suspected)	93.0%	M		93.4%	
3		A&E: Maximum waiting time of four hours from arrival / admission / transfer / discharge (Trust)	95.0%	M	September	93.7%	
4		Maximum time of 18 weeks from point of referral to treatment- incomplete pathway	92.0%	M	September	89.5%	
		% of Patients waiting less than 6 weeks from referral for a diagnostics test	99.0%	N		98.1%	
3	A&E Performance Indicators	Total time in A&E: 4 hours (95th percentile) HH:MM	04:00	N	September	04:51	
		A&E Admitted patients total time in A&E (95th percentile) HH:MM	04:00	N		07:17	
		A&E Non-admitted patients total time in A&E (95th percentile) HH:MM	04:00	N		03:59	
		A&E: Time to treatment decision (median) HH:MM	01:00	N		00:58	
		A&E unplanned re-attendance rate %	5.0%	N		0.4%	
		A&E: Left without being seen %	5.0%	N		3.3%	
		Ambulance Handovers Breaches -Number waited over 15 & Under 30 Minutes		N	September	716	
		Ambulance Handovers Breaches-Number waited over 30 & under 60 Minutes				129	
		Ambulance Handovers Breaches -Number waited over 60 Minutes				26	
5	Stroke	Proportion of patients scanned within 1 hour of clock start (Trust)	48.0%	N	July	60.9%	
		Proportion of patients directly admitted to a stroke unit within 4 hours of clock start (Trust)	90.0%	N		73.9%	
		Percentage of eligible patients (according to the RCP guideline minimum threshold) given thrombolysis (Trust)	20.0%	N		13.0%	
		Percentage of patients treated by a stroke skilled Early Supported Discharge team (Trust)	40.0%	N		57.8%	
		Percentage of those patients who are discharged alive who are given a named person to contact after discharge (Trust)	95.0%	N		82.2%	
		Implementation of Stroke Strategy - TIA Patients Assessed and Treated within 24 Hours	60.0%	N	September	85.2%	
	Theatres & Outpatients	Cancelled Operations	0.8%	N	September	1.0%	
		Cancelled Operations-28 Day Standard	0	N		1	
		Out Patients: DNA Rate		L		9.5%	
		Out Patients: DNA -Total Number of Patients who DNA		L		4544	
		Out Patients: Hospital Cancellation Rate		L		7.7%	
		Out Patients: Hospital Cancellation - Total Number of Clinics cancelled		L		208	
	Effective	Emergency Readmissions within 30 days (PbR Methodology)		L	August	6.0%	

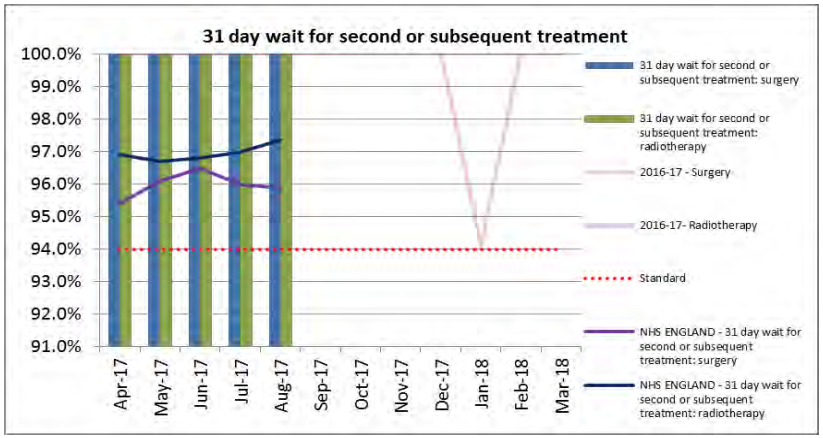
Page		Indicator	Current Month	Month Actual (TRUST)	Month Actual (DRI)	Month Actual (BDGH)	Data Quality RAG Rating
9	Fractured Neck of Femur	% of patients achieving Best Practice Tariff Criteria	September	55.2%	50.0%	66.6%	
		Best Practice Criteria					
		36 hours to surgery Performance		65.7%	65.3%	66.6%	
		72 hours to geriatrician assessment Performance		86.8%	80.7%	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		10.50%	7.70%	16.70%	

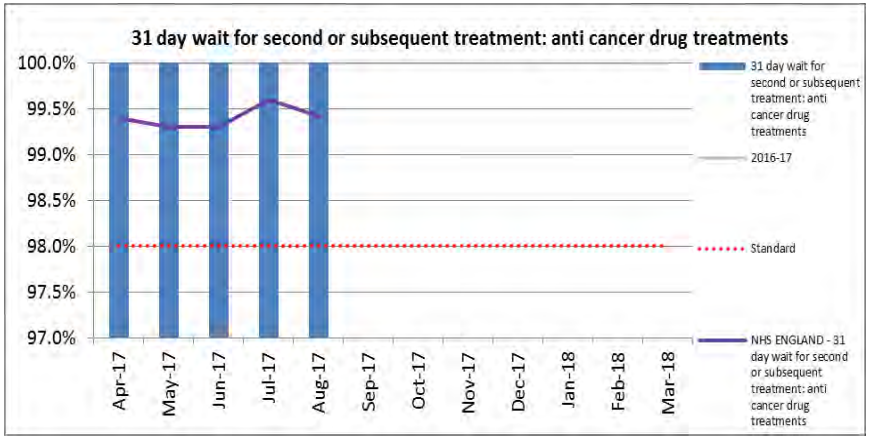
Page		Indicator	Standard (Local, National Or Monitor)		Current Month	Month Actual	Data Quality RAG Rating
11	Safe	Infection Control C.Diff	4 Per Month for Qtr 2 - 45 full year	M	September	2	
		Infection Control MRSA	0	L		0	
9		HSMR (rolling 12 Months)	100	N	July	88.39	
		Never Events	0	L	September	0	
		VTE	95.0%	N		95.0%	
11		Pressure Ulcers	12 Per Month 144 full Year	L		8	
		Falls that result in a serious Fracture	2 Per Month 23 full Year	L		0	
		Catheter UTI	Snap shot audit			0.74%	

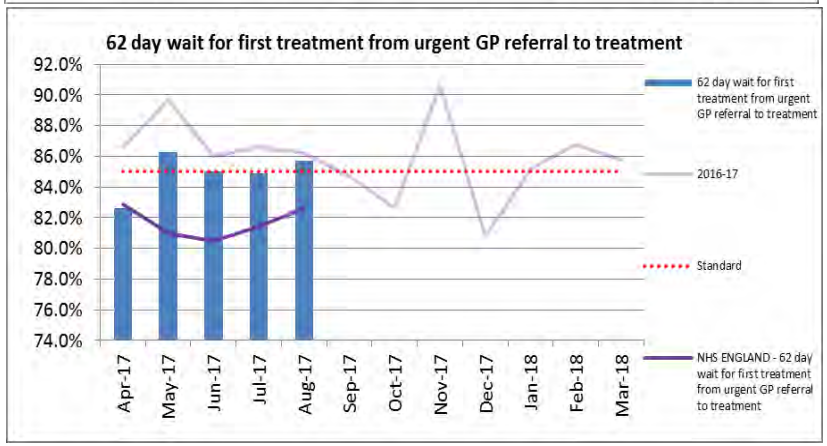
Page		Indicator	Current Month	Month Actual	Data Quality RAG Rating
12	Complaints & Claims	Complaints received (12 Month Rolling)	September	511	
		Concerns Received (12 Month Rolling)		847	
		Complaints Performance		21.0%	
		Clinical Negligence Scheme for Trusts (CNST)		Awaiting Data	
		Liabilities to Third Parties Scheme (LTPS)		Awaiting Data	
		Claims per 1000 occupied bed days		Awaiting Data	

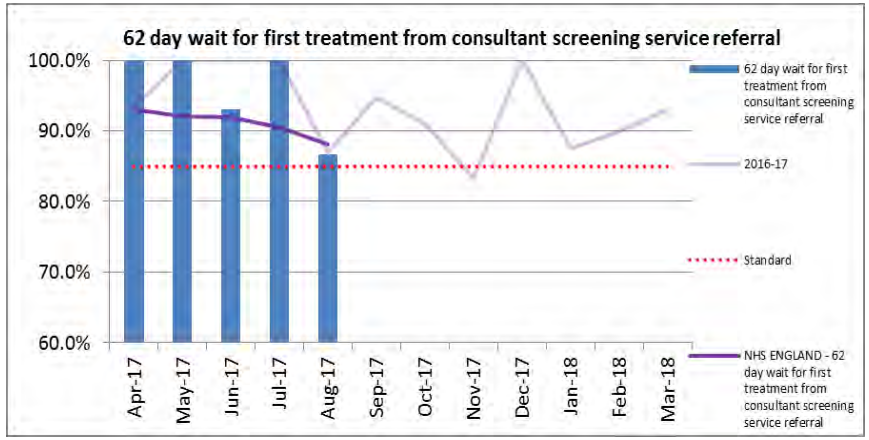
Page		Indicator	Current Month	YTD (Cumulative)	Data Quality RAG Rating
17	Workforce	Appraisals	September	54%	
16		SET Training		70%	

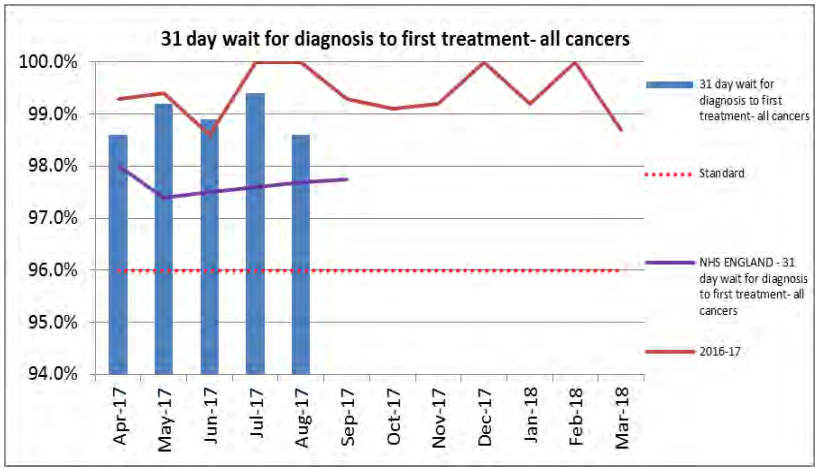
Monitor Compliance Framework: Cancer - Graphs - August 2017 (Month 5)

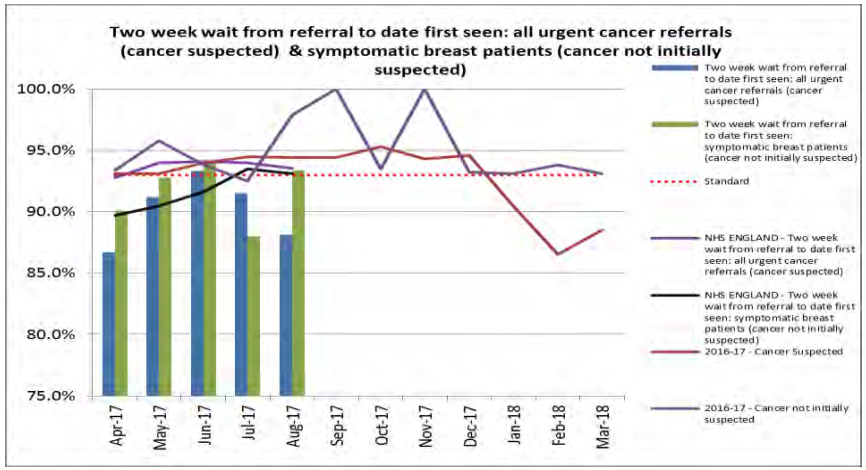




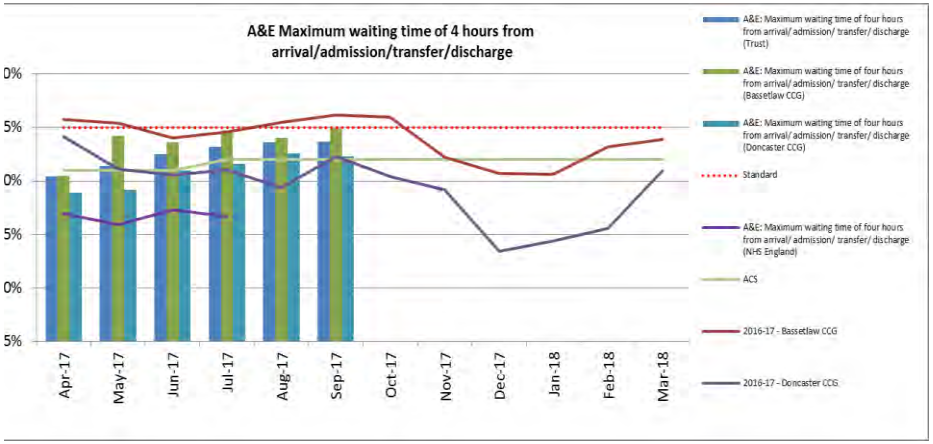


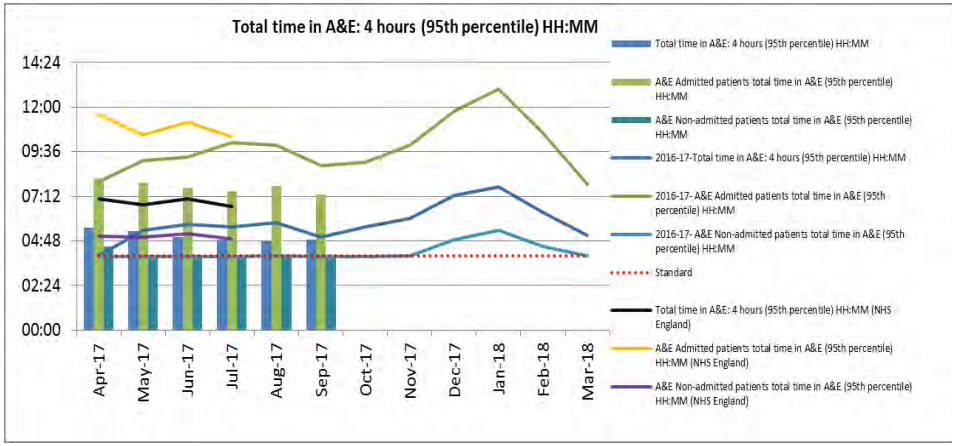


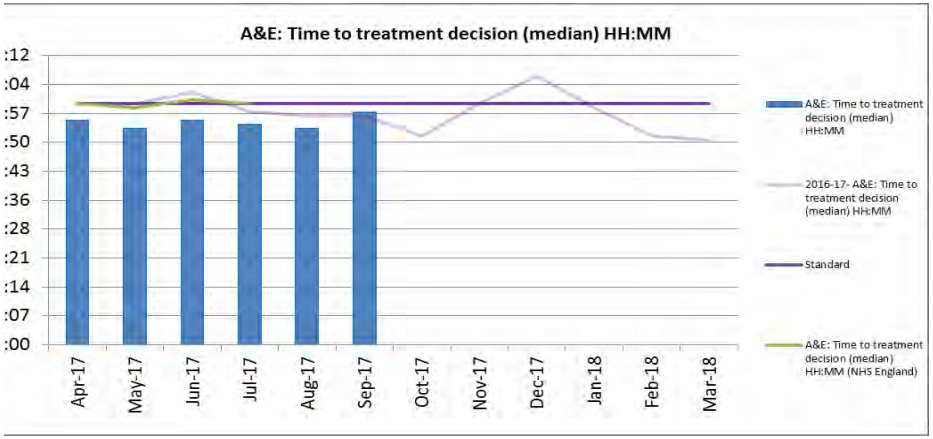


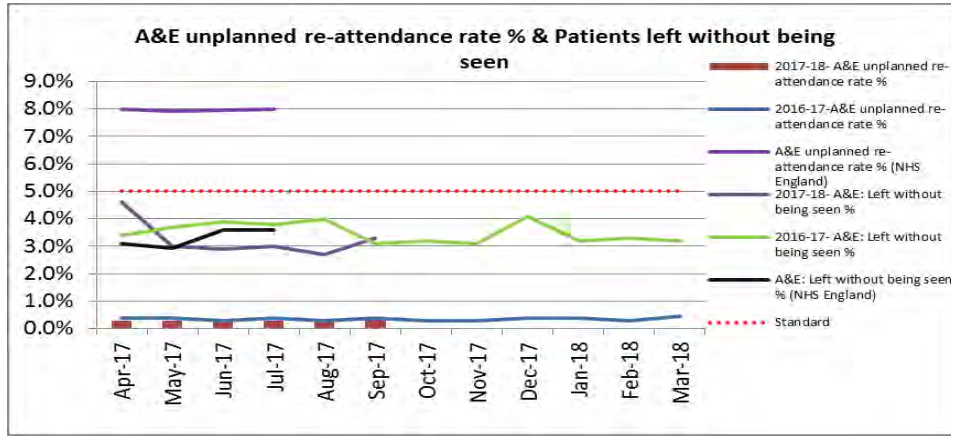


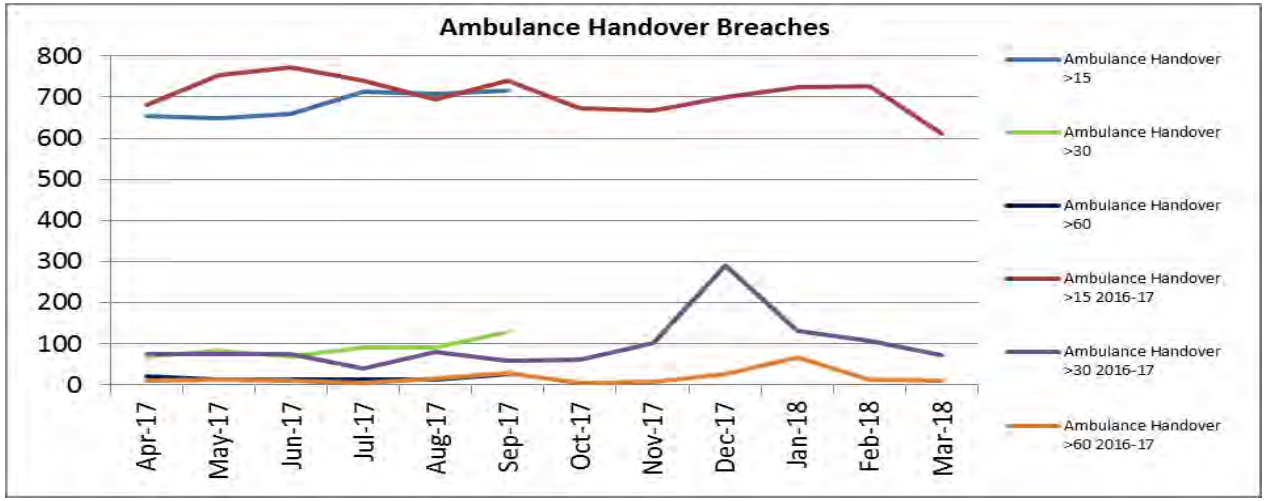
Monitor Compliance Framework: A&E - Graphs - September (Month 6)



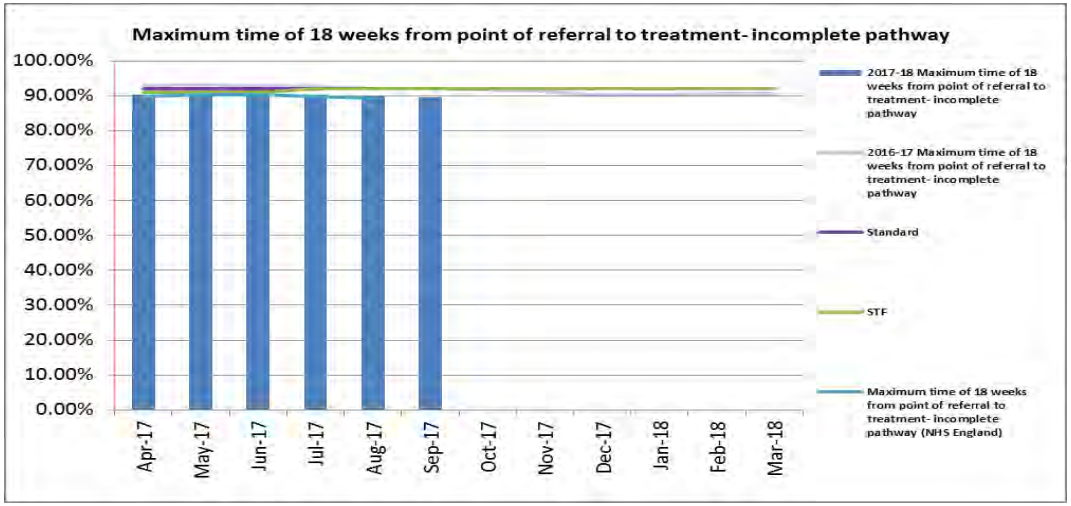


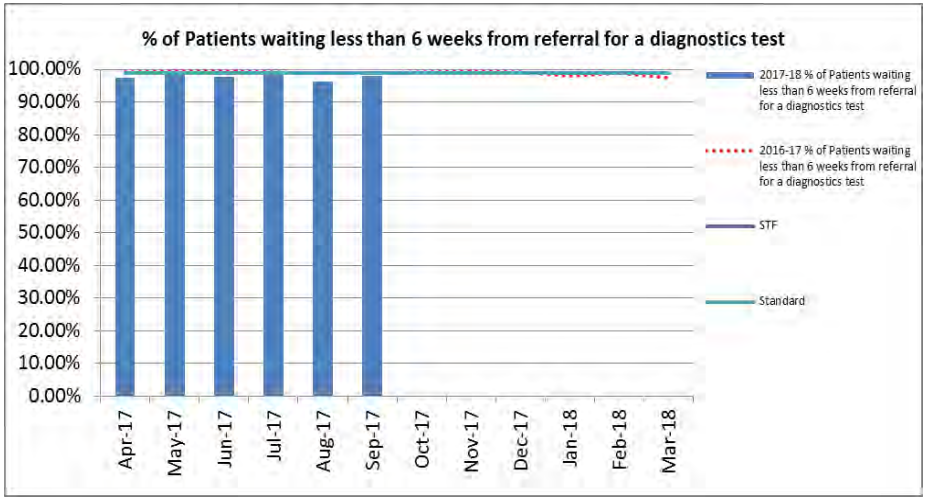


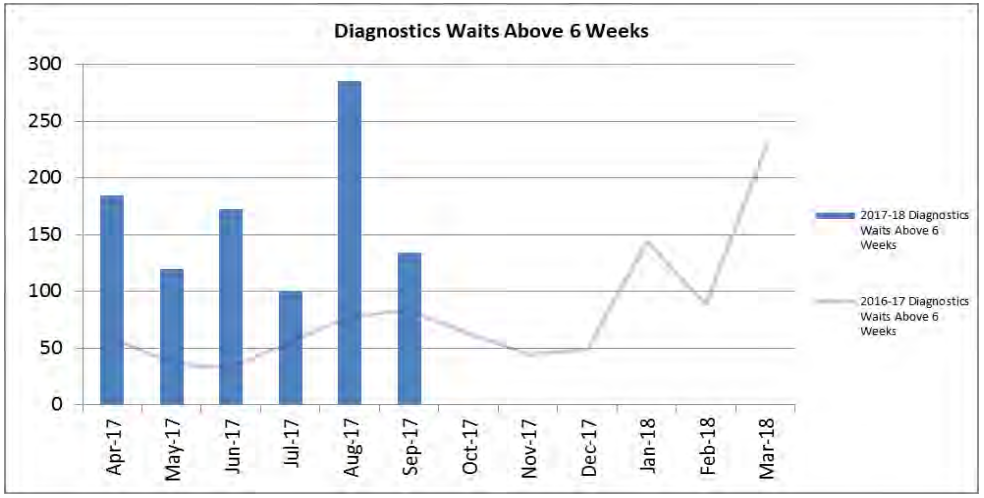




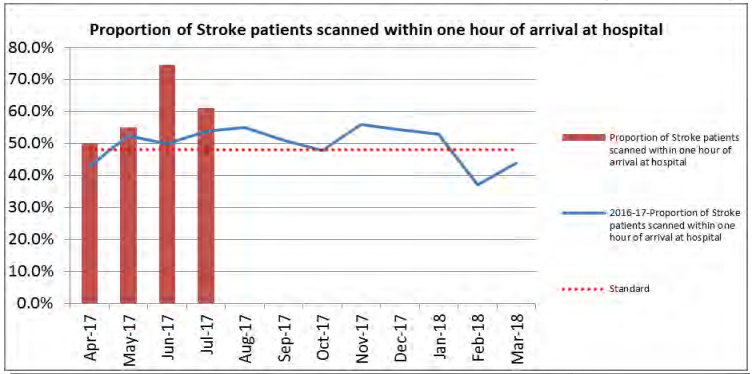
Monitor Compliance Framework: 18 Weeks & Diagnostics - September (Month 6)

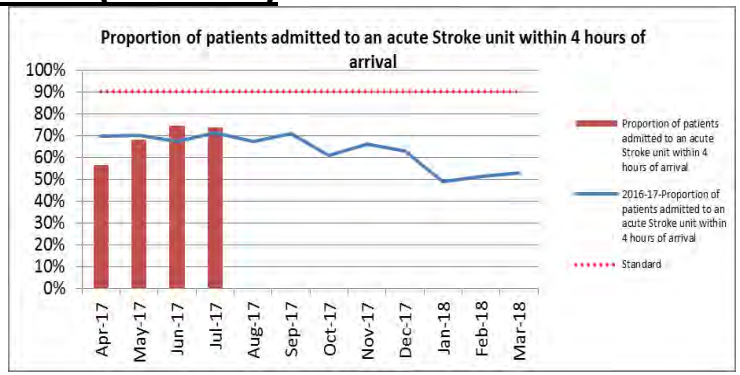


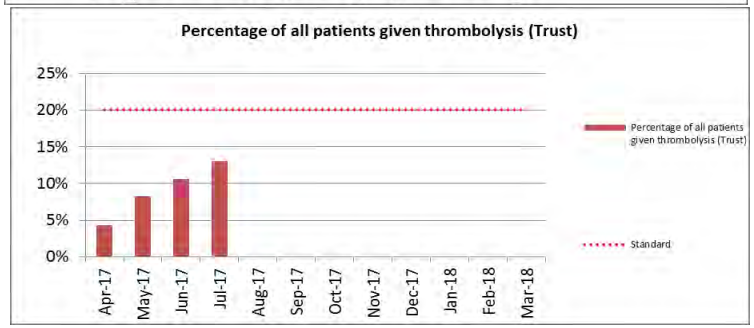


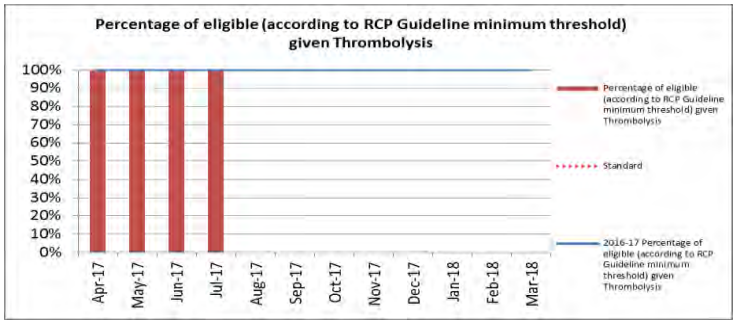


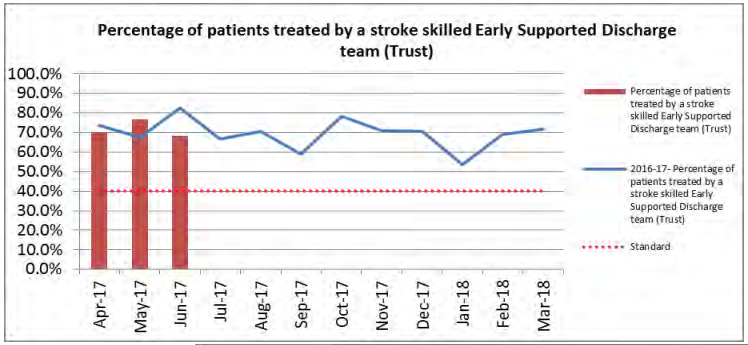
Stroke - Graphs July 2017 (Month 4)

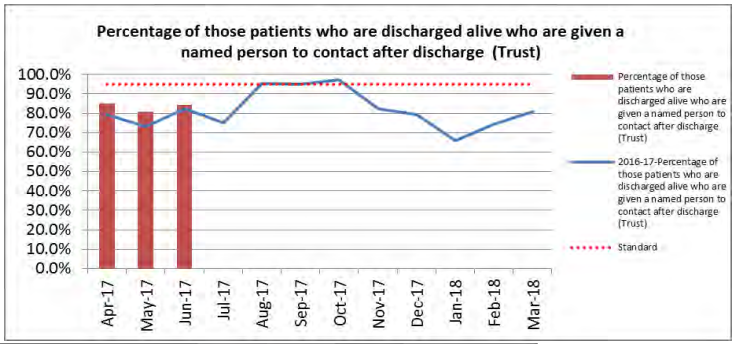


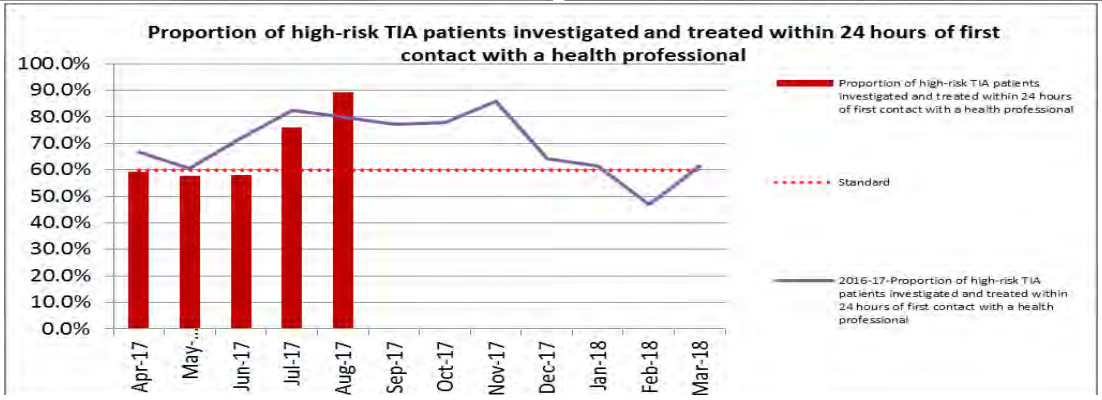




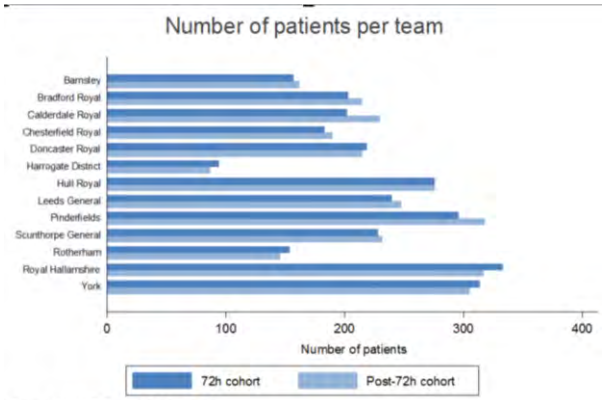




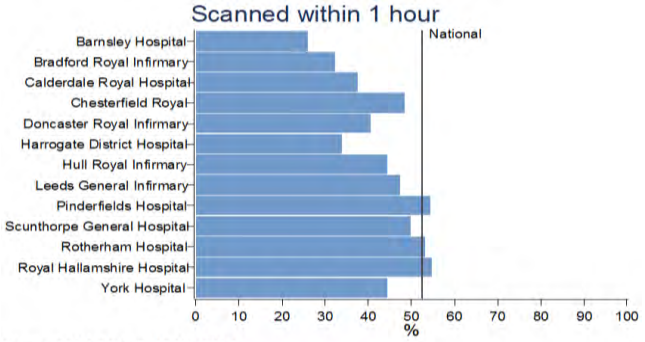




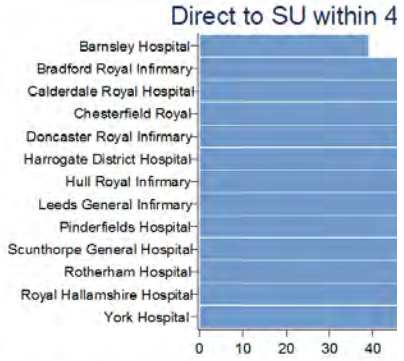
Stroke - Graphs South Yorkshire December 2016- March 2017



