



The meeting of the Board of Directors

**To be held on Monday, 30 April 2018 at 9.00am
in the Boardroom, DRI**

AGENDA

Part I

	Enclosures
1. Apologies for absence	(Verbal)
2. Declarations of Interest	Enclosure A
3. Actions from the previous meeting	Enclosure B
4. Presentation slot – Clinical Portal Simon Marsh – Chief Information Officer	Presentation
Reports for decision	
5. GDPR Readiness and Appointment of a Data Protection Officer for DBTH Simon Marsh – Chief Information Officer	Enclosure C
6. Provider Collaboration Agreement Richard Parker – Chief Executive	Enclosure D
7. Process for Strategy Milestones Marie Purdue – Director of Strategy & Transformation	Enclosure E
Reports for assurance	
8. Chairs Assurance Logs for Board Committees held 24 April 2018 Neil Rhodes – Chair of Finance and Performance Committee Linn Phipps – Chair of Quality and Effectiveness Committee	Enclosure F (QEC to follow)
9. Finance Report as at March 2018 Jon Sargeant – Director of Finance	Enclosure G
10. Performance Report – March 2018 Led by David Purdue – Deputy Chief Executive & Chief Operating Officer	Enclosure H
11. Q2 & Q3 Learning from Deaths Sewa Singh – Medical Director	Enclosure I
12. Staff Survey Action Plan Karen Barnard – Director of People and Organisational Development	Enclosure J
13. Annual Estates and Facilities Performance Report Kirsty Edmondson-Jones – Director of Estates and Facilities	Enclosure K

14. Board Assurance Framework & Corporate Risk Register Q4 2017/18
Matthew Kane – Trust Board Secretary Enclosure L
15. Compliments, Comments and Complaints Q4
Moira Hardy – Director of Nursing, Midwifery and Allied Health Professionals Enclosure L2

Reports for information

16. Chair and NEDs' Report
Suzy Brain England – Chair Enclosure M
17. Chief Executive's Report & Q4 Objectives
Richard Parker – Chief Executive Enclosure N
18. Minutes of Finance and Performance Committee, 26 March 2018
Neil Rhodes – Chair of Finance and Performance Committee Enclosure O
19. Minutes of Quality and Effectiveness Committee, 23 February 2018
Linn Phipps – Chair of Quality and Effectiveness Enclosure P
20. Minutes of Audit and Non-clinical Risk Committee, 4 January 2018
Philippe Serna – Chair of Audit and Non-clinical Risk Committee Enclosure Q
21. Minutes of Management Board, 12 March 2018
Richard Parker – Chief Executive Enclosure R
22. **To note:**
Board of Directors Agenda Calendar
Matthew Kane – Trust Board Secretary Enclosure S

Minutes

23. To approve the minutes of the previous meeting held 27 March 2018 Enclosure T
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: 22 May 2018

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
24 April 2018

NOTICE FOR THE PUBLIC

DBTH is committed to ensuring its Part 1 Board meetings are open and accessible. If any adjustments need to be made in order for you to access this meeting, please contact us.

If you are Deaf and need a BSL interpreter, or would like to request information in Braille, you can contact us at matthew.kane1@nhs.net or text 0799 9924276.

Doncaster & Bassetlaw Teaching Hospitals NHS Foundation Trust

Register of Directors' Interests and 'Fit and 'Proper Person' Declarations

Register of Interests

Alan Armstrong

Director, Armstrong Logic Limited (consultancy)

Linn Phipps, Non-executive Director

Lay member, NICE (National Institute for Health and Clinical Excellence) Highly Specialised Technologies Evaluation Committee (HSTEC) and Indicator Advisory Committee (IAC)

Lay Member, Independent Reconfiguration Panel

Chair, NHS England Patient Online Programme Stakeholder Forum

Associate Lay Member, Leeds Teaching Hospitals NHS Trust

Deputy Chair, Healthwatch Leeds & Health and Well-being representative on CCG Leeds South and East, GP Commissioning (Conflicts) Committee

Owner and Director, Ceist Consulting

Sewa Singh, Medical Director

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

Suzy Brain England, Chair of the Board

Lay Representative of Health Education England: Yorkshire and Humber

Trustee, NHS Providers Board

Kath Smart, Non-Executive Director

Independent Audit Committee Member – Doncaster Metropolitan Borough Council

Non-Executive Director – ACIS Group (Housing provider)

Court Secretary – Foresters Friendly Society

Trust Associate Manager – (TAM – or 'Hospital Manager' under the Mental Health Act) – Rotherham, Doncaster & South Humber NHS FT

Husband is a Head of Services for PLUSNET

The following have no relevant interests to declare:

Karen Barnard	Director of People & Organisational Development
Moira Hardy	Director of Nursing, Midwifery and Quality
Richard Parker	Chief Executive
David Purdue	Chief Operating Officer
Neil Rhodes	Non-executive Director
Jon Sargeant	Director of Finance
Philippe Serna	Non-executive Director
Patricia Drake	Non-Executive Director
Marie Purdue	Director of Strategy and Improvement
Simon Marsh	Chief Information Officer
Kirsty Edmondson-Jones	Director of Estates and Facilities

(as at 4 April 2018)

Fit and Proper Person Declarations

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

- (i) are not an undischarged bankrupt or a person whose estate has had sequestration awarded in respect of it and who has not been discharged;
- (ii) are not the subject of a bankruptcy restrictions order or an interim bankruptcy restrictions order or an order to like effect made in Scotland or Northern Ireland;
- (iii) are not a person to whom a moratorium period under a debt relief order applies under Part VIIA (debt relief orders) of the Insolvency Act 1986;
- (iv) have not made a composition or arrangement with, or granted a trust deed for, their creditors and not been discharged in respect of it;
- (v) have not within the preceding five years been convicted in the British Islands of any offence and a sentence of imprisonment (whether suspended or not) for a period of not less than three months (without the option of a fine) was imposed on them;
- (vi) are not subject to an unexpired disqualification order made under the Company Directors' Disqualification Act 1986;
- (vii) have the qualifications, competence, skills and experience which are necessary for the relevant office or position or the work for which they are employed;
- (viii) are able by reason of their health, after reasonable adjustments are made, of properly performing tasks which are intrinsic to the office or position for which they are appointed or to the work for which they are employed;
- (ix) have not been responsible for, been privy to, contributed to or facilitated any serious misconduct or mismanagement (whether unlawful or not) in the course of carrying on a regulated activity or providing a service elsewhere which, if provided in England, would be a regulated activity;
- (x) are not included in the children's barred list or the adults' barred list maintained under section 2 of the Safeguarding Vulnerable Groups Act 2006, or in any corresponding list maintained under an equivalent enactment in force in Scotland or Northern Ireland;
- (xi) are not prohibited from holding the relevant office or position, or in the case of an individual from carrying on the regulated activity, by or under any enactment;
- (xii) have not been convicted in the United Kingdom of any offence or been convicted elsewhere of any offence which, if committed in any part of the United Kingdom, would constitute an offence;
- (xiii) have not been erased, removed or struck-off a register of professionals maintained by a regulator of health care or social work professionals; and
- (xiv) have not been dismissed from paid employment otherwise than by reason of redundancy, by the coming to an end of fixed term contract or through ill health.

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

(as at 4 April 2018)



Action Notes

Meeting: Board of Directors
Date of meeting: 27 March 2018
Location: Boardroom, Montagu
Attendees: SBE, RP, KB, MH, DP, SS, AA, LP, JP, NR, JS, PS
Apologies: RA

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	Partially complete. Research and development discussions at QEC complete. Phase 2 subject to discussions on where research sits within management.
2.	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	May 2018 (date amended from April)	Policy review in final stages with assurance report to come to Board in May.



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

No.	Minute No	Action	Responsibility	Target Date	Update
3.	17/06/34	Board to meet with care group directors regarding EEPs.	MK	June/July 2018 (amended from January)	Meeting was due to take place in April but was postponed due to sickness. Will be rearranged.
4.	17/12/21	To provide assurance that risks relating to the IM&T Strategy are being managed appropriately.	SM	April 2018	Complete.

Date of next meeting: 30 April 2018
Action notes prepared by: M Kane
Circulation: SBE, AA, NR, KB, DJ, MH, KS, PD, DP, JS, SS, JP, RP, LP, PS



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

Title	GDPR Readiness and appointment of a Data Protection Officer for DBTH		
Report to	Board of Directors	Date	30 April 2018
Author	Simon Marsh (CIO and Trust SIRO) and Roy Underwood (Head of Information Governance)		
Purpose	To assure the Finance and Performance committee and then the Board of Directors of DBTH on the readiness of the Trust regarding the implementation of the European General Data Protection Regulations (GDPR) on May 25 th 2018 and a decision on the appointment of Roy Underwood as the Data Protection Officer in line with the regulation	Tick one as appropriate	
	Decision	X	
	Assurance		
	Information		

Executive summary containing key messages and issues

GDPR and the new Data Protection Act 2018 (DPA) come into force on May 25th 2018. This is a major change to data privacy and data processing across the European Union. The regulation requires organisations to meet upgraded standards across a number of data privacy areas and appoint a Data Protection Officer. At the time of this report, the DPA has not been finalised by the House of Commons. Consequently, there may be minor changes regarding the impact on healthcare organisations and their ability to share patient data for the ongoing care of the individual that are not currently identified and may influence the final impact of the GDPR regulation.