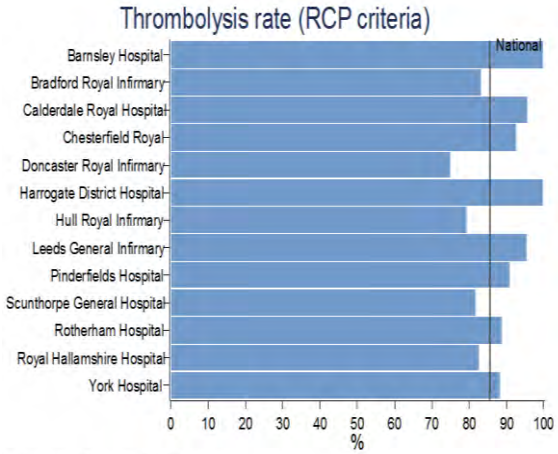
Source: SSNAP Dec 2016-Mar 2017
Number of patients in both patient-centred cohorts - D2.2 and D5.2



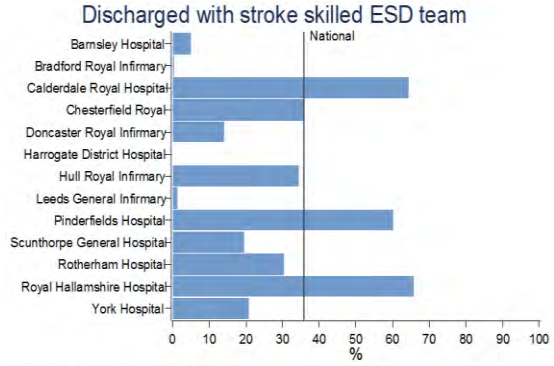
Source: SSNAP Dec 2016-Mar 2017
Patient-centred results at team level for Key Indicator 1.1A



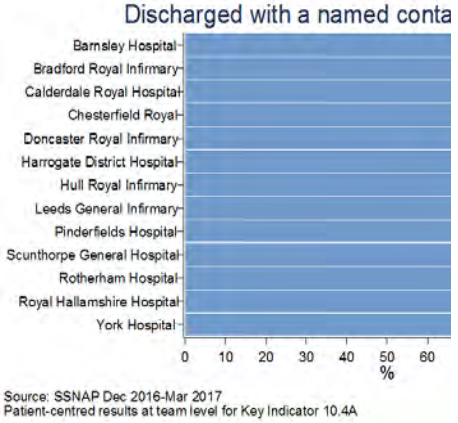
Source: SSNAP Dec 2016-Mar 2017
Patient-centred results at team level for Key Indicator 2.1A



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



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



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

Doncaster and Bassetlaw Hospitals NHS
NHS Foundation Trust

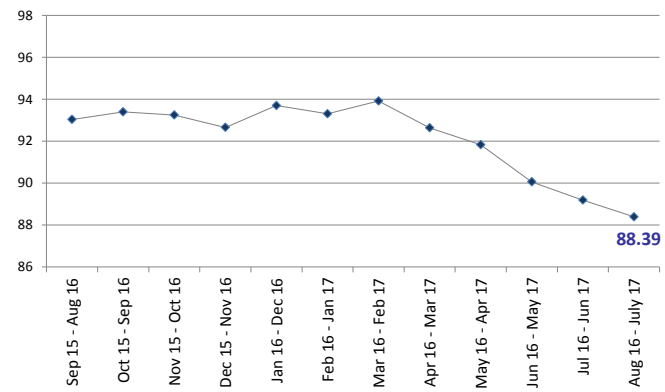
Executive summary - Safety & Quality -September 2017 (Month 6)

HSMR:	Overall Trust 12 month HSMR remains better than expected at 88.4
Fractured Neck of Femur:	September saw the introduction of a cross-site integrated trauma service. BPT achieved in approximately 55% of patients. We have completed an in depth review of #NOF mortality over last 12 months at BDGH. Detail of the review is provided to Board. There were no avoidable deaths.
Serious Incidents:	The number of SIs remain on trajectory to achieve inmprovement this year compared with last two SIs reported in month.
Executive Lead: Mr S Singh	

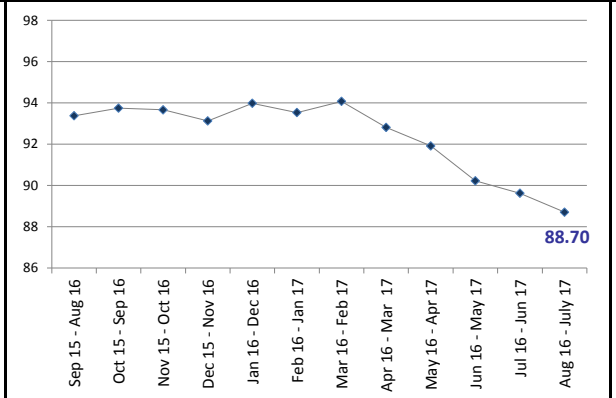
C.Diff:	The rate of cases is slighlty above trajectory compared to last year. Interventions on Deep Cleaning, Antibiotic stewardship and monitoring hand washing compliance continue.
Fall resulting in significant harm:	The number of falls remains below trajectory
Hospital Acquired Pressure Ulcers:	The rate of case is slighlty above trajectory this month, but this is expected to reduce when demonstrated unavoidable through investigation
Complaints and concerns:	Normal variation is seen in the rate of complaints and concerns. Performance on reply times has deteriorated further this month. Weekly meetings with care groups to review complaint reply compliance are being undertaken in conjunction with quality improvement work
Friends & Family Test:	Performance remains better than the national average with the exception of ED response rates
Executive Lead: Mrs M Hardy	

Hospital Standardised Mortality Ratio (HSMR) - July 2017 (Month 4)

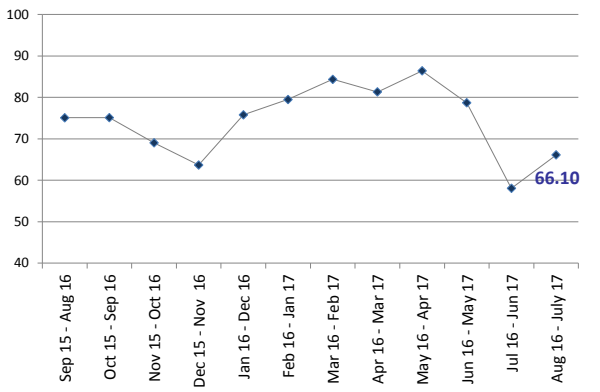
Overall HSMR (Rolling 12 months)



HSMR - Non-elective Admission (Rolling 12 months)



HSMR - Elective Admission (Rolling 12 months)

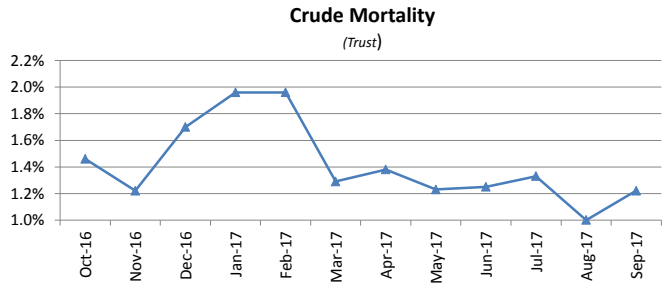


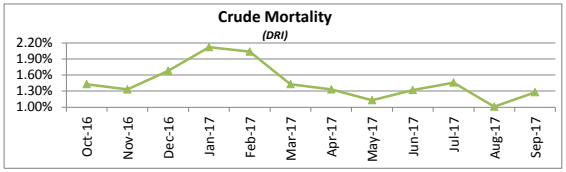
HSMR Trend (monthly)

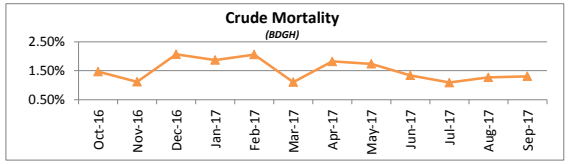
	2014	2015	2016	2017
January	115.45	116.80	99.21	94.91
February	99.11	99.94	97.73	105.54
March	102.91	90.54	97.37	82.71
April	110.49	105.91	88.50	81.46
May	90.93	101.15	96.60	76.78
June	113.74	80.27	93.67	82.10
July	109.94	92.56	97.73	87.02
August	120.18	100.27	87.52	
September	110.10	90.26	95.34	
October	106.58	90.29	88.66	
November	106.84	88.98	82.30	
December	115.87	82.30	93.52	

Crude Mortality (monthly) - September 2017 (Month 6)

(number of deaths/number of patient discharged)



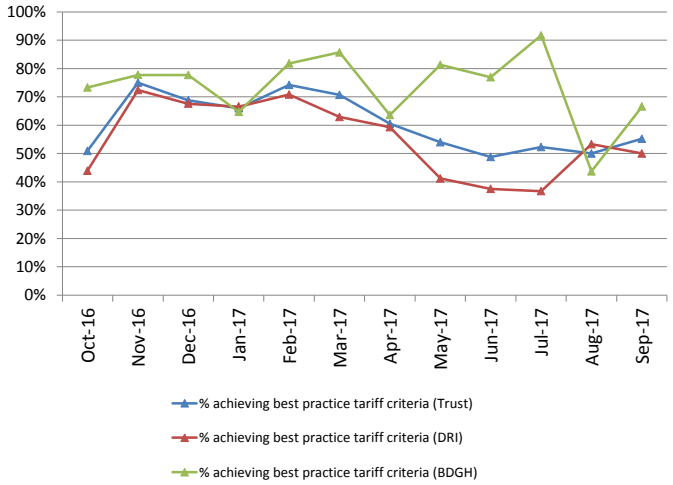




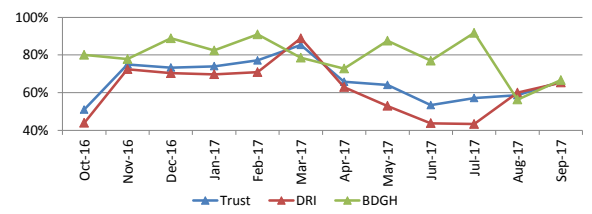
	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17
Trust	1.38%	1.22%	1.70%	1.96%	1.96%	1.29%	1.38%	1.22%	1.25%	1.33%	1.01%	1.22%
Doncaster	1.43%	1.33%	1.68%	2.12%	2.04%	1.43%	1.33%	1.13%	1.32%	1.46%	1.01%	1.28%
Bassetlaw	1.47%	1.12%	2.07%	1.87%	2.06%	1.11%	1.82%	1.74%	1.34%	1.09%	1.27%	1.31%

NHFD Best Practice Pathway Performance - September 2017 (Month 6)

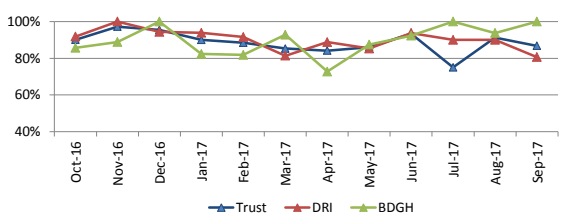
Best Practice Criteria Performance



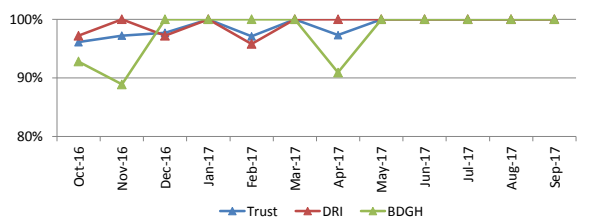
36 Hours to Surgery Performance



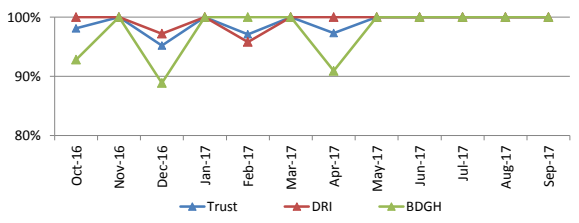
72 hours to Geriatrician Assessment Performance



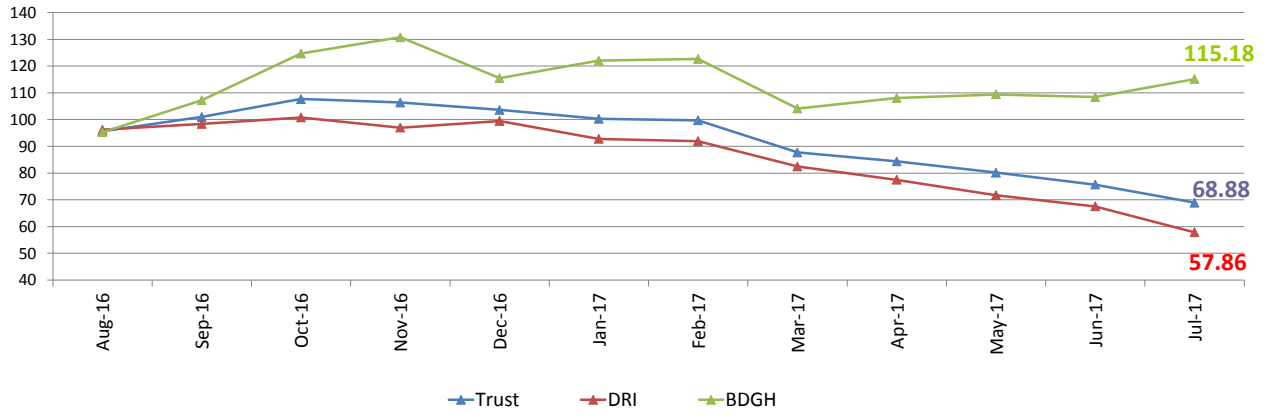
Bone Protection Medication Assessment



Falls Assessment Performance



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



Serious Incidents - September 2017 (Month 6)

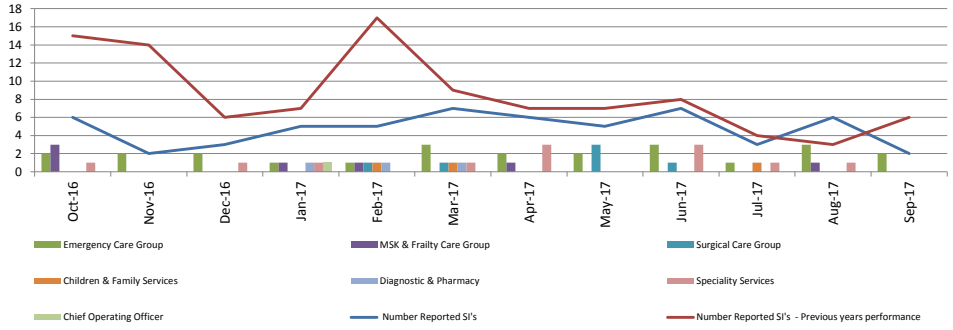
(Data accurate as at 11/09/17)

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

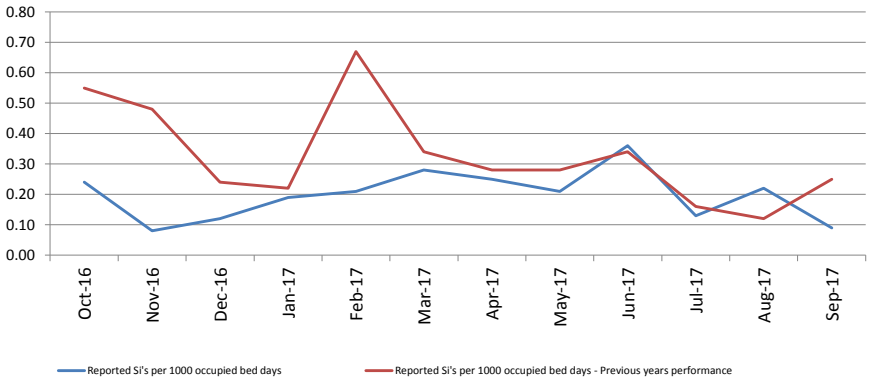
Overall Serious Incidents

Number Serious Incidents Reported

(Trust & Care Group)



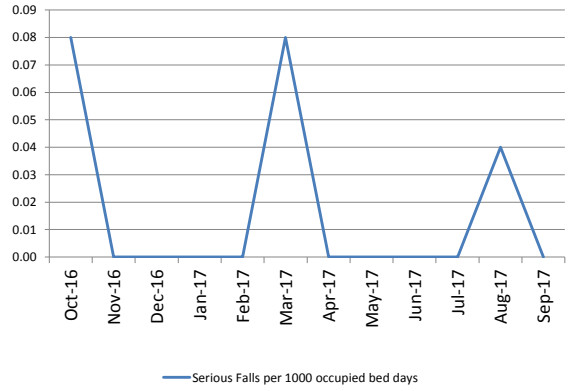
Serious Incidents per 1000 occupied bed days



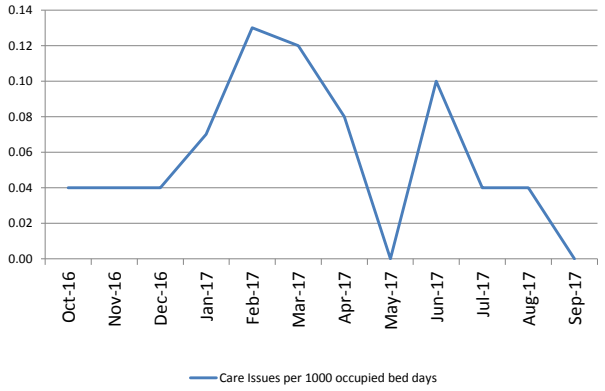
Current YTD reported SI's (Apr 17-Sep 17)	29	Number reported SI's (Apr 16-Sep 16)	63
Current YTD delogged SI's (Apr 17-Sep 17)	12	Number delogged SI's (Apr 16-Sep 16)	13

Themes

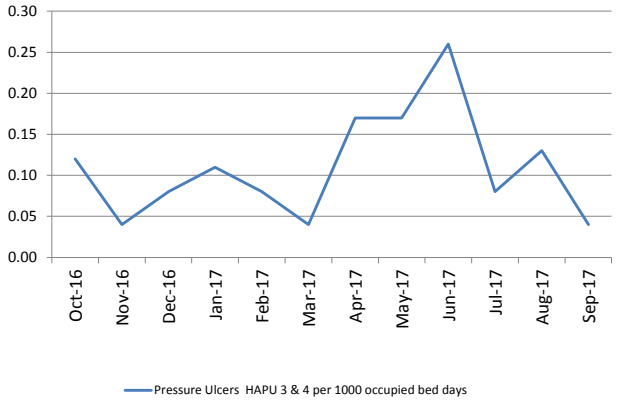
Serious Falls



Care Issues

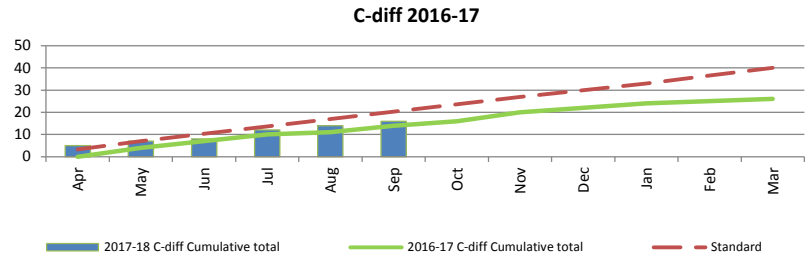


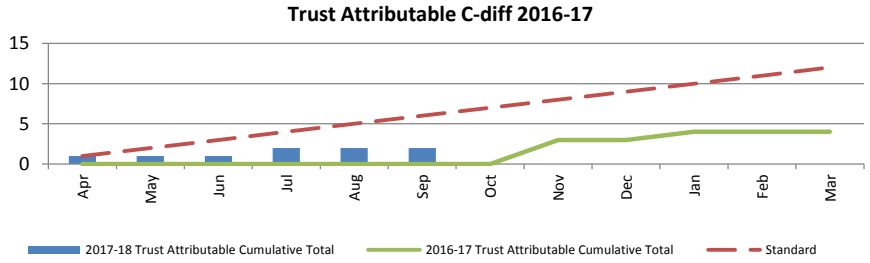
Pressure Ulcers - Category 3 & 4 (HAPU)



Monitor Compliance Framework: Infection Control C.Diff - September 2017 (Month 6)
(Data accurate as at 19/10/2017)

	Standard	Q1	Jul	Aug	Sep	YTD
2017-18 Infection Control - C-diff	40 Full Year	8	4	2	2	16
2016-17 Infection Control - C-diff	40 Full Year	7	3	1	3	14
2017-18 Trust Attributable	12	1	1	0	0	2
2016-17 Trust Attributable	12	0	0	0	0	0

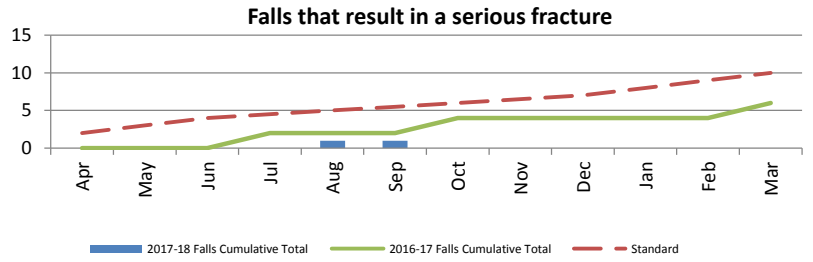




Pressure Ulcers & Falls that result in a serious fracture - September 2017 (Month 6)
(Data accurate as at 19/10/2017)

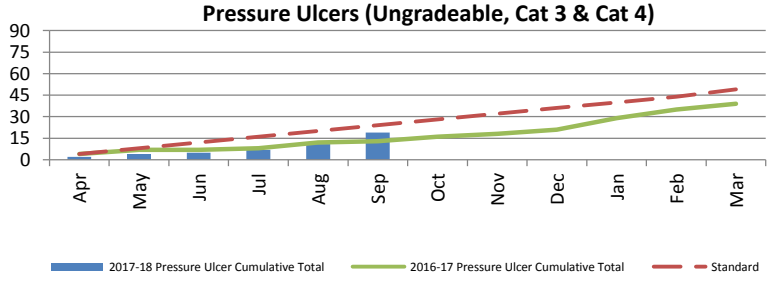
	Standard	Q1	Jul	Aug	Sep	YTD
2017-18 Serious Falls	10 Full Year	0	0	1	0	1
2016-17 Serious Falls	19 Full Year	0	2	0	0	2

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



	Standard	Q1	Jul	Aug	Sep	YTD
2017-18 Pressure Ulcers	34 Full Year	5	2	4	8	14
2016-17 Pressure Ulcers	60 Full Year	7	1	4	1	13

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

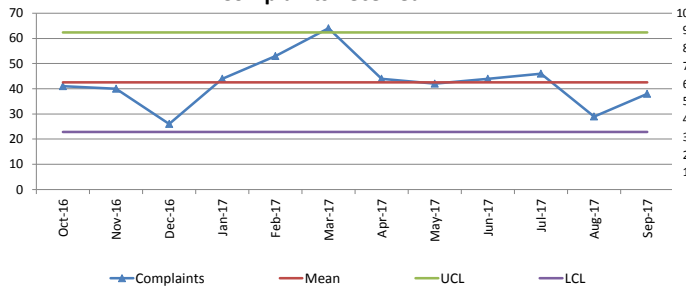


Complaints & Claims - September 2017 (Month 6)

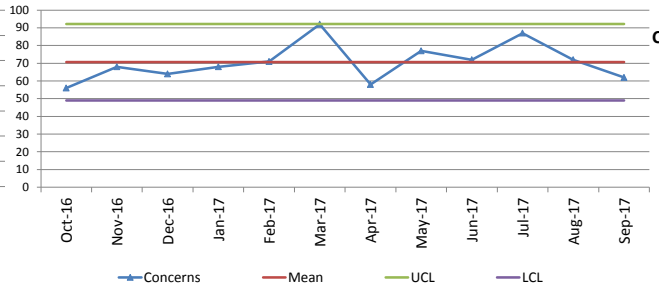
(Data accurate as at 18/09/2017)

Complaints

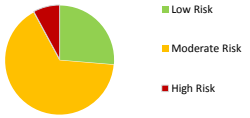
Complaints Received



Concerns Received



September 2017 Complaints Recieved Risk Breakdown

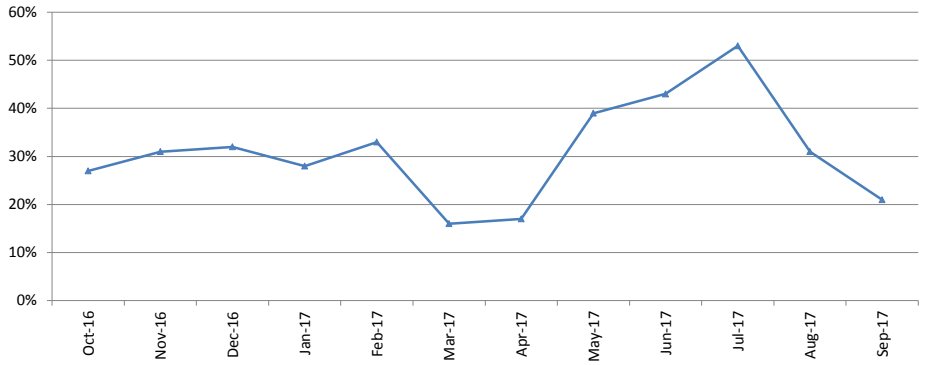


Year to Date Complaints Recieved Risk Breakdown

Complaints - Resolution Perfomance

(% achieved resolution within timescales)

Complaints Resolution Performance



Please note: Performance as a percentage is calculated on the cases replied and overdue, compared to the due date. Any current investigations that have not gone over deadlines are excluded data.

Parliamentary Health Service Ombusdman (PSHO)

Month	Number of cases referred for investigation	Number Currently Oustanding
Sep-17	Awaiting data	6

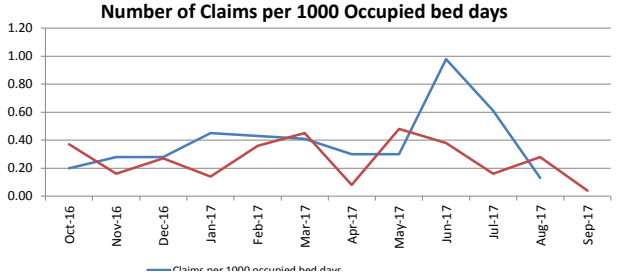
	Number referred for investigation YTD	Outcomes YTD	
2016/17	8	Fully / Partially Upheld	1
		Not Upheld	4
		No further Investigation	0
		Case Withdrawn	0
2017/18	4	Fully / Partially Upheld	0
		Not Upheld	1
		No further Investigation	0
		Case Withdrawn	0

Claims

	Current Month	Month Actual	YTD
Clinical Negligence Scheme for Trusts (CNST)	Sep-16	Awaiting data	42
Liabilities to Third Parties Scheme (LTPS)	Sep-16	Awaiting data	8

Please note: At the time of producing this report the number of claims reported are provisional and prior to validation

Number of Claims per 1000 Occupied bed days

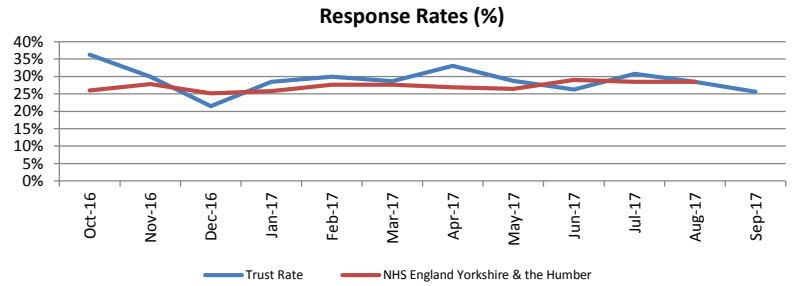


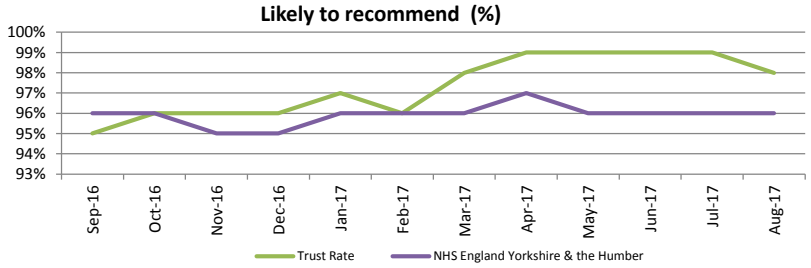
Friends & Family - September 2017 (Month 6)

(Data accurate as at 11/09/2017)

Inpatients

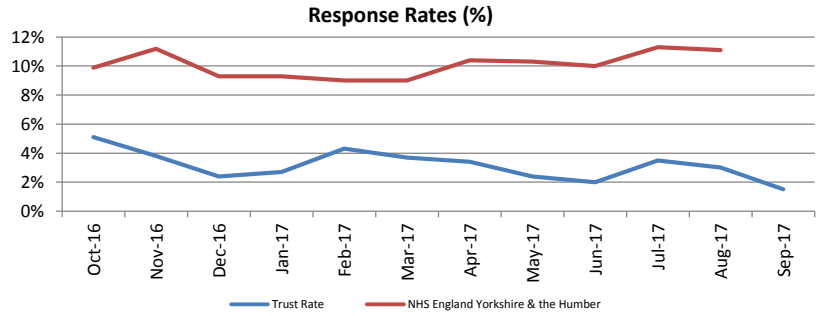
Please note: At the time of producing this report no further benchmarking data is available from NHS England.

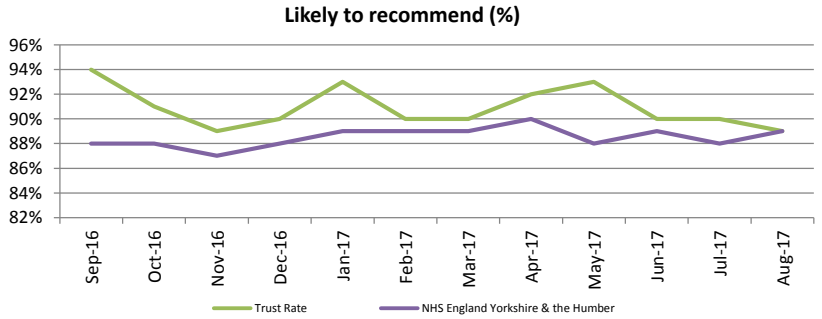




Accident & Emergency

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





Doncaster and Bassetlaw Hospitals NHS
NHS Foundation Trust

Executive summary - Workforce - September 2017 (Month 6)

Sickness absence

September has seen a further rise in sickness levels to 4.37% in month resulting in a cumulative figure of 4.24%. The increase in episodes of absence has been associated with absences of less than 28 days and a small rise in episodes of 3 months in duration. The HR Business Partners will therefore be emphasising the need to undertake return to work interviews.

Appraisals

The Trusts appraisal completion rate has dipped to 54% whcih is diappointing as several areas were expecting to be closer to the target by the end of September. We are aware that there have been some delays in appraisals being entered onto ESR which will be reviewed over the coming month.

SET

We have seen a small rise in compliance with Statutory and Essential Training in August to 70% but generally across most areas the upwards trajectory continues.