It is necessary according to GDPR to appoint a Data Protection Officer (DPO). It is proposed that the current IG Lead, Roy Underwood, is appointed to this role. In conjunction with DBTH, the post holder will also provide DPO support to Bassetlaw CCG. Work has taken place at ICP and ICS level to see if there can be a single DPO appointed across multiple Trust organisations in line with GDPR regulation. However, it has not been possible to identify such an individual as each organisation embeds GDPR into their own business and dealing with the multiple issues around data sharing at ICP and ICS level.

GDPR places significant responsibility on the organisation and the DPO. However, the regulation is viewed as evolution from the exiting DPA 1998 and not revolution. Guidance is still being received from the Information Commissioners Office (ICO) as to how the regulation will be enforced especially during the transitional period.

New individual GDPR regulations regarding the ability for an individual to 'be forgotten' and to opt out of particular uses of data are still to be finalised when referring to clinical and medical records.

There is a risk that the Trust, and the NHS and associated social care in general, could be unprepared for the full extent of the new GDPR and DPA regulations. This may impact interoperability and the ability to share data for ongoing patient care at ICP and ICS level.

There is a risk that the NHS will not be able to recoup charges currently made for subject access requests (SAR). Combined with a decreased timeline for responding to SAR's and the need to deploy technology or employ more staff to cope with either a static or increased workload, this MAY introduce a risk to Trust finances.

The fines associated with breaches of GDPR are now £20m or 4% of turnover. It is anticipated that the DPA will modify these downwards but the full extent of these variances are not yet known.

Finally, this report details the readiness of the Trust to on-board GDPR and DPA regulation. At this time, the Trust SIRO (CIO) and the Trust IG Lead can assure the DBTH Board that the Trust will be ready for May 25th.

Key questions posed by the report

1. Does the Trust accept the report regarding the readiness to enable GDPR by May 25th 2018?
2. Does the Trust Board require further clarification or assurance?
3. Does the Trust formally appoint the current IG lead, Roy Underwood, to the statutory post of Data Protection Officer and support the provision of a Data Protection Officer service to Bassetlaw CCG?
4. Does the Trust recognize, and hold in reserve, any potential revenue cost pressures resulting from decreased income from subject access requests and the need to reduce SAR turnaround from 40 to 30 days in line with the GDPR regulation.

How this report contributes to the delivery of the strategic objectives

GDPR is a statutory requirement effective from May 25th 2018. Adopting GDPR into the Trust is therefore a legal requirement and enables the Trust to continue to process patient data.

How this report impacts on current risks or highlights new risks

Risks exist on a number of levels. Without a robust GDPR regime, the Trust could leave itself open to fines, loss of patient confidence and further penalties from the ICO.

Recommendation(s) and next steps

Board is asked to appoint the Head of Information Governance as the Trust Data Protection Officer.

General Overview



1. The General Data Protection Regulation (GDPR) and UK Data Protection Law

2. The GDPR will come fully into effect on the 25th May 2018; it has direct effect across all EU member states.

3. GDPR requires DBTH to comply with this regulation. In conjunction with GDPR rules, a new Data Protection Act 2018 (DPA) will be introduced that specifies how certain derogated provisions within the GDPR will be enacted in certain industries and businesses in the UK including the NHS. DPA is yet to be finalised and receive Royal Assent (RA). RA is expected in late April or early May 2018 depending on the business of the government

It is therefore important the GDPR and DPA legislation are read side by side.

4. There are a number of NHS and commercial organisations providing guidance to the Trust on the impact of the GDPR legislation. Three members of the Trust (Simon Marsh, CIO and Trust SIRO; Roy Underwood, Head of Information Governance; and Robin Smith, IT Security Manager) have attended appropriate courses by a recognised body, and are certified as GDPR Practitioners. Therefore, there is a depth of knowledge within the Trust concerning the GDPR legislation as well as an existing breadth of experience in the management of cyber security, data protection and data privacy within the IM&T department.
5. The current IG Toolkit will cease to exist when the GDPR comes into force. This will be replaced the Data Protection and Security (DPS) toolkit with effect from the 2018/19 financial year. It should be noted that the Trust received a Green with Significant Assurance rating for the implementation of the IG Toolkit in 2017/18.
6. Work has been ongoing since March 2017 to understand the implications for the processing and storage of all data held within the Trust. This not only includes patient data but other data that is managed and processed by the organisation. Notwithstanding the delay in Royal Assent (RA) for the DPA 2018, these activities are at an advanced stage. Communications are in place to all staff. Data sharing agreements with other NHS and social care bodies are in place. Data Privacy notices have been created and are ready to be published and data processing agreements with vendors are in place.
7. From a finance perspective, one of the key considerations for the GDPR and DPA is the impact on Subject Access Requests (SAR). The Trust receives circa 4,000 per year. These are made by members of the public and the Trust has an obligation under current regulation to provide requested information if available within 40 days with a charge between £10 and £50 depending on the complexity of the request. Under GDPR, such requests now become free and must be dealt with within 30 calendar days. Therefore, there is a potential direct recurring financial risk to the Trust between £100k and £200k of lost income together with a need to increase staffing or deploy technology to enable existing annual requests and a potential increase in the number (as they are now free) to be processed within the 30 days.
8. GDPR also increases the fines for data breaches to £20m or 4% of turnover for the most serious breach. The Trust has not incurred any serious data breaches resulting from loss of data. This

does not mean that such an event will not occur in the future despite cyber security controls with policies and process being updated, communicated and trained, especially for manual handling of data. Investigation into risk insurance is being explored.

9. It is understood that amendments to the DPA are being proposed that may limit some of the impact of such costs and potential fines on the NHS. Details will not be known until the bill is finalised.
10. Data Privacy Impact Notices are being prepared for patients, members of the public and other citizens for whom we hold data, including members. All users of Trust services that we manage data for must be informed of the data we collect, the use that it will be put to and with whom we share, if at all. These notices will be a mixture of notices to patients when they attend the Trust, emails, letters and general notices throughout the hospital sites.
11. Policies are being updated to reflect the GDPR regulations and will be signed off when complete by the Information Governance Group.
12. Under the GDPR it is a legal requirement to appoint a Data Protection Officer (DPO) who has specific responsibilities contained within the regulation. The DPO can be dedicated to the organisation or a shared resource. Discussions have taken place with other local organisations to identify whether a joint DPO can be appointed. Due to staffing considerations and the impact of implementing projects at an ICS and ICP level, this has not been possible. Bassetlaw CCG have approached the Trust to provide, at a fee, the services of the DBTH DPO in a joint position. This has been agreed in principle.
13. It is proposed to appoint Roy Underwood, the current Trust IG officer, into the role of DBTH DPO and also provide support to Bassetlaw CCG. This appointment needs to be formally agreed and minuted at Board of Directors. Simon Marsh, the Chief Information Officer, will remain as the Trust Senior Information Risk Owner (SIRO). The DPO will report directly to the CIO but will have absolute right of access to the Chief Executive for DPO responsibilities.
14. In common with most other NHS organisations where we have contact, the trust has prepared its implementation plan for the GDPR based on guidance and information provided by the Information Commissioners Office (ICO) about how to get ready for the GDPR in their 12 steps document: [Guide to the GDPR](#). These steps, together with the completed and planned activities, and any risks or constraints are set out in the table below.
15. Target dates are identified within the plan. The overall plan indicates GDPR readiness to be complete by May 14th 2018, approximately two weeks ahead of the implementation date. This completion date may be delayed slightly once the final DPA 2018 is published and depending on any final review required.

The 12 steps to Implementing the GDPR as recommended by the Information Commissioners Office

Key:

In Progress
Some Progress
Significant progress
Target week for Actions to be completed
Task completed/signed off by IGG

GDPR requirement	Objective	Action points and Responsibility	2017	Jan 2018	Feb 2018	March 2018	w/c 16 th April	w/c 23 rd April	w/c 30 th April	w/c 7 th May	w/c 14 th May	w/c 21 st May	Friday the 25 May
1 - Awareness	Establish an implementation programme and responsibilities, and ensure that all staff are aware of GDPR, the revised Data Protection Act, and their personal responsibilities where it applies	<p>The Trust Information Governance Group are responsible for developing and implementing the 12 point action plan as defined by the ICO – Roy Underwood (RGU)/Simon Marsh (SM)</p> <p>In Progress - with RGU and Comms and Engagement</p> <p>Actions: Ensure that all staff are GDPR aware:</p> <ul style="list-style-type: none"> - Ongoing BUZZ Communiques ✓ - Embedded in the Trust SET eLearning Booklet ✓ - Posters around all trust sites and waiting areas 									w/c 14 th May		

GDPR requirement	Objective	Action points and Responsibility	2017	Jan 2018	Feb 2018	March 2018	w/c 16 th April	w/c 23 rd April	w/c 30 th April	w/c 7 th May	w/c 14 th May	w/c 21 st May	Friday the 25 th May
2 – Information Assets Articles 6, 7, & 9	Ensure there is a comprehensive understanding of the information held and how it is used	<p>Completed</p> <p>Actions: Catalogue the information we hold</p> <ul style="list-style-type: none"> - Build on the historical Information Asset Registration and IT Architecture Infrastructure Database Registration Processes in order to complete a forensic analysis of all Trust Personal Data Assets (manual & Electronic) and assign ownership thereto. ✓ - Review and amend appropriate sections of the Information Asset Registration Policy CORP/ICT 3 ✓ 											
3 – Communicating Privacy Information Articles 12, 13, 14 & 24	<p>Use the findings from the information audit and flow mapping to ensure all current processing activities have data protection compliant technical and organisational controls in place.</p> <p>Carry out DPIAs to ensure proposed processing activities are also protected.</p>	<p>In Progress - with RGU & C&E</p> <p>Actions: Review Privacy Notices. Privacy Notices (PNs) are being developed for the website and for poster presentations across all areas of the trust. The key PN's are required for:</p> <ul style="list-style-type: none"> • The adult patient cohort ✓ • Children's Services (see step 8) In Progress with RGU & Children's Services • Foundation Trust Members In Progress with MK <p>Publish PN's into relevant areas of the trust website</p>								w/c 14 th May			