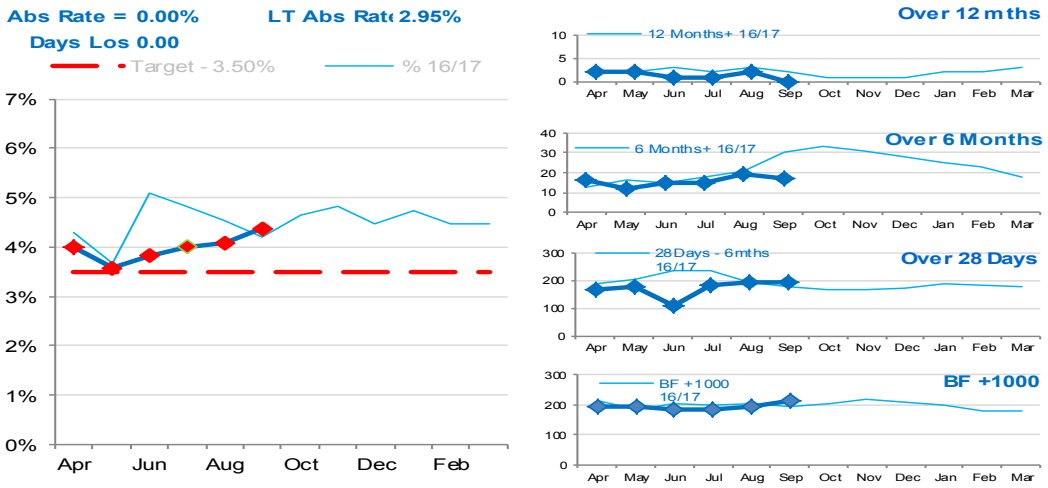
Staff in post

Please see attached tab covering staff in post by staff group

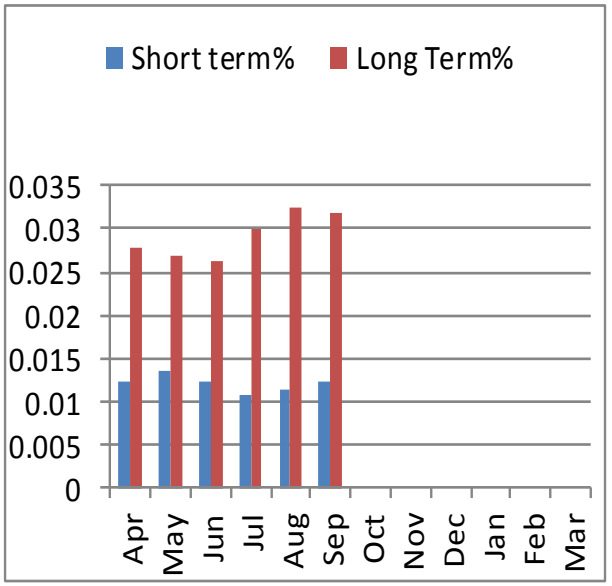
Workforce: Sickness Absence - September (Month 6)

CG & Directorate Sickness Absence - Sep 2017 (Q2)

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



Long term / Short Term



	Apr-17		May-17		Jun-17		Jul-17		Aug-17		Sep-17		Cumulative	
	Days Lost	% Rate	Days Lost	% Rate	Days Lost	% Rate	Days Lost	% Rate	Days Lost	% Rate	Days Lost	% Rate	Days Lost	% Rate
Doncaster & Bassetlaw Teaching Hospita	**6616.12**	**4.01%**	**5553.89**	**3.26%**	**5770.06**	**3.50%**	**6862.34**	**4.02%**	**7025.61**	**4.12%**	**7200.57**	**4.37%**	**42,639.63**	**4.24%**
Chief Executive Directorate	21.00	2.56%	0.00	0.00%	0.00	0.00%	0.00	0.00%	0.00	0.00%	0.69	0.08%	21.69	0.43%
Children & Family Care Group	837.73	4.78%	672.61	3.75%	738.05	4.28%	790.83	4.43%	746.01	4.21%	704.77	4.05%	4,558.66	4.32%
Diagnostic & Pharmacy Care Group	699.21	3.87%	507.84	2.72%	427.74	2.39%	507.66	2.73%	652.67	3.49%	748.19	4.18%	4,455.17	4.05%
Directorate Of Strategy & Improvement	1.00	0.23%	0.00	0.00%	1.80	0.42%	27.00	6.09%	5.00	0.99%	1.81	0.35%	13.61	0.48%
Emergency Care Group	1049.38	4.84%	931.75	4.19%	628.94	2.92%	739.50	3.32%	745.49	3.38%	871.92	4.08%	5,627.00	4.29%
Estates & Facilities Directorate	1105.83	6.50%	892.26	5.09%	1014.74	6.00%	1182.10	6.76%	1277.73	7.33%	1128.03	6.71%	6,433.14	6.25%
Recharge Medics	1.00	0.06%	0.00	0.00%	2.00	0.13%	2.00	0.12%	0.00	0.00%	19.00	1.08%	27.00	0.27%
Finance & Healthcare Contracting Directorat	43.60	2.00%	13.40	0.60%	93.41	4.35%	92.04	4.20%	113.84	5.05%	82.60	3.86%	584.88	4.42%
IT Information & Telecoms Directorate	66.97	2.05%	39.13	1.15%	51.73	1.58%	122.75	3.72%	92.27	2.84%	58.00	1.79%	537.47	2.73%
MSK & Frailty Care Group	722.98	3.00%	681.04	2.71%	751.38	3.06%	899.74	3.52%	795.62	3.11%	759.90	3.07%	5,022.35	3.36%
Medical Director Directorate	2.00	0.94%	0.00	0.00%	0.00	0.00%	3.00	1.36%	0.00	0.00%	0.00	0.00%	7.24	0.53%
Nursing Services Directorate	33.27	2.17%	24.80	1.51%	36.20	2.22%	52.41	3.00%	49.60	2.87%	62.93	3.75%	323.65	3.22%
People & Organisational Development Direct	42.28	1.55%	34.00	1.18%	66.08	2.40%	102.05	3.60%	102.00	3.73%	57.75	2.13%	579.60	3.48%
Performance Management Directorate	120.40	1.95%	102.52	1.60%	109.79	1.76%	126.85	1.96%	163.09	2.56%	221.13	3.70%	1,317.20	3.51%
Speciality Services Care Group	602.71	3.42%	574.26	3.13%	693.14	3.91%	723.88	3.94%	766.62	4.19%	880.99	5.00%	4,752.65	4.40%
Surgical Care Group	1266.77	4.21%	1080.28	3.48%	1155.05	3.87%	1490.53	4.84%	1515.67	4.91%	1602.85	5.34%	8,374.31	4.58%

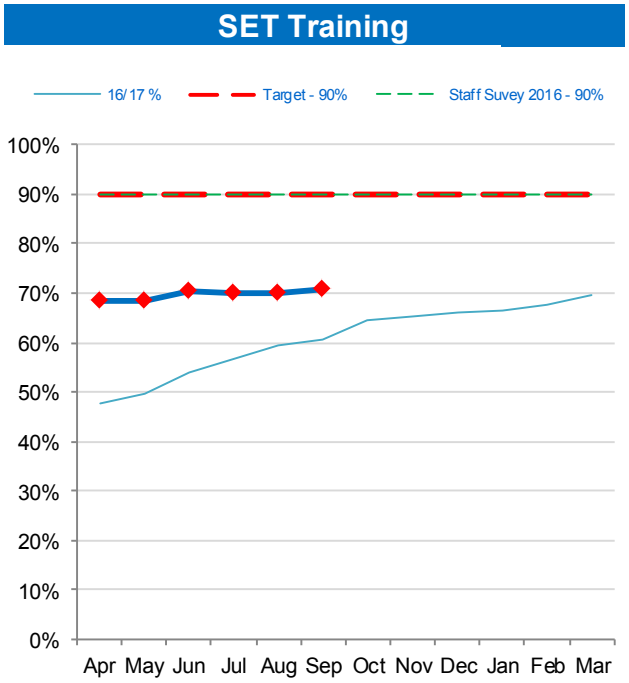
Top 10 Absence Reasons

S10 Anxiety/stress/depression/other psy	2,020.00	22.00
S12 Other musculoskeletal problems	972.00	10.60
S25 Gastrointestinal problems	960.00	10.50
S98 Other known causes - not elsewhere	959.00	10.50
S11 Back Problems	740.00	8.10
S13 Cold, Cough, Flu - Influenza	534.00	5.80
S26 Genitourinary & gynaecological diso	524.00	5.70
S28 Injury, fracture	485.00	5.30
S99 Unknown causes / Not specified	276.00	3.00
S15 Chest & respiratory problems	260.00	2.80

Workforce: SET Training - September (Month 6)

CG & Directorate SET Training - Sep 2017 (Q2)

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

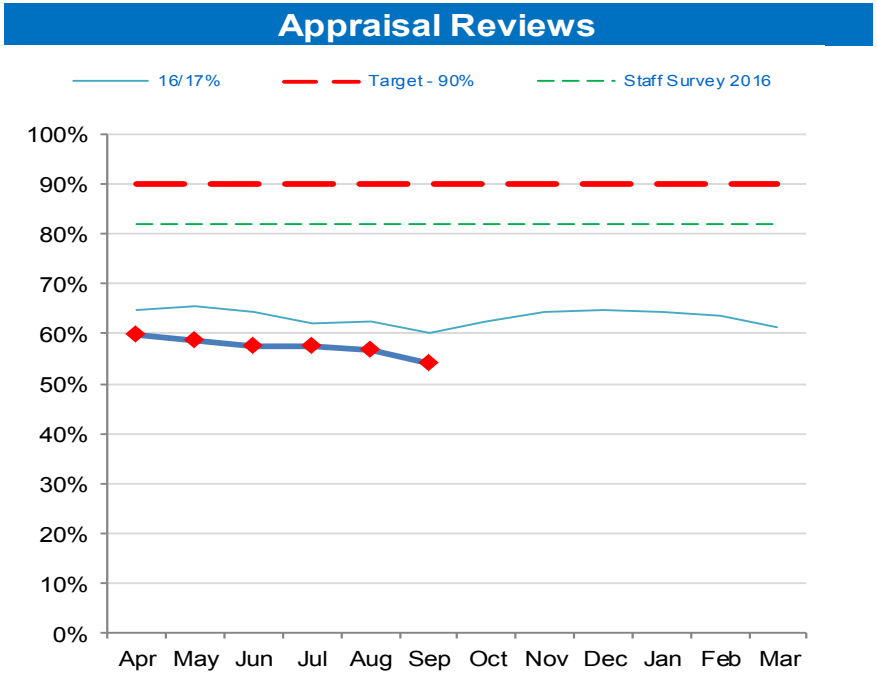


	% Compliance
Doncaster & Bassetlaw Teaching Hospitals NHS	**70.79%**
Chief Executive Directorate	**68.64%**
Children & Family Care Group	**74.38%**
Diagnostic & Pharmacy Care Group	**79.68%**
Directorate Of Strategy & Improvement	**97.87%**
Emergency Care Group	**62.80%**
Estates & Facilities	**48.66%**
Finance & Healthcare Contracting Directorate	**96.76%**
IT Information & Telecoms Directorate	**95.69%**
MSK & Frailty Care Group	**80.30%**
Medical Director Directorate	**80.00%**
Nursing Services Directorate	**75.10%**
People & Organisational Directorate	**91.89%**
Performance Directorate	**75.84%**
Speciality Services Care Group	**67.51%**
Surgical Care Group	**70.13%**

Workforce: Appraisals - September (Month 6)

CG & Directorate Appraisals - Sep 2017 (Q2)

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



Trust Total

	% Completed
Doncaster & Bassetlaw Teaching Hospitals	**54.13**
Chief Executive Directorate	**17.86**
Children & Family Care Group	**51.83**
Diagnostic & Pharmacy Care Group	**67.70**
Directorate Of Strategy & Improvement	**93.75**
Emergency Care Group	**48.48**
Estates & Facilities	**5.48**
Finance & Healthcare Contracting Directorate	**52.78**
IT Information & Telecoms Directorate	**73.73**
MSK & Frailty Care Group	**75.87**
Medical Director Directorate	**75.00**
Nursing Services Directorate	**67.19**
People & Organisational Directorate	**87.50**
Performance Directorate	**82.72**
Speciality Services Care Group	**55.52**
Surgical Care Group	**54.43**

Workforce: Staff in post - September (Month 6)

Staff in post

	FTE	Headcount	FTE	Headcount	FTE	Headcount	FTE	Headcount	FTE	Headcount	FTE	Headcount
Staff Group	**Apr-17**		**May-17**		**Jun-17**		**Jul-17**		**Aug-17**		**Sep-17**	
Add Prof Scientific and Technic	173.34	189.00	173.68	189.00	174.74	191.00	172.45	188.00	176.46	192.00	171.70	187.00
Additional Clinical Services	1,116.66	1,356.00	1,124.68	1,365.00	1,134.49	1,376.00	1,136.40	1,378.00	1,126.65	1,366.00	1,135.30	1,373.00
Administrative and Clerical	1,089.28	1,338.00	1,097.51	1,344.00	1,091.66	1,339.00	1,090.42	1,338.00	1,086.26	1,333.00	1,084.51	1,327.00
Allied Health Professionals	317.79	369.00	316.78	367.00	320.54	372.00	325.55	378.00	331.05	384.00	336.40	389.00
Estates and Ancillary	572.83	825.00	571.80	827.00	571.28	826.00	572.38	828.00	569.27	828.00	565.03	821.00
Healthcare Scientists	129.53	143.00	129.10	142.00	127.60	141.00	127.07	140.00	124.47	137.00	122.23	136.00
Medical and Dental	498.11	523.00	497.26	522.00	501.41	616.00	500.76	617.00	497.55	636.00	499.65	633.00
Nursing and Midwifery Registered	1,593.42	1,850.00	1,593.67	1,850.00	1,585.23	1,838.00	1,584.72	1,838.00	1,581.52	1,835.00	1,568.02	1,821.00
Students	3.00	3.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	1.44	2.00
Grand Total	**5,493.97**	**6,596.00**	**5,504.48**	**6,606.00**	**5,506.95**	**6,699.00**	**5,509.75**	**6,705.00**	**5,493.23**	**6,711.00**	**5,484.28**	**6,689.00**

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Title	**Winter Assurance**		
Report to	**Board of Directors**	**Date**	**31.10.2017**
Author	**David Purdue**		

Purpose		Tick one as appropriate
	Decision	
	Assurance	*x*
	Information	

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

Winter Plan Assurance 2017/2018

Following recent meetings and correspondence from NHSI and NHSE, the board of Directors are required to be sighted on the potential activity growth and risks to the 4hr Access Target as a result of winter pressures.

The Board signed off the Winter Plan at the July Board Meeting but needs to be sighted on the additional reporting requirements and key metrics that will be measured over the next 2 quarters.

Reporting Metrics

Monday ED attendances and subsequent ED and GP admissions, this is to test the 7 day services offered in primary care and the impacts of increased GP access.

Weekend discharge rates as a percentage of the week.

These measures are included in the Business Intelligence Report but the headlines are

- 18.7% of all of DRI discharges take place at a weekend and 14.6% at BDGH
- If the rest of the week was at the same attendance level as Mondays then we would see an extra 500 patients a week at DRI and an extra 400 patients at BDGH
- A&E attendances on a Monday at DRI account for 15.5% of weekly activity rising to 15.9% at BDGH
- Non Elective Admissions information on a weekday the GP admissions account for 20.2% of all Emergency Admissions at DRI but only 9.3% at BDGH. When we move into the weekend this drops to 10.9% at DRI and 2.7% at BDGH

The Trust must report its Opel level on a daily basis via the daily situation report

Opel levels range from 1 to 4, with level 1 meaning no pressure in the system to level 4 meaning extreme pressure. The Trust currently reports this daily but as part of the work being undertaken by The Urgent and Emergency Care Network, there is plan to report via an Escalation management System for South Yorkshire and Bassetlaw.

NHSI and NHSE have identified that there are differentials in the numbers which Trust report against the 4hr Access Target. Trusts which have developed alternative pathways to the Emergency Department have been requested to review these pathways to include in the 4hr access denominator. The pathways must have an identified clock start and stop within a 4hr framework to be eligible for inclusion in the figures.

DBTH information department has reviewed the pathways which could be included and these are in the process of being ratified.

The potential impact is identified on the table below, these pathways are for patients who attend in an emergency and do not attend into an allocated time slot.

Month	Total Breaches (Trust)	A&E Performance excluding GP Admissions (Trust)	A&E Performance Including alternative pathways	Difference in Performance when alternative pathways included (Trust)
Jan-17	1990	85.1%	86.9%	1.8%
Feb-17	1360	88.7%	90.1%	1.4%
Mar-17	1035	92.6%	93.5%	0.9%
Apr-17	1273	90.4%	91.4%	1.0%
May-17	1239	91.4%	92.2%	0.8%
Jun-17	1071	92.5%	93.2%	0.7%
Jul-17	989	93.2%	93.9%	0.7%
Aug-17	888	93.6%	94.2%	0.6%
Sep-17	861	93.7%	94.3%	0.6%

The Department of Health have identified 6 key areas which systems must act on to improve performance over the next 2 quarters.

- Access to 111
- Ambulance Response Programme, increased clinical triage
- GP Accessibility (increased GP assess monies for each CCG)
- Urgent Treatment Centres , Doncaster plan to be first wave for an Urgent Care Centre
- ED streaming
- Flu Vaccinations, DBTH achieved 75% of front line staff

Progress against these initiatives are being reviewed by the A&E Delivery Board.

The DBTH Winter Plan was launched during System Perfect between the 5th to the 12th of September. This initiative successfully brought together teams across the Doncaster and Bassetlaw Health and Social Care community to improve patient flow and experience, and to better understand Urgent and Emergency Care pathways.

The aims of the week were:

- to identify issues impacting on patient care, transfer or discharge home
- to work collaboratively to resolve any delays, to share good practice
- to ensure that learning from the week led to sustainable change and improvement.

Immediate impact during the week

Stranded patients reduced from 67 to 29

Patient care pathways and discharges processes were facilitated for a number of reasons:

- Specific roles and existing pathways and processes were clarified
- There was better information sharing, relationship building and partnership working between clinical teams
- Awareness of community and voluntary services was increased and teams were visible and available
- There was a proactive approach to the coordination of patient transport

Sustainable change

The following more permanent service changes to be implemented:

- Community services and Older People's Mental Health in-reach into ED
- Community nursing in-reach into the acute hospital wards on both sites
- Social care review of Positive Steps capacity for complex patients, an additional 5 social workers put in place
- The development of a Social Care bridging pilot 'Home First', to be launched in November in both areas
- 7 day social care support at BDGH
- Health and well-being officers to support the acute hospital team

Wider system learning

- The need to improve the provision and responsiveness of services at the weekend was identified as highlighted in the weekend discharge data

- More effective and timely communication is required both within, and between organisations. The development of IT to support multi-agency clinical team working is essential
- Patient and family empowerment is fundamental to fully support patient discharge and transfer. A review of the use of the discharge passport is recommended
- A joint approach to staffing and vacancies to support the whole system
- In order to embed effective system working, it will be necessary to develop a genuine culture of working together and strengthen relationships at all levels

Progress against the Winter Plan will be reported monthly to the Board of Directors as part of the Business Intelligence Report.

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Title	**Nursing Workforce Information**		
Report to	**Board of Directors**	**Date**	**31 October 2017**
Author	**Moira Hardy, Acting Director of Nursing, Midwifery & Quality** **Rick Dickinson, Acting Deputy Director of Nursing, Midwifery & Quality**		
Purpose			Tick one as appropriate
	Decision		
	Assurance		
	Information		✔

Executive summary containing key messages and issues

This paper updates the committee on key issues relating to the Nursing Workforce, using information from the UNIFY return for September 2017 planned and actual hours:

- The workforce data submitted to UNIFY demonstrates the overall planned versus actual hours worked to be 99% for September 2017.
- Care Hours Per Patient Day (CHPPD) for September 2017 is similar to recent months at 7.59.
- Workforce information and Quality and Safety profile meeting requirements of NHS England (NHSE), relating to Hard Truths demonstrates that two wards were Red for Quality. A quality summit is being arranged including Non-Executive Director representation.

Key questions posed by the report

- Does the triangulation of staffing and quality data provide the assurance on the adequacy of resources balanced with quality improvement potential?

How this report contributes to the delivery of the strategic objectives

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

How this report impacts on current risks or highlights new risks

Risks associated to the inability to recruit to establishment and develop staff to provide harm free care, delivered with compassion and of appropriate quality.

Risk associated with not meeting regulatory and commissioner requirement.

The risks identified have been mitigated by the use of temporary staffing to provide planned versus actual hours worked at 99% in September. Despite the use of temporary staff to maintain safe staffing levels the Trust has remained within the 3% agency cap. The main risk in relation to staffing continues to be the recruitment to Registered nurse and midwifery vacancies and opportunities to recruit are actively being explored.

Recommendation(s) and next steps

The Board of Directors is asked to NOTE the content of this paper and SUPPORT the actions identified to ensure that the risks associated with inappropriate nurse staffing levels are appropriately managed.

Key issues and actions include:
- the continuing work of the Non-Medical workforce utilisation programme as part of DBTH Strategy and Improvement programme
- Exploring recruitment opportunities for nursing and midwifery
- Reviewing the staffing establishment using AUKUH data and analysis of clinical activity.

1. INTRODUCTION

This paper provides the Board of Directors with detailed information relating to the Nursing Workforce; highlighting issues which may impact upon the Trusts ability to provide appropriate staffing levels and skill mixes. It also updates on the implementation on Care Hours per Patient Day (CHPPD), which has been a required national return since 01 May 2016 and the data submitted to UNIFY.

2. WORKFORCE INFORMATION

The workforce data submitted to UNIFY provides the actual hours worked in September 2017 by registered nurses and health care support workers compared to the planned hours. The Trusts overall planned versus actual hours worked was 99% in September 2017, similar to recent months.

2a. Actual versus planned staffing levels (based on daily data capture)

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

- within 5% for 19 Wards (46%), two more than August
- between 5% – 10% for 13 Wards (32%) the same as August
- surpluses over 10% for 4 Wards (10%) one less than August
- deficits over 10% for 5 Wards (12%) three more than August

The wards where there were surpluses in excess of 10% of the planned hours are Gresley Unit, Rehab 2, Wards 16, CCU/C2 and 25; each ward requiring additional staff to support patients requiring enhanced care.

The wards where there were deficits in excess of 10% of the planned hours are B5, B6, M1, The Respiratory Unit and Labour Ward (Bassetlaw Hospital). The lower than planned staffing levels were due to:

- Labour Ward and M1 are due to staff sickness absence and vacancies. The service was optimised through the maternity service on call management and use of community staff to ensure safe services.
- B6 and B5 have had a higher bed availability, so staff supplementing wards elsewhere.
- The Respiratory Unit has vacancies and shortfall of back fill through temporary staffing routes.

2b. Care Hours Per Patient Day (CHPPD)

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

Care Hours Per Patient Day (CHPPD) – September 2017			
Site Name	**Registered midwives/ nurses**	**Care Staff**	**Overall**
BASSETLAW HOSPITAL	5.2	3.4	8.6
DONCASTER ROYAL INFIRMARY	4.3	3.3	7.6
MONTAGU HOSPITAL	2.3	2.4	4.7
TRUST	**4.33**	**3.23**	**7.56**

The CHPPD care hours data from May 2016 –September 2017 remain consistent.

2c. Quality and Safety Profile

The Quality Metrics (appendix 1) for adult wards include 19 indicators that cover each of the five CQC Key Assessment Criteria (safe, effective, caring and responsive, with the overall score illustrating well

led). Ward A5 has flagged as high risk for August and September 2017, with The Respiratory Unit flagging red in September 2017. The issues for A5 from the quality metrics are the lack of data for clinical observations and fluid balance audit, handwashing compliance rate, FFT positive and negative recommendations and low appraisal rates. The Respiratory Unit have an SI, multiple falls rate, Medicines storage, missed observation audit, handwashing compliance rate, FFT response rate and unlikely to recommend, complaint and concerns, and the appraisal compliance rate. A Quality Summit is being arranged with the nursing leadership team and a Non-Executive Director will be invited.

3. PLANNED ACTIONS AND KEY RISKS

The major issue facing most acute hospitals nationally, and locally, continues to be the challenge of filling qualified vacancies. The actions to mitigate the risks which have been detailed in previous papers are continuing, along with systems and processes to meet the expectations outlined in the safe staffing and efficiency correspondence. These are:

- The continuing work of the Non-Medical workforce utilisation programme as part of DBTH Effectiveness and Efficiency programme.
- Reviewing the staffing establishment using AUKUH data and analysis of clinical activity.
- Provide further detailed comparison CHPPD data as this becomes available nationally
- Continue to explore recruitment opportunities for nursing and midwifery

4. RECOMMENDATION

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

APPENDIX 1: HARD TRUTHS October 2017 Paper

Workforce /Quality/Safety Profiles September 2017 Data

				Planned v Actual	Safe	Effective	Caring	Responsive	Well Led	Profile		WQAT annual assessment 2015/6	WQAT annual assessment 2016/17
Care Group	Matron	Ward	No of Funded Beds	Variance	Total score	Total score	Total score	Total score	QM total score	Work-force	Quality	Rating	Rating
Surgical	NS	B6	16	86%	1.5	0.5	0.0	0.5	2.5				
	NS	20	27	105%	1.0	0.0	2.0	0.5	3.5				
	NS	21	27	100%	1.0	0.0	0.5	1.0	2.5				
	LM	S12	20	93%	2.0	0.0	1.0	2.5	5.5				
	RF	SAW	21	91%	3.0	1.0	1.5	2.0	7.5				
	LC	ITU DRI	20	98%	1.0	0.0	0.0	2.0	3.0				
	LC	ITU BDGH	6	99%	0.0	1.0	4.0	1.0	6.0				
				97%									
MSK and Frailty	SS	A4	24	99%	1.5	0.0	0.0	0.5	2.0				
	SS	B5	30.7	83%	1.0	0.0	0.0	0.5	1.5				
	AH	St Leger	35	99%	2.5	1.0	2.0	2.0	7.5				
	AH	1&3	23	102%	1.5	0.0	0.0	1.5	3.0				
	SS	Mallard	16	108%	2.0	0.0	1.0	1.0	4.0				
	SS	Gresley	32	118%	1.0	0.5	4.0	1.5	7.0				
	SS	Stirling	16	105%	1.0	1.0	1.0	1.0	4.0				
	KM	Rehab 2	19	113%	0.0	0.0	1.0	1.0	2.0				
	KM	Rehab 1	29	97%	4.0	1.0	0.0	2.5	7.5				
				102%									
Specialty Service	JP	18	12	99%	3.0	1.0	3.0	1.0	8.0				
	JP	18 CCU	12	97%	0.0	0.0	4.0	2.0	6.0				
	AW	32	18	95%	2.0	1.0	0.5	3.0	6.5				
	AW	16	24	112%	3.0	0.0	0.0	2.5	5.5				
	RM	17	24	106%	3.0	2.0	2.0	2.0	9.0				
	JP	CCU/C2	18	100%	2.5	1.0	0.5	3.0	7.0				
	RM	S10	20	98%	2.5	0.0	1.0	1.5	5.0				
	RM	S11	19	99%	1.5	0.0	0.5	2.0	4.0				
				102%									
Emergency	MH	ATC	21	97%	1.0	1.0	2.5	2.5	7.0				
	SS	AMU	40	99%	3.0	1.0	1.0	2.5	7.5				
	MH	A5	16	108%	3.0	2.5	2.0	2.5	10.0				
	MH	C1	16	105%	1.5	1.5	1.0	2.5	6.5				
	SC	24	24	94%	2.5	3.0	2.0	2.0	9.5				
	SC	25	16	112%	3.5	0.0	0.0	1.5	5.0				
	SC	Respiratory unit	56	90%	4.5	3.0	3.0	2.0	12.5				
				98%									
Children and Families	AB	SCBU	8	99%	0.0	0.0	0.0	1.5	1.5				
	AB	NNU	18	98%	0.5	0.0	0.0	1.5	2.0				
	AB	CHW	18	96%	0.5	0.0	0.0	1.0	1.5				
	AB	COU/CSU	21	97%	0.5	0.0	0.5	1.0	2.0				
	SS	G5	24	95%	1.5	1.0	3.5	2.0	8.0				
	SS	M1	26	88%	0.0	1.0	0.0	2.0	3.0				
	SS	M2	18	94%	1.5	1.0	1.0	1.5	5.0				
	SS	CDS	14	92%	1.0	0.0	2.0	1.0	4.0				
	SS	A2	18	91%	0.0	3.0	0.0	2.0	5.0				
	SS	A2L	6	85%	0.0	1.0	1.0	2.0	4.0				
				93%									
		Trust Position		**99%**									

NHS
Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Title	**Bassetlaw Mortality – Fractured Neck of Femur**		
Report to	**Board of Directors**	**Date**	**31st October 2017**
Author	**Sewa Singh, Medical Director**		
Purpose			Tick one as appropriate
	Decision		
	Assurance		√
	Information		

Executive summary containing key messages and issues

The rolling 12 month relative risk mortality (HSMR) for Fractured Neck of Femur showed a divergence in outcome between Doncaster Royal Infirmary (57.86) and Bassetlaw Hospital (115.18) giving an overall HSMR for the Trust 68.88.

In order to identify possible causes for this discrepancy between the two sites a review was undertaken for the period September 2016 to August 2017 inclusive through a mortality review process using the structured judgement method. This review has highlighted 10 recorded deaths for this period of which 9 deaths relate to orthopaedics, the other death being outwith the specialty and raises a coding issue.

Of the 9 deaths, six were reviewed with three case notes still awaited despite an exhaustive search for the said documents. Of the 6 cases reviewed only 5 had a fractured neck of femur, the other case suffering from metastatic spinal disease.

Of the 5 fractured neck of femurs only 4 were operated on with one patient being treated conservatively due to this being a re-fracture of an old fracture.

Significant co-morbidities were identified in 4 patients (dementia) and 2 patients suffered from severe chronic obstructive pulmonary disease.

The cause of death was recorded as chest infection (2), myocardial infarction (1) and severe dementia (1). Structured Judgement Review of the 6 cases reviewed show that overall care was rated as good (4), excellent (1) and adequate (1). All cases were discussed at the morbidity and mortality meeting of the specialty.

Learning points identified in the course of the discussion as follows:

- Consideration of appropriateness of surgery in the very frail. This is the subject of much debate and remains very much a matter of clinical judgement.
- Decision to treat patients expectantly should be taken early in the course of illness to facilitate end of life care

These points mirror the outcome of reviews in other specialties which have highlighted similar issues and for which action is being taken through local governance processes.

In conclusion, on review of this cohort of patients there does not appear to be any cause for concern with the quality of care despite the apparent increase in mortality. The numbers involved are fairly small and therefore no appropriate judgement on the HSMR could be made as to its significance. Coding has been identified as an issue at the Bassetlaw end and the orthopaedic specialty has now adopted the Nottingham Hip Fracture Score which tends to highlight the potential role of co-morbidities on predicted mortality. However this score is not transferrable to coding and therefore action has been taken to directly identify the relevant co-morbidities with respect to improving coding.

The orthopaedic department has also strengthened their mortality review process with input from ortho-geriatricians into case note reviews and the completeness of the reviews is monitored by the Matron. All deaths are now the subject of a Structured Judgement Review.

It is also the case that the majority of patients with fractured neck of femur will be operated on at Doncaster as part of the trauma and orthopaedics re-organisation.

This report has also been considered at the Clinical Governance Committee.

Key questions posed by the report

Action has been taken in the form of re-organisation of services and detailed attention to coding.

How this report contributes to the delivery of the strategic objectives

Provision of high quality care.

How this report impacts on current risks or highlights new risks

None

Recommendation(s) and next steps

Continue with Structured Judgement Reviews of deaths in orthopaedics and trauma consistent with the Learning from Deaths Policy.

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Title	**Board Assurance Framework & Corporate Risk Register**		
Report to	**Board of Directors**	**Date**	**31 October 2017**
Author	**Matthew Kane, Trust Board Secretary**		
Purpose			Tick one as appropriate
	Decision		
	Assurance		X
	Information		

Executive summary containing key messages and issues

This report provides an opportunity to review the risks on the Board Assurance Framework and Corporate Risk Register which have been evaluated by executive leads prior to this meeting.

Board Assurance Framework

The Board Assurance Framework (BAF) contains all of the risks to the Trust's five strategic objectives. Two risks were added to the BAF during the period, under Strategic Aim 4 (support the development of enhanced community based services, prevention and self-care):

Risk	Ref	Current score	Target score
Reduction in hospital activity and subsequent income due to increase in community provision	F&P14	L4 x I3 = 12	L4 x I2 = 8
Commissioner plans do not come to fruition and do not achieve the required levels of acute service reduction	F&P15	L3 x I3 = 9	L3 x I2 = 6

In addition, there have been two changes to existing risks on the BAF:

Risk	Ref	Previous score	New score
Failure to sustain a viable specialist and non-specialist range of services	F&P7	L2 x I2 = 4	L3 x I3 = 9
Failure to engage with patients around the quality of care and proposed service changes	Q&E5	L2 x I3 = 6	L3 x I3 = 9

Controls and assurances for all risks have been reviewed and updated.

Corporate Risk Register

The Corporate Risk Register shows those risks that are 'extreme', rated 15 and above. One change has been made to the Corporate Risk Register in the period:

Risk	Ref	Previous score	Current score
Failing to address the effects of the medical agency cap	F&P5	L3 x I4 = 12	L4 x I4 = 16

Risk refresher sessions

Five sessions on risk management have taken place which covered the Datix system, key principles of risk management, risk ratings and risk registers. A copy of the feedback from the events so far is attached as an appendix.

Further sessions are planned as follows.

Wednesday 1 November, 2.30 – 4pm
Boardroom, Bassetlaw Hospital

Key questions posed by the report

- Are the Board assured by the controls and assurances in place?

How this report contributes to the delivery of the strategic objectives

The BAF highlights the key risks to the strategic objectives.