GDPR requirement	Objective	Action points and Responsibility	2017	Jan 2018	Feb 2018	March 2018	w/c 16 th April	w/c 23 rd April	w/c 30 th April	w/c 7 th May	w/c 14 th May	w/c 21 st May	Friday the 25 th May
4 - Individual Rights Articles 12 – 23 inclusive	Ensure that we properly inform our Patients, Staff and Foundation Trust members of their individual rights	<p>In Progress - with RGU and C&E</p> <p>Actions: Whilst GDPR and DPA gives all EU citizens fundamental rights to privacy, Article 17 the ‘right to be forgotten’ may not apply to health data; everyone is waiting for the final version of the DPA 2018 In Progress with Parliament in the Data Protection Bill</p> <p>Privacy Notices (PNs) are being developed for the website and for poster presentations across all areas of the trust, describing individual’s rights. (see also 3 above)</p>									w/c 14 th May		

GDPR requirement	Objective	Action points and Responsibility	2017	Jan 2018	Feb 2018	March 2018	w/c 16 th April	w/c 23 rd April	w/c 30 th April	w/c 7 th May	w/c 14 th May	w/c 21 st May	Friday the 25 th May
5 - Subject Access Requests (SARs) Article 15	Update Subject Access policies and procedures with regards to costs and timescales	<p>In Progress - RGU, Legal & Risk, and Casenote Release</p> <p>Actions: The costs for Subject Access Requests (SARs) have been identified as a budgetary cost pressure – Jon Sargeant, DoF. ✓</p> <p>There will be a shorter time scale for SARs (1 month as opposed to 40 days under the DPA 1998) but can be extended by a further 2 months under certain circumstances. Casenote Release Policy and Process changes are underway</p> <p>There is the potential for an increase in the number of SARs – because there’s no charge; any patient for whom the Trust holds records, could – in theory – request a personal viewing or copy notes of everything we hold that is personal to them. This will also hold true for staff personal data records. The workload is unknown at this time Casenote release to amend their SARs policies and procedures to take account of the final version DPA 2018 In Progress</p>								w/c 14 th May			

GDPR requirement	Objective	Action points and Responsibility	2017	Jan 2018	Feb 2018	March 2018	w/c 16 th April	w/c 23 rd April	w/c 30 th April	w/c 7 th May	w/c 14 th May	w/c 21 st May	Friday the 25 th May
6 - Lawful Basis for Processing Article 16	Identify the lawful basis for all of our data processing (see 3)	<p>In Progress - RGU, Caldicott Guardian & SIRO</p> <p>Actions: Working with partner trusts on a common approach in line with a legal basis for processing as in GDPR Article 9.2(h)</p> <p>Each sharing requirement will invite an agreed Service Level Agreement which will be accompanied by an appropriate DPIA, as in the iDCR Project (see 10)</p>									w/c 14 th May		
7 – Consent Article 7	Update our communication materials – through Privacy Notices et al - to support people being properly informed.	<p>In Progress - with RGU, IAOs, and C&E</p> <p>Actions: Review how we seek, record and manage consent to process data, and whether we need to make any changes. Refresh existing consents now if they don't meet the GDPR standard.</p>									w/c 14 th May		

GDPR requirement	Objective	Action points and Responsibility	2017	Jan 2018	Feb 2018	March 2018	w/c 16 th April	w/c 23 rd April	w/c 30 th April	w/c 7 th May	w/c 14 th May	w/c 21 st May	Friday the 25 th May
8 - Managing Children's Rights Article 12	Provide age-appropriate communication materials; and implement processes to enable the Trust to demonstrate that we can verify the child's age, and that consent is always freely given, specific, informed and unambiguous.	<p>In Progress - with RGU & Children's Services</p> <p>Actions: The trust needs to put systems in place to verify an individual's age, and to obtain parental or guardian consent for any data processing activity.</p> <p>GDPR Article 12 provides that the obligations to ensure that information provided to data subjects is concise, transparent and in plain language are to be met "in particular for any information addressed specifically to a child".</p> <p>The term "child" is not defined by the GDPR. We should therefore address these requirements in notices directed at teenagers and young adults.</p> <ul style="list-style-type: none"> - There is a conflict between the age at which someone can consent for themselves; this is considered to be 13 in the EU and currently 15 in the UK. It is expected the DPA will provide further guidance. - Continue to put systems in place to verify an individual's age and to obtain parental or guardian consent for any data processing activity. 	Yellow	Yellow	Yellow	Yellow	Yellow				w/c 14 th May		
9 - Data Breaches Article 33	Ensure that we have the right procedures in place to detect, report and investigate a personal data breach – within 72 hours.	<p>Completed</p> <p>The right procedures are in place to detect, report and investigate a personal data breach – within 72 hours – through Information Governance Risk Policy and NHS Digital's Data Security and Protection Toolkit (DSPT) ✓</p>	Green	Green	Green	Green							



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

Title	Provider Collaboration Agreement		
Report to	Board of Directors	Date	30 April 2018
Author	Richard Parker, CEO		
Purpose		Tick one as appropriate	
	Decision	X	
	Assurance		
	Information		

Executive summary containing key messages and issues

The purpose of this report is to establish an agreement between providers in Doncaster to achieve better integration of services. The Trust is a party to the agreement which is not legally binding and will be reviewed in a year's time. The ambition for integration of local Health and Social care services is a key policy priority for Team Doncaster and part of the Doncaster Place Plan. Details of key opportunities brought about by the work are attached as Appendix 1.

The Provider Collaboration Agreement (attached here as Appendix 2) sets out the work required to enable ourselves – working with other bodies across the public sector - to enter into a more formal provider arrangement in the future. A separate commissioner agreement between the Council and CCG has also been developed.

The work has been led by the CCG and Council, working with Hill Dickinson, over a number of months. A number of matters still to be resolved are set out at Appendix 3, for which delegated powers are sought. The Agreement contains significant commitments and expectations of collaborative working and governance arrangements to support it.

The governance structure includes a Provider Collaboration Executive Group and Operational Group. Terms of reference for the two groups are available should Board wish to look over them. There is a reporting line to the Council's Health and Well Being Board.

Significant consultation has taken place at various meetings with lead Providers to produce the draft agreements.

Key questions posed by the report

Is the Board sufficiently assured by the documentation to sign off the Agreement?

How this report contributes to the delivery of the strategic objectives

The Agreement supports the strategic aim around increasing partnership working to benefit local communities.

How this report impacts on current risks or highlights new risks

The key risks and mitigations are as follows:

i. That partners across the health and social care system will not engage in a collaborative approach.

Extensive engagement work has been undertaken to ensure that partners are engaged at leadership and management levels in the approach and appreciate its benefits in terms of health and well - being, care and quality and finance and efficiency, at system and organisational level. Through a workforce development and empowerment focus, work will also take place to engage front line staff and teams in specific areas of opportunity.

ii. That the integration of commissioning and delivery is not prioritised or effectively resourced by partners.

This is a key challenge as all partner organisations are working with increasingly stretched resources. This has been addressed at Executive Leadership level and plans are being developed to secure effective leadership and management of key workstreams through existing resources. Additional support to provide specialist inputs and to gap fill and back fill where required will be provided through use of Better Care Fund, subject to agreement of business cases.

iii. That integration activity is contained between major provider partners 'crowding - out' other smaller and local organisations who can play a key role in improving health and well - being outcomes.

The work to date has recognised the need to ensure that the existing role and potential of other providers, for example local community and voluntary sector organisations is

fully embraced within the model.

Some local VCF organisations have been engaged directly in planning to date, and engagement work to widen engagement collaboration with the sector is under way to ensure a fully inclusive and diverse approach to delivery.

This will include specific support for the local community, voluntary, faith and social enterprise sector to engage in the process and play a full part. This will be especially crucial to the intention to focus more on preventative community based activity to support health and well-being.

Recommendation(s) and next steps

Board is asked to:

- (1) APPROVE the Provider Collaboration Agreement, including the establishment of the proposed governance structure.
- (2) DELEGATE to the Chief Executive power to resolve the matters detailed in Appendix 3.