How this report impacts on current risks or highlights new risks

The report sets out progress in relation to current risks and prompts Board to consider any emerging risks.

Recommendation(s) and next steps

To note the Board Assurance Framework and Corporate Risk Register in Quarter 2.

Risk Refresher Feedback – Cumulative results

56 forms returned

Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

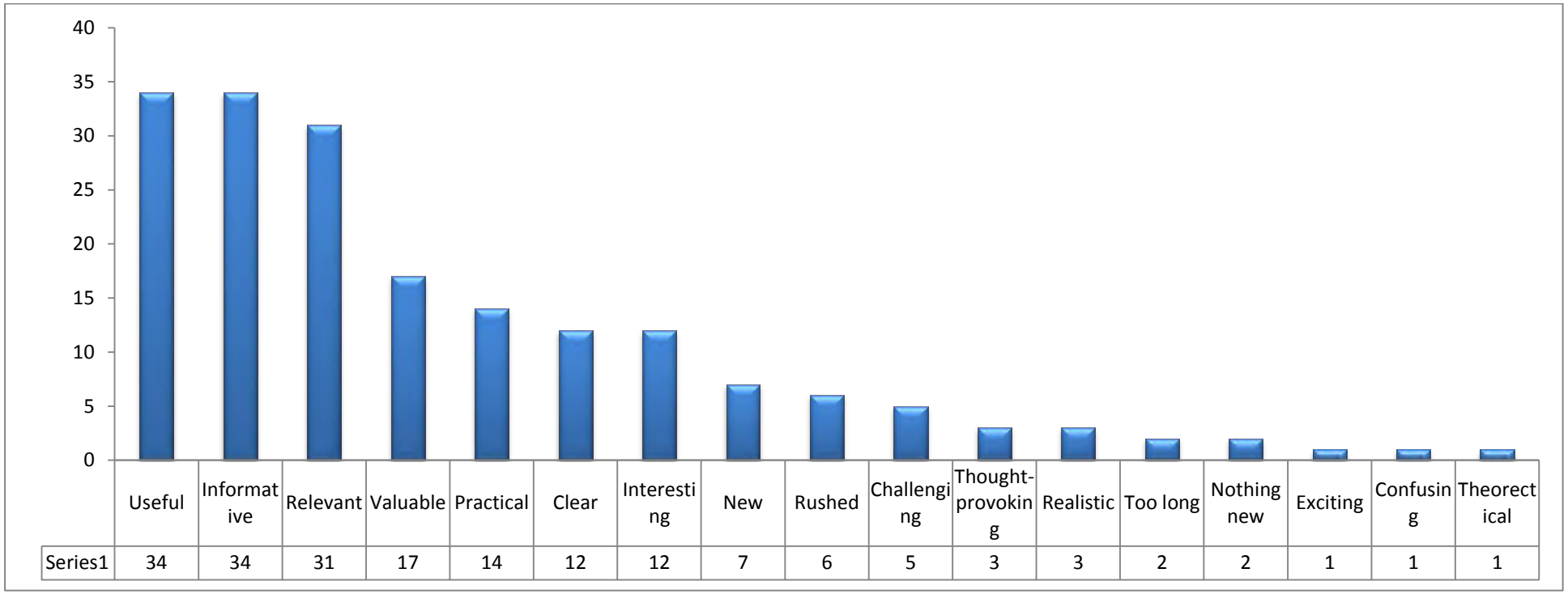
Question	(1= no definitely not, 5= yes definitely)					Comments on Structure and format	Done better, taken out, added	What other information would you like to see?
	1	2	3	4	5			
Did you find the session interesting?	0	1	5	20	30	The lighting very bright made it difficult to see the boards Good examples I think it was well presented and of the right length Good format, clear – flowed Structured well The lights in the room are very bright Very informative and relevant information. Well structured, made sense re the order of things. Too rushed at the end. Good. Good – may have promoted more discussion working in smaller groups. Relevant and appropriate. Understand risk assessment process. Just had a couple of questions that were answered. Flowed well. Good. Good update. The assumption was everyone had knowledge of a Risk Register, a starting point could have been what is a risk register, why have one, who should maintain it etc.	Probably not More time for practical No – right duration for subject Consistent consequence/likelihood charts might have been better between presentation and hand-out The time appeared too short – could not fully go through all slides None Longer sessions may be helpful Handouts for the presentation as too rushed to make notes. User input was too rushed for beginners – too much to absorb A little bit longer on the slides at times. A bit more practical work would help (pairs or groups) More time spent on adding risks to Datix. Access to and demonstration through Datix rather than hard copies would have been clearer. Right amount of discussion and theory. Longer bit on Datix. Introduce the presenters. Please stick to time allocated. Better as a 2 hour session to have a better Datix demonstration. The practical demo on Datix was a little rushed at the end of the session. Was adequate as an overview but session ran over. Put Datix demo at the start.	Examples of real risks around the Trust for context How to make reports I need further training including on Datix reporting Datix – help for handlers in changing selected categories etc Could have been better to have this session 2+ years ago Is this a refresher, has there been a first one?
Did you understand the content of the session?	0	1	5	20	30			
Do you feel confident on phrasing risks using the three elements to describe risk?	1	1	6	27	21			
Do you feel confident in your ability to add and review risks on Datix?	1	4	10	24	17			

Facilitators: Rick Dickinson, Tracy Evans-Phillips and Matthew Kane

Risk Refresher Feedback – Cumulative results 56 forms returned

Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

Overall Experience:



	Useful	Informative	Relevant	Valuable	Practical	Clear	Interesting	New	Rushed	Challenging	Thought-provoking	Realistic	Too long	Nothing new	Exciting	Confusing	Theoretical
Series1	34	34	31	17	14	12	12	7	6	5	3	3	2	2	1	1	1

Facilitators: Rick Dickinson, Tracy Evans-Phillips and Matthew Kane

Strategic Aim 1 We will work with patients to continue to develop accessible, high quality and responsive services.								
KEY STEPS	Ensure the delivery of the Trusts financial plan and the implementation of an agreed improvement and effectiveness plan with identified work streams and SROs. Delivering service change and savings through achieving agreed targets and milestones							
	To create a stable and motivated finance function, measured by staff turnover, implementation of restructures, staff survey							
	Implement a Patient and Carer Experience and Engagement Strategy. Implementing national and international best practice in the use of feedback to improve services.							
	Provide appropriate technology support to the Trust for the development of the Single Oversight Framework throughout 2017.							
PROGRESS	PMO moved to DoF at end June 2017. Review of governance processes being undertaken. New accountability measures instituted including refreshed effectiveness and efficiency committee. Consutlation, slotting in processes and recruitment completed for Fiannce. New staff starting during October. Patient Experience and Engagement Strategy completed and to be presented to BoD October 2017. SOF not delivered in full. Some drill downs and alerts in place. Rest to be delivered in accordance with prioritised timeframes as discussed with Director of Strategy.						Direction	
RISKS	LINK TO CRR	EXEC	CURRENT RR	CONTROLS	ASSURANCE	GAPS IN ASSURANCE	ACTION TO ADDRESS GAPS	TARGET RR
Failure to sustain a viable specialist and non-specialist range of services leading to (i) Regulatory action (ii) Impact on reputation	F&P7	Medical Director/Chief Operating Officer	L3 x I3 = 9	(i) Participation in WTP (ii) Commissioner engagement (iii) Involvement/influence NHSE commissioning intentions (iv) R & D support for specialist services (v) Quarterly Executive discussions with STH (vi) Contribution to reconfiguration discussions	(i) Peer review programe outcome (9 June 2016) (ii) Patient outcome and service quality as published by National Registries (iii) Agreement with Sheffield over vascular services	(i) Strategic review of specialised services in Y&H currently in progress and due to report September 2017	(i) Medical Directors' participation in review of specialised services (August - October 2017) (ii) Fit for the Future work (Autumn 2017)	L2 x I2 = 4
Failure to protect against cyber attack leading to (i) Trust becoming non-operational (ii) Inability to provide clinical services (ii) Negative impact on reputation	F&P11	Chief Information Officer	L3 x I5 = 15	(i) Penetration test of systems to identify gaps and risks; (ii) Firewalls, passwords, anti-virus equipment. (iii) Policies and reinforcement through communication to staff; (iv) Staff awareness through Certified Security Professional course and other training; (v) Trigger alerts; (vi) Care Cert system at NHS Digital (vii) All servers and systems patched to appropriate level (viii) Computers and network infrastructure get security patches automatically applied	(i) Trust unaffected by cyber attack in May 2017 (ii) Governors briefing June 2017 (iii) Cyber security audit and action plan reported via ANCR to Board, Septembr 2017	N/A	N/A	L1 x I4 = 4
Failure to ensure adequate medical records system leading to (i) Impact on safety (ii) Impact on reputation	Q&E4	Chief Operating Officer	L3 x I3 = 9	(i) Review of bays and action plans in place (ii) RFID business case agreed (iii) Plans to make DRI a closed library	(i) Storage bays reviewed (ii) Presentation before Board in August 2017 on RFID (iii) RFID installed, October 2017	Medical records action plan	N/A	L2 x I2 = 4
Failure to engage with patients around the quality of care and proposed service changes leading to (i) Negative patient and public reaction towards the Trust (ii) Impact on reputation	Q&E5	Acting Director of Nursing, Midwifery and Quality/ Medical Drector	L3 x I3 = 9	(i) Consultations on major service changes (ii) CCC report to Board (iii) Friends and Family Test (iv) Monitoring through Patient Engagement & Expderience Committee (including CCG & Healthwatch membership) (v) Training on communication (vi) Work on learning from deaths (vii) Governor walkabouts (viii) Ward QAT (ix) Picker national surveys (x) Social media e.g. Facebook, Twitter	(i) Consultation on HASU and children's tirer 2 surgery (ii) Consultation on new strategic direction (iii) Bassetlaw Governors engagement work with the public (iv) Case law and advice taken in respect of service changes (v) F4H Strategy special, September 2017 (vi) Strategy stand at AMM	(i) Clinical service, Communications and Engagement and Qii strategies to be developed and means of consultation	(i) Strategies to go to Board in October and November 2017	L2 x I2 = 4
Failure to adequately prepare for CQC inspection leading to (i) Sub-optimal performance in inspection (ii) Risk of regulatory involvement (iii) Impact on reputation	Q&E7	Acting Diretcor of Nursing, Midwifery and Quality	L2 x I3 = 6	(i) Self-assessment and mock inspection processes (ii) Engagement meetings with CQC (iii) Nottinghamshire Looked after Children and Safeguarding monitored by Trust Safeguarding People's Board	(i) Report to QEC and Board - June 2017 (ii) CQC internal audit (iii) IRMER inspection and action plan in place (iv) Reports to Board and QEC (v) CQC Insights	(i) Positive assurance from CQC (ii) Good inspection and self-assessment outcomes (iii) KPMG audit of Trust against CQC criteria	(i) Iinternal audit on CQC preparedness to be reported to QEC (October 2017)	L2 x I2 = 6

Strategic Aim 2 - We will ensure our services are high performing, developing and enhancing elective care facilities at Bassetlaw Hospital and Montagu Hospital and ensuring the appropriate capacity for increasing specialist and emergency care at Doncaster Royal Infirmary.								
KEY STEPS	Development of a 5 year Estates Strategy, to include a Capital Development Programme linked to Condition Surveys and Corporate Risk Register.							
	Produce a clinical service model for the delivery of safe and sustainable emergency, elective, diagnostic and support services across the Trust							
	Maintain Compliance with all NHSI Access Targets and Outcomes Objectives with Sustainability and with Transformation Fund associated Targets (Four Hour Wait and RTT) as a priority.							
	Increase elective activity at BDGH and MMH to best utilise available resources and facilities							
	Produce and implement a Quality Improvement & Innovation Strategy that is based on best practice and developed with staff, containing a plan to increase QII capacity and capability within DBTH (and potentially with partners)							
	Maintain a robust and effective Programme Management Office ensuring robust systems and processes to drive, monitor and escalate effectiveness & efficiency, enabling and strategic clinical plans.							
PROGRESS	Estates Strategy now due at Finance and Performance in Oct, Board of Directors on November. Clinical Site Strategy agreed. Three key strategic steering groups set up with ToR. Work plans agreed with set timescales for service changes. STF achieved for 4hr access in Q1/2. RTT plans agreed with NHSi to be compliant by Q4. Qii Strategy to go to Board In October.						**Direction**	
RISKS	**LINK TO CRR**	**EXEC**	**CURRENT RR**	**CONTROLS**	**ASSURANCE**	**GAPS IN ASSURANCE**	**ACTION TO ADDRESS GAPS**	**TARGET RR**
Failure to achieve compliance with financial performance and achieve financial plan leading to (i) Adverse impact on Trust's financial position (ii) Adverse impact on operational performance (iii) Impact on reputation (iv) Regulatory action	F&P1	Director of Finance	L3 x I5 = 15	(i) Business and budget planning processes. (ii) Financial governance policies and procedures. (iii) Monthly monitoring of financial performance. (iv) Data analysis of trends and action to address deterioration. (v) Continued liaison with budget holders to identify risks to delivery. (vi) Demand and capacity planning proccesses. (vii) Detailed monitoring by Finance and Performance Committee. (viii) Budgets set on recurrent outturn resulting in a more robust financial plan. (ix) Budgets signed off by care groups and corporate departments. (x) Monthly monitoring at Board and directorate level. (xi) Uncommitted general contingency reserve. (xii) Regular finance meetings with budget holders. (xiii) Performance review meetings with NHSI. (xiv) All directorates signed up to control total.	(i) Exceeded control total in 2016/17 (ii) Production of 2017/18 budget (iii) Unqualified opinion on 2016/17 accounts (vi) Accounts submitted to NHSI by deadline (v) Financial plans submitted to NHSI (vi) Board approval of budgets (vii) Budget setting approved by Finance and Performance Committee (viii) Minutes of accountability and NHSI meetings (ix) External Audit review of financial performance (within Annual Accounts work) (x) First round of accountability meetings taken place	(i) Consistent reporting of achievement against plan (ii) 2017/18 external audit (iii) Audit of CIP governance work	(i) CIP Governance review coming to F&P (October 2017) (ii) Additional support on CIP programme (business case to be developed)	L2 x I5 = 10
Failure to deliver accurate financial reporting underpinned by effective financial governance leading to (i) Regulatory action (ii) Impact on reputation	F&P2	Director of Finance	L3 x I4 = 12	(i) Checklist of control accounts reviewed by the Finance and Performance Committee (ii) Board report reconciled to general ledger on a monthly basis (iii) All CIPs reported as actioned have been through budget retraction (iv) Governance structure for SBS system	(i) Unualified opinion on 2016/17 accounts (ii) Consistency of reporting over sustained period (iii) Internal audit reports show significant assurance with only minor improvements in respect of financial reporting	(i) Continued positive audits on financial reporting (ii) M9 accounting position	N/A	L1 x I4 = 4
Failure to deliver Cost Improvement Plans in this financial year leading to (i) Negative impact on Turnaround (ii) Negative impact on Trust's financial positon (iii) Loss of STF funding	F&P3	Director of Finance	L4 x I4 = 16	(i) Full Quality Risk Assessment and operational deliverability assessment of plans. (ii) Regular consideration of schemes by Management Board and Executive Team. (iii) Collaboration with other providers, to identify joint opportunities. (iv) CIP tracker developed to provide visibility of progress agianst plan. (v) Engagement in working together programme. (vi) PMO, with associated management processes, key deliverables, risk logs and reporting to Finance and Performance Committee. (vii) Implementation of innovation from external reviews. (viii) Regular meetings with NHSI to track progress.	(i) Performance against CIP for 16/17 of £11.9m (ii) Monthly CIP reports to Finance and Performance and Board (iii) Assurance provided to NHSI at quarterly meetings (iv) New PMO governance processes agreed and implemented	(i) Audit of existing PMO processes (ii) Implement new governance arrangements (iii) Outstanding CIP target to be found	(i) CIP Governance review coming to F&P (October 2017) (ii) Additional support on CIP programme (business case to be developed)	L1 x I5 = 5
Failure to ensure that estates infrastructure is adequately maintained and upgraded in line with current legislation, standards and guidance. **Note:** A number of different distinct risks are contained within this overarching entry. For further details please consult the E&F risk register. leading to (i) Breaches of regulatory compliance and enforcement (ii) Claims brought against the Trust (iii) Inability to provide safe services (iv) Negative impact on reputation (v) Reduced levels of business resilience (vi) Inefficient energy use (increased cost) (vii) Increased breakdowns leading to operational disruption (viii) Restriction to site development	F&P4	Director of Estates and Facilities	L4 x I5 = 20	(i) Annual business plan supports identification of issues by Care Groups / Directorates (ii) Risk-based capital investment plans (iii) Maintenance and support service contracts (iv) Independant Authorising Engineers appointed for key services, providing annual audits and technical guidance (v) Revised business planning process for all capital investments (vi) Estate condition and backlog maintenance assessment undertaken via 6-7 facet survey (vi) Progress and monitoring of actions undertaken through compliance committees e.g. health and safety committee	(i) Compliance in fire safety at Montagu (ii) Presentations to Finance and Performance and Governors Briefings (iii) Catering contract agreed May 2017 (iv) New service assistants in post April 2017 (v) Completed 6/7 facet survey. (vi) Asbetos and window surveys complete. (vii) Asbestos management plan up to date. (viii) Window risk assessments complete. (ix) Water management protocols complete and progress commenced. (x) Electrical infrastructure surveys complete.	(i) Estates Strategy in development (ii) Outcomes of NHSI estates work	(i) KEJ presenting Estates and Facilities Strategy to F&P in October and Board in November 2017 (ii) MP developing capital schemes for ACS funding (Autumn 2017)	L2 x I5 = 10

Failing to address the effects of the medical agency cap leading to (i) Negative patient and public reaction towards the Trust (ii) Impact on reputation	F&P5	Director of People and OD/ Chief Operating Officer/Medical Director	L4 x I4 = 16	(i) International recruitment programme. (ii) Teaching hospital status communicated through recruitment. (iii) Care Group to escalate recruitment difficulties to MD/COO. (iv) Use of Trust staff in first instance to address gaps wherever possible. (v) Signed memo of understanding between all Trusts in the WTP to abide by a standard set of principles. (vi) P&OD / Workforce reports to BoD. (vii) Workforce and Education Committee. (viii) Agency spend and breaches going to Exec Team and Finance and Performance. (ix) Better system around rate-to-fill and fill rates. (x) Use of social media to attract new candidates. (xi) Relationships with universities. (xii) GMC Survey. (xiii) Medical agency locum panel.	(i) Recruitment report to Board May 2017 . (ii) Workforce and Education Committee assurance reports to QEC & F&P. (iii) Agency spend and breaches going to Exec Team and F&P. (iv) Improved rate-to-fill and fill rates. (v) Latest GMC Survey, in upper quartiles for a number of specialties. (vi) F&P monitoring agency spend and reporting to Board	(i) Develop new service model to mitigate medical staff shortage. (ii) Develop and progress workforce from using alternative workforce for service delivery. (iii) Agree with Trusts in WTP to minimise cap breaches. (iv) Decrease local agency spend. (v) Agency spend to F&P. (vi) Scrutiny of qualified nursing process to be put in place. (vii) Flexible use of staff across ACS system. (viii) Acute hospital review (March 2018).	(i) MH to put in place process for scrutinising qualified nurses (October 2017) (ii) Discussions around using flexible staff taking place (October/November 2017).	L3 x I2 = 6
Failure to achieve compliance with performance and delivery aspects of the Single Oversight Framework, CQC and other regulatory standards leading to (i) Regulatory action (ii) Impact on reputation	F&P6	Chief Operating Officer	L4 x I4 = 16	(i) Performance Management and Accountability Framework. (ii) Business planning processes (iii) Relevant policies and procedures. (iv) Daily, weekly & monthly monitoring of targets. (v) Regular monitoring of compliance. (vi) Data analysis of trends and action to address shortfalls. (vii) Continued liaison with leads to identify risks to delivery. (viii) CQC Compliance Governance and Assurance Process. (ix) External reviews policy. (x) Monitoring at monthly Care Group accountability meetings. (xi) A&E QAT process. (xii) Demand and capacity planning proccesses. (xiii) Weekly review of A&E Action plan in accountability meeting chaired by COO.	(i) Full and unconditional registration with CQC (ii) Business Intelligence Reports (iii) Annual Report & Quality Account (iv) CE quarterly objectives report (BoD - quarterly) (v) Internal audit of CQC readiness (vi) CQC Intelligent Monitoring reports & risk ratings (viii) (vii) In Group 2 on four hour waits (viii) A&E Improvement Progarmme North - showcasing best practice (ix) System Perfect	(i) CQC self-assessments and mock inspections (ii) Well-led review of effectiveness 2017	(i) New accountability framework linked to SOF being put in place for care groups and corporate depts (ii) Internal audit of CQC readiness to report October 2017	L3 x I3 = 9
Failure to ensure that estates infrastructure is adequately maintained and upgraded in accordance with the Regulatory Reform (Fire Safety) Order 2005 and other current legislation standards and guidance. **Note:** a number of different distinct risks are conatained within this overarching entry. For further details please consult the EF risk register. leading to (i) Breaches of regulatory compliance could result in Enforcement or Prohibition notices issued by the Fire and Rescue Services (ii) Claims brought against the Trust (iii) Inability to provide safe services (iv) Negative impact on reputation	F&P12	Director of Estates and Facilities	L4 x I5 = 20	(i) Regular external inspections from SYRS and Notts Fire Service (ii) Improved fire safety risk assessments and evacuation strategies (iii) Improved Fire Safety Training (iv) Programme upgrade of fire detection systems (v) Programme upgrade of structural fire precautions (compartments) (vi) External Audit Fire Authorised Engineer (vii) Fire safety training Trust Board and Exec Team (viii) Further Development of Fire Safety Response Team structure (ix) Risk based Capital Investment plans identified by estate condition and backlog maintenance assessments via 6 - 7 facet surveys (x) Progress and monitoring of actions undertaken through compliance committees eg health and safety committee	(i) Physical works to DRI and MMH (ii) Fire safety action plan (iii) Report to Board in June 2017 (iv) Fire safety training for BoD scheduled July 2017 (v) 96% of staff trained in fire safety - June 2017 (vi) Removal of enforcement notice at DRI (vii) Compartmentalisation, fire stopping, fire doors, fire dampers to the East Ward Block (DRI) basement, ground floor and level seven and other areas across the site (viii) Upgrade of existing, and provision of additional, fire alarm and detection systems at DRI and Montagu Hospital.	(i) Full compliance with requirements of Fire Service	(i) Capital invtestment in fire works over 2017/18 (discussions to take place over capital commitments, October 2017)	L2 x I5 = 10
Inability to meet Trust's needs for capital investment leading to (i) Inability to sustain improveemnts in Trust's estate. (ii) Negative impact on patient safety. (iii) Negative impact on reputation.	F&P13	Director of Finance	L4 x I4 = 16	(i) Finance reports to Board and Finance and Performance Committee. (ii) Capital governance structure - Corporate Investment Group and Capital Monitoring Group. (iii) Guidance and templates for investment and disinvestment.	(i) DBTH part of bidding process for STP funds	(i) Knowledge of possible funding remaining for capital schemes after ACS schemes	(i) Prioirtisation of capital work (KEJ, Octobr 2017) (ii) MP developing capital schemes for ACS funding (Autumn 2017)	L1 x I4 = 4
Lack of adequate CT scanning capacity at DRI leading to (i) Negative impact on patient safety. (ii) Inability to safely manage the emergency and inpatient activity.	Q&E2	Chief Operating Officer	L3 x I3 = 9	(i) Allocation within 2017/18 capital programme. (ii) Engagement with care group directors.	N/a	(i) Final decision on bid for scanning capacity	(i) Final case being submitted to DOH (October 2017)	L2 x I2 = 4
Risk of fraud leading to (i) Impact on Trust's finance (ii) Negative impact on reputation	ANCR1	Director of Finance	L2 x I4 = 8	(i) Local Counter Fraud Specialist work plan and investigations (ii) Fraud awareness training. (iii) DH Counter-Fraud regime and oversight (iv) Liaison with DOF and Chair of ANCR	(i) Quarterly and annual LCFS reports (i-iii) (ii) Achievement of satisfactory NHS Protect Quality Assessment outcome (i-iii) (iii) Full completion of 2016/17 operational fraud plan (iv) Completion of fraud staff survey (vii) 79% completed fraud awareness training in 2017/18 (viii) NHS Protect assurance report to Board, October 2017	N/A	(i) Report on impact of loss of NHS Protect support to come to Board (October 2017)	L1 x I4 = 4

Strategic Aim 3 - We will increase partnership working to benefit people and communities.		
KEY STEPS	Work with STP and Place based partners to ensure that the Trust maintains a sustainable future to deliver the needs of the local populations and the legal responsibilities required by NHSI and the CQC	
	Ensure the completion of the Trusts Strategic Vision to reflect the aims and objectives for the Trust within the STP, Place and legal and regulatory requirements of NHSI and the CQC	
	Work with external partners to review service delivery across the wider STP footprint to ensure services which support place based ambitions and the delivery of high quality and sustainable services	
	Develop a specific programme of work to ensure that the future structure of the Medical Directors office reflects the future needs of the Trust, STP and Place and the composition of the medical workforce	
	Evaluate the potential for Public/Private Partnerships, linked to the Trust strategic direction.	
PROGRESS	Evidence of active particpation in Doncaster Place Plan implementation. Strategic Direction includes input on both place plans, involved partner governors and has been presented at DCCG and Bassetlaw ACP. Strategic Direction 2017-2022 agreed and submitted to NHSI. Acute Hospitals Review has DBTHFT clinicians and managers on five key workstreams. Review of roles and reponsibilities within the MD's office has been completed. Options for Capital funding through JV/WOS models disucssed at commercial board	Direction

RISKS	LINK TO CRR	EXEC	CURRENT RR	CONTROLS	ASSURANCE	GAPS IN ASSURANCE	ACTION TO ADDRESS GAPS	TARGET RR
Breakdown of relationship with key partners and stakeholders leading to (i) Negative impact on strategic objectives (ii) Negative impact on reputation	F&P9	Chief Executive	L3 xl4 = 12	(i) Partnership working processes - Working Together, STP, Accountable Care Systems, HWB (ii) Engagement with commissioners & other local trusts (iii) Attendance at CCG governing body meetings (iv) CE meetings with NHS England (v) Regular briefings to Members of Parliament (vi) Partner Governor seats on the Board of Governors (vii) Regular item on Exec Team for feeding back	(i) CE Reports (ii) Updates on HWB activity (iii) Updates regarding Working Together and STP programme via CE report (BoD) (ii) (iv) Committees in common and STP MoUs (v) Support from commissioners (vi) Bassetlaw and Doncaster Place Plans endorsed. (vii) Well Led Governance Review reinforces the Trust's partnership arrangements.	(i) Approval of Provider MoU (ii) Clarity on SCR devolution proposals	(i) Place Plan MoU to be brought to Board of Directors, Autumn 2017 (ii) First meeting of CiC to take place, October 2017	L2 x I4 = 8
Failure to ensure business continuity / respond appropriately to major incidents leading to (i) Negative impact on reputation (ii) Regulatory enforcement (iii) Negative impact on performance	F&P10	Chief Operating Officer	L2 x I4 = 8	(i) Business continuity plans (ii) Business Continuity Policy (iii) Statement of Compliance against National Core Standards for EPRR (iv) BRSG which monitors BC planning progress (v) Business Continuity Group linked to operational structures (vi) Major Incident Plan (vii) Training of A&E staff on CBRN incidents (viii) Emergency response plans in place (annually reviewed) - Evacuation of a hospital site - Mass Casualty Plan - Pandemic Influenza Plan - Severe Eeather Plan - Prison Plan - CBRNE plan (ix) Incident Control Room in line with EPRR Command and Control guidelines (x) Communications exercises undertaken twice yearly as required by statute (xi) Command & control training for BoD & senior managers on-call (xii) Revision of plans following test exercises.	(i) Power outage testing Summer 2017 (ii) Annual confirmation of compliance against National Core Standards for Emergency Preparedness, Resilience and Response (BoD, Nov 2016) (iii) Test exercises: Sickness, fuel (2016) (iv) Internal Audit follow-up review of business continuity arrangements (v) Risk assessment of major incident and business continuity plans with NHS England (2015) (vi)Y&H peer review of major incident plans 2016. (vii) External review of HAZMAT - compliant (September 2015) (viii) Hazardous Substances policy agreed by Board 29.11.2016 (ix) Tabletop exercises undertaken, SY risk assessment completed and two power cuts (x) Working with Care Groups to develop relevant desktop exercises. (xi) Trust unaffected by system-wide cyber attack, May 2017 (xii) Winter planning agreed by Board in July 2017 (xiii) Compliance with Annual Statement of Compliance against the NHS Core Standards for Emergency Preparedness, Resilience and Response (2017/18)	(i) Business continuity plans reviewed (ii) Further testing of plans	(i) Emergency plans in process of review (JR, October) (ii) Major exercise planned 12 December 2017	L2 x I3 = 6

Strategic Aim 4 - We will support the development of enhanced community based services, prevention and self-care.								
KEY STEPS	Work with partners to reduce demand on the acute services to ensure that demand equates to available resources							
PROGRESS	CCGs quip monitored monthly. PLCV agreed with both CCGs. Referrals being monitored against overall referral patterns, evaluated at the joint Planned care Board. Care groups being monitored against contracted activity.						Direction	
RISKS	LINK TO CRR	EXEC	CURRENT RR	CONTROLS	ASSURANCE	GAPS IN ASSURANCE	ACTION TO ADDRESS GAPS	TARGET RR
Inability to sustain the Paediatrics service at Bassetlaw leading to (i) Withdrawal of overnight service (ii) Negative impact on local community	Q&E3	Chief Operating Officer	L2 x I2 = 4	(i) Consultant led paediatric assessment unit in place. (ii) Arrangements for transferring overnight stays to DRI. (iii) Communication with CCG and HOSC. (iv) Arrangements with Sheffield Children's Hospital. (v) Ongoing paediatric nurse recruitment.	(i) Reports on transferrals (ii) Positive response to recruitment (iii) Discussions with Notts Health O&S Committee in July 2017 (iv) Report to Board, August 2017 regarding future of overnight paediatric service	(i) Firm acceptance of offers to new nurses	(i) Regular recruitment exercises	L2 x I2 = 4
Reduction in hospital activity and subsequent income due to increase in community provision leading to (i) Increased pressure on acute services (ii) Negative impact on financial plan	F&P14	Director of Finance	L4 x I3 = 12	(i) Measures to ensure ward base matches with cost base (ii) Contract negotiation (III) Nursing workforce report (iv) Agency bank report (v) Corporate Investment Group processes (vi) Business change processes for associated service changes (vii) Contract changes to go to F&P	(i) DBTH input into Place Plan (ii) Assessment received for MoU	(i) Understanding of impact of Place Plan	(i) Meetings taking place with Council and other partners to assess impact (Autumn 2017)	L4 x I2 = 8
Commissioner plans do not come to fruition and do not achieve the required levels of acute service reduction leading to (i) Increased pressure on acute services (ii) Negative impact on strategic direction (iii) Negative impact on financial plan	F&P15	Chief Operating Offcer	L3 x I3 = 9	(i) Potential to dual run services (ii) Contractual negotiations (iii) External advice on contractual changes	(i) Active monitoring of position	(i) Finance Strategy (ii) Clinical Service Strategy	Both strategies being presented to F&P in Ocober and Board in November	L2 x I3 = 6

Strategic Aim 5 - As a Teaching Hospital we are committed to continuously developing the skills, innovation and leadership of our staff to provide high quality, efficient and effective care.								
KEY STEPS	Co-ordinate the development of an innovative and sustainable workforce plan across the Trust. Developing and implementing plans to improve leadership, recruitment and retention initiatives							
	Co-ordinate, develop and ensure the implementation, delivery and monitoring of the staff engagement action plan to ensure the delivery of the Trusts values and an improvement in the national staff survey results for 2017/ 18							
	Co-ordinate the production and delivery of Board and Executive Team Development Programmes							
	To create a stable and motivated finance function, measured by staff turnover, implementation of restructures, staff survey							
PROGRESS	Support from HEE identified to deliver refresher training to Calderdale facilitators and to develop an internal trainer. Work underway to map trainee ACPs to future workforce models. Workforce models being developed in support of the 3 steering groups. Recruitment site on website refreshed with associated material. Trust wide staff experience group established, 2 meetings held. Flu CQUIN target achieved. Staff survey in progress. Active communications to demonstrate progess this year and to deliver improved response rate. Action plans in place within Care Groups and directorates. Board development programme being shaped - various sessions held.						**Direction**	
RISKS	**LINK TO CRR**	**EXEC**	**CURRENT RR**	**CONTROLS**	**ASSURANCE**	**GAPS IN ASSURANCE**	**ACTION TO ADDRESS GAPS**	**TARGET RR**
Inability to recruit right staff and have staff with right skills leading to (i) Increase in temporary expenditure (ii) Inability to meet FYFV and Trust strategy (iii) Inability to provide viable services	F&P8	Director of People & OD	L4 x I4 = 16	(i) HR policies and procedures. (ii) Monitoring of use of agency staff through robust processes to stay within cap. (iii) Medical staff recruitment action plans. (iv) Care Group Business Plans – workforce plans. (v) E-Rostering processes. (vi) VCF processes. (vii) Consultant appointment approval processes. (viii) NHS Professionals processes & management information. (ix) Pilot of Assistant Practitioner role. (x) Links with universities, increasing local placements.	(i) Increased fill-rate (ii) Recruitment report to Board, May 2017 (iii) Regular NHSI reporting which is reported to Exec Team (iv) Benchmarking work (v) WTP work (vi) New style agency report reported monthyl to Exec Team (vii) Work with ACS Local Workforce Action Board (viii) Accountability arrangements embedded	Workforce tracker	N/A	L2 x I4 = 8
Failure to engage and communicate with staff and representatives in relation to immediate challenges and strategic development leading to (i) Deterioration in management-staff relationships (ii) Negative impact on performance (iii) Negative impact on reputation	Q&E1	Director of People & OD	L3 x I4 = 12	(i) Staff survey action plan. (ii) Process to engage with LNC. (iii) Process to engage with Partnership Forum. (iv) HR policies and procedures. (v) Staff engagement project strands. (vi) Staff experience group. (vii) New style 'Licence to Operate' accountability meetings.	(i) Suspensions/exclusions reports to ANCR (ii) P&OD reports to Board (iii) Briefings regarding staff engagement during restructures (iv) Records of ongoing engagement via Partnership Forum (v) Staff Survey results (vi) Grievance and employment tribunal rates (vii) Outcomes of negotiation & work with staff side. (ix) Delivery of engagement plan KPIs. (x) Listening events (xi) Buzz and social media interaction	Staff survey action plans (corporate & local). Care Group action plans being developed.	(i) Care group action plans being developed for September 2017	L2 x I4 = 8
Failure to improve staff morale leading to (i) Recruitment and retention issues (ii) Impact on reputation	Q&E6	Director of People and OD	L3 x I4 = 12	(i) Monitoring by staff experience group (ii) Revised appraisal process (iii) Chief Executive's listening exercises and 'you said, we did' (iv) Staff involved in strategy engagement (v) Management passport qualification developed (vi) Localised action plans (vii) Staff survey action plan monitored by Board and QEC (viii) Revamped staff brief (xi) 'Bugbears and bright ideas' approach (x) Agreed approach to staffside - management meetings	(i) Feedbcak from Friends and Family Q1 (ii) Feedback from CEO's listening events (iii) Bugbears and bright ideas (iv) Report to QEC and Board, June 2017, on staff survey action plan (v) Place to work indicator in staff F&F up 11% in Q1 (vi) WEC assurance report to QEC	(i) Consistent positive scores for staff Friends and Family Test (ii) Refreshed P&OD Strategy	(i) Additional listening exercises (ii) P&OD Strategy coming to QEC in September and F&P and Board October 2017	L2 x I4 = 8

Doncaster & Bassetlaw Teaching Hospitals Corporate Risk Register - Finance & Performance																
No.	Description of Risk		Exec owner	Relevant committee	Original Risk Score 1:Low...5:Extreme		Overall Original Risk Score	Controls	Current Risk Score 1:Low 5:Extreme		Overall Current Risk Score	Direction of travel	Target Risk Score 1:Low 5:Extreme		New and developing controls	Owner and target date
	Source (Lack of....Failure to ....)	Consequences (Results in ....Leads to ....)			Like-lihood	Impact			Like-lihood	Impact			Like-lihood	Impact		
F&P1	Failure to achieve compliance with financial performance and achieve financial plan	(i) Adverse impact on Trust's financial position (ii) Adverse impact on operational performance (iii) Impact on reputation (iv) Regulatory action	Director of Finance	Finance & Performance	4	5	20	(i) Business and budget planning processes. (ii) Financial governance policies and procedures. (iii) Monthly monitoring of financial performance. (iv) Data analysis of trends and action to address deterioration. (v) Continued liaison with budget holders to identify risks to delivery. (vi) Demand and capacity planning processes. (vii) Detailed monitoring by Finance and Performance Committee. (viii) Budgets set on recurrent outturn resulting in a more robust financial plan. (ix) Budgets signed off by care groups and corporate departments. (x) Monthly monitoring at Board and directorate level. (xi) Uncommitted general contingency reserve. (xii) Regular finance meetings with budget holders. (xiii) Performance review meetings with NHSI. (xiv) All directorates signed up to control total.	3	5	15	⟷	2	5	N/A	
F&P3	Failure to deliver Cost Improvement Plans in this financial year	(i) Negative impact on Turnaround (ii) Negative impact on Trust's financial positon (iii) Loss of STF funding	Director of Finance	Finance & Performance	4	5	20	(i) Full Quality Risk Assessment and operational deliverability assessment of plans. (ii) Regular consideration of schemes by Management Board and Executive Team. (iii) Collaboration with other providers, to identify joint opportunities. (iv) CIP tracker developed to provide visibility of progress agianst plan. (v) Engagement in working together programme. (vi) PMO, with associated management processes, key deliverables, risk logs and reporting to Finance and Performance Committee. (vii) Implementation of innovation from external reviews. (viii) Regular meetings with NHSI to track progress.	4	4	16	⟷	1	5	PMO governance processes.	JS - October 2017
F&P4	Failure to ensure that estates infrastructure is adequately maintained and upgraded in line with current legislation, standards and guidance. **Note:** A number of different distinct risks are contained within this overarching entry. For further details please consult the E&F risk register.	(i) Breaches of regulatory compliance and enforcement (ii) Claims brought against the Trust (iii) Inability to provide safe services (iv) Negative impact on reputation (v) Reduced levels of business resilience (vi) Inefficient energy use (increased cost) (vii) Increased breakdowns leading to operational disruption (viii) Restriction to site development	Director of Estates and Facilities	Finance & Performance	5	5	25	(i) Annual business plan supports identification of issues by Care Groups / Directorates (ii) Risk-based capital investment plans (iii) Maintenance and support service contracts (iv) Independant Authorising Engineers appointed for key services, providing annual audits and technical guidance (v) Revised business planning process for all capital investments (vi) Estate condition and backlog maintenance assessment undertaken via 6-7 facet survey (vi) Progress and monitoring of actions undertaken through compliance committees e.g. health and safety committee	4	5	20	⟷	2	5	(i) Estates and facilities strategy (ii) Review and develop buisness continuity and disaster recovery plans (iii) Comprehensive review of Estates and facilities risk register and risk escalation process (iv) Seek Additional funding to rectify condition and backlog maintenanace issues	KEJ - Oct/Nov 2017 DP - Oct 2017 KEJ - Oct 2017 TBC
F&P5	Failing to address the effects of the medical agency cap	(i) Negative patient and public reaction towards the Trust (ii) Impact on reputation	Director of People and OD/ Chief Operating Officer/Medical Director	Finance & Performance	N/A	N/A	N/A	(i) International recruitment programme. (ii) Teaching hospital status communicated through recruitment. (iii) Care Group to escalate recruitment difficulties to MD/COO. (iv) Use of Trust staff in first instance to address gaps wherever possible. (v) Signed memo of understanding between all Trusts in the WTP to abide by a standard set of principles. (vi) P&OD / Workforce reports to BoD. (vii) Workforce and Education Committee. (viii) Agency spend and breaches going to Exec Team and Finance and Performance. (ix) Better system around rate-to-fill and fill rates. (x) Use of social media to attract new candidates. (xi) Relationships with universities. (xii) GMC Survey. (xiii) Medical agency locum panel.	4	4	16	↑	3	2	(i) Develop new service model to mitigate medical staff shortage. (ii) Develop and progress workforce from using alternative workforce for service delivery. (iii) Agency spend to F&P. (iv) Scrutiny of qualified nursing process to be put in place.	KB/SS/DP - ongoing As above KB, September 2017 MH, September 2017
F&P6	Failure to achieve compliance with performance and delivery aspects of the Single Oversight Framework, CQC and other regulatory standards	(i) Regulatory action (ii) Impact on reputation	Chief Operating Officer	Finance & Performance (impact on performance) Quality & Effectiveness (impact on quality)	5	4	20	(i) Performance Management and Accountability Framework. (ii) Business planning processes (iii) Relevant policies and procedures. (iv) Daily, weekly & monthly monitoring of targets. (v) Regular monitoring of compliance. (vi) Data analysis of trends and action to address shortfalls. (vii) Continued liaison with leads to identify risks to delivery. (viii) CQC Compliance Governance and Assurance Process. (ix) External reviews policy. (x) Monitoring at monthly Care Group accountability meetings. (xi) A&E QAT process. (xii) Demand and capacity planning proccesses. (xiii) Weekly review of A&E Action plan in accountability meeting chaired by COO.	4	4	16	⟷	3	3	None.	N/A

F&P8	Inability to recruit right staff and have staff with right skills	(i) Increase in temporary expenditure (ii) Inability to meet FYFV and Trust strategy (iii) Inability to provide viable services	Diretcor of People & OD	Finance & Performance	5	4	20	(i) HR policies and procedures. (ii) Monitoring of use of agency staff through robust processes to stay within cap. (iii) Medical staff recruitment action plans. (iv) Care Group Business Plans – workforce plans. (v) E-Rostering processes. (vi) VCF processes. (vii) Consultant appointment approval processes. (viii) NHS Professionals processes & management information. (ix) Pilot of Assistant Practitioner role. (x) Links with universities, increasing local placements.	4	4	16	⟷	2	4	(i) Exploring recruitment with other partners and through other methods. (ii) Agency report development	MH - Sept/Oct 2017 KB - Oct 2017
F&P11	Failure to protect against cyber attack	(i) Trust becoming non-operational (ii) Inability to provide clinical services (ii) Negative impact on reputation	Chief Information Officer	Finance & Performance	5	5	25	(i) Penetration test of systems to identify gaps and risks; (ii) Firewalls, passwords, anti-virus equipment. (iii) Policies and reinforcement through communication to staff; (iv) Staff awareness through Certified Security Professional course and other training; (v) Trigger alerts; (vi) Care Cert system at NHS Digital.	3	5	15	⟷	1	4	N/A	N/A
F&P12	Failure to ensure that estates infrastructure is adequately maintained and upgraded in accordance with the Regulatory Reform (Fire Safety) Order 2005 and other current legislation standards and guidance. **Note:** a number of different distinct risks are conatained within this overarching entry. For further details please consult the EF risk register.	(i) Breaches of regulatory compliance could result in Enforcement or Prohibition notices issued by the Fire and Rescue Services (ii) Claims brought against the Trust (iii) Inability to provide safe services (iv) Negative impact on reputation	Director of Estates and Facilities	Finance & Performance	5	5	25	(i) Regular external inspections from SYRS and Notts Fire Service (ii) Improved fire safety risk assessments and evacution strategies (iii) Improved Fire Safety Training (iv) Programme upgrade of fire detection systems (v) Programme upgrade of structural fire precautions (compartments) (vi) External Audit Fire Authorised Engineer (vii) Fire safety training Trust Board and Exec Team (viii) Further Development of Fire Safety Response Team structure (ix) Risk based Capital Investment plans identified by estate condition and backlog maintenance assessments via 6 - 7 facet surveys (x) Progress and monitoring of acations undertaken through compliance committees eg health and safety committee	3	5	15	⟷	2	5	(i) Further review of Risk Based capital investment plans (ii) Comprehensive review of Estates and Facilities risk regster and risk escalation process (iii) Seek additional funding to rectify condition and backlog maintenance issues	JS - October 2017 KEJ - Oct 2017 TBC
F&P13	Inability to meet Trust's needs for capital investment	(i) Inability to sustain improveemnts in Trust's estate. (ii) Negative impact on patient safety. (iii) Negative impact on reputation.	Director of Finance	Finance & Performance	5	4	20	(i) Finance reports to Board and Finance and Performance Committee. (ii) Capital governance strcuture - Corporate Investment Group and Capital Monitoring Group. (iii) Guidance and templates for investment and disinvestment.	4	4	16	⟷	1	4	Clarity around process over STP capital projects.	TBC

	PROBABILITY
1 RARE	Less than 5%
2 UNLIKELY	5% to 20%
3 POSSIBLE	21% to 50%
4 LIKELY	51% to 80%
5 ALMOST CERTAIN	More than 80%

	BUSINESS OBJECTIVE	FINANCE	COMPLIANCE	SAFETY	REPUTATION	SERVICE DELIVERY
1 NEGLIGIBLE	Negligible impact/delay/ overspend/ difficulty	Minor loss < £1,000	Trivial, very short-term single non-compliance	Insignificant injury (no intervention)	Low level public awareness/ concern	Negligible impact/ unnoticed by service users
2 MINOR	Small impact/ delay/ overspend/ difficulty	Small loss £1,001 - £10,000	Small, single, short-term non-compliance	Minor injury (local intervention)	Short-term local media coverage	Small impact/ small inconvenience
3 MODERATE	Medium scale impact/delay/ overspend/ difficulty	Moderate loss £10,001 - £100,000	Sustained single or a few short-term non-compliances	Moderate injury (professional intervention)	Longer-term local media coverage	Medium level impact/ moderate inconvenience
4 MAJOR	Significant impact/delay/ overspend/ difficulty	Significant loss £100,001 - £1,000,000	Multiple sustained non-compliances	Major injury (hospital stay)	Short-term national media coverage	Significant impact/ serious inconvenience
5 CATAS-STROPHIIC	Substantial impact/delay/ overspend/ difficulty	Substantial loss > £1,000,000	Multiple, long-term, significant non-compliances	Fatal injury	Longer-term national media coverage	Substantial/ Complete service failure

Doncaster & Bassetlaw Teaching Hospitals Corporate Risk Register - Quality and Effectiveness																	
No.	Description of Risk		Exec owner	Relevant committee	Original Risk Score 1:Low...5:Extreme		Overall Original Risk Score	Controls	Current Risk Score 1:Low 5:Extreme		Overall Current Risk Score	Direction of travel	Target Risk Score 1:Low 4:Extreme		New and developing controls	Owner and target date
	Source (Lack of....Failure to ....)	Consequences (Results in ....Leads to ....)			Like-lihood	Impact			Like-lihood	Impact			Like-lihood	Impact		
F&P7	Failure to achieve compliance with performance and delivery aspects of the Single Oversight Framework, CQC and other regulatory standards	(i) Regulatory action (ii) Impact on reputation	Chief Operating Officer	Finance & Performance (impact on performance) Quality & Effectiveness (impact on quality)	5	4	20	(i) Performance Management and Accountability Framework. (ii) Business planning processes (iii) Relevant policies and procedures. (iv) Daily, weekly & monthly monitoring of targets. (v) Regular monitoring of compliance. (vi) Data analysis of trends and action to address shortfalls. (vii) Continued liaison with leads to identify risks to delivery. (viii) CQC Compliance Governance and Assurance Process. (ix) External reviews policy. (x) Monitoring at monthly Care Group accountability meetings. (xi) A&E QAT process. (xii) Demand and capacity planning proccesses. (xiii) Weekly review of A&E Action plan in accountability meeting chaired by COO.	4	4	16	⟷	3	3	None.	N/A

	PROBABILITY
1 RARE	Less than 5%
2 UNLIKELY	5% to 20%
3 POSSIBLE	21% to 50%
4 LIKELY	51% to 80%
5 ALMOST CERTAIN	More than 80%

	BUSINESS OBJECTIVE	FINANCE	COMPLIANCE	SAFETY	REPUTATION	SERVICE DELIVERY
1 NEGLIGIBLE	Negligible impact/delay/ overspend/ difficulty	Minor loss < £1,000	Trivial, very short-term single non-compliance	Insignificant injury (no intervention)	Low level public awareness/ concern	Negligible impact/ unnoticed by service users
2 MINOR	Small impact/ delay/ overspend/ difficulty	Small loss £1,001-£10,000	Small, single, short-term non-compliance	Minor injury (local intervention)	Short-term local media coverage	Small impact/ small inconvenience
3 MODERATE	Medium scale impact/delay/ overspend/ difficulty	Moderate loss £10,001 - £100,000	Sustained single or a few short-term non-compliances	Moderate injury (professional intervention)	Longer-term local media coverage	Medium level impact/ moderate inconvenience
4 MAJOR	Significant impact/delay/ overspend/ difficulty	Significant loss £100,001 - £1,000,000	Multiple sustained non-compliances	Major injury (hospital stay)	Short-term national media coverage	Significant impact/ serious inconvenience
5 CATAS-STROPHIIC	Substantial impact/delay/ overspend/ difficulty	Substantial loss > £1,000,000	Multiple, long-term, significant non-compliances	Fatal injury	Longer-term national media coverage	Substantial/ Complete service failure

Doncaster & Bassetlaw Teaching Hospitals Corporate Risk Register - Audit & Non-clinical Risk Committee															
No.	Description of Risk		Exec owner	Relevant committee	Original Risk Score 1:Low...5:Extreme		Overall Original Risk Score	Controls	Current Risk Score 1:Low 5:Extreme		Overall Current Risk Score	Direction of travel	Target Risk Score 1:Low 4:Extreme		New and developing controls	Owner and target date
	Source (Lack of....Failure to ....)	Consequences (Results in ....Leads to ....)			Like-lihood	Impact			Like-lihood	Impact			Like-lihood	Impact		

	PROBABILITY
1 RARE	Less than 5%
2 UNLIKELY	5% to 20%
3 POSSIBLE	21% to 50%
4 LIKELY	51% to 80%
5 ALMOST CERTAIN	More than 80%

	BUSINESS OBJECTIVE	FINANCE	COMPLIANCE	SAFETY	REPUTATION	SERVICE DELIVERY
1 NEGLIGIBLE	Negligible impact/delay/ overspend/ difficulty	Minor loss < £1,000	Trivial, very short-term single non-compliance	Insignificant injury (no intervention)	Low level public awareness/ concern	Negligible impact/ unnoticed by service users
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4 MAJOR	Significant impact/delay/ overspend/ difficulty	Significant loss £100,001 - £1,000,000	Multiple sustained non-compliances	Major injury (hospital stay)	Short-term national media coverage	Significant impact/ serious inconvenience
5 CATAS-STROPHIIC	Substantial impact/delay/ overspend/ difficulty	Substantial loss > £1,000,000	Multiple, long-term, significant non-compliances	Fatal injury	Longer-term national media coverage	Substantial/ Complete service failure

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Title	**Chair's and NEDs' Report**		
Report to	**Board of Directors**	**Date**	**31 October 2017**
Author	**Suzy Brain England, Chair**		
Purpose			Tick one as appropriate
	Decision		
	Assurance		
	Information		x

Executive summary containing key messages and issues
The report covers the Chair and NEDs' work in October 2017 and includes updates on a number of activities: • Women of the Year Awards • Butterfly Volunteers • Non-executive Director update • Governor update • Other meetings this month • Governor activity
Key questions posed by the report
N/A
How this report contributes to the delivery of the strategic objectives
The report relates to all of the strategic objectives.

How this report impacts on current risks or highlights new risks
N/A
Recommendation(s) and next steps
That the report be noted.

Chair's Report – October 2017

Women of the Year Awards

Earlier this month I was joined by executive colleagues at the Barclays Women of the Year awards in Birmingham.

The awards brings together more than 400 women from all walks of life for their achievements and contribution to society. Awards are presented to exceptional women who have each proved an inspiration to others through their courage, selflessness and dedication both in the UK and globally. The Women of Achievement award was presented collectively to all those working in the Emergency Services for their response to terrorist attacks in London and Manchester. Coming from an acute trust ourselves, it made us proud to share in this accolade.

The woman of the year winner was NHS worker, Laura Prescott, who as a bereavement liaison nurse based at the Royal Bolton Hospital, who supported victims of the recent Manchester Arena attack and was part of a specialist team who comforted bereaved families affected by the tragedy.

Butterfly Volunteers

It will be my pleasure on 23 October to meet with Karen Lanaghan, Palliative Care Macmillan Nurse, about the sterling work of the Trust's Butterfly Volunteers.

Sadly, a number of patients who are facing the end of their life die alone at our hospitals each month. The Butterfly project has a dozen or so specially trained volunteers providing companionship for those people who do not have any visitors. The volunteers also help families and carers with support and respite whilst their loved one is dying.

I am looking forward to working with Karen to see how we can raise the profile of the Butterfly Volunteers and get more people volunteering for this important vocation.

Non-executive Director update

I have spent a part of October meeting people interested in the NED roles the Trust will be advertising shortly. There has been an excellent response to the four NED briefing sessions we are holding on 23 and 24 October at Bassetlaw and Doncaster, including our existing governors.

October has also been spent carrying out Non-executive Director appraisals, the outcomes from which will be reported to Governors on 26 October. Thanks to everyone who contributed to those by giving feedback.

As reported at the last Board meeting, following Martin's departure, I met with Governors at the end of September to agree the appointment of an Associate Non-executive Director who will cover the period between now and when we make a permanent clinical NED appointment in c. January 2018.

Details of the recommended candidate will be presented to Board of Governors on 26 October for approval and will join us at Board on 31 October as well as getting involved in some of the Board committees.

Governor Update

The latest briefing saw two of our senior clinical staff attend to present and answer governors' questions. Moira Hardy, Acting Director of Nursing, Midwifery and Quality, spoke about the work the Trust was doing around patient experience and engagement and this was followed by a briefing from Medical Director, Sewa Singh, on learning from deaths and the Hospital Services Review. It was well attended and there was excellent engagement from governors.

Our next big Governor event is on the morning of 27 October when we host Alan Johnson, former Home Secretary and Secretary of State for Health, and Sir Bruce Keogh, NHS England's outgoing Medical Director, at our ACS Governors' Conference at Rotherham United's New York Stadium. At the last count, 110 people had confirmed their attendance.

Other meetings this month

I attended a Leadership Networking Event on 5 October hosted by Veredus where former England and Great Britain rugby league captain, Jamie Peacock, gave his reflections on leadership. It was an insightful and very motivational evening. I have also been keeping abreast with developments in finance, particularly in relation to the CIP governance review and the Trust's financial position.

NED Activity

On 12 September, Philippe attended a meeting of all audit chairs from NHS organisations within the SYB ACS. Present were both providers and commissioners. The meeting was held at Doncaster CCG and chaired by Sir Andrew Cash.

The history of the ACS was recounted and the current timetable going forward explained. Unsurprisingly, much focus was placed on the governance structures (both within and outside of the NHS) that have been put in place to manage the programme.

Much discussion took place, with most of the audit chairs participating, and it was made clear that as it stands there is no change to the governance of the entities themselves. The meeting finished with an invitation to the audit chairs of each "Place" to nominate one of their number to sit on and contribute to one of the existing ACS governance committees. This was agreed.

Chief Executive's Report
31 October 2017

Preparing for Winter

We are now ramping up our winter plans. The Trust has clear and defined escalation plans in place to help teams to pull in the same direction during peak periods.

NHS Improvement have asked Boards, led by medical directors and nurse directors, to consider all of the options available to them and make decisions that weigh risk up in the round.

A new National Emergency Pressures Panel has also been established to take a national view of developing pressures.

Safety and Quality of Emergency Care

The CQC's Chief Inspector of Hospitals wrote to NHS chief executives recently to advise of a best practice exercise they had carried out with 34 senior clinicians and nursing staff from 16 trusts that have a good or outstanding rating for their urgent and emergency care services. Key areas where patients could be at risk were identified and the advice from these clinical staff helped the CQC define the future approach. In anticipation of the final conclusions, the key themes were as follows:

Ambulance arrivals

Any patient physically on the hospital site should be regarded as under the care of the emergency department and should be booked into the department without delay; the clock should start ticking at that point. Patients should not wait in ambulances and should not be delayed being booked into the department, to avoid a 'two tier' system whereby patients who arrive independently are booked in on arrival.

First clinical assessment

Patients needing urgent care should be consistently identified in a timely way. First clinical assessment of all patients attending the emergency department should be undertaken without delay and should give the department confidence that they know whether each patient has a serious problem or not.

Use of inappropriate physical spaces

Patients should receive safe and effective care in an environment that allows for their privacy and dignity to be protected. This means for example, that they are always in sight of clinical staff, and that there are sufficient numbers of clinical staff in that area to care for them. Inappropriate areas, such as a corridor, should be avoided. Where a department does use such an area, there should be a plan to address this, so that the practice does not become routine. The CQC's view on the use of inappropriate areas extends to other areas of the hospital.

Specialist referrals

There should be no undue delay to patients being seen by the appropriate specialist team once they have been referred. Once referred, the patient should remain under the specialist team's care and should not be referred back to the emergency department. It is not acceptable for patients to be held for prolonged periods in the emergency department waiting for specialist assessment.

Escalation

There should be a consistent and effective trust-wide escalation process that enables an adequate and safe response to unexpected surges in demand. It is the responsibility of trusts as a whole, and potentially the wider health system, to deal with these surges, not just the emergency department.

Deteriorating patients

Emergency departments need a consistent, effective and audited system for identifying patients whose condition is deteriorating. This may be by means of early warning scores, a safety checklist – which have been found to be effective in some trusts – or by another method suited to local circumstances.

Patient outcomes

Information about effectiveness of people's care and treatment should be routinely collected, monitored, and used to drive quality improvement. Trusts should consider incorporating the Royal College of Emergency Medicine and other relevant clinical standards into their patient outcome monitoring systems.

Staff

Effective and consistent clinical leadership is essential for both patient safety and staff well-being. Staff are working under great pressure in most emergency departments and issues around leadership and culture can add to the difficulties they face. Emergency departments with good and empathic leadership that recognise the importance of staff well-being will be better able to meet the workforce challenges that exist throughout the system.

Objectives

Performance against Q2 objectives are attached to this report as an appendix.

State of Care Report

This year's State of Care report – published by the CQC – shows that thanks to the efforts of staff and leaders, the quality of health and social care has been maintained despite very real challenges and the majority of people are receiving good, safe care.

However, it also warns that the health and social care system is at full stretch and struggling to meet the more complex needs of today's population, meaning that maintaining quality in the future is uncertain.

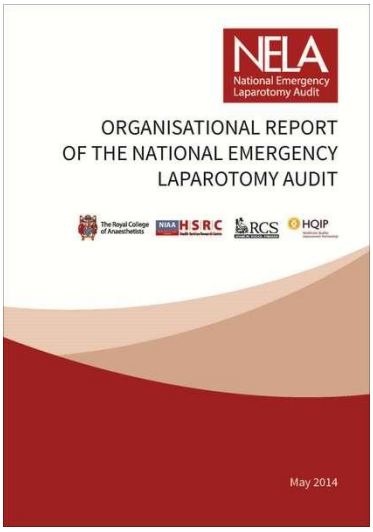
The report sets out the CQCs analysis of the quality of health and social care across the country based on the first full round of rated inspections covering almost 29,000 services.

It shows that, as of 31 July 2017, 78% of adult social care services were rated good as were 55% of NHS acute hospital core services; and that many services originally rated as inadequate have used the findings of CQC inspections to make changes and improve their rating.

However, there are also clear warnings from the changing nature of demand – increasing numbers of older people who are physically frail, many with dementia and more people with long term complex conditions – all of this is placing unprecedented pressure on the system.

In acute hospitals, this means more people waiting over four hours at A&E; more planned operations cancelled, and people waiting longer for treatment. In adult social care, the number of beds in nursing homes has decreased across most of England and domiciliary care contracts are being handed back to councils because providers say the funding is insufficient to meet people's needs.

Emergency laparotomy audit



An emergency laparotomy (emergency bowel surgery) is a surgical operation for patients, often with severe abdominal pain, to find the cause of the problem and treat it. General anaesthetic is used and usually an incision made to gain access to the abdomen. Emergency bowel surgery can be carried out to clear a bowel obstruction, close a bowel perforation and stop bleeding in the abdomen, or to treat complications of previous surgery. If left untreated, these conditions could be life-threatening.

The National Emergency Laparotomy Audit was started in 2013 because studies showed this is one of the most risky types of emergency operation.

The latest report highlights that 24,897 emergency laparotomies were done in 2016 and an additional 300 lives were saved this year using the procedure. Improvements in care have reduced patients' average hospital stay from 19.2 days in 2013 to 16.6 days in 2016 and these improvements in care have saved almost £30m.

The audit also found that 76% of hospitals meet the target for getting most of their most urgent patients to the operating theatre within two hours. Around 78% of hospitals meet the accepted standard of admitting their high risk patients directly to critical care after surgery.

Festival of Research

Doncaster's Festival of Research was a week-long event which is a new initiative set to showcase the high quality of health-related research taking place in Doncaster.

The event ran from 17 to 20 October and showcased Doncaster's existing research and innovation and demonstrated its potential for more research, to positively impact the health and wellbeing of local residents.

The keynote event on 17 October 2017 focused on the work of Professor Steve Peters, author of the Chimp Paradox, a programme designed to help people achieve success, confidence and happiness.

iFit

The Trust's iFit system was launched earlier in the month. This innovative new system will allow us to quickly and easily track our medical records, resulting in a more efficient service, as well as reducing cancellations.

Changes at NHS Improvement

Baroness Dido Harding has been selected as the chair for NHS Improvement to replace Ed Smith. Her appointment was confirmed by the health select committee on 17 October. Baroness Harding, a Conservative peer, is the former chief executive of TalkTalk communications.

Jim Mackey, who has been chief executive of NHSI since its inception in 2016, following the effective merger of Monitor and the NHS Trust Development Authority, is due to stand down at Christmas.

Bob Alexander, deputy chief executive and director of resources at NHSI, is also leaving later this month to lead the Sussex and East Surrey STP – but will formally remain in post until January.

Staff Survey Launch

The staff survey launched week commencing 9 October and provides staff with an opportunity to have their say, share their experiences and highlight any issues faced as a member of DBTH.

All staff received an email from Picker, our staff survey provider, with a link to the survey. All responses are private and confidential.

Board will be aware that the Trust scored disappointing results in a number of areas last year. Since then myself, working with the Chair and Executive Team, have instituted a range of changes:

- I personally attended more than 25 listening event meetings with staff from across a range of services to understand concerns and ensure that key issues are communicated well from Board to ward.

- We changed the staff car parking charges, introducing a lower rate for part time and lower band staff and where possible created more staff spaces at DRI.

- There is more senior management presence at Bassetlaw Hospital, with Emma Challans, Deputy Chief Operating Officer, basing herself at the site.

- We ensured staff had the opportunity to shape the strategic direction, through social media, postcards, meetings and surveys. More than 700 staff provided feedback which significantly changed our vision and objectives.

- We have continued to focus on taking positive action on staff health and wellbeing, introducing new classes, groups, organised events and team sports, recruiting and training more than 50 health champions, introducing stress management courses and mindfulness awareness courses

- We have set up a staff experience group who meet to discuss concerns and challenges faced by staff.

Whilst I know the actions above do not address all of the concerns raised, I am committed to continuously speaking with staff, listening to their feedback and turning this into action so we can make the improvements necessary to make DBTH as great a place to work as it is to receive treatment and care.

Senior management restructure

Finally, this is to publicly report that at the private Board meeting in September 2017 the following changes were agreed to the senior management structure at DBTH:

- A new Deputy Chief Executive role has been created to assist the Trust in managing the demands of the ACS and in succession planning. The role – which will be a designation on top of an existing executive directors' role - will be initially temporary until the end of 2018.

- Marie Purdue will become Director of Strategy and Transformation responsible for strategy, quality improvement and innovation. This again will be temporary until the end of 2018.

- A substantive Director of Nursing, Midwifery and Allied Health Professionals will go out for public recruitment shortly.

- A review of the Chief Executive's line management responsibilities will take place after the appointment of the Deputy Chief Executive.