Appendix 1: The Place Plan areas of opportunity at a glance

April 2018

Life stage	Area of opportunity	What are we planning	What outcomes do we expect to improve?
Starting well	First 1001 days	<ul style="list-style-type: none"> • A joined up long term campaign promoting healthy choices, healthy families and health children • Understanding the need and future capacity required to deliver good outcomes in the first 1001 days • A common understanding of expected outcomes at each life stage • Rationalise access routes • Develop a whole family operating model 	<ul style="list-style-type: none"> • More children have the best start in life • More children are healthy , have a sense of wellbeing and are resilient • Families who need support can access it
	Vulnerable adolescents	<ul style="list-style-type: none"> • Integrated assessment and planning to include psychological, emotional, educational , communication and life skills needs • Rationalise the access routes • Develop a diverse service menu promoting personal, social, educational, emotional and physical development • Local accommodation options for looked after children which are sufficient, timely and matched to their needs. Moving away from out of area placements • A new operating model for young people on the 	<ul style="list-style-type: none"> • More children are healthy , have a sense of wellbeing and are resilient • More children have access to the right services at the earliest opportunity • Fewer people require health and social care services and vulnerable people are safe • Families who need support can access it • No child suffers significant harm as a result of neglect

Appendix 1: The Place Plan areas of opportunity at a glance

April 2018



Appendix 1: The Place Plan areas of opportunity at a glance

April 2018

Living Well and all age

Learning disability

- A better accommodation offer to supported living in the community
- Enable children and young people to stay in or come back to the Borough
- Earlier life planning with young people and their families to improve transition from children's services to adult services
- Better access to day time activities
- Better options for emergency and planned respite

- Health life expectancy increases
- Quality of life is good
- Fewer people are homeless or in unsuitable accommodation
- More children and young people are healthy and have a sense of wellbeing and are resilient
- More people are in sustained work
- People are healthy and independent for longer
- Fewer people are socially isolated
- Fewer people die from causes considered preventable
- Vulnerable people are safe

Ageing well

Intermediate Care

- Single point of access and ability to deploy services across the partners to meet people's needs
- Integrated intermediate care bed base across physical, mental health and social care
- Locality-based care with wrap around support for physical, mental health and social care needs
- More step-up support
- Rapid response, intensive support
- Integrated rehabilitation and reablement programmes
- An integrated operating model

- Health life expectancy increases
- Quality of life is good
- People are healthy and independent for longer
- Fewer people die from causes considered preventable
- Fewer people are delayed leaving hospital
- Fewer older people require health and social care services and vulnerable people are safe
- Families who need support can access it

1. DONCASTER AND BASSETLAW TEACHING HOSPITALS NHS FOUNDATION TRUST
 2. DONCASTER CHILDREN'S SERVICES TRUST
 3. PRIMARY CARE DONCASTER LIMITED
 4. FCMS (NW) LIMITED
5. ROTHERHAM, DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST
 6. DONCASTER BOROUGH COUNCIL
 7. ST LEGER HOMES OF DONCASTER LIMITED

**PROVIDER COLLABORATION AGREEMENT
FOR THE DEVELOPMENT OF GREATER INTEGRATION
OF SERVICES ACROSS PROVIDER ORGANISATIONS IN DONCASTER UNDER THE
DONCASTER PLACE PLAN**

No	Date	Version Number	Author
1	09.01.18	0-1	RM
2	12.01.18	1-2	RM
3	12.02.18	1-3	EV
4	23.02.18	1-4	RM
5	16.03.18	1-5	RM/RP

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Overarching Note – The Doncaster Provider Collaboration Agreement

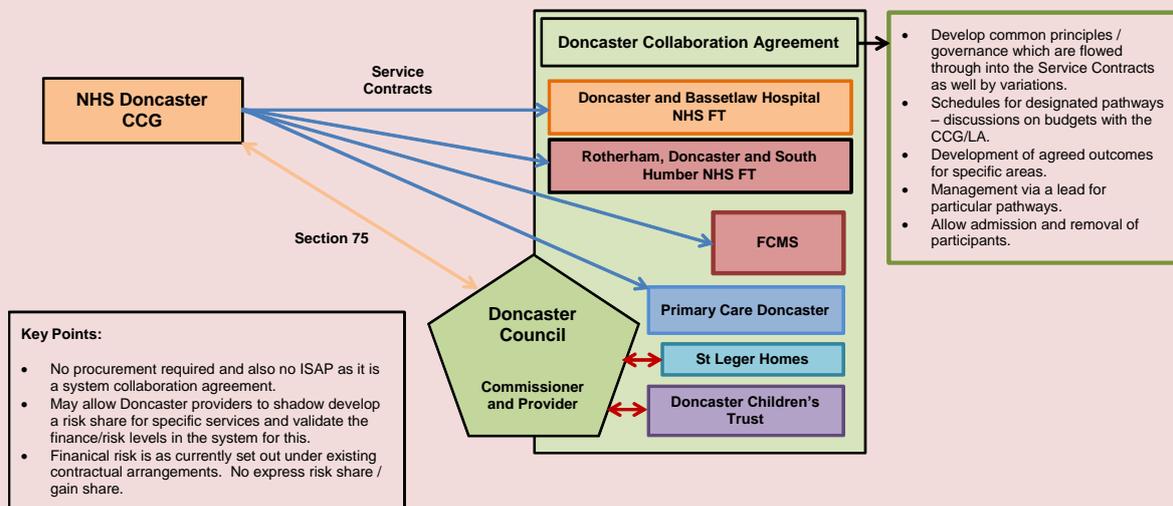
Initially this Provider Collaboration Agreement (PCA) will only apply to the agreed first wave 'areas of opportunity' and such other services as may be agreed by the Providers from time to time and inserted in Schedule 3 (Integrated Services).

This PCA is based on a Memorandum of Understanding (MOU) approach to provide an overarching, non-legally binding, arrangement which governs a more integrated multi-party solution signed by, and transparent to all parties. The format is designed to work alongside existing services contracts such as the NHS Standard Contract (the Services Contract here) which will set out specific requirements in relation to regulatory requirements, services environment, responding to emergency incidents etc.

The PCA is only intended to be legally binding for specific elements, which are identified, such as confidentiality and intellectual property.

Some areas of the PCA will need significant development around the nature and function of the Provider Collaboration over time including: (i) payment mechanism, incentives - risk sharing and any outcomes performance regime; (ii) the scope/description of the Integrated Services; and (iii) interaction with the terms of the 17/18 NHS Standard Contract and other Provider contracts.

Potential Doncaster position for April 2018



This **Provider Collaboration Agreement (“PCA”)** is made between:

1. **Doncaster Borough Council** of Civic Office, Waterdale, Doncaster, DN1 3BU (**“the Council”**);
2. **Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust** of Doncaster Royal Infirmary, Armthorpe Road, Doncaster DN2 5LT;
3. **FCMS (NW) Limited** of Newfield House, Vicarage Lane, Blackpool FY4 4EW;
4. **Primary Care Doncaster Limited** of Oakwood Surgery Masham Road, Cantley, Doncaster, South Yorkshire, DN4 6BU;
5. **Doncaster Children’s Services Trust** of The Blue Building, 38 - 40 High St, Doncaster DN1 1DE;
6. **Rotherham, Doncaster and South Humber NHS Foundation Trust** of Woodfield House, Tickhill Road Site, Weston Road, Balby, Doncaster DN4 8QN; and
7. **St Leger Homes of Doncaster Limited** of St Leger Court, White Rose Way, Doncaster DN4 5ND,

together referred to in this PCA as the **“Providers”** and **“Provider”** shall be construed accordingly.

BACKGROUND

1. The Five Year Forward View (the **“Forward View”**) sets out a clear goal that “the NHS will take decisive steps to break down the barriers in how care is provided between family doctors and hospitals, between physical and mental health, between health and social care.” The national policy framework for both adults and childrens social care is also strongly focused on integration with health services to deliver more person centred care, with better quality and outcomes.
2. The Doncaster Health and Social Care Economy has significant challenges with regards to its local population in terms of socioeconomics, life expectancy and growing financial pressures on the system. System leaders within Doncaster have recognised the need to modernise and improve services for residents through greater integration via a place based accountable care system.
3. As a response to this, the Doncaster Place Plan (the Place Plan) has been developed and agreed as the strategic driver for the integration of a wide range of health and

social care services across the public, private and community and voluntary sector. It sets an ambitious agenda for reform, integration and delivery, with a strong focus on creating a person centred, whole system, increasingly preventive and localised health and social care system.

4. This is a major undertaking and an urgent one. The aim of the Place Plan is to respond to demand and funding pressures in health and social care, but with a laser like focus on improving user experiences, life chances and outcomes for Doncaster people.
5. The Doncaster vision is that care and support will be tailored to community strengths to help Doncaster residents maximise their independence, health and wellbeing. Doncaster residents will have access to excellent community and hospital based services when needed.
6. The ambition of the Place Plan spans all ages – from maternity care to support for people in their older years. A key focus of the plan is to ensure that a range of health and social care services work well together at key transition points and events throughout people’s lives. This is where good collective, accessible, person centred work can manage risks and improve physical and mental health as well as social and economic outcomes. These are also moments where if things do not go well for people, the impacts for them and their families and carers can be huge, often leading to high demand and costs for health and social care and other public services.
7. The Providers and the Commissioners have committed to a first wave of ‘Areas of Opportunity’. These are a number of key transition points where integration is needed and/or where the key dimensions of the Place Plan policy intent can be modelled – for example in developing more community based provision that can ease demands for secondary health care. These wave 1 areas of opportunity are:
 - (a) Starting Well - aiming to drive further integration in commissioning and delivery of support health and social care support for children and families, with an initial focus on the ‘first 1001 days’ through pregnancy up to age 2;
 - (b) Urgent & Emergency Care (developed specification exists) - focused on helping people who need urgent care to get the right advice in the right place, first time and ensuring that adults and children with more serious or life threatening emergency needs receive treatment in centres with the right facilities. This involves strengthening connections between all urgent and emergency care services;
 - (c) Complex Lives - focused on people whose lives are affected by a combination of

homelessness, rough sleeping, drug and alcohol addiction, mental ill health, poor physical health – often connected to childhood trauma or other major life events;

- (d) Intermediate Care - focused on promoting faster recovery from illness, preventing unnecessary acute admissions, supporting timely discharge where an admission is necessary and premature admission to long term residential care – with a focus on maximising independent living;
 - (e) Vulnerable Adolescents - aiming to drive further integration in commissioning and delivery of support for young people at risk of poor outcomes in their adolescent years. This will include a specific initial focus on prevention of young people needing tier 4 services, including issues around mental health and drugs and alcohol;
 - (f) Dermatology - focused on a change in delivery setting for some dermatology services from acute to community where it is safe to do so. This will test a key dimension of the Place Plan approach, which can both deliver more preventive, accessible services to residents and offer transferable lessons to other areas of opportunity; and
 - (g) Learning Disability - focused on improving independence and quality of life for people with learning disabilities. Within this there are a number of crucial transition points which can determine outcomes and demand and costs on the system – notably the transition from childhood to adult services.
8. This PCA is a joint working agreement between the Providers to work towards the establishment of more collaborative delivery of services for the population of Doncaster in line with the Place Plan.
 9. Each of the Providers has individual Services Contracts with one or more of the Commissioners. This PCA will be referred to in, supplement and works alongside those Services Contracts. This PCA is the overarching agreement that sets out how the Providers will work together in a collaborative and integrated way to deliver the Integrated Services for the Areas of Opportunity. The Services Contracts set out how each Provider will provide their respective services including elements of the Integrated Services as identified in this PCA.
 10. The Providers acknowledge that certain of them provide services outside of the Doncaster area. Services provided by any Provider outside of the Doncaster area do not fall within the scope of this PCA. Services which are not included in the Integrated Services will also be outside the scope of this PCA.

11. The Council has a role within Doncaster as both a commissioner of early help, children and adult social care, and education services but also as a provider of social care services either through direct delivery or through various sub-contracts. In its role as a provider of social care services it shall be a Provider under this PCA. The Council recognises the need to ensure that any potential conflicts of interest in its dual roles are appropriately identified and managed and that it will look to develop an appropriate internal service level agreement to manage the differing roles.

OPERATIVE PROVISIONS

1. DEFINITIONS AND INTERPRETATION

- 1.1 In this PCA, capitalised words and expressions shall have the meanings given to them in Schedule 1.
- 1.2 In this PCA, unless the context requires otherwise, the following rules of construction shall apply:
 - 1.2.1 a person includes a natural person, corporate or unincorporated body (whether or not having separate legal personality);
 - 1.2.2 a reference to a “Provider” or “Commissioner” includes its personal representatives, successors or permitted assigns;
 - 1.2.3 a reference to a statute or statutory provision is a reference to such statute or provision as amended or re-enacted. A reference to a statute or statutory provision includes any subordinate legislation made under that statute or statutory provision, as amended or re-enacted;
 - 1.2.4 any phrase introduced by the terms “**including**”, “**include**”, “**in particular**” or any similar expression shall be construed as illustrative and shall not limit the sense of the words preceding those terms;
 - 1.2.5 documents in “**agreed form**” are documents in the form agreed by the Providers and initialled by them for identification and attached to this PCA ; and
 - 1.2.6 a reference to writing or written includes faxes and e-mails.

2. PURPOSE AND EFFECT OF THE PCA

- 2.1 The Providers have agreed to work together on behalf of Service Users and the population of Doncaster to deliver the best possible experience and outcomes within available resources for the Integrated Services. The Providers wish to record the basis on which they will collaborate with each other to this end in this PCA and intend to act in accordance with its terms.
- 2.2 This PCA sets out:
- 2.2.1 the key objectives for the development and delivery of the Integrated Services;
 - 2.2.2 the principles of collaboration;
 - 2.2.3 the governance structures the Providers will put in place; and
 - 2.2.4 the respective roles and responsibilities of the Providers.
- 2.3 The Providers agree that, notwithstanding the good faith consideration that each Provider has afforded the terms set out in this PCA and save as provided in Clause 2.4 below, this PCA shall not be legally binding. The Providers enter into this PCA intending to honour all their obligations.
- 2.4 Clauses 12 (Information Sharing and Conflicts of Interest), 15 (Charges and Liabilities), 17 (Confidential Information), 18 (Intellectual Property), 22 (Counterparts) and 23 (Governing Law and Jurisdiction) shall come into force from the date hereof and shall give rise to legally binding commitments between the Providers.

3. ACTIONS TAKEN PRIOR TO AND POST THE COMMENCEMENT DATE

- 3.1 Each of the Providers acknowledges and confirms that as at the date of this PCA it has obtained all necessary authorisations to enter into this PCA.

4. DURATION

- 4.1 This PCA shall commence on the Commencement Date and will continue for the Initial Term, unless and until terminated in accordance with its terms.
- 4.2 On the expiry of the Initial Term this PCA will expire automatically without notice unless, no later than 12 months before the end of the Initial Term, the Providers agree in writing that the term of the PCA will be extended for a further term to be agreed between the Providers (the “**Extended Term**”).

SECTION A: DONCASTER PRINCIPLES

5. THE DONCASTER PRINCIPLES

- 5.1 The aim of this Clause 5 is to identify the high level principles which underpin the delivery of the Providers' obligations under this PCA and to set out key factors for a successful relationship between the Providers for the Integrated Services.
- 5.2 The Providers acknowledge and confirm that the successful delivery of the project will depend on the Providers' ability to effectively co-ordinate and combine their expertise, workforce, and resources as providers in order to deliver an integrated approach to the provision of the Integrated Services under this PCA.
- 5.3 The principles referred to in Clause 5.1 are that the Providers will work together in good faith and, unless the provisions in their individual service contract or this PCA state otherwise, the Providers will:
- 5.3.1 ensure that decisions will be focused on the interests and outcomes of Service Users and people in Doncaster, and that the Providers will collaborate to prioritise those interests and keep them at the heart of the activities which they provide under the Integrated Services;
 - 5.3.2 collaborate and co-operate to ensure that activities are delivered and actions taken as required. Offer mutual support to other Providers around organisationally difficult decisions in accordance with these Doncaster Principles;
 - 5.3.3 be accountable. Take on, manage and account to each other for performance of the respective roles and responsibilities set out in this PCA and look to consider the wider impact across the system on each other of behaviours and proposals around the Integrated Services;
 - 5.3.4 be open. Communicate openly about major concerns, issues or opportunities relating to the PCA and adopt transparency on all aspects of their services, subject always to appropriate treatment of commercially sensitive information in accordance with Clause 17 and competition law;
 - 5.3.5 adhere to statutory requirements and best practice. Comply with applicable laws and standards including EU procurement rules, competition law, data protection and freedom of information legislation;

- 5.3.6 act in a timely manner. Recognise the time-critical nature of the PCA and respond accordingly to requests for support;
 - 5.3.7 manage stakeholders effectively. Doncaster Commissioners, Service Users, carers and partners will help to shape the future of Doncaster services together with the Providers;
 - 5.3.8 deploy appropriate resources. Make available sufficient and appropriately qualified resources who are authorised to fulfil the responsibilities set out in this PCA; and
 - 5.3.9 achieve continuous, measurable, and measured improvement. Agree improvements which are specific, challenging, add value, and eliminate waste,
- and together these are the “**Doncaster Principles**”.

6. PROBLEM RESOLUTION AND ESCALATION

- 6.1 The Providers agree to adopt a systematic approach to problem resolution which recognises the Doncaster Principles and mutual objectives set out in Clause 5.
- 6.2 If a problem, issue, concern or complaint comes to the attention of a Provider in relation to the Integrated Services or any matter within the scope of this PCA, such Provider shall notify the other Providers and the Providers each acknowledge and confirm that they shall then seek to resolve the issue by a process of discussion.
- 6.3 Save as otherwise specifically provided for in this PCA, any dispute arising between the Providers out of or in connection with this PCA will be resolved in accordance with Schedule 5 (*Dispute Resolution*).
- 6.4 If any Provider receives any formal inquiry, complaint, claim or threat of action from a third party (including, but not limited to, claims made by a supplier) in relation to the Integrated Services, the Provider will liaise with the Provider Collaborative Group as to the contents of any response before a response is issued.

SECTION B: DELIVERY OF THE INTEGRATED SERVICES IN LINE WITH THE DONCASTER PRINCIPLES

7. OBLIGATIONS AND ROLES OF THE PARTIES

- 7.1 The Providers will (subject to Clause 7.2 below) in respect of the Integrated Services and within the resources available to them:
- 7.1.1 act collaboratively and in good faith with each other in accordance with Guidance, the Law and Good Practice to ensure the performance of the Integrated Services in having at all times regard to the welfare of the population of Doncaster;
 - 7.1.2 actively promote a culture that facilitates integrated working and empowers staff to work collaboratively with other Providers to deliver better outcomes for the population of Doncaster;
 - 7.1.3 develop the Integrated Services to better respond to the needs and personal goals of the person and their family/ carers and to take into account physical, social, mental health and social care needs;
 - 7.1.4 look to ensure that the population of Doncaster have access to excellent hospital based services when needed but with a wider focus on developing out of hospital care, enablement, maximising independence, promoting self-care and maintaining social networks together;
 - 7.1.5 support each other (informally and publicly) in taking decisions in the best interests of the population of Doncaster which are recommended by the Provider Collaboration Group;
 - 7.1.6 co-operate fully and liaise appropriately with each other (including in order to ensure a co-ordinated approach to promoting the quality of care across the Integrated Services and so as to achieve continuity in provision that avoids inconvenience to, or risk to the health and safety of the population of Doncaster or other members of the public);
 - 7.1.7 implement performance recording to allow progress against the outcomes for the Integrated Services to be tracked;
 - 7.1.8 take responsibility for and manage the risks in performing the Integrated Services together as a system;

- 7.1.9 adhere to standards relevant to the Integrated Services and as defined by the Commissioners;
- 7.1.10 promote and develop a co-operative and high performing culture, and way of working across the Providers:
- (i) that promotes and drives co-operation, innovation and continuous improvement across the system;
 - (ii) where information is shared;
 - (iii) where communication is honest and respectful; and
 - (iv) which is founded upon ethical and responsible behaviour and decision making,
- without losing sight of each Provider's corporate and individual accountability;
- 7.1.11 seek to provide the Integrated Services in an integrated way through collaborative working in accordance with the Doncaster Principles; and
- 7.1.12 provide skilled resources for delivery of the Integrated Services (i.e. including relevant know-how).