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

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

Objective	Lead	Supporting Actions	Expected Outcome	Impact on Risks	Expected Outcome at 31/ 03/ 2018	Measurable Milestones	Update on delivery at September 2017	Rating	Update on delivery at December 2017	Rating	Update on Delivery at March 2018	Rating	Actions to be taken forward to 2018/ 2019
Ensure the delivery of the Trusts financial plan and the implementation of an agreed improvement and effectiveness plan with identified work streams and SROs. Delivering service change and savings through achieving agreed targets and milestones	CEO	**Director of Finance** Maintain and develop the programme management office, ensuring robust systems and processes to drive, monitor and escalate effectiveness & efficiency, enabling and strategic clinical plans.	PMO processes reviewed to meet needs of revised Board sub-committees (Finance and Performance) Milestones and resources required clearly identified for sign off by SRO Up to date position on EEP available monthly Escalations made appropriately to the Transformation Board and F & P Committee	Reduces likelihood of failure to deliver financial plan and Cost Improvement Plans in this financial year	**DOF** - EEP delivery is in line with forecasts and expectations Progress with delivery of strategic and enabling work streams is documented accurately and all escalations have been appropriately managed	**DOF** - Review for F&P by July 2017 Up to date accurate information - ongoing	PMO moved to DoF at end June 2017. Review of governance processes being undertaken. New accountability measures instituted including refreshed effectiveness and efficiency committee.	Amber					
		Directors Lead agreed improvement work streams as SRO, delivering service change and savings through achieving agreed targets and milestones			Programmes managed to deliver agreed programme outcomes and within agreed timeframes.	Delivery to agreed programme plans	Strategic workplans developed to contribute to CIP	Amber					
Work with STP and Place based partners to ensure that the Trust maintains a sustainable future to deliver the needs of the local populations and the legal responsibilities required by NHSI and the CQC	CEO	**Directors** Ensure that the Trust maintains strong and effective partnerships at Place and STP level	**DS&I** - Place plans reflected in Strategic Direction Ongoing involvement in ACP development	Reduces likelihood of failure to sustain a viable specialist and non-specialist range of services through inability to recruit right staff and have staff with right skills	**DS&I** - Place plans reflected in Strategic Direction Ongoing involvement in ACP development	**DS&I** - Evidenced by joint projects - t.b.c.	Evidence of active participation in Doncaster Place Plan implementation. Strategic Direction includes input on both place plans, involved partner governors and has been presented at DCCG and Bassetlaw ACP. Joint projects and contractual arrangements in development	Green					
Ensure the completion of the Trusts Strategic Vision to reflect the aims and objectives for the Trust within the STP, Place and legal and regulatory requirements of NHSI and the CQC	CEO	**Director of Strategy and Improvement** Produce a final DBTH Strategic Vision document to the NHSI timescales that is approved by the Board, with input from all appropriate stakeholders	**DS&I** - Completed Strategic Vision document approved by Board Strategic plan with milestones and responsibilities identified Robust evidence of communication and engagement plan being implemented with stakeholders. Launch in line with Communications Plan	Reduces the likelihood of failing to achieve compliance with performance and delivery aspects of the Single Oversight Framework, CQC and other regulatory standards	**DS&I** - Progress on strategic milestones as per plan with any escalations being appropriately managed Robust process for escalation where plans are not on track Evidence of functioning governance structure	**DS&I** - Strategic Vision to NHSI by end July 2017 Launch in line with Communications Plan August 2017	Strategic Direction 2017-2022 agreed and submitted to NHSI. Communications plan developed with Comunications team and implemented.	Green					
		Executive Directors Lead the refresh of the strategies related to areas of responsibility to ensure the delivery of the Trust's revised Strategic Direction	**DS&I** - Completed QII Strategy and implementation plan agreed by Board		**DS&I** - Completed QII Strategy agreed by Board and implementation in line with plan	**DS&I** - Completed QII Strategy agreed by Board and implementation in line with plan	QII Strategy developed reviewed by QEC and minor amends implemented - Board sign off due in October 2017	Amber					
Produce a clinical service model for the delivery of safe and sustainable emergency, elective, diagnostic and support services across the Trust	**COO** **Medical Director** **Director of Nursing Midwifery and Quality**	**Directors** Work with the Lead Directors to ensure the delivery of the clinical service model	Publication of a clinically engaged site strategy to deliver improvements in site efficiency and effectiveness	Reduces likelihood of failing to sustain a viable specialist and non-specialist range of services through inability to recruit right staff and have staff with right skills	Increased elective capacity on BDGH and MMH. Improved emergency/trauma pathways at DRI	Published strategy July 2017 Service site reorganisations Q2-3	Clinical Site Strategy agreed. 3 key strategic steering groups set up with ToR. Work plans agreed with set timescales for service changes. Changes being mapped against the Acute Services Review	Amber/Green					
Maintain Compliance with all NHSI Access Targets and Outcomes Objectives with Sustainability and with Transformation Fund associated Targets (Four Hour Wait and RTT) as a priority.	**COO**	**Directors** Support the COO to deliver national access and outcome standards in line with the trajectories set by contract or NHSI	Meet/exceed NHSI agreed trajectories	Reduces the likelihood of failing to achieve compliance with performance and delivery aspects of the Single Oversight Framework, CQC and other regulatory standards	DBTHFT is green for governance	Quarterly updates via single oversight framework	STF achieved for 4hr access in Q1/2. RTT plans agreed with NHSi to be compliant by Q4. Discussions on going with CCG to develop confirm sustainable RTT trajectories.	Amber/Green					
Work with partners to reduce demand on the acute services to ensure that demand equates to available resources		**Directors** Support the COO to deliver a capacity and demand plan to deliver activity plans in line with trajectories set by contract of NHSI	Support CCGs to deliver Quipp and manage demand within existing resources	Reduces the likelihood of failing to sustain a viable specialist and non-specialist range of services through inability to recruit right staff and have staff with right skills	Contractual levels of activity are met for patient needs	Quarterly updates via single oversight framework	CCGs quip monitored monthly. PLCV agreed with both CCGs. Referrals being monitored against overall referral patterns, evaluated at the joint Planned care Board. Care groups being monitored against contracted activity	Green					
Increase elective activity at BDGH and MMH to best utilise available resources and facilities		**Directors** Take the actions necessary to support the COO with transfer of appropriate elective and diagnostic activity to BDGH and MMH	COO - Meet service demands within existing resources DS&I - Contribution by S&I to review of elective activity by site and plan for future outsourcing requirement		**COO** - Service reorganisations are in place to maximise elective capacity **DS&I** - Contribution by S&I to review of elective activity by site and plan for future outsourcing requirement	**COO** - Site strategy milestones identified **DS&I** - Milestones will be contained within the plan	Work plans agreed as part of the Planned Care Workstream with set milestones for service transfer	Green					
Work with external partners to review service delivery across the wider STP footprint to ensure services which support place based ambitions and the delivery of high quality and sustainable services		**Directors** Take an active role across the area of responsibility within the STP and Place to ensure services are safe and sustainable and meet the needs of the local populations	DBTHFT role in the place and ACS is maximised to deliver sustainable high quality services		DBTHFT place plan clearly identifies the Trust as a key stakeholder in the ACS	Active involvement in ACS work streams to represent DBTH	Acute Hospitals Review has DBTHFT clinicians and managers on 5 key workstreams	Green					
Co-ordinate the development of an innovative and sustainable workforce plan across the Trust. Developing and implementing plans to improve leadership, recruitment and retention initiatives	**Director of People and Organisational Development**	**Executive Directors** Take appropriate actions within areas of responsibility to develop and deliver a sustainable workforce plan using Calderdale framework and alternative profesions.	Workforce plan in place which will enable/facilitate the delivery of the Trust's service plans. Commissions in place with HEI/FEs in order to deliver the workforce models. Reduced vacancy levels and reduced spend on bank and agency staff.	Reduces the likelihood of failing to engage and communicate with staff and representatives in relation to immediate challenges and strategic development	Workforce plan developed with clear description of workforce models to be adopted. Clarity as to required commissions through HEE/HEI/FEs. Recruitment plan in place for each staff group.	Capacity developed for use of Calderdale framework across the trust. Recruitment strategy for hard to recruit to staff groups developed. Recruitment section of website refreshed.	Support from HEE identified to deliver refresher training to Calderdale facilitators and to develop an internal trainer. Work underway to map trainee ACPs to future workforce models. Workforce models being developed in support of the 3 steering groups. Recruitment site on website refreshed with associated material.	Amber					
		Executive Directors Develop the leadership skills within own teams and Care Groups. Identifying and developing talent at all levels to ensure effective succession planning	Leadership teams equipped to deliver the Trust's strategy and supporting strategies. Future talent pool identified together with agreed approach to harness that talent.		Leadership teams are equipped to deliver the Trust's strategic direction and operational plans effectively.	Identification of leadership development requirements. Offering developed ensuring best use of external resource that is available. Approach to identifying future talent in place. Talent pool identified with associated development plan.	QII workshop delivered to senior leaders. Roles and responsibilities workshop for senior leaders in support of strategy delivery delivered. Insights development programme scheduled for November. Leadership development has explicit reference in P&QD strategy	Amber					
Co-ordinate, develop and ensure the implementation, delivery and monitoring of the staff engagement action plan to ensure the delivery of the Trusts values and an improvement in the national staff survey results for 2017/ 18		**Directors** Review the staff survey results relating to areas of responsibility and contribute to the development and delivery of the corporate action plan and the necessary improvements.	Improved staff survey results. Achievement of CQUIN target for health and wellbeing. Well functioning staff experience group.		Improved staff survey results. Improvements in health and wellbeing scores in order to achieve the CQUIN target. Improved involvement of staff in service change.	Staff experience group established. All Care Groups/Directorates to have agreed action plans to improve their survey results. Action plan in place to achieve health and wellbeing CQUIN. Progress against the Trust wide staff survey action plan.	Trust wide staff experience group established, 2 meetings held. Flu CQUIN target achieved. Staff survey in progress. Active communications to demonstrate progess this year and to deliver improved response rate. Action plans in place within Care Groups and directorates.	Amber					
Co-ordinate the production and delivery of Board and Executive Team Development Programmes		**Directors** Take an active role in the delivery of effective Board and Executive Team development days	The Trust will have a Board and Executive Team which works effectively and which is driving forward the Trust's vision, values and strategic direction		Executive Team and Board development plans in place with regular development sessions scheduled. Positive assessment against CQC/NHSI's well led domain. Positive feedback through staff survey results.	Identification of development requirements. Programme developed together with identification of delivery partner. Programme in place.	Board development programme being shaped - various sessions held. Ongoing programme in development.	Amber					
To create a stable and motivated finance function, Measured by staff turnover, implementation of restructures, staff survey	**Director of Finance**	**Directors** Ensure the finance team are integrated into Corporate and Care Group Teams		Reduces likelihood of failing to achieve compliance with financial performance, delivering accurate financial reporting underpinned by effective financial governance and delivering financial plan			Consultation, slotting in processes and recruitment completed. New staff starting during October. Work extended to add in PMO to process with a review of the PMO to take place in q3 2017/18.	Amber					
To stabilise and embed systems within the organisation and finance function to deliver a strong financial control environment. Measured by delivery of strong financial information, audit reports, understanding of financial performance.		**Directors** Ensure the delivery of the agreed financial plans within the areas of responsibility					Trust behind plan, work with BDO is intended to bring the plan back in line. Additional governance for CIP and additional senior leadership resource being put in place.; Action plans and stronger controls being identified in line with external assurance report on area and control	Amber					
Ensure a robust clinical governance system is maintained and developed across the Trust to deliver the national quality, performance and professional standards applicable to the Trusts services. Taking proactive actions to identify and address any areas of weakness.	**Medical Director**	**Directors** Ensure that systems and process are in place within the areas f responsibility to support good governance	Sustain and improve care quality and patient safety	Reduces the likelihood of failing to sustain a viable specialist and non-specialist range of services through inability to recruit right staff and have staff with right skills	Sustain performance and improve across a range of quality metrics	Maintain care quality metrics within planned trajectory	Quality metrics defined in accordance with CQC Insights and incorporated within a Quality dashboard. These metrics have been employed to set Care Group quality and effectiveness objectives. The dashboard will be monitored at CQC and QEC. At present, overall Trust care quality is on trajectory to deliver end of year objectives.	Green					
Complete the delivery of the action plan following the Royal College Review.		**Directors** Support the delivery of the RCOG action plan.	Deliver all actions to address the Clinical Governance recommendations in the RCOG report		Improved obstetric patient safety, care quality and patient feedback	Delivery of action plan within defined timeline	Action plan in reponse to RCOG review has been developed by the Care Group and it is expected that all actions will be complete by April 2018. Weekly meetings are held to monitor progress and we remain on track to deliver the vast majority of the actions in line with the defined timeline. Embedding an improved culture focussed on quality may take longer.	Amber					
Develop a specific programme of work to ensure that the future structure of the Medical Directors office reflects the future needs of the Trust, STP and Place and the composition of the medical workforce		**Directors** Support the development of clinical leadership to maintain the Trusts influence at Place and within the STP	Enhance capacity and capability of the Medical Director's office to meet Trust requirements		Delivery of all Medical Director, Responsible Officer and Caldecott Guardian functions	Progress to delivery of Medical Director objectives	Review of roles and reponsibilities within the MD's office has been completed. There will be considerable overlap between HR and the WD's office in many areas. These have been agreed and progress is being made towards implementation	Amber					
Implement a Patient and Carer Experience and Engagement Strategy. Implementing national and international best practice in the use of feedback to improve services.	**DNMQ**	**Directors** Increase experience and engagement in the delivery of services to ensure high quality patient centred services, with tangible measurements, improvement targets and KPI reports to the PEC.	1.Patient experience and engagement strategy completed. 2.Tools and techniques to engage with patients agreed. 3. Increased participation of patients to service improvement work. 4. Metrics for measuring patient experience agreed. 5.Monitoring of patient experience metrics monitored and reported to PEEC monthly. 6.Positive patient experience reported in addition to complaints data.	Reduces likelihood of breakdown of relationship with key partners and stakeholders	Tools and techniques to engage with patients used routinely in clinical areas. Data demonstrates improved patient experience	Timescale for; 1. July 2017. 2. September 2017 3. December 2017 4. September 2017 5. September 2017 6. September 2017	Patient Experience and Engagement Strategy completed and to be presented to BoD October 2017. Strategy Outlines tools and techniques to engage with patients and involve them in QII work. Metrics for measuring patient experience in development and to be presented to QEC October 2017. Metrics will be monitored at PEEC once tool agreed (DCI 17). Template to capture all feedback developed and to be launched October 17 PEEC	Green					
Review the quality assurance tool and quality metrics in line with national quality guidance and launch in May 2017.		**Directors** Ensure that reliable metrics are in plan in all areas to demonstrate the quality of services	1. Review and agree Quality Metrics. 2. Monitor Quality Metrics via QEC / Board 3. Implement Perfect Ward App Trust wide		Metrics demonstrate improved and sustained quality for patients.	Timescale for delivery; 1. May 2017 2. May 2017 3. September 2017	Quality Metrics reviewed and agreed in Q1. Metrics monitored at QEC in June / August / Oct 2017. Outline proposal for Perfect Ward app to be developed - October 2017	Green					
Oversee the development of a 3 year plan with appropriate milestones to support the implementation of the DBTH Strategic Vision	**Director of Strategy and Improvement**	**Directors** Ensure that the Director of Strategy and Service Improvements is aware of developments within clinical and support services at local, Place and STP levels	S&I Director is made aware of developments and engaged in discussions about implementation and support required	Reduces the likelihood of failing to achieve compliance with performance and delivery aspects of the Single Oversight Framework, CQC and other regulatory standards	All service developments are made in line with strategy objectives and can evidence S&I discussion	Ongoing - as new developments come online	Ongoing - stakeholders still not always using this route of communication into DBTH	Amber					
Produce and implement a Quality Improvement & Innovation Strategy that is based on best practice and developed with staff, containing a plan to increase QII capacity and capability within DBTH (and potentially with partners)		**Directors** Within the areas of responsibility support the development of capacity and capability in the identification and delivery of quality, efficiency and effectiveness programmes and projects	All capacity and capability issues identified to the PMO and Director of S&I by the SROs of all programmes		All project implementation plans are signed off by SRO and QII training implemented as planned in the QII strategy	Work stream sign off by July 2017 QII plan milestone sin line with strategy - currently being agreed	QII training plan rolled out as planned - not all PMO PMs attended yet. Projects identified for supporting workstreams and strategic workplans including pre-operative assesment, stroke repatriation and LOS (DRI/BDGH), transport and enhanced recovery.	Amber					
Maintain a robust and effective Programme Management Office ensuring robust systems and processes to drive, monitor and escalate effectiveness & efficiency, enabling and strategic clinical plans.		**Directors** Within the areas of responsibility ensure the identification, delivery and monitoring of efficiency and effectiveness programmes	Ensure current and developing efficiency and effectiveness programmes have robust and measurable programme management arrangement in place.		All programmes have measurable programme management arrangements in place	Arrangements and metrics in place in Quarter 1	Transferred to DoF for E&E - currently agreeing support of Steering Group projects	Amber					
Prepare for and implement the GDPR legislation within the Trust by the end of March 2018		**Directors** Take actions necessary to support the delivery of the GDPR	GDPR readiness by April 2018. financial impacts completed for budgeting purposes. SET training updated. DPO appointed	N/A	GDPR ready to implement for May 18	Plan available by October 17	Plan is on track for presentation by end of October.	Green					

Deliver, with available resource, the prioritised IT work plan and associated projects in support of the care group initiatives, the transformation agenda and the CIP activities	**Chief Information Officer**	**Directors** Take actions necessary to identify the IT needs within the areas of responsibility	Develop portfolio approach to projects. Fstablish governance group. Deliver regular updates to care groups. Deliver planned work	Reduces the likelihood of failing to deliver Cost Improvement Plans in this financial year	Portfolio governance and communication plan agreed and rolled out. 80% of project delivered - depending on resource and finance at capital level	Governance mechanism agreed October 17	Portfolio of projects established and monitored. IT and Information governance group TOR to be signed off October, reporting to MB and FPC. First meeting likely to be Nowember 17. Communications regularly with care group GM community. Capital has been constrained in H1 with expectation that funds will be available in H2. Focus on current environment	Green						
Deliver the appropriate integration and interoperability technology in support of the Doncaster Place based Intermediate Care Record and if appropriate the STP		**Directors** Take actions necessary to support the delivery of the Intermediate Care Record	Develop the internal DBTH architecture to deliver first stage data to the ICR. Develop technology that supports the internal and external portal. Deliver the clinical viewer for internal use	Reduces likelihood of breakdown of relationship with key partners and stakeholders	Architecture agreed. Contributions to ICDR at Doncaster CCG level. Pilot of clinical viewer complete. Engagement with care groups and consultant community	Architecture draft agreed October 17. Initial pilot presented to clinicians December 17	Significant work in providing data to ICDR within project timelines, Clinical viewer is on track to deliver Alpha version by end of financial year. Demo's of progress regularly made to exec and clinical community. Enabling works necessary to ensure technical costs remain very low during pilot	Green						
Provide appropriate technology support to the Trust for the development of the Single Oversight Framework throughout 2017.		**Directors** Take actions necessary to support the development and delivery of the Single Oversight Framework	Deliver the first stage of the BI framework and 80% of the Single Oversight Framework	Reduces likelihood of failing to achieve compliance with performance and delivery aspects of the Single Oversight Framework, CQC and other regulatory standards	BI framework designed and implemented. Initial build of BI dashboards in ED and one other identified care group. SOF implemented for systems used today - explore options for getting information from non Trust environments e.g. EMS	BI Framework to pilot by Nov 17. SOF first iteration by Aug 17 including alerts and drill down	SOF not delivered in full. Some drill downs and alerts in place. Rest to be delivered in accordance with prioritised timeframes as discussed with Director of Strategy. BI pilot framework output is on track to deliver late November 17. ED dashboard in development	Amber						
Development of a 5 year Estates Strategy, to include a Capital Development Programme linked to Condition Surveys and Corporate Risk Register.	**Director of Estates & Facilities**	**Directors** Take actions necessary to identify the needs of the areas services within the areas of responsibility	The publication of a new 5 year EFM Strategy, linked to a revised Clinical Site Development Strategy	Reduces likelihood of failing to ensure that appropriate estates infrastructure is in place	The availability of an EFM Strategy Document	Draft document available for comment by July 17, ratified by Aug 17	Draft doc delayed until other supporting strategies were available, now due at Finance and Performance in Oct, Board of Directors on Nowember	Amber						
Evaluate the potential for Public/Private Partnerships, linked to the Trust strategic direction.		**Directors** Contribute to the evaluation of all options for developing the Trusts infrastructure and estate	**DE&F** - The development of capital funding options to support the Trust Strategic Direction		**DE&F** - Opportunities identified and agreed by Board of Directors. **DS&I** - Support business case development with Finance Team Evaluation of DBTH benefits realisation methodology	**DE&F** - Options developed through new Commercial Board monthly meetings **DS&I** - Project implementation reviews to include lessons learned from business case development	Options for Capital funding through JV/WOS models disucssed at commercial board. Letter received 6th Oct from NHSi regardng NHS Trusts evoiding tax - which will impact on desirability of progressing WOS schemes. Capital bids will be submitted as calls for funding become available as with successfull bid for CT/HASU - ED DRI outstanding. EFM Strategy will contain 5-7 year backlog investment programme.	Amber						

DONCASTER & BASSETLAW TEACHING HOSPITALS NHS FOUNDATION TRUST

Minutes of the Finance & Performance Committee held at 9:15am on Tuesday 19 September 2017 in the Boardroom, DRI

PRESENT	:	Neil Rhodes, Non-executive Director (Chair) Martin McAreavey, Non-executive Director Philippe Serna, Non-executive Director Jon Sargeant, Director of Finance David Purdue, Chief Operating Officer
ALSO IN ATTENDANCE:		Matthew Kane, Trust Board Secretary Kate Sullivan, Corporate Governance Officer Jackie Simpkin, Cancer Services Manager Ruth Bruce, Head of Performance Kirsty Edmondson Jones, Director of Facilities & Estates Anthony Jones Deputy Director of People & OD *(for Karen Barnard)* Marie Purdue, Acting Director of Strategy & Improvement
OBSERVER	:	Bev Marshall, Governor Observer Simon Michaels, BDO James Nichols, BDO
APOLOGIES	:	Karen Barnard, Director of People & Organisational Development

Action

Apologies for Absence

17/09/1 Apologies were noted from Karen Barnard. Neil Rhodes welcomed representatives from BDO to the meeting.

Action Notes from Previous Meeting

17/09/2 The action log was reviewed and updated.

Any other business

17/09/3 No additional business was declared.

PERFORMANCE

62 Day Cancer Deep Dive

17/09/4 Jackie Simpkin, Cancer Services Manager was welcomed to the meeting to co-present the deep dive topic with David Purdue. The presentation had been circulated with the meeting papers.

17/09/5 The presentation provided insight in to the background to cancer waiting times, an overview of the 62 day pathway, both local and shared care, where the patient was seen by one provider, diagnosed by either the original or tertiary

provider and treated within a tertiary centre. the key element within this pathway was the 38 day 'Transfer of Care' target and the impact on this.

17/09/6 An overview of the basis for the DBTH 62 day recovery plan was provided along with details of the key elements of the recovery plan including pathway planning, pathway change, access and improvement and sustainability. An overview was provided of the key elements from the High Impact evaluation and work being undertaken to ensure compliance, shared care pathways performance and the impact on performance for all cancer waiting times (CWT) by individual tumour groups was also shared. It was noted that in 2020 national diagnosis targets would shorten and this was a key challenge for the future. Some funding from NHSE & NHSI was available to support the recovery plan.

17/09/7 David Purdue provided some context in terms of national performance against the 62 day standard. The target had been failed nationally for three years and was high on the national agenda. The Trust had achieved the target overall but there had been significant pressures and, as an ACS, South Yorkshire had failed the target. The Criteria for allocating breaches for shared care had changed; the original provider now received the whole breach if the target was not met, where previously half the breach had been allocated to the original provider.

17/09/8 The committee discussed issues with shared care pathways in detail and in response to a query from Neil Rhodes about whether, in terms of other providers, there were any significant failures in the pathway, work was being undertaken regionally to look at why some Trusts were performing better than others. An overview of key issues and the reallocation process was provided.

17/09/9 Martin McAreavey asked for assurance in terms of whether the Trust had identified the key priorities of the 62 day pathway and key challenges meeting the shared care pathway and this was discussed; in terms of shared care pathways it was felt that it would be more appropriate if some pathways did not start with the Trust, particularly where a lot of enabling work was required prior to referral to a tertiary provider. Jackie Simpkin provided some examples of these types of cases. Sometimes, there were also issues around access in terms of in-reach consultants and access to radiology. A key area of concern in terms of performance was the urology prostate pathway; David Purdue gave an update on improvements made however there were still some issues.

17/09/10 Currently the system was sustainable however changes to targets in 2020 would present significant challenges. Martin McAreavey asked for assurance that the Trust had the strategy in place and was making improvements at the pace required to meet future pressures and this was discussed in detail. Overall the Trust was delivering the 62 day target, however some services were particularly challenged and work was being undertaken in those areas. There were also issues in terms shortage of histopathololologists. In terms of Shared Care, work was being undertaken as part of work with the ACS. With regard to the changes to targets in 2020 work was underway and Jackie Simpkin was working on a Trust Cancer Strategy to consider this. It was noted that the Cancer Alliance was part of the ACS.

17/09/11 Bev Marshall asked about the level of patients transferred to Sheffield and the reasons why; Jackie Simpkin advised that in August 2017 over 30 patients had been treated at Sheffield. Some treatments were only available at Sheffield, for example radiotherapy, prior to these treatments being available at Sheffield patients would have had to go much further afield for treatment. The Trust had started carrying out some tests which prevented some patients having to go to Sheffield.

17/09/12 A hand-out outlining the Yorkshire and Humber Clinical Network; Prostate Cancer Future High Value Pathway was provided. This would be circulated outside of the meeting. **JSi**

The 62 Day Cancer Deep Dive Report was NOTED.

Performance Report

17/09/13 Ruth Bruce presented the report which was presented in a new format. It included new performance charts and additional narrative; she drew attention to the following:

17/09/14 Cancer - Cancer performance was discussed in detail; the 62 target had been failed nationally. The Trust had not achieved the target in July, 84.9% against the 85% standard. However the Trust was performing well in comparison to national performance and the performance of peer Trusts; new graphs were provided in the report to illustrate this.

17/09/15 The 2 week wait standard had been failed, 91.5% against the 93% Standard. A pilot for 2 week wait booking had ended and an evaluation of the effectiveness of a separate 2 week wait booking team had been undertaken. Gaps in service provision had led to some administrative issues which had caused breaches and plans were in place to move a separate team back in with the central booking office to allow for increased flexibility. Patient Choice continued to be the main issue for patients not being seen within 2 weeks. Patients were contacted to ask why they did not want to be seen within the two weeks and the cancer management team were meeting regularly with the CCGs to review the information given to primary care to support the two week wait position.

17/09/16 4hr Access Target – The Trust achieved 93.57% in August against the 95% target. NHSI required the Trust to achieve 93.1% in Q2; at the end of month 2 of the quarter the position stood at 93.28%. The position had been challenging nationally and the Trust would run a perfect week at the end of September to support ED to achieve target. In terms of the national and local context, Bev Marshall and Neil Rhodes acknowledged the hard work of staff to achieve this level of performance.

17/09/17 RTT Incomplete pathways were discussed; data quality and ensuring pathways were generated correctly the first time was key to improving performance. To assist with the 'Getting it Right First Time' initiative, a training package to be delivered through the data quality team was being developed.

17/09/18 Cancelled operations for non-clinical reasons had been 1.1% (56 patients) of Trust operations in August. An overview of the reasons for cancellation were illustrated in a chart and this was welcomed.

17/09/19 The new format of the report, particularly the quality of analysis and benchmarking data, was commended. It was noted that the number of patients for cancelled operations had been included and it was agreed to provide numbers of patients where percentages were used throughout the report in future. The graphs in some areas of the report were particularly helpful and it was also agreed to update the report to include graphs and tables throughout. **DP**

17/09/20 Bev Marshall commented that there was a slight inconsistency in terms of reporting of performance and the narrative on Ambulance Handover times; it was agreed to provide a narrative to explain the inconsistency in reporting. **DP**

The Performance Report was NOTED.

PEOPLE

Workforce Report

17/09/21 Anthony Jones, Deputy Director of People & Organisational Development provided an update to the Committee which focussed on vacancy levels, agency spend & usage, sickness rates, appraisals and SET training. It was the first time the Committee had received the new separate Workforce report and feedback was therefore requested from members for future reports. Turnover and stability index information were not included in this first report but would be included in future reports. **KB/AJ**

17/09/22 An executive summary containing key messages and issues was presented. Vacancy levels had been derived from the finance system and therefore were reporting a month in arrears; overall the Trust vacancy rate was 7.5% against a target of 5%, if medical and dental vacancies were removed the rate reduced to 5.75%. The report also included an update on areas where there were significant staff shortages and included a breakdown of consultant vacant posts and rota gaps and an update on work being undertaken to understand the gaps, recruitment activity and action being taken.

17/09/23 Ophthalmology – 3 consultant posts had been re-advertised as they had not been filled and it had been recognised that a network approach would be required. In response to a request from Philippe Serna for more information about this David Purdue gave an update. A key issue was paediatric ophthalmology with the Trust only having one paediatric ophthalmologist. Ophthalmology was one of the specialities being looked at by the ACS in terms of where patients needed to go. It was noted that Sheffield had started to build new ophthalmology centre.

17/09/24 Agency Spend - The Committee asked for assurance that the vacancy rate was reducing, that reductions in vacancies were having the expected impact on reducing agency staffing costs and that there was sufficient grip on agency spend. This was discussed in detail. Both bank and agency staff were being used

to cover vacancies and gaps in rotas with agency staff also being used to cover sickness, maternity leave and other absences. Due to this it was difficult at this stage to give precise detail on savings due to vacancies being filled and further work was required to analyse reasons for agency usage. Jon Sargeant reported that so far the Trust had not seen the reductions predicted based on expectations in terms of filling vacancies. To ensure grip on medical agency the Trust had recently set up a weekly director led medical agency review meeting and tighter controls had been put in place for the authorisation of agency usage. The Trust had not exceeded NHSI target for agency usage.

17/09/25 Bev Marshall asked if there was any scope to use the apprentice levy to support recruitment or develop apprentices in to the roles the Trust needed. The Trust was undertaking significant work around apprentices. Access to levy had only been available since July and the Trust had already appointed around 12 apprentices and was looking at developing clinical support workers and some band 5 posts.

17/09/26 The Committee considered the agency spend report in detail; following discussion about how the Trust compared nationally in terms of agency spend in areas of national short or good supply of staff it was agreed to sub-categorise agency spend by department or disciplines. **KB/AJ**

17/09/27 Sickness – The report included benchmarking data which demonstrated that the Trust was in the middle of the pack when compared to other Acute Trusts across Yorkshire & Humber for sickness rates. There was work to do to make further progress and all managers were being given the opportunity to access further support and training in sickness absence.

17/09/28 Appraisal rates had reduced over last few years and the key issues were discussed. HR Business Partners were working with their Care Group/Directorate leadership teams to explore how they could ensure all staff had an appraisal. Work had also been undertaken to look at the work undertaken at other trusts and several approaches were being considered including a more condensed window for conducting appraisals which would avoid the summer and winter periods. The Committee noted poor performance in some corporate directorates and this was discussed; It was acknowledged that some directorates were small and therefore compliance could appear low based on a very few members of staff however the Committee emphasised that it was key to ensure that the performance reflected the expectations of the executive.

17/09/29 SET rates had significantly improved over the previous 18 months but there was more work to do. A review had been undertaken to ensure only the right training was being provided at the right level. Compliance was discussed and it was agreed to consider phasing the SET compliance trajectory, e.g. 25% for Q1, 50% by Q2 etc. and to seek feedback on this from the Chief Executive. **KB/AJ**

17/09/30 The Workforce Report was NOTED.

FINANCE

Catering Services Outsource Update

17/09/31 Kirsty Edmondson-Jones delivered a presentation on catering service outsource. A detailed paper and the Internal Audit 'Catering Contract Review and Follow Up' were also included in the papers to provide the Committee with information and assurance on the work undertaken as part of the project in order that they could recommend the approval of the contract to the Board of Directors.

17/09/32 The presentation provided an overview of the original key project objectives, the contract development and assurance process, aligning of DBTH Values and objectives with Sodexo, the new approach to and key objectives of Patient Dining Services, menu development, electronic meal ordering, a case study, hybrid meal solutions, meal trolley/driver collection, compliance with legislation, compliance and with Trust policies and a patient satisfaction case study; Imperial College Healthcare NHS Trust had seen an month on month improvement in survey results; Sodexo would provide monthly satisfaction survey results.

17/09/33 The presentation also covered the new approach to retail services including detailed layout plans for the DRI Main Entrance and East dining room, CQUIN compliance, new innovations and opening times, which were greater than the times opening times currently offered, and retail mobilisation plans.

17/09/34 DBTH Staff becoming part of Sodexo and the Sodexo on site structure was discussed. An overview was provided of those staff to be retained by the Trust. Sodexo's employee engagement and performance and talent management and recognition models were shared.