7.2 Each Provider acknowledges and confirms that:

- 7.2.1 it remains responsible for performing its obligations and functions for delivery of services to the Commissioners in accordance with its Services Contract;
- 7.2.2 it will be separately and solely liable to the Commissioners for the provision of the elements of the Integrated Services under its own Services Contract; and
- 7.2.3 the intention of the Providers is to work together to achieve better use of resources and better outcomes for the population of Doncaster initially in the Integrated Services but to create a collaborative culture in their organisation and working with the Commissioners to ensure that integrated provision is reflected in the Providers' Services Contracts.

General assistance and co-operation and Provider undertakings

- 7.3 Each Provider undertakes to co-operate in good faith with the others to facilitate the proper performance of this PCA and in particular will:

- 7.3.1 use all reasonable endeavours to avoid unnecessary disputes and claims against any other Provider;
 - 7.3.2 not interfere with the rights of any other Provider and its servants, agents, representatives, contractors or sub-contractors (of any tier) on its behalf in performing its obligations under this PCA nor in any other way hinder or prevent such other Provider or its servants, agents, representatives, or sub-contractors (of any tier) on its behalf from performing those obligations; and
 - 7.3.3 (subject to Clause 7.4) assist the other Providers (and their servants, agents, representatives, or sub-contractors (of any tier)) in performing those obligations so far as is reasonably practicable.
- 7.4 Nothing in Clause 7.3 shall:
- 7.4.1 interfere with the right of each of the Providers to arrange its affairs in whatever manner it considers fit in order to perform its obligations under this PCA in the manner in which it considers to be the most effective and efficient; or
 - 7.4.2 oblige any Provider to incur any additional cost or expense or suffer any loss of profit in excess of that required by its proper performance of its obligations under this PCA.
- 7.5 Each of the Providers severally undertakes that it shall:
- 7.5.1 subject to the provisions of this PCA, comply with all Laws applicable to it which relate to the Integrated Services;
 - 7.5.2 not wilfully impede the other Providers in the performance of their obligations under this PCA (having regard always to the interactive nature of the activities of the Providers and the Integrated Services or any other of the Providers' statutory functions); and
 - 7.5.3 inform the Provider Collaborative Group as soon as reasonably practicable if at any time it becomes unable to meet any of its financial obligations and in such case inform, and keep the Provider Collaborative Group informed, of any course of action to remedy the situation recommended or required by the Secretary of State for Health and Social Care or other competent authority

provided that, to avoid doubt, nothing in this Clause shall in any way fetter the discretion of the Providers in fulfilling their statutory functions.

7.6 The Providers agree that the payments for the Integrated Services in the financial year 2018-19 will be as set out in the Services Contracts. The Providers intend to develop payment structures over the course of the financial year 2018-19 in conjunction with the Commissioners that better reflect system wide outcomes and may incorporate risk and reward sharing mechanisms to incentivise collaborative working for the Integrated Services for the financial year 2019-20. The proposed approach to develop this between the Providers and with the Commissioners is set out in the provisions of Schedule 4 (*Payment Mechanism*). To avoid doubt, the Providers have not agreed to share risk or reward in financial year 2018-19 and any future introduction of this will require additional legally binding provisions between the relevant Providers.

8. INTEGRATED SERVICES

8.1 A key reason why the Providers have entered into this PCA is to transform how the Integrated Services are provided. The Providers want to go further with the Integrated Services to transform the approach to support for the population of Doncaster across their organisations and Services Contracts. The Providers will therefore aim to provide the Integrated Services in accordance with the Doncaster Principles and the Providers agree that the provisions of Schedule 3 (*Integrated Services*) will apply.

8.2 Each of the Providers will actively seek ways to continually innovate the provision of the Integrated Services so as to provide them in an integrated way and:

8.2.1 identify areas where the Services Contracts can be revised to reflect a common approach by the Providers across the system (such as integrated management and reporting systems); and

8.2.2 achieve agreed outcomes in each of the Integrated Services areas in which they are involved,

and will propose changes to their Services Contracts and Variations to this PCA through the Provider Collaboration Group in order to achieve this where possible.

8.3 For the purposes of this Clause 8, where there is any conflict between the provisions of this PCA and a Provider's obligations under its Services Contract, the provisions of the Services Contract will prevail.

9. RECORDS

9.1 The Providers will co-operate with each other to ensure that:

- 9.1.1 Service User Records for all Service Users receiving Integrated Services are created, maintained, processed, shared, stored and retained in accordance with the Law and Good Practice; and
 - 9.1.2 there is an appropriate records management system in place so that each of the Providers can comply with their obligations under Clause 9.1.1 and the terms of their Services Contracts.
- 9.2 The Providers acknowledge their respective duties under the Data Protection Legislation and shall give all reasonable assistance to each other where appropriate or necessary to facilitate compliance with such duties in their work across the Integrated Services.

10. REPORTING REQUIREMENTS

10.1 Each of the Providers will during the Term:

10.1.1 promptly provide to any other Provider involved in the performance of the Integrated Services, such information about their elements of the Integrated Services and such co-operation and access as the other Provider may reasonably require from time to time in connection with the Doncaster Principles, provided that if the provision of such information, co-operation or access amounts to a change to this PCA then it will need to be proposed as such to the Provider Collaboration Group and the variation procedure set out in Clause 16 will apply; and

10.1.2 identify and obtain all consents necessary for the fulfilment of its obligations in respect of the Integrated Services and under the Services Contracts,

limited in each case to the extent that such action does not cause a Provider to be in breach of any Law, its obligations under Clause 12 (Information Sharing and Conflicts of Interest) Clause 17 (Confidentiality) or any legally binding confidentiality obligations owed to a third party.

10.2 Subject to compliance with Clauses 12 (Information Sharing and Conflicts of Interest), 16 (Variation Procedure), 17 (Confidentiality) and 18 (Intellectual Property), and any associated Schedules:

10.2.1 the Providers must during the Term promptly notify each other of any modification, upgrade, improvement, enhancement or development to their services which could be applied to the Integrated Services, in each case focused on the best interests and outcomes of Service Users and people in Doncaster; and

10.2.2 where appropriate and practicable, the Providers agree to develop consolidated reports and feedback responses to the Commissioners in respect of the Integrated Services.

SECTION C: GOVERNANCE ARRANGEMENTS

11. GOVERNANCE

Provider Collaboration Group

- 11.1 The Providers all agree to establish the Provider Collaboration Group. For the avoidance of doubt the Provider Collaboration Group shall not be a committee of any Provider or any combination of Providers.
- 11.2 The Provider Collaboration Group is the group responsible for leading the Providers' collaborative approach to the Integrated Services and working in accordance with the Doncaster Principles across the Doncaster system. The Provider Collaborative Group will hold to account the Provider Operational Group. It will have other responsibilities as defined in its terms of reference set out in Part 1 of Schedule 2 (Provider Collaboration Group – Terms of Reference).

Provider Operational Group

- 11.3 The Providers agree to establish the Provider Operational Group which will be responsible for managing the input into the Integrated Services workstreams for the Providers and the delivery of the Integrated Services. For the avoidance of doubt the Provider Operational Group shall not be a committee of any Provider or any combination of Providers.
- 11.4 The terms of reference for the Provider Operational Group shall be as set out in Part 2 of Schedule 2 (Provider Operational Group – Terms of Reference).
- 11.5 The Providers will communicate with each other clearly, directly and in a timely manner to ensure that the members of the Provider Collaboration Group and the Provider Operational Group are able to make effective and timely decisions in relation to the Integrated Services.
- 11.6 The Providers will ensure appropriate attendance from their respective organisations at all meetings of the Provider Collaboration Group and the Provider Operational Group and that their representatives act in accordance with the Doncaster Principles.

12. INFORMATION SHARING AND CONFLICTS OF INTEREST

- 12.1 The Providers will provide to each other all information that is reasonably required in order to achieve improvements in the Integrated Services and take decisions on a Best for Doncaster basis as well as to design and implement changes to the ways in which Integrated Services are delivered (and where the Integrated Services are delivered from).
- 12.2 The Providers have obligations to comply with competition law. The Providers will therefore make sure that they share information, and in particular Competition Sensitive Information, in such a way that is compliant with competition law and, accordingly, the Provider Collaboration Group will ensure that the exchange of Competition Sensitive Information will be restricted to circumstances where:
- 12.2.1 it is essential;
 - 12.2.2 it is not exchanged more widely than necessary;
 - 12.2.3 it is subject to suitable non-disclosure or confidentiality agreements which include a requirement for the recipient to destroy or return it on request or on termination or expiry of the PCA; and
 - 12.2.4 it may not be used other than to achieve the aims of this PCA in accordance with the Doncaster Principles.
- 12.3 The Providers acknowledge that it is for each Provider to decide whether information is Competition Sensitive Information but recognise that it is normally considered to include any internal commercial information which, if it is shared between Providers who are providers, would allow them to forecast or co-ordinate commercial strategy or behaviour in any market.
- 12.4 The Providers will make sure the Provider Collaboration Group establishes appropriate non-disclosure or confidentiality agreements between and within the Providers so as to ensure that Competition Sensitive Information and Confidential Information are only available to those Providers who need to see it for the purposes of the better delivery of the Integrated Services on a Best for Doncaster basis and for no other purpose whatsoever so that they do not breach competition law.
- 12.5 It is accepted that the involvement of the Providers in this PCA may give rise to situations where information will be generated and made available to the Providers, which could give them an unfair advantage in competitions or which may be capable of distorting such competitions (for example, disclosure of pricing information or approach to risk may provide one Provider with a commercial advantage over a separate Provider). The Providers therefore recognise the need to manage the information referred to in this Clause 12.5 in a way which maximises their opportunity to take part in

competitions operated by the Commissioners by putting in place appropriate procedures, such as appropriate non-disclosure or confidentiality agreements in advance of the disclosure of information.

12.6 Nothing in this PCA shall absolve any of the Providers from their obligations under each Services Contract.

12.7 Where there are any Patient Safety Incidents or Information Governance Breaches relating to the Integrated Services, for example, the Providers shall ensure that they each comply with their individual Services Contract and work collectively and share all relevant information for the purposes of any investigations and/or remedial plans to be put in place, as well as for the purposes of learning lessons in order to avoid such Patient Safety Incident or Information Governance Breach in the future.

12.8 The Providers will:

12.8.1 disclose to each other the full particulars of any real or apparent conflict of interest which arises or may arise in connection with this PCA or the performance of the Integrated Services, immediately upon becoming aware of the conflict of interest whether that conflict concerns the Provider or any person employed or retained by them for or in connection with the performance of the Integrated Services;

12.8.2 not allow themselves to be placed in a position of conflict of interest or duty in regard to any of their rights or obligations under this PCA (without the prior consent of the other Providers) before they participate in any decision in respect of that matter; and

12.8.3 use best endeavours to ensure that their representatives on the Provider Collaboration Group and the Provider Operational Group also comply with the requirements of this Clause 12 when acting in connection with this PCA or the performance of the Integrated Services.

13. TERMINATION, EXCLUSION AND WITHDRAWAL

13.1 The Provider Collaborative Group may resolve to terminate this PCA in whole where:

13.1.1 a Dispute cannot be resolved pursuant to the Dispute Resolution Procedure;

13.1.2 automatically and immediately where there exists just one Provider that remains party to this PCA; or

13.1.3 where the Providers agree for this PCA to be replaced by a formal legally binding agreement between them.

Partial termination / exclusion

13.2 This PCA will partially terminate, in respect of a Provider:

13.2.1 automatically upon the expiry or termination of that Provider's Services Contract (insofar as it relates to the Integrated Services); or

13.2.2 where a Provider is subject to insolvency.

13.3 A Provider may be excluded from this PCA on written notice from all of the remaining Providers in the event of a material or a persistent breach of the terms of this PCA by the relevant Provider which has not been rectified within 30 calendar days of notification issued by the remaining Providers or which is not reasonably capable of remedy. In such circumstances this PCA shall be partially terminated in respect of the excluded Provider.

Voluntary withdrawal of a Provider

13.4 Any Provider may withdraw from this PCA by giving at least 30 calendar days' notice in writing to the other Providers.

Consequences of termination / exclusion / withdrawal

13.5 Where a Provider is excluded from this PCA, or withdraws from it, the Providers recognise that the associated Services Contract is also likely to be terminated and/or amended to reflect how the impacted services are to be delivered. In addition to any specific obligations under the relevant Services Contract to ensure a smooth transfer of Services the Providers agree to work together in good faith to agree the necessary changes so that Integrated Services continue to be provided for the benefit of the Service Users. The excluded Provider shall procure that all data and other material belonging to any other Provider shall be delivered back to the relevant Provider, deleted or destroyed as soon as reasonably practicable and confirm to the remaining Providers when this has been completed.

14. INTRODUCING NEW PROVIDERS

- 14.1 Additional providers may become parties to this PCA on such terms as the Providers will jointly agree, acting at all times on a Best for Doncaster basis. Any new provider will be required to agree to the terms of this PCA (including the legally binding elements) before admission.

SECTION D: GENERAL PROVISIONS

15. CHARGES AND LIABILITIES

- 15.1 Except as otherwise provided, the Providers shall each bear their own costs and expenses incurred in complying with their obligations under this PCA, including in respect of any losses or liabilities incurred due to their own or their employees' actions.
- 15.2 Except as otherwise provided, no Provider intends that any other Provider shall be liable for any loss it suffers as a result of this PCA.

16. VARIATIONS

- 16.1 The provisions of this PCA may be varied at any time by a Notice of Variation signed by the Providers in accordance with this Clause 16.
- 16.2 If a Provider wishes to propose a variation to this PCA ("**Variation**"), that Provider must submit a draft notice setting out their proposals in accordance with Clause 16.3 (a "**Notice of Variation**") to the other Providers and the Chair of the Provider Collaborative Group to be considered at the next meeting (or when otherwise determined by the Providers) of the Provider Collaborative Group.
- 16.3 A draft Notice of Variation must set out:
- 16.3.1 the Variation proposed and details of the consequential amendments to be made to the provisions of this PCA;
 - 16.3.2 the date on which the Variation is proposed to take effect;
 - 16.3.3 the impact of the Variation on the achievement of the Integrated Services and the Doncaster Principles as well as the Best for Doncaster consideration; and
 - 16.3.4 any impact of the Variation on any Services Contracts.
- 16.4 The Provider Collaborative Group will consider the draft Notice of Variation and either:

- 16.4.1 accept the draft Notice of Variation (all Providers consenting), in which case all Providers will sign the Notice of Variation;
 - 16.4.2 amend the draft Notice of Variation, such that it is agreeable to all Providers, in which case all Providers will sign the amended Notice of Variation; or
 - 16.4.3 not accept the draft Notice of Variation, in which case the minutes of the relevant Provider Collaborative Group shall set out the grounds for non-acceptance.
- 16.5 Any Notice of Variation of this PCA will not be binding unless set out in writing and signed by or on behalf of each of the Providers.

17. CONFIDENTIAL INFORMATION

- 17.1 Each Provider shall keep in strict confidence all Confidential Information it receives from another Provider except to the extent that such Confidential Information is required by Law to be disclosed or is already in the public domain or comes into the public domain otherwise than through an unauthorised disclosure by a Provider. Each Provider shall use any Confidential Information received from another Provider solely for the purpose of delivering the Integrated Services and complying with its obligations under this PCA and the Integrated Services in accordance with the Doncaster Principles and for no other purpose. No Provider shall use any Confidential Information received under this Agreement for any other purpose including use for their own commercial gain in services outside of the Integrated Services or to inform any competitive bid for any elements of the Integrated Services without the express written permission of the disclosing Provider.
- 17.2 To the extent that any Confidential Information is covered or protected by legal privilege, then disclosing such Confidential Information to any Provider or otherwise permitting disclosure of such Confidential Information does not constitute a waiver of privilege or of any other rights which a Provider may have in respect of such Confidential Information.
- 17.3 The Parties agree to procure, as far as is reasonably practicable, that the terms of this Clause 17 (*Confidential Information*) are observed by any of their respective successors, assigns or transferees of respective businesses or interests or any part thereof as if they had been party to this PCA.
- 17.4 Nothing in this Clause 17 (*Confidential Information*) will affect any of the Providers' regulatory or statutory obligations, including but not limited to competition law.

18. INTELLECTUAL PROPERTY

18.1 In order to meet the Doncaster Principles each Provider grants each of the other Providers a fully paid up non-exclusive licence to use its existing Intellectual Property insofar as is reasonably required for the sole purpose of the fulfilment of that Providers' obligations for the Integrated Services under this PCA.

New Intellectual Property

18.2 If any Provider creates any new Intellectual Property through the development of the Integrated Services between the Providers, the Provider which creates the new Intellectual Property will grant to the other Providers a fully paid up non-exclusive licence to use the new Intellectual Property for the sole purpose of the fulfilment of that Providers' obligations for the Integrated Services under this PCA.

19. FREEDOM OF INFORMATION

19.1 If any Provider receives a request for information relating to this PCA or the Integrated Services under the Freedom of Information Act 2000 or the Environmental Information Regulations 2004, it shall consult with the other Providers before responding to such request and, in particular, shall have due regard to any claim by any other Provider to this PCA that the exemptions relating to commercial confidence and/or confidentiality apply to the information sought.

20. NOTICES

20.1 Any notice or other communication given to a Provider under or in connection with this PCA shall be in writing, addressed to that Provider at its principal place of business or such other address as that Provider may have specified to the other Provider in writing in accordance with this Clause, and shall be delivered personally, or sent by pre-paid first class post, recorded delivery, commercial courier or fax.

20.2 A notice or other communication shall be deemed to have been received: if delivered personally, when left at the address referred to in Clause 20.1; if sent by pre-paid first class post or recorded delivery, at 9.00 am on the second Operational Day after posting; if delivered by commercial courier, on the date and at the time that the courier's delivery receipt is signed; or, if sent by fax, one (1) Operational Day after transmission.