17/09/35 Summary of Financial Proposal – Kirsty Edmondson-Jones provided an overview of how savings would be delivered, clarified pay and non-pay costs and the profit share on retail. An analysis of direct savings over 10 years and public sector comparator information was provided.

17/09/36 It was noted that an extended Internal Audit review of the contract documentation, public sector comparator and a draft sensitivity analysis document had been undertaken. The resulting report (provided as an appendix in the papers) included 9 recommendations, these were provided to Capsticks solicitors and the contract was amended accordingly. Through the contract all key project objectives would be achieved or exceeded, there would be improved quality and choice, improved compliance and capital investment and savings would be achieved. It was planned to mobilise the plans from 1st October to commence in January 2018.

17/09/37 The Committee asked for assurance that existing staff would be given the opportunity to apply for the new positions, how many posts were to be filled internally and engagement with staff; Kirsty Edmondson-Jones undertook to clarify the Sodexo retain structure and recruitment policy and to provide an update on how many staff were to be TUPED to Governors. **KEJ**

17/09/38 Philippe Serna had discussed the review of the contract with Internal Audit and he gave assurances that they had considered it to be in good shape. What would happen during the intervening period to mobilisation, including impact sales/revenue was discussed. Wider communication plans were being developed with the Communications Department and various methods would be used to keep staff updated.

17/09/39 Following further discussion it was agreed to have a presentation to Governors and this would be taken forward. The Committee commended the hard work of those staff who had worked on the contract. **KEJ/MK**

17/09/40 The Committee resolved to recommend to Board agreement of the contract with Sodexo.

The Catering Services Outsource Update was NOTED.

Reference Costs

17/09/41 The Committee received the third and final report of a series of reports which provided an overview of the reference costs submission for 2016/17.

17/09/42 The report provided further assurance of the final mandatory Reference Costs Submission which had been submitted on time the previous week. In response to a query about future plans, Jon Sargeant gave assurance that Internal Audit had carried out assurance tests the previous week, the outcome of which would be taken through the ANCR and F&P.

The Reference Costs report was NOTED.

Financial Performance Report – Month 4 2017/17

17/09/43 The Director of Finance presented to the Committee a paper summarising performance in month 5. A deficit position of £12.8m was noted, 704k behind plan. However it was noted that the reported position included £419k of STF income relating to 2016/17 that could not be counted towards the Trust's control total. The restated position to be used was a deficit of £13.3m, £1.1m worse than the control total target to date.

17/09/44 Income was ahead of expectations in August but high agency and non-pay expenditure had continued. Key drivers were agency spend, temporary staffing spend, particularly medical staff, and non-delivery of CIPs. A key issue in month had been that where substantive pay costs had gone up the Trust did not see the expected commensurate reduction in agency spend and this needed to be understood. There had also been significant agency costs in other areas, particularly therapies and admin and the issues needed to be investigated and understood. Agency costs were discussed; a key priority was controlling agency spend particularly on medical staffing. Additional sessions were also being looked at.

17/09/45 In response to an enquiry from Philippe Serna about income, Jon Sargeant gave assurance that he was comfortable with the income forecast; what kept moving

was costs and that needed to be understood.

17/09/46 Month 5 delivery of the efficiency and effectiveness programme was reported at £1,485k against a plan of £3,843k which was £2,358k behind plan. The Director of Finance drew attention to CIP performance by Care Group and he shared concerns around grip on medical agency spend in some areas and this was discussed. The Chair asked when the Trust would have an overall projection for the year; A top level forecast had been produced based on month 4, but this needed to be revisited and since that time a review had commenced and meetings had taken place with all Care Groups and around half of the Corporate Directorate management teams.

17/09/47 The Director of Finance had met with the Chief Executive to discuss expectations; Care Groups needed to have greater involvement in governance and this would be picked up through ongoing meetings. There was generally a poor understanding of ownership of targets and the Trust needed to ensure the right infrastructure was in place to support work streams. It had been recognised that clear dedicated time needed to be set aside for the work needed to deliver CIPs. The Chair asked for assurance that processes were in place to ensure CIP delivery; Some of this would come out of the review but it was clear that controls needed to be tightened in terms of temporary staffing and overall staffing numbers.

17/09/48 There was a detailed discussion about CIP delivery. Key issues to address included; what could be done now to help, did the Trust have the right information, people and resources, how would the Trust ensure it delivered the core schemes and that there was no further slippage, plans for next year. Following further discussion it was agreed that 2 CIP schemes to be brought to the Committee for deep dive. **JS**

17/09/49 It was agreed to provide the following information/indicators in future reports: **JS**

- A RAG rating indicator to show how achievable each scheme was considered to be.
- Work streams escalated at SRO level
- Schemes that would be delivered without remedial action.

17/09/50 Management of the e-rostering system was discussed in terms of managing rotas; this was a key area of concern and there needed to be a focus on the management of the system.

The Financial Performance Report was NOTED.

RISK

Corporate Risk Register, BAF and Identification of New Risk

17/09/51 The Trust Board Secretary updated the Committee on changes to the Corporate Risk Register (CRR) and Board Assurance Framework (BAF) since the last meeting. A list of current risks and their alignment to the respective committees was provided for information. A list of planned Risk Refresher Sessions for staff was provided, NEDs were welcome to attend.

17/09/52 The report was NOTED.

Items for escalation to the Board of Directors

17/09/53 No items were noted for escalation

Future Deep Dive Topics

17/09/54 2 CIP Schemes, to be agreed with the Director of Finance and Chief Executive. **JS**

Minutes of the meeting held on 22 August 2017

17/09/55 The minutes of the meeting were agreed as a true record of the meeting.

Time and date of next meeting:

Date: 24 October 2017
Time: 9:15am
Venue: Boardroom, DRI

Signed:…….. **…….**
Neil Rhodes **Date**

DONCASTER & BASSETLAW TEACHING HOSPITALS NHS FOUNDATION TRUST

Minutes of the Quality & Effectiveness Committee
held at 2pm on Tuesday 22 August 2017
in the Boardroom, DRI

PRESENT	:	Linn Phipps, Non-executive Director (Chair) Alan Armstrong, Non-executive Director Martin McAreavey, Non-executive Director Sewa Singh, Medical Director Karen Barnard, Director of People & OD Moira Hardy, Acting Director of Nursing, Midwifery & Quality
IN ATTENDANCE	:	Clive Tattley, Governor Observer Peter Abell, Governor Observer Matthew Kane, Trust Board Secretary Angela O'Mara, Exec Team PA
APOLOGIES:		Andrew Beardsall, Doncaster and Bassetlaw CCGs

Action

Introductions

17/8/1 The governor observers were welcomed to their first meeting and introductions were made around the table.

Apologies

17/8/2 Apologies were noted from Andrew Beardsall.

Agenda Review

17/8/3 The Chair took the opportunity to reflect on the proposed agenda and outlined the format of the meeting, including the supporting debrief and agenda planning sessions. Timing for the RCOG agenda item was revised and Moira Hardy advised of an item for escalation from the Clinical Governance Committee (CGC).

Action Log

17/8/4 The action log was reviewed and updated.

17/8/5 17/6/12 - following the review of the enabling strategies assigned to QEC members would consider if further assurance was required and agree an appropriate next step. **MK**

17/8/6 17/6/7 – the Chair proposed the matter be considered as a future discussion item and that members should agree what assurance they required relating to the Trust's research activity. **SS**

17/8/7 17/6/16 – no further suggestions were offered and the Committee AGREED to adopt the previously documented principles of an assurance report. See appendix.

17/8/8 17/6/50 – at the Chair's request identification of new risks will be removed from the standard risk agenda item and be taken as a stand-alone item at the end of the agenda.

Strategic Discussion Item – Patient Experience and Engagement

17/8/9 Moira Hardy presented to the committee an overview of the Trust's current level of patient engagement and the manner in which quantitative and qualitative data was collected and utilised to demonstrate and improve patient experience. The presentation was designed using the "agenda as questions" methodology with 4 questions, and examining for each,

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

It was recognised that the current data focused heavily on the negative aspect through the reporting of complaints and a need to capture positive experiences was highlighted. The Committee decided to focus on questions 3 and 4.

17/8/10 A discussion took place around assurance question 3, ***"How do we get assurance on effective, listening and examples of change?"*** a summary of current examples of effective listening was shared, including ways in which they informed change. However, to ensure that a complete range of evidence was captured, positive experiences required promotion. Acknowledging good practice, incorporating learning from survey results and recognising positive patient feedback were all areas where improvements could be made. A template to capture such evidence at Care Group level had been drafted and would be taken to the Patient Experience & Engagement Committee for approval. Subject to approval being received Moira Hardy agreed to share with the Committee. **MH**

17/8/11 Mr Singh highlighted that the CQC's new "Insights" composite indicators incorporated both hard and soft metrics. Whilst the quality of service delivery was demonstrated by hard performance/quality metrics, soft intelligence would support and extend this evidence to demonstrate a complete quality of care picture.

17/8/12 The Chair recognised there was a need to consider a wide range of data, evidence and feedback and the option to display this in a balanced scorecard format was suggested. This also related to our commitment in our Quality Accounts to develop a composite measure of patient experience. Moira Hardy agreed to consult with her Deputy and the Acting Deputy Director of Quality & Governance on this. A detailed understanding of the recently announced CQC composite indicators was also required and discussions would be progressed through the Patient Experience & Engagement Committee and CGC. Opportunities to consult with other organisations and utilise available resources would be explored too. **MH/SS**

17/8/13 With regards to assurance question 4, ***"How do we correlate staff and patient experience?"*** whilst research had proven a direct correlation between a positive staff and patient experience, the tracking of this within the Trust was limited Some correlation can already be seen around the level of staff appraisals/ mandatory training and the link to the standards of patient care. Generally, data was available but not necessarily cross referenced to ascertain the impact from a patient's perspective. Karen Barnard and Moira Hardy agreed that they would explore opportunities to develop this. **KB/MH**

17/8/14 Martin McAreavey shared a view of the limited exposure of the patient voice at Board, however, to avoid duplication it was confirmed that patient experience should be considered by the relevant sub and feeder committees with a view to escalating areas of concern to the Board, where appropriate. A future discussion item was agreed, to consider those matters on which QEC would provide assurance to the Board of Directors. **All**

17/8/15 The importance of governor involvement in the sponsored ward visits was highlighted by Clive Tattley to allow unbiased patient feedback. The use of Buzz, the internet/intranet and social media were all welcomed and suggestions were made by Peter Abell as to how to best structure feedback templates to assist with extraction of data and collation of results by use of key words and coding.

The Patient Experience and Engagement presentation was NOTED.

Clinical Governance Assurance Report

17/8/16 The report assured the Committee that the necessary systems were in place to contribute to patient safety and care. As an addition to the report the Medical Director advised of the recent inspection by the CQC Ionising Radiation Medical Exposure Regulations (IRMER) team to inspect radiation safety procedures. An externally led and advised review, commissioned by the Trust, provided assurance on revised quality assurance and governance arrangements.

17/8/17 Alan Armstrong questioned the challenges identified by the Infection Prevention and Control Committee and was assured by the Medical Director that following internal and external reviews an improvement to the infection rate for hip surgery had been seen. Procedural changes had recently been revisited to refresh and reinforce best practice following an increasing infection trend.

17/8/18 With regards to the CQUIN for reduction of use of antibiotics, the Medical Director acknowledged this was a challenge in A&E, however, the recent introduction of a test to establish the root cause of infection, as viral or bacterial, was expected to contribute to a reduction in usage.

17/8/19 Martin McAreavey challenged how the Medical Director sought assurance that the necessary practices were in place, and it was confirmed a variety of measures verified this, including monitoring by the care group clinical governance team, sampling by the IPC team and evidence in C. diff and MRSA

rates.

17/8/20 In response to a question by Martin McAreavey, Moira Hardy advised that Dr Ganguly had now taken on the role of Child Death Overview Panel Lead on a permanent basis. However, following a number of recent Paediatric appointments additional capacity would be available to offer support, when required.

17/8/21 Moira Hardy escalated a concern from August's CGC meeting which related to the call wait times for both internal and external calls to be answered by switchboard. The matter had previously been raised with the Executive Team but the situation had not improved. The Chief Information Officer had advised that a number of measures were planned to alleviate the issues, including additional staffing at peak times and options to page staff on call. The Committee were partially assured by the proposed actions but in view of the fact that QEC only meet on a bi-monthly basis it was agreed to receive an update at the planned extraordinary QEC meeting on 26 September 2017. **SM**

17/8/22 Whilst the use of temporary medical notes was escalated as an ongoing concern, the Medical Director advised that this was an improving picture but was unlikely to be completely resolved until the introduction of electronic records. The introduction of RFID would significantly improve the situation and the identified risk was included within the Corporate Risk Register.

17/8/23 For future assurance reports the Chair requested that the period covered by Assurance Reports be documented on the cover sheet, with the option to provide a verbal update where the timing of meetings prevented a full written update.

The Clinical Governance Committee Assurance Report was NOTED.

CQC Inspection Update

17/8/24 The paper summarised activities and progress in the following areas to demonstrate the Trust's readiness for inspection and provided an update on the CQC inspection and monitoring arrangements:

- Nottinghamshire Looked After Children and Safeguarding Action Plan
- Internal Audit CQC Action Plan
- CQC Engagement Meetings

17/8/25 The Chair acknowledged the wealth of information contained within the report and suggested the potential for this to be presented in a more assurance focused style at future meetings. The Chair posed the question, what is the assurance question we are seeing to answer with this group of reports? Possibly, how assured are we regarding our readiness for CQC inspections and plans to maintain and improve our scores? Moira Hardy identified that in addition to assurance around the action plans, a necessary addition would be the CQC insights data which provided a trust overview, detail on core services and peer assessment. Currently no concerns were identified from this data, which was expanded upon in the National Quality Board Framework paper.

The CQC Inspection Update was NOTED and QEC supported the identified next steps.

Nursing Workforce & Ward Quality Metrics

17/8/26 The Committee received the Nursing Workforce report and supporting data. Attention was drawn to planned versus actual staffing hours, care hours per patient day, the Trust's position regarding safe nurse staffing and efficiency and quality and safety metrics; supporting commentary explained what the data was telling us. An additional data assurance question was suggested by the Chair for future use "What are good practices and achievements?"

17/8/27 In order to demonstrate the direction of travel for ward quality measures an additional column had been added. Areas of least compliance were noted as appraisal, SET and hand washing. The latter measure being impacted upon by the introduction of an increased target from 95% to 97%, this had been implemented to drive a reduction in C. diff infection rates.

The Nursing Workforce and Ward Quality Metrics report was NOTED and identified actions supported.

LEADERHIP AND IMPROVEMENT CAPABILITY

Workforce & Education Assurance Report

17/8/28 Karen Barnard summarised the key areas of focus for the Workforce & Education Committee, including updates from meetings up to 31 July 2017 and plans for future development of WEC. Workforce data relating to sickness/absence, appraisals, SET and staff in post was received by the Finance & Performance Committee.

17/8/29 In response to a question from Alan Armstrong regarding leadership capacity, Karen Barnard offered assurance of plans to develop this through the re-launch of the management skills passport, delivery of Quality, Improvement and Innovation workshops, Insights Profiling sessions for Heads of Nursing and General Managers, introduction of a Board Development programme and exploring options available via the Leadership Academy. These plans would shape the required attitudes and behaviours which could subsequently be measured through 360 degree feedback. Further thought would be given to the desired outcomes of the various plans and how success would be measured for inclusion in future assurance reports.

The Workforce and Education Assurance Report was NOTED.

GOVERNANCE AND RISK

Workforce & Education Committee Terms of Reference

17/8/30 In response to a question regarding inclusion of the student voice, Karen Barnard confirmed this was referred to in the external quality assurance data sourced from GMC and PPQA, within the duties and programmed of work section. In order to provide clarity it was agreed that alternative wording would MM/KB

be agreed for this statement.

17/8/31 The following amendments were proposed:

- Inclusion of an accountability tree in the "responsible to" section
- To replace the word "strategies" in "Approve strategies relating to workforce..." within the duties and work programme section.

Subject to the above amendments the Committee APPROVED the Workforce & Education Terms of Reference.

RCOG Action Plan

17/8/32 The Medical Director advised that the action plan, owned and delivered by Obstetrics and Gynaecology, would be monitored on a monthly basis by the CGC. The three key areas of focus being:

- Service redesign
- Improved team work
- Strengthening clinical governance processes within the specialities

17/8/33 It was recognised that the most difficult areas to address within the action plan were cultural change, and staff being clear on their contractual and professional commitments. Leadership skills within the management team were being addressed and improved team working across the wider team was expected to progress alongside the service redesign plans. A need to monitor soft metrics through staff feedback was recognised to be crucial in terms of demonstrating progress and measuring success, and Sewa Singh proposed that soft feedback be collected now and 6 monthly to determine progress.

17/8/34 In response to a question from Martin McAreavey with regards to the pace of change. Mr Singh offered an assurance that all clinical governance and patient safety issues had now been addressed. Improved teamwork and service redesign was recognised to be interlinked with improved standards of care and quality. Due to the nature of the required change this would be a journey over time rather than an overnight change. Work on patient pathways was also underway, although this may require review within the next 2-3 months to validate the required resources for delivery.

17/8/35 The Chair acknowledged the efforts made to populate the action plan and expressed appreciation of the progress to date. The Committee were assured that a comprehensive process was in place and active at CGC, and felt significantly more assured than when the action plan had previously been discussed. A need to progress the level of assurance for the long term soft issues relating to teamwork, leadership and service redesign (sections 36-37) was noted. An update on the following sections of the plan 12, 16, 17, 18, 21-23 and 28-30 inclusive would be provided at the next meeting. **SS**

The RCOG Action Plan was NOTED.

Board Assurance Framework and Corporate Risk Register

17/8/36 The Trust Board Secretary updated the Committee on changes to the Board Assurance Framework (BAF) and Corporate Risk Register (CRR) since the last meeting of the Committee. A list of current risks and their alignment to the respective committees was provided for information. In order to ensure appropriate staff knowledge a series of risk refresher sessions have been planned and Non-Executive Directors were welcomed to attend these.

17/8/37 The Committee considered interrogation of a specific risk as a deep dive topic. No extreme risks were assigned to this committee and whilst staff morale was considered to be a high risk the timing of the next meeting was not ideal in view of the forthcoming staff survey. A discussion took place around those risks that had a financial value and also impacted upon the quality of care and it was agreed that further thought would be given to risk interrogation as a discussion topic at the debrief meeting on 7 September 2017. **All**

The Board Assurance and Corporate Risk Register were NOTED and the Committee AGREED to adopt use of the risk interrogation template provided by the Chair.

Annual Revalidation Assurance Report

17/8/38 The Medical Director updated the Committee on completion of the annual medical revalidation process. During the first cycle the majority of appraisals had been successfully completed. The second cycle would drive care quality improvement through the appraisal process and the Committee would look to seek assurance on this link in future years.

17/8/39 Mr Singh highlighted work was underway to link information within Datix to the current appraisal system; this would provide relevant data, such as incidents, claims and complaints. An increase in hard metrics to support the soft intelligence would increase the level of challenge within the process. It was recognised that such changes would be secured over a period of time, and in order to provide assurance on progress the Medical Director agreed to present an update to the Committee in six months. **SS**

17/8/40 To avoid unnecessary duplication the Chair of the Board had agreed that this report need not be presented to the Board, instead assurance would be offered within the Chair's log.

The Committee NOTED the progress to deliver the first cycle of revalidation and recognised aspirations to move to a more demanding process in the second cycle, linked to patient care.

Mr Singh left the meeting

National Quality Board Framework

17/8/41 The paper updated the Committee on a shared commitment to quality. The Trust was engaged in all relevant activities and the work on the Single Oversight Framework and development of the Clinical Governance Dashboard would demonstrate how the Trust would utilise the quality of care information.

17/8/42 As the CQC insights had only been received shortly before the meeting, work to understand and present the data was still in progress. A report summary supported the data to provide commentary on those areas of concern and the associated actions.

17/8/43 Whilst the data would be presented to CGC on a monthly basis there was a need to agree the reporting process and frequency for this Committee, alongside data within the Business Intelligence Report. In Mr Singh's absence as the Chair of CGC it was agreed to defer this discussion to the debrief meeting on 7 September2017. **MH/SS**

The National Quality Board Framework was NOTED and next steps acknowledged.

Minutes of sub-committees

17/8/44 The minutes of the following committees were NOTED:

- Clinical Governance & Quality Committee held on 16 June 2017
- Workforce & Education Committee held on 15 May 2017.

17/8/45 The minutes of the Patient Experience and Engagement Committee meetings dated 26 May and 30 June 2017 need not have been received as the Committee reported directly to CGC. As agreed previously, QEC would receive a six monthly assurance report, the first of which would be presented at October's meeting.

Minutes of the meeting held on 23 June 2017

17/8/46 The minutes were APPROVED as a true record. The Chair requested that future minutes be circulated for member's comment at the earliest opportunity following the meeting. Amendments to be completed using the track change facility.

Any other business

17/8/47 No other business was declared.

Governor questions regarding the business of the meeting

17/8/48 Peter Abell questioned if the concerns referred to within the RCOG action plan had been raised as part of the appraisal process. The Executive Directors explained that staff concerns had been escalated internally to the then Director of Nursing, Midwifery & Quality and also externally. This had resulted in an internal investigation and the Trust commissioning an external review by the Royal College of Obstetrics and Gynaecology. The Care Group in question demonstrated a strong appraisal completion rate but the detail/quality of the appraisal discussions were not known.

17/8/49 Peter Abell acknowledged the content, quality and transparency of the People & OD Strategy and confirmed he felt assured by this and the discussions today in respect of anecdotal staff morale feedback.

17/8/50 Clive Tattley questioned the priority given to risks contained within the Corporate Risk Register, including the consideration given to the impact on the patient. He sought assurance that risks were reviewed on an ongoing basis rather than a one-off exercise. The use of a deep dive to review a specific risk would offer assurance and the Chair suggested an assurance question could focus on "Could more be done to mitigate the risk" and to ensure that actions translate into outcomes. The members would reflect on this when considering interrogation of a risk at the debrief meeting.

Meeting Round-up

17/8/51 The Chair suggested consideration be given to membership of the Committee. **All**

Future Discussion Topics

17/8/52 The Chair summarised the following topics identified for future discussion:

- Research Activity & Governance Arrangements
- QEC's Quality Metrics Requirements
- Risk Interrogation
- Progress against RCOG Action Plan
- Governance Arrangements for Assurance to the Board

Any additional items for inclusion should be shared with the Chair.

Identification of New Risks

17/8/53 No new risks were identified.

Items for Escalation to the Board

17/8/54 None.

Time and date of next meeting:

Extra-ordinary Meeting
Date: 26 September 2017
Time: 9am
Venue: Boardroom, DRI

Regular Bi-Monthly Meeting
Date: 24 October 2017
Time: 2pm
Venue: Boardroom, DRI

Signed:…….. **…….**

Linn Phipps **Date**

Appendix

Agreed scope and structure of Assurance reports (and data reports):

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

DONCASTER & BASSETLAW TEACHING HOSPITALS NHS FOUNDATION TRUST

Minutes of the Extraordinary Quality & Effectiveness Committee
Held at 9am Tuesday 26 September 2017
in the Boardroom, DRI

PRESENT	:	Linn Phipps, Non-executive Director (Chair) Alan Armstrong, Non-executive Director Martin McAreavey, Non-executive Director Karen Barnard, Director of People & OD Moira Hardy, Acting Director of Nursing, Midwifery & Quality Sewa Singh, Medical Director
IN ATTENDANCE	:	Peter Abell, Governor Observer Clive Tattley, Governor Observer Matthew Kane, Trust Board Secretary Petra Bryan, Head of Quality Improvement & Innovation Marie Purdue, Acting Director of Strategy & Improvement Kate Sullivan, Corporate Governance Officer Simon Marsh, Chief information Officer Emma Shaheen, Head of Communications & Engagement
APOLOGIES:		Andrew Beardsall, Bassetlaw CCG

Action

Introductions

17/09/1 The extraordinary meeting had been convened to review the Trust's Strategies and the Chair set out the process by which the Committee would do this. It was agreed that the committee would:

- Consider areas of good practice in each strategy and any areas for improvement.
- Consider interdependencies with other strategies and whether each strategy demonstrated how it would support the 5Ps and the strategic objectives.
- Consider the strength of monitoring and evaluation of each strategy; how the Trust felt assured the strategy is actually working / being delivered.

17/09/2 The Chair asked whether it would be possible to make any amendments to the strategies and this was discussed. It was agreed that a feedback summary would be provided to Executives and that where possible to do so this would be incorporated.

17/09/3 It was noted that the Clinical Services Strategy had not been provided in the papers; The Trust Board Secretary explained that some key information relating to Hospital Services Review needed to be considered for inclusion. The Clinical Services Strategy would therefore be considered at the next QEC meeting. It was also noted that development of the R&D Strategy was ongoing; it would be

aligned with the other strategies at a later date.

Apologies

17/09/4 Apologies were noted from Andrew Beardsall.

Enabling Strategies

17/09/5 Each of the strategies below had been circulated prior to the meeting. The committee reviewed each strategy in line with the process set out in 17/09/01. Feedback is summarised in Appendix 1 which sets out; Good practices and areas for improvement for each strategy; Areas of frequently good practice recommended for inclusion in all strategies; Areas generally requiring development to be aligned across all strategies.

- Clinical Governance & Assurance Strategy
- P&OD Strategy
- Patient Experience & Engagement Strategy
- Quality, Improvement & Innovation Strategy
- Communications & Engagement Strategy

17/09/6 The feedback summary would be circulated to the committee and executives later the same day. **KS**

17/09/7 **Action plans** - The inclusion of action plans was a key area of inconsistency across the strategies. The committee considered to what extent action plans should/should not be included and this was discussed at various stages of the meeting. It was resolved that including actions plans risked replicating work already being undertaken and that instead there should be clear cross referencing to existing actions plans and the committees through which they were monitored. There therefore needed to be strong and consistent governance sections which set out the monitoring process so the committee could be assured there was a process for evaluation. This section should also describe what kind of KPIs would be in place and what kind of assurance there would be.

17/09/8 **Strategy Presentation –** It was noted that each strategy was around 15 pages long and there were approximately 10 separate strategies in total. The committee considered this in terms of asking various audiences to read over 150 pages of information and this was discussed. The committee asked the following questions; Who was the audience and how would the Trust manage the communication of key information.

17/09/9 It was important to emphasise key points and priorities; the committee discussed how this might be achieved. It was agreed that each strategy should set out key priorities and the Head of Communications and Engagement undertook to take away the development of a 'Strategy on a Page' document. **Execs & ES**

17/09/10 **Future Assurance and Monitoring -** The committee considered which committee would receive the strategies in the future, this was discussed and it was agreed that all strategies should be taken through the QEC. **ALL**

17/09/11 There was further discussion about how the Committee would monitor progress; it was agreed it would be useful to be provided with examples of projects and stories of change as well as the overarching data. The committee liked the Process, Learning and Outcome framework used in the QII Strategy and would consider this as a framework for monitoring the strategies in the future. **MK**

17/09/12 **How assured are the Committee that appropriate links exist between the Clinical Service Strategy and People & OD Strategy?**

The item was deferred as the Clinical Services Strategy was not available. **DP/MK**

17/09/13 **How assured are the Committee that appropriate cross referencing and alignment is in place for all strategies?**

Great work had been done by all teams to produce the strategies and this was commended. However looking at all the strategies together, good practices had not been replicated across them all; therefore there were opportunities to capture these and also to feed in to the Clinical Services Strategy.

17/09/14 The Committee would specifically recommend that it was not helpful to include an action plan as this would look inconsistent; strategies did therefore need a governance section to describe the governance process and how it was going to be monitoring so the Trust could be assured that there would be a process for evaluation.

17/09/15 On behalf of the committee the Chair would verbally RECOMMEND the strategies presented subject the incorporation of the feedback set out in Appendix 1. **LP**

17/09/16 **Items escalated from Clinical Governance Committee**

Switchboard call waiting times

A report had been circulated with the papers. Simon Marsh outlined the key challenges. It was noted that The switchboard at DRI took over 4,000 calls per day with around a 46% abandonment rate after being on hold for a minute. There had been some challenges since implementation of the new system including issues with directory but the key issue was that more calls were coming in than the Trust had capacity to cope with at DRI and Bassetlaw was not yet configured to take overflow calls from DRI.

17/09/17 A business case to complete the work required for Bassetlaw to take overflow calls had been approved at CIC the previous day however it required capital investment (£244k), the availability of which was yet to be determined.

17/09/18 There were also some behavioural issues in terms of managing phones, for example the practices of forwarding calls and using the answering service were not embedded across the Trust. Unanswered calls were transferred back

to switchboard after 1 minute if unanswered. All letters to patients included departmental direct dial numbers however patients often called the main DRI number.

17/09/19 The chair asked what the main impacts of the problem were and what risks this presented to the Trust. This was discussed. Key issues and risks included:

- Clinical Risk
- Patient experience
- Reputational risk
- Staff frustration
- DNAs

17/09/20 The Medical Director outlined areas of concern in terms of clinical risks and safety concerns relating to the ability of Theatres, ED, Resuscitation and the Labour suite to contact medical colleagues in the event of an emergency and the ability to contact on-call doctors; this was considered in detail. The Medical Director asked if these calls could be prioritised and this was discussed. Simon Marsh undertook to look in to this. As a remedial measure he suggested providing these areas with a separate extension number to contact switchboard which would have the highest priority but at the same time he also raised concern that if this number were to be too widely circulated it could become overused. **SM**

17/09/21 In summary there were both human factors and technological issues to address. The technological issues would take time, staffing issues would have a quicker impact but the posts were yet to be filled and would not resolve all of the issues. After further consideration of the key issues, and due to the clinical and reputational risk to the Trust, it was agreed to escalate the matter to the Board of Directors meeting later the same day.

17/09/22 Items for escalation to the Board of Directors

- Switchboard call waiting times **LP**

17/09/23 Any other business

17/09/24 No other business was declared.

Time and date of next meeting:

Date: 24 October 2017
Time: 2pm
Venue: Boardroom, DRI

Signed:…….. **…….**
Linn Phipps **Date**

Minutes of the meeting of the Charitable Funds Committee
Held on Tuesday 25 July 2017
In the Boardroom, Doncaster Royal Infirmary

Present:	John Parker	Non-executive Director (Chair)
	Suzy Brain England OBE	Chair of the Board
	Alan Armstrong	Non-executive Director
	Neil Rhodes	Non-executive Director
	Sewa Singh	Medical Director
In attendance:		
	Matthew Kane	Trust Board Secretary
	Peter Brindley	Executor of Fred and Ann Green Estate
	Phil Beavers	Public Governor
	David Cuckson	Public Governor
	Andy Sidney	Head of Financial Control

ACTION

Welcome and apologies for absence

17/07/1 Apologies for absence were presented on behalf of Richard Parker, Jon Sargeant, Linn Phipps and Martin McAreavey.

Minutes of the meeting held on 23 May 2017

17/07/2 The minutes of the meeting of the Committee held on 23 May 2017 were APPROVED as a correct record.

Governance Ratification Action Plan

17/07/3 The Committee considered a report of the Director of Finance that provided a summary on progress against the action plan and advised of an upcoming procurement process for a new charitable funds system using unrestricted charitable funds.

17/07/4 The Committee was advised that issues with the current charitable funds system had led the senior management team in Finance to conclude that a new system was required and this was planned for December along with the movement of a range of dormant funds into the general fund.

17/07/5 Whilst noting the update, the Committee commented that they expected to see further detail about the steps required to fulfil the action plan and how restricted funds were managed, particularly those with a research and education focus. The Committee supported the case for the new system subject to its progression through the usual business case processes.

17/07/6 The Committee also challenged whether it was possible to meet the timescales within the action plan and how the work would be delivered. It was noted that a lot of the delivery was attributed to one member of staff, the Head of Financial Control.

17/07/7 There was a discussion around the Trust's efforts to fundraise and a view that a professional fundraiser may be able to move this work on at pace. The website would be another key avenue through which funds could be raised. It was agreed to invite the Head of Communications and Engagement to the next meeting to discuss ideas.

17/07/8 The Committee NOTED progress against the Governance Rectification Action Plan.

Changes to Terms of Reference of Fred and Ann Green Advisory Group

17/07/9 The Committee considered a report of the Trust Board Secretary that proposed changes to the terms of reference for the Fred and Ann Green Advisory Group, principally to address some of the issues relating to the appointment of lay people on to the group. The importance of emphasising the link to Montagu in any advert was made.

17/07/10 The Committee AGREED that the terms of reference for the Fred and Ann Green Advisory Group appended to the report be adopted.