21. NO PARTNERSHIP

21.1 Nothing in this PCA is intended to, or shall be deemed to, establish any partnership between any of the Providers, constitute any Provider the agent of another Provider,

SCHEDULE 1

Definitions and Interpretation

1 The following words and phrases have the following meanings in this PCA:

Best for Doncaster	a focus in each case on making a decision based on the best interests and outcomes for Service Users and the population of Doncaster
Commencement Date	[insert]
Commissioners	NHS Doncaster CCG and Doncaster Borough Council (where it is acting as a commissioner of social care services and not a provider)
Competition Sensitive Information	Confidential Information which is owned, produced and marked as Competition Sensitive Information by one of the Providers and which that Provider properly considers is of such a nature that it cannot be exchanged with the other Providers without a breach or potential breach of competition law. Competition Sensitive Information may include, by way of illustration, trade secrets, confidential financial information and confidential commercial information, including without limitation, information relating to the terms of actual or proposed contracts or sub-contract arrangements (including bids received under competitive tendering), future pricing, business strategy and costs data, as may be utilised, produced or recorded by any Provider, the publication of which an organisation in the same business would reasonably be able to expect to protect by virtue of business confidentiality provisions
Confidential Information	all information which is secret or otherwise not publicly available (in both cases in its entirety or in part) including commercial, financial, marketing or technical information, know-how, trade secrets or business methods, in all cases whether disclosed orally or in writing before or after the date of this PCA, including Commercially Sensitive Information and Competition Sensitive Information;

Data Protection Legislation	<ul style="list-style-type: none"> (i) the Data Protection Act 1998; (ii) the General Data Protection Regulation (Regulation (EU) 2016/679); (iii) the Law Enforcement Directive (Directive (EU) 2016/680) and any applicable national Laws implementing them as amended from time to time; (iv) the Data Protection Act 2018; and (v) all applicable Law about privacy, confidentiality or the processing of personal data including but not limited to the Human Rights Act 1998, the Health and Social Care (Safety and Quality) Act 2015, the common law duty of confidentiality and the Privacy and Electronic Communications (EC Directive) Regulations
Dispute	any dispute arising between two or more of the Providers in connection with this PCA or their respective rights and obligations under it
Dispute Resolution Procedure	means the procedure set out in Schedule 5 (<i>Dispute Resolution Procedure</i>) to this PCA
Good Practice	Good Clinical Practice and/or Good Health and/or Social Care Practice (each as defined in the Services Contracts), as appropriate
Guidance	any applicable health or social care guidance, guidelines, direction or determination, framework, code of practice, standard or requirement to which the Providers have a duty to have regard (and whether specifically mentioned in this PCA or not), to the extent that the same are published and publicly available or the existence or contents of them have been notified to the Provider by a Commissioner and/or any relevant regulatory body
IG Guidance for Serious Incidents	NHS Digital's Checklist Guidance for Information Governance Serious Incidents Requiring Investigation June 2013, available at https://www.igt.hscic.gov.uk/KnowledgeBaseNew/HSCIC%20

	1G%20SIRI%20%20Checklist%20Guidance%20V2%200%201st%20June%202013.pdf
Information Governance Breach	an information governance serious incident requiring investigation, as defined in the IG Guidance for Serious Incidents
Initial Term	[2] Years from the Commencement Date
Integrated Services	the integrated services provided, or to be provided, by the Providers pursuant to this PCA as set out in Schedule 3 (<i>Integrated Services</i>) and as may be amended from time to time by a Notice of Variation
Intellectual Property	patents, rights to inventions, copyright and related rights, trade marks, business names and domain names, goodwill, rights in designs, rights in computer software, database rights, rights to use, and protect the confidentiality of, Confidential Information and all other intellectual property rights, in each case whether registered or unregistered and including all applications and rights to apply for and be granted, renewals or extensions of, and rights to claim priority from, such rights and all similar or equivalent rights or forms of protection which subsist or will subsist now or in the future in any part of the world
Law	<p>any applicable statute or proclamation or any delegated or subordinate legislation or regulation;</p> <p>any enforceable EU right within the meaning of section 2(1) European Communities Act 1972;</p> <p>any applicable judgment of a relevant court of law which is a binding precedent in England;</p> <p>Guidance;</p> <p>National Standards (as defined in the NHS Standard Contract); and</p> <p>any applicable code</p> <p>and "Laws" shall be construed accordingly</p>

PCA	this memorandum of understanding incorporating the Schedules
NHS Standard Contract	the NHS Standard Contract as published by NHS England from time to time
Operational Days	a day other than a Saturday, Sunday or bank holiday in England
Patient Safety Incident	any unintended or unexpected incident that occurs in respect of a Service User, during and as a result of the provision of the Services, that could have led, or did lead to, harm to that Service User
Place Plan	the Doncaster Place Plan, available at: http://www.doncasterccg.nhs.uk/wp-content/uploads/2016/10/Doncaster-Place-Plan.pdf
Provider Collaboration Group	the group established by the Providers pursuant to Clause 11.1
Provider Operational Group	the group established by the Providers pursuant to Clause 11.3
Service Users	people within the Doncaster population served by the Commissioners and who are in receipt of the Integrated Services
Service User Record	a record which consists of information and correspondence relating to the particular physical or mental health or condition or social care needs of a Service User (whether in electronic form or otherwise) and “Service User Records” shall be construed accordingly
Services	the services provided, or to be provided, by a Provider to a Commissioner pursuant to its respective Services Contract which may include some service elements contained within the Integrated Services
Services Contract	a contract entered into by one of the Commissioners and a Provider for the provision of Services, and references to a

	Services Contract include all or any one of those contracts as the context requires
Term	the Initial Term of this PCA plus any Extended Term(s) agreed in accordance with the terms of this PCA.

SCHEDULE 2

Governance

Part 1 Terms of Reference for the Provider Collaborative Group

Part 2 Terms of Reference for the Provider Operation Group

Annex 1

Areas for development between the Providers for Year 1 of the PCA

- **Outcomes / Risk Share:** The Providers could look to incorporate an agreed percentage from each Service Contract retained for the collaborative to be set towards common system outcomes across all Providers. Shared risk on performance under the outcomes would be designed to align Providers with a degree of risk but ring-fenced within a proportion of their own contracts. The complexity of setting this risk share arrangement up is likely to mean it is introduced at a later stage, and is likely to require a more developed agreement on a legally binding basis.
- **Annual planning:** The Providers can look to develop an annual plan for future areas of opportunity in the system / meeting the outcomes / inclusion of other providers which is submitted for approval by the Commissioners (consider how the Commissioners will interface with the PCA).
- **Lead arrangement:** The development of a Provider lead on specific areas/pathways could be a virtual approach under the PCA. This could ultimately evolve into a move to a single contract with sub-contracting or a Lead Provider arrangement with management provisions in the PCA.
- The Lead will take more accountability for management and delivery of the outcomes in the pathway under this approach which would require the Commissioners to agree with the approach and lead on this route which may impact on procurement and require compliance with the Integrated Support and Assurance Process if new contracts are needed. This is also likely to move the Providers towards a more developed agreement on a legally binding basis.
- **Joint Arrangement with the CCG:** The Providers may wish to agree a common approach with the CCG though this could change the nature of the provider-based approach and would also need to carefully manage the separate statutory role carried out by the CCG to ensure that it is not seen to have unlawfully delegated

any of its functions. It will also be key to ensure that any conflicts of interest are managed at the outset and throughout the process, particularly if procurements are required at a later stage.

- **Aligning Incentives:** The Providers may engage in joint work with Commissioners about how the incentives within the Doncaster system can be better developed and align to create the conditions for effective integrated and increasingly preventative and localised working.
- This would include a review on performance frameworks, payment mechanisms and the impact of regulatory frameworks on collaborative behaviours.

SCHEDULE 3

Integrated Services

The Providers will identify the relevant Integrated Services (as may be agreed and amended from time to time) and list the relevant Service Contracts in the following form in respect of any services which have been agreed and inserted into Schedule 3 below.

The inclusion of additional Integrated Services under this Schedule may be made only with the mutual written consent of all the Providers

Part A: Integrated Services to be covered by the PCA between the Providers

- (1) Urgent & Emergency Care (developed specification exists);
- (2) Complex Lives;
- (3) Intermediate Care;
- (4) Starting Well (1001 days);
- (5) Vulnerable Adolescents (Tier 4 Specialist Services) and
- (6) Dermatology
- (7) Learning Disabilities.

Part B: Current Service Contracts for the Integrated Services covered under the PCA

Integrated Services Area	Services/ Contract	Commissioner	Provider	Date	Term
URGENT AND EMERGENCY					
COMPLEX LIVES					
INTERMEDIATE CARE					
STARTING WELL					
VULNERABLE ADOLESCENTS					
DERMATOLOGY					
LEARNING DISABILITIES					

Part C: Initial delivery of the Integrated Services: roles and responsibilities

Integrated Services	Leading Provider	Assuring Provider
[DETAILS]	[Name]	[Name]

For the purpose of the table above:

Leading Provider: the Provider that has principal responsibility for undertaking the particular task for the Integrated Services in question, and that will be authorised to determine how to undertake the task. The Leading Provider must act in compliance with the Doncaster Principles at all times, and consult with the other Providers in advance if they are identified as having a role to Assure the relevant services activity;

Assuring Provider: the Provider that will defer to the Leading Provider on a particular task, but will have the opportunity to review and provide input to the Leading Provider before they take a final decision on any activity/ make a recommendation to the Provider Collaborative Group. All assurance must be provided in a timely manner. Any derogation raised must be limited to raising issues that relate