Update on Fund Balances

17/07/11 The Committee received a verbal report on the Trust balances which stood at £8.8m. The Committee was advised that the Funds had supported small (below 10k) projects in the previous months. In future it was requested that all spend should be brought back to the Committee, both that done under delegated powers and that which the Committee is requested to approve.

17/07/12 The Committee NOTED the position.

Any other business

17/07/13 The Governor representative was invited to speak at this point during which time he echoed some of the concerns raised by others during the meeting.

Date and time of next meeting

17/07/14 The next meeting of the Committee would take place on 26 September 2017 at 11am in the Boardroom, DRI.

John Parker **Date**
Chair of the Committee

UNAPPROVED

Minutes of the Meeting of the Management Board
of
Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust
on
Monday 11 September 2017 at 2pm
in the Boardroom, DRI

Present:

Richard Parker	Chief Executive (in the Chair)
Andrew Barker	Care Group Director - Diagnostics & Pharmacy
Karen Barnard	Director of People & Organisational Development
Kirsty Edmondson-Jones	Director of Estates & Facilities
Moira Hardy	Acting Director of Nursing, Midwifery and Quality
Eki Emovon	Care Group Director - Children and Families
Thrinath Kumar	Care Group Director - MSK & Frailty
Nick Mallaband	Acting Care Group Director - Emergency
Simon Marsh	Chief Information Officer
Tim Noble	Associate Medical Director
Gillian Payne	Care Group Director - Speciality Services
David Purdue	Chief Operating Officer
Marie Purdue	Acting Director of Strategy & Improvement
Jon Sargeant	Director of Finance
Jochen Seidel	Acting Care Group Director - Surgical

In attendance:

Leanne Shaw	Executive PA (minutes)
Matthew Kane	Trust Board Secretary

Apologies:

Sewa Singh	Medical Director
Willy Pillay	Deputy Medical Director

Action

Minutes of the previous meeting

MB/17/8/1 The minutes of Management Board on 7 August 2017 were approved as an accurate record of the meeting, subject to the following amendments;

MB/17/8/2 17/7/15 - Last bullet point should read "Improvement in performance / 4th in the country for deanery survey".

Matters arising and action notes

MB/17/8/3 The action notes were reviewed and updated.

MB/17/8/4 MB/16/6/28 - David Purdue agreed to contact Khalid Habib for an update in relation to the review of the Nurse Endoscopists. **DP**

Post meeting note: Non-Medical Endoscopist recruited and in post. It was noted that the funding source had been provided through the resignation of a Nurse Consultant post.

MB/17/8/5 MB/17/6/21 - Due to the change in agency provider, the Medical Director had discussed the issues with locum salaries at the Care Group Director's meeting on 6 September 2017.

MB/17/8/6 MB/17/6/43 - Karen Barnard provided an update in relation to the government's proposed changes to the NHS and the recruitment of additional medical staff.

MB/17/8/7 MB/17/7/6 - Simon Marsh confirmed that emails could not be auto-deleted after a period of two years.

Post Implementation Review - Payroll SBS

MB/17/8/8 Karen Barnard presented the paper and provided an update on the project that outsourced the Trust's Employee Services function to Shared Business Services (SBS).

MB/17/8/9 Key elements of the post implementation review were summarised as follows;

- Assessment of costs highlighted actual project costs were greater than initially proposed and savings were significantly reduced to £58.9k over five years.
- The financial benefits were negatively impacted due to the redundancy of the TUPE'd team by SBS, and a clause in the contract had made the Trust liable for the redundancy costs.
- The lack of notice period meant that the transfer of local knowledge had been lost and the quality of service had been affected.
- The Knowledge Acquisition document to identify skills gaps had not been as comprehensive as it should have been.
- A new customer contact portal for recording calls from employees had been implemented and the new system would be assessed after a settling down period.

MB/17/8/10 Karen Barnard agreed to circulate the action plan that had been developed to address continued performance issues and progress would initially be monitored on a fortnightly basis. SBS had been given six months to complete activities detailed in the action plan and a further meeting would take place to review if improvements had not been made in this period. **KB**

MB/17/8/11 A lengthy discussion took place in relation to the redundancy process and

Richard Parker asked for the Trust's existing business processes to be sense checked, to ensure that lessons were learnt.

The SBS Payroll Post Implementation Review was NOTED.

Terms of Reference

MB/17/8/12 The Terms of Reference for the following sub-committees of Management Board were presented;

- Children's and Family Board
- Elective Care Steering Group
- Urgent & Emergency Care Steering Group

MB/17/8/13 Marie Purdue reported that minor amendments to the Elective Care Steering Group terms of reference would be made to reflect that the Children's and Family Board would consider elective as well as emergency paediatric care. Any further comments or amendments to be sent to Marie. **MP**

The Terms of Reference were NOTED.

Finance Report as at 31 July 2017

MB/17/8/14 Jon Sargeant presented the finance report that set out the Trust's financial position at month 5 and drew attention to key points as follows;

- The month 4 position was £2.384m deficit, £475k worse than plan
- The YTD deficit position was £10.380m, £461k worse than plan
- Top down forecasts undertaken
- Medical staffing spend continued to be high
- Unidentified CIPs generated a significant overspend
- Income had been £1.298m better than expected
- Cash levels were strong
- BDO had been contracted to undertake a governance review of the Trust's CIP process and the quality and deliverability of schemes

MB/17/8/15 Jon Sargeant explained that the Trust could miss out on STF funding if the plan at the end of the financial year was not achieved.

The Finance Report was NOTED.

Feedback from Care Groups / Corporate Directorates

MB/17/8/16 Diagnostics & Pharmacy - Andrew Barker provided the following update;

- Overspend
- Plan to bring additional MR capacity onto the Bassetlaw site
- Diagnostic waiting times - over target

- Appraisal rate low
- Assistant Care Group Director appointed

MB/17/8/17 Richard Parker agreed to circulate correspondence relating to the rationalisation of Pathology Services. **RP**

MB/17/8/18 Children's & Families - Eki Emovon provided the following update;

- Increased medical agency costs due to sickness levels / resignation
- Paediatric medical rotas
- Obs & Gynae job planning - PA allocation agreed
- CIP allocation to be agreed
- Feedback sessions taking place for RCOG report
- Paediatric nurses
- 2ww breaches
- Response to ODN required in relation to SCBU medical cover
- K2 system
- TriHealth - end of the contract
- Appraisal rate improving
- Sickness helpline established
- Fundraising opportunities to support neonatal unit
- Full establishment in midwifery - staggered induction programme
- Difficult to employ oncology gynaecologist

MB/17/8/19 MSK & Frailty - Thrinath Kumar provided the following update;

- Moved to a single on call rota
- Finances behind plan - support required to get back on track
- CoTE performance on target / T & O 1% behind target
- Staffing issues with consultants
- Appraisals
- Job planning almost complete
- Issues with middle grade rotas resolved

MB/17/8/20 Emergency - Nick Mallaband provided the following update;

- 4hr access target above 93% - doing well nationally
- RTT for respiratory and gastro on target
- Finances behind plan
- Recruitment - A & E Consultant / Operational Business Manager appointed
- Front door work at Bassetlaw is delayed
- Agreed primary care stream to be provided by FCMS at Bassetlaw
- Risks around overnight ED middle grade staff at Bassetlaw
- Major risk with night shift and how to remunerate consultants covering

- Caesar consultants - update

[Nick Mallaband left the meeting].

MB/17/8/21 Surgical - Jochen Seidel provided the following update;

- Significant overspend on pay
- Four substantive posts recruited to
- Recruited a middle grade to assist with on call rota for intensive care
- Firework on floor 7 restarted
- Training of ACPs in intensive care
- Difficulty recruiting to middle grade rota at Bassetlaw
- RTT position in ophthalmology and ENT - regular meetings with COO
- Resignation of Assistant Care Group Director
- Five vacancies out to advert in ophthalmology (3rd recruitment drive)

MB/17/8/22 A lengthy discussion took place in relation to the sustainability of the ophthalmology service.

MB/17/8/23 Specialty Services - Gill Payne provided the following update;

- Two diabetes posts advertised
- Resignation in dermatology
- Pseudomonas outbreak in urology scopes
- Staffing issues on ward 17
- Urology / vascular - job planning outstanding
- Listening events took place
- Issue with RTT position in cardiology
- Issues with diagnostic waits

MB/17/8/24 People & Organisational Development - Karen Barnard reported that medical staffing recruitment had been successful and three posts had been appointed to.

MB/17/8/25 Estates & Facilities - Kirsty Edmondson-Jones thanked the estates team for working hard to reduce the backlog of outstanding jobs from 1600 down to 100. Recruitment was underway which would hopefully improve service delivery.

MB/17/8/26 IT - Simon Marsh reported that challenges had been faced in relation to the recent migration to NHS2mail and a meeting would take place with the provider to discuss their performance and any issues.

The feedback from Care Groups / Corporate Directorates was NOTED.

Update on Financial & Performance Committee activity

MB/17/8/27 Nothing further to note.

Corporate Risk Register

MB/17/8/28 Matthew Kane presented the Corporate Risk Register and Board Assurance Framework and highlighted the extreme risks that had been registered on Datix. It was proposed that these risks would be managed within Care Group risk registers, and risk refresher training sessions would take place to include the Datix system, key principles of risk management, risk registers and the matrix for scoring risks.

MB/17/8/29 Jochen Seidel raised a query in relation to how risks were considered to be the responsibility of the Care Group or Corporate areas and commented that some risks would not be resolvable within Care Groups. Matthew Kane explained that extreme risks on Datix would be discussed at Management Board and a decision would be made as to whether it should be added to the corporate risk register. The risks on the corporate risk register would typically be strategic risks and / or in relation to corporate objectives. Not all risks could be resolved; the key thing was to manage them to an appropriate level.

The Board Assurance Framework and Corporate Risk Register was NOTED.

Forthcoming Assessments, Inspections and Reviews

MB/17/8/30 Matthew Kane presented the summary report showing forthcoming reviews and previous reviews which had resulted in action plans.

MB/17/8/31 Members would be reminded to notify the Trust Board Office of any upcoming external reviews, visits, inspections and accreditations so that they could be added to the register and report. **All/MK**

MB/17/8/32 Richard Parker commented that the proposed visit scheduled for 7 December would focus on ED performance and the delivery through Winter.

The Forthcoming Assessments, Inspections and Reviews report was NOTED.

Chief Executive's Report

MB/17/8/33 Richard Parker provided an update in relation to the ACS plan. The expectation was that by the start of 2019, the ACS would be fully accredited and be responsible for its own performance and financial challenges.

MB/17/8/34 The Chief Executive's report was NOTED.

Business Intelligence Report as at 31 July 2017

MB/17/8/35 The Business Intelligence Report was provided for information and NOTED.

Minutes of the Corporate Investment Group meeting

MB/17/8/36 The minutes of the Corporate Investment Group meeting held on 24 July 2017 were provided for information and NOTED.

Minutes of the Planned Care Board meeting

MB/17/8/37 The minutes of the Planned Care Board meeting held on 20 July 2017 were provided for information and NOTED.

Minutes of the Children's & Family Board meeting

MB/17/8/38 The minutes of the Children's & Family Board meeting held on 14 July 2017 were provided for information and NOTED.

Any Other Business

MB/17/8/39 In response to a query from Tim Noble in relation to 62 day performance and 2ww, David Purdue agreed to investigate and clarify the process for alerting the clinical team to book CT scans. **DP**

MB/17/8/40 In response to a query from Tim Noble in relation to requesting PET scans at Nottingham, David Purdue agreed to clarify if there was an existing cost code for DBTH. **DP**

MB/17/8/41 In response to Gill Payne, Thrinath Kumar suggested contacting Alasdair Strachan for details of the Caesar Lead. **GP**

MB/17/8/42 Thrinath Kumar raised ongoing concerns in relation to staffing and Karen Barnard commented that a report highlighting any workforce issues would be presented to the Finance and Performance Committee on a monthly basis. Richard Parker echoed that the sustainability of the Trust's workforce was a top priority.

Items for escalation to the Board of Directors

MB/17/8/43 None.

Items for escalation from Sub-Committees

MB/17/8/44 None.

Date and Time of Next Meeting:

MB/17/8/45 Date: 9 October 2017
Time: 2pm
Venue: Boardroom, DRI

Board of Directors Agenda Calendar

STANDING ITEMS			OTHER / AD HOC ITEMS
MONTHLY	**QUARTERLY**	**BIANNUAL / ANNUAL**	
NOVEMBER 2017			
CE Report	QEC minutes	Annual Compliance against the National Core Standards for Emergency Preparedness, Resilience and Response (EPRR)	Enabling Strategies
Business Intelligence Report	Board Assurance Framework & corporate risk register Q2		
Nursing Workforce			
MB Minutes			
Finance & Performance Minutes			
Finance Report			
Chairs' Assurance Logs			
DECEMBER 2017			
CE Report	Report from the Chair of the ANCR committee (Verbal)		
Business Intelligence Report			
Nursing Workforce			
MB Minutes			
Finance & Performance Minutes			
Finance Report			
Chairs' Assurance Logs			
JANUARY 2018			
CE Report	ANCR minutes (16.12.16)	Budget Setting / Business Planning / Annual Plan	
Business Intelligence Report	Chief Executive's Objectives	SOs, SFI, Scheme of Delegation	
Nursing Workforce	Complaints, Compliments, Concerns and Comments Report		
MB Minutes	R&D Strategy metrics (in BIR)		
Finance & Performance Minutes	Safeguarding & maternity metrics (in BIR)		

As at 19 July 2017

Finance Report	P&OD Quarterly report		
Chairs' Assurance Logs			
FEBRUARY 2018			
CE Report	QEC Minutes	Budget Setting / Business Planning / Annual Plan	
Business Intelligence Report	Monitor Quarterly Declaration Q3		
Nursing Workforce	Board Assurance Framework & corporate risk register Q3		
MB Minutes			
HWB Decision Summary			
Finance & Performance Minutes			
Finance Report			
Chairs' Assurance Logs			
MARCH 2018			
CE Report	Report from the Chair of the ANCR committee (Verbal)	Budget Setting / Business Planning / Draft Annual Plan	
Business Intelligence Report	Monitor Q3 Results Notification	Staff Survey	
Nursing Workforce		Fred & Ann Green Legacy minutes	
MB Minutes			
HWB Decision Summary			
Finance & Performance Minutes			
Finance Report			
Chairs' Assurance Logs			
APRIL 2018			
CE Report	ANCR minutes	Draft Annual Report	Mandatory training update
Business Intelligence Report	Chief Executive's Objectives	Draft Quality Account	
Nursing Workforce	Complaints, Compliments, Concerns and Comments Report	Budget Setting / Business Planning / Final Annual Plan	
MB Minutes	R&D Strategy metrics (in BIR)		
HWB Decision Summary	Safeguarding & maternity metrics (in BIR)		
Finance & Performance	P&OD Quarterly report		

Minutes			
Finance Report			
Chairs' Assurance Logs			
MAY 2018			
CE Report	Monitor Quarterly Declaration Q4	Annual Report	
Business Intelligence Report	QEC Minutes	Quality Account	
Nursing Workforce	Report from the Chair of the ANCR committee (Verbal)	Annual accounts	
MB Minutes	Board Assurance Framework & corporate risk register Q4 (inc. annual assurance summary)	ISA260 and quality account assurance	
HWB Decision Summary		Charitable Funds minutes	
Finance & Performance Minutes		Mixed Sex Accommodation	
Finance Report			
Chairs' Assurance Logs			
JUNE 2018			
CE Report	Board Assurance Framework	MB Annual Report	
Business Intelligence Report	Report from the Chair of the ANCR committee (Verbal)	SOs, SFI, Scheme of Delegation	
Nursing Workforce	Monitor Q4 Results Notification	ANCR Annual Report	
Bed Plan			
MB Minutes			
Finance & Performance Minutes			
Finance Report			
Chairs' Assurance Logs			
JULY 2018			
CE Report	Chief Executive's Objectives		Reference Costs
Business Intelligence Report	Complaints, Compliments, Concerns and Comments Report		Diversity and Inclusion
Nursing Workforce	R&D Strategy metrics (in BIR, to include R&D annual summary)		
MB Minutes	Safeguarding & maternity metrics (in BIR)		
Finance & Performance	ANCR Minutes		

Minutes			
Finance Report	P&OD Quarterly report		
Chairs' Assurance Logs			
AUGUST 2018			
CE Report	QEC minutes	Proposed AMM arrangements	Health and Wellbeing
Business Intelligence Report	ANCR Minutes	Annual Security Report	
Nursing Workforce		Infection Control Annual Report	
MB Minutes		Risk Policy	
Finance & Performance Minutes			
Finance Report			
Chairs' Assurance Logs			
SEPTEMBER 2018			
CE Report			Catering Report
Business Intelligence Report			Teaching Hospital
Nursing Workforce			
MB Minutes			
Finance & Performance Minutes			
Finance Report			
Chairs' Assurance Logs			
OCTOBER 2018			
CE Report	ANCR minutes	Charitable Funds minutes	
Business Intelligence Report	Chief Executive's Objectives	Fred & Ann Green Legacy minutes	
Nursing Workforce	Complaints, Compliments, Concerns and Comments Report		
MB Minutes	R&D Strategy metrics (in BIR)		
Finance & Performance Minutes	Safeguarding & maternity metrics (in BIR)		
Finance Report	P&OD Quarterly report		
Chairs' Assurance Logs			

OTHER ITEMS			
Review the appointment of Peter Brindley (Executor of Fred and Ann Green Will)			3 yearly (May 2018)
Constitution review			3 yearly (Jan 2018)

Minutes of the meeting of the Board of Directors
Held on Tuesday 26 September 2017
In the Lecture Theatre, Doncaster Royal Infirmary

Present:	Suzy Brain England OBE	Chair of the Board
	Alan Armstrong	Non-executive Director
	Karen Barnard	Director of People and Organisational Development
	Moira Hardy	Acting Director of Nursing, Midwifery and Quality
	Martin McAreavey	Non-Executive Director
	Richard Parker	Chief Executive
	Linn Phipps	Non-executive Director
	David Purdue	Chief Operating Officer
	Neil Rhodes	Non-executive Director
	Jon Sargeant	Director of Finance
	Sewa Singh	Medical Director
In attendance:	Marie Purdue	Acting Director of Strategy and Improvement
	Simon Marsh	Chief Information Officer
	Matthew Kane	Trust Board Secretary
	Emma Shaheen	Head of Communications and Engagement
	Mark Bright	Public Governor
	David Cuckson	Public Governor
	Lynne Logan	Public Governor
	George Webb	Public Governor
	Clive Tattley	Partner Governor
	Dr Jayant Dugar	Guardian for Safe Working
	Plus 20 staff	

ACTION

Welcome and apologies for absence

17/09/1 Apologies for absence were received on behalf of Philippe Serna. The Chair welcomed all present including members of staff who had joined the meeting to observe.

Declarations of Interest

17/09/2 Board was reminded of the need to keep their registers of interests up-to-date.

Actions from the previous minutes

17/09/3 The list of actions from previous meetings was noted and updated.

The Quality of Junior Doctor and Student Training at DBTH

17/09/4 The Board considered a report and presentation of the Director of Education which set out details of the quality of junior doctor training at the Trust.

17/09/5 Board was advised that the quality of teaching of students and junior doctors was central to the delivery of a high quality workforce to care for patients. The quality of the Trust's teaching was recognised by key stakeholders in the attainment of Teaching Hospital status and it continued to be a key focus. Student and trainee experience at DBTH was also important for future workforce recruitment and retention.

17/09/6 The paper demonstrated how DBTH collated feedback from all learners; both medical and non-medical, and how the organisation used this information to inform improvements within Training and Education and supervisory arenas.

17/09/7 In response to a question from John Parker about the breadth of junior doctor experience at Bassetlaw, the Director of Education advised that work was ongoing to enhance the learning experience of those who attended the Hospital. Board was advised that anaesthetics, which had declined in the year, was now seeing an improving trajectory.

17/09/8 In response to a question from Neil Rhodes, the Board was advised that the Trust actively listened to trainees and sought to improve training and safety as these were areas that helped to attract new students to the Trust.

17/09/9 The Board AGREED with these programmes and tasked the Workforce and Education Committee to ensure the success of these actions.

***We Care* for our Junior Doctors**

17/09/10 The Board considered a report of the Director of Education that set out the programme of work the Trust was undertaking to help with improving morale amongst junior doctors.

17/09/11 Nationally it had been highlighted that the morale of junior doctors was at a historic low point which was being reflected in the number of trainees taking breaks from training or leaving training in the UK. Issues included not feeling valued, feeling disconnected from the senior management of the organisation they were working in, and not having their views considered.

17/09/12 The paper made a number of recommendations under the following headings:

- Engagement with Senior Management
- Quality Improvement and the role of junior doctors
- We Care for our trainees

17/09/13 In response to a question from the Chief Executive about how the Trust knew that these actions were what the junior staff wanted, the Board were advised that these initiatives were being driven from the junior doctors themselves rather than by management. Other initiatives, such as to improve the junior doctors' communal environment, were also considered as part of the programme.

17/09/14 The Board of Directors:

(1) SUPPORTED the initiatives within the paper and tasked the Workforce and Education Committee to ensure success.

(2) SUPPORTED the work of the Director of P&OD and Director of Education to take forward actions to improve senior managerial engagement with junior doctors.

Learning from Deaths

17/09/15 The Board considered a report of the Medical Director that provided assurance of the systems and processes in place to ensure that in-hospital deaths, including those in the Emergency Department, were scrutinised in a structured way in line with national guidance.

17/09/16 Board was advised that in quarter one there were 445 patient deaths at the Trust, 305 of which had been screened and approximately five per cent of these had been through a structured judgment review that had found that none of the deaths were attributable to care issues. 94% of the case notes were easy to review. It was noted that there was currently a time lag between deaths and their review and this needed to be shortened.

17/09/17 Further to a question from Martin McAreavey, the Board was advised that action plans would be devised where any issues were uncovered and these would be actively monitored.

17/09/18 The Board NOTED the report and the following actions:

- The time lapse to mortality review needed to be shortened.
- Explore ways of systematically listening to families and carers.
- Learning from Deaths Report to be tabled at local clinical governance meetings and for those specialties who have not reached 100% compliance should develop an action plan to achieve 100% by end of Q3.

Report from the Guardian for Safe Working

17/09/19 The Board considered a report of Dr Jayant Dugar, the Guardian for Safe

Working that presented a Quarter 2 update. The report was a requirement of the 2016 Junior Doctors contract.

17/09/20 In the quarter no gross safety issues had been raised with the Guardian by any trainee. There had been 45 exceptions raised by junior doctors that had been resolved without any fines being levied, two of which were education related. The 2016 contract continued to be implemented with 38 junior doctors employed by this Trust on the 2016 contract as at June 2017.

17/09/21 In response to a question from Linn Phipps about the numbers of junior doctors still not on the 2016 contract, Board was advised that the approach was an agreed transition and plans were in place to manage the effective transfer of all junior doctors.

17/09/22 The Board NOTED the update.

Annual Statement of Compliance against the NHS Core Standards for Emergency Preparedness, Resilience and Response (2017/18)

17/09/23 The Board considered a report of the Chief Operating Officer that advised of the recent self-assessment the Trust had undertaken against the NHS Core Standards for Emergency Preparedness, Resilience and Response and sought approval of the statement of compliance and improvement plan for submission to NHS England.

17/09/24 The Trust was a category one responder under the Civil Contingencies Act 2004 (CCA), which meant it had a key role in preparing for and responding to a range of emergency situations and significant service disruptions. Each year Acute Trusts were required to self-assess against 47 National Core Standards for Emergency Preparedness, Resilience and Response (EPRR).

17/09/25 In 2017/18, the Trust was compliant against all but two of the standards which were scored amber. The improvement plan, appended as a report, set out how those two areas would be addressed.

17/09/26 The Board:

(1) NOTED the self-assessment process undertaken for 2017/18.

(2) APPROVED the statement of compliance at Appendix A of the report for submission to NHS England (Yorkshire and the Humber).

(3) APPROVED the Improvement Plan at Appendix B of the report for submission to NHS England (Yorkshire and the Humber).

WTP Committees in Common

17/09/27 The Board considered a report of the Chief Executive that presented for approval the draft terms of reference and joint working agreement for the Working Together Partnership committees in common (CiC).

17/09/28 In June, Board agreed to approve the establishment of a CiC which would be a committee of the Board and to appoint to it the Chair and Chief Executive for the Acute Vanguard in order to build a confederated approach that supported the development and implementation of a high level clinical strategy for the WTP.

17/09/29 The Board also approved the draft Joint Working Agreement and a generic set of terms of reference for the Committee. Minor revisions to the JWA had been made to improve clarity of purpose and a specific (DBTH) branded set of terms of reference were now presented for approval, enabling the first meetings of the CiC to progress in October.

17/09/30 The Board APPROVED the WTP CiC draft terms of reference and joint working agreement.

Chairs Assurance Logs for Board Committees held 19 September 2017

17/09/31 The Board considered the assurance reports of the Chairs of Finance and Performance and Audit and Non-clinical Risk Committees, following their meetings on 19 September.

17/09/32 The Finance and Performance Committee had received new performance and workforce reports, as well presentations into 62-day cancer performance and the catering contract. A forecast of the Trust's financial performance would be brought to October's meeting.

17/09/33 The Chair of the Audit and Non-clinical Risk Committee was not present but his report was before the Board for consideration. Two audits had recently been completed and a better picture was evident in respect of historic audit recommendations.

17/09/34 Board RECEIVED the reports for assurance.

NHS Protect – Withdrawal of Support for Local Counter Fraud

17/09/35 The Board DEFERRED this item until the October meeting of the Board to enable the Chair of Audit and Non-clinical Risk Committee to present assurances.

Strategy and Improvement Report

17/09/36 The Board considered a report that provided assurance on progress on the strategic plan implementation process and quality improvement and innovation agenda.

17/09/37 Following Board's approval in June, the Strategic Direction 2017-22 had been forwarded to NHS Improvement. NHSI were still in the process of reviewing local strategies and would feedback following that review. The strategy launch was underway, supported by the Communications Team and had commenced with a launch at Management Board. An information stand and strategy specific edition of Foundations for Health was presented at the Annual Members Meeting.

17/09/38 The three clinical steering groups had now met to begin driving and overseeing the strategy implementation in the following areas: Urgent & Emergency Care (including Intermediate Care); Elective Care (including Cancer Services); and Childrens' and Families.

17/09/39 The business planning processes were currently being updated to reflect the new Strategic Direction and the annual planning process for 2017/18 would commence at the end of the month.

17/09/40 Enabling strategies were being reviewed in full by board sub-committees to ensure alignment with the Strategic Direction and summary documents would be provided to Board. Linn Phipps fed back on the work undertaken earlier in the day by the Quality and Effectiveness Committee in reviewing five of the strategies.

17/09/41 Board NOTED the report.

Finance Report as at 30 August 2017

17/09/42 The Board considered a report of the Director of Finance that set out the Trust's financial position at month 5, 2017/18.

17/09/43 The month five position was a £2.881m deficit, £663k worse than plan and the Year to Date (YTD) position was a £13.261m deficit, £1.123m worse than plan. For the month, income was ahead of expected levels, however high agency and non-pay expenditure continued. A lack of progress in identifying Cost Improvement Plans (CIP) had also resulted in significant overspends. The cash position at the end of August was £13m in the bank.

17/09/44 In response to a question from Linn Phipps about CIP underachievement, the Board was advised of the work being undertaken by BDO on the CIP governance process and the new grip and control measures led by the Chief Executive.

17/09/45 The Trust was committed to driving down agency spend and achieving the plan. Failure to do so may impact on the Trust's receipt of future Sustainability and Transformation funding. The Chief Executive and Director of Finance were also meeting with the CCG and mental health trust to encourage a system-wide approach.

17/09/46 The Board NOTED the Trust's financial position.

Performance Report as at 30 August 2017

17/09/47 The Board considered a report of the Chief Operating Officer, Medical Director, Acting Director of Nursing, Midwifery and Quality and Director of People and Organisational Development that set out clinical and workforce performance in month 5, 2017/18.

17/09/48 Performance against key metrics included:

4 hour access - In August the Trust achieved 93.6% against the 95% standard (94.45% including GP access), a slight improvement on last month. The Trust remained in the top third of trusts nationally for performance.

RTT – In July, the Trust performed below the standard of 92% achieving 90.1%, with four specialities with a high number of patients above 18 weeks, these being: Ophthalmology, ENT, General Surgery and Orthopaedics.

Cancer targets – In July, the 62-day performance did not achieve the 85% standard, coming in at 84.9. Two-week waits achieved the 93% standard.

HSMR – The Trust's rolling 12 month HSMR remained better than expected at 89.5. The Mortality Monitoring Group continued to work in specific areas to improve this performance.

C.Diff – The rate of cases remained above trajectory. In light of the continued increase in C.Diff cases, Infection, Prevention and Control were investigating the reasons for an increase.

Appraisal rate - The Trust's appraisal completion rate dipped to 56.6%. The Trust continued to focus on this standard as part of the revised accountability meetings, with particular attention given to all senior managers having their appraisal as close to the start of the financial year as possible and other staff appraisals being aligned to meet the peaks and troughs of operational demand.

SET training - There had been a decrease in compliance with Statutory and Essential Training (SET) and at the end of August the rate was 69.9%.

Sickness absence – The Trust had continued to see a rise in sickness, with August being 4.12% and the year-to-date position 4.08%. Last month the Trust saw a rise in the number of staff off sick across all timescales. Whilst the Trust continued to benchmark favourably across Yorkshire and Humber, this rise would be scrutinised in August.

17/09/49 In response to a question from Alan Armstrong about the patient pathway transformation project, the Board was advised that it was currently

working to reduce the number of 'did not attends' and that work would be reported to the Board.

17/09/50 Linn Phipps shared the work the Quality and Effectiveness Committee were doing around what quality meant, particularly in relation to soft metrics.

17/09/51 The Business Intelligence report was NOTED.

Nursing Workforce Report

17/09/52 The Board considered a report of the Acting Director of Nursing, Midwifery and Quality which provided detailed information relating to the nursing workforce, highlighting issues that could impact on the Trust's ability to sustain appropriate staffing levels and skill mixes.

17/09/53 The overall planned versus actual hours worked in August 2017 was 100%, a one per cent increase since July. Care Hours Per Patient Day (CHPPD) remained at 7.8. Ward A5 was assessed red for quality in the month and would be subject of a quality summit.

17/09/54 The Board of Directors NOTED the content of the paper and SUPPORTED the actions identified to ensure that the risks associated with inappropriate nurse staffing levels were appropriately managed.

Reports for Information

17/09/55 The following items were NOTED:

- Chair and NEDS' report
- Chief Executive's report
- Finance and Performance Committee minutes, 22 August 2017
- Audit and Non-clinical Risk Committee minutes, 20 July 2017
- Minutes of Management Board, 7 August 2017
- Board of Directors' Calendar

Items escalated from Sub-Committees

17/09/56 None.

Minutes

17/09/57 The minutes of the meeting of the Board of Directors on 29 August 2017 were APPROVED as a correct record.

Any other business

Martin McAreavey

17/09/58 The Board passed on its congratulations and appreciation to Martin McAreavey who was leaving the Board after having secured a position as the new Medical Director of the University of Bradford.

Annual Members' Meeting

17/09/59 The Chair thanked members of the public and governors who came to the annual members meeting at Montagu Hospital in September. She reflected that the Trust had much to celebrate in terms of the progress towards financial viability and the successful delivery of quality services. However, there were also some limitations in how the meeting was run with limited time for the public and governors to discuss matters and ask questions, poor acoustics in part and a less than optimal slide show. Some valuable input had been given on how to make the meeting more inclusive next year.

Switchboard

17/09/60 A matter was escalated from Quality and Effectiveness Committee earlier in the day regarding effective switchboard arrangements in light of concerns that consultants were unable to locate appropriate staff at important times of the day.

17/09/61 It was reported that a business case for the next phase of the Switchboard had been approved but capital monies were still awaited to take this forward.

17/09/62 Board was advised that the Trust faced a number of estates and utility issues which were subject to a robust prioritisation programme. Solutions were in place to manage the current risk to the Switchboard.

Governors questions regarding business of the meeting

17/09/63 David Cuckson commended the proposal to involve junior doctors in some of the Trust's operational committees. He asked what assurance there was that the work of the committees in common would be fed back to governors. The Chief Executive advised that minutes of the Trust's committee in common would be fed back through Board of Directors and Board of Governors.

17/09/64 Clive Tattley asked who the non-executive lead for emergency planning was. The Board was advised that it was Neil Rhodes.

Date and time of next meeting

17/09/65 9.00am on Tuesday 31 October 2017 in the Boardroom, DRI.

Exclusion of Press and Public

17/09/66 It was AGREED that representatives of the press and other members of the public be excluded from the remainder of the meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest.

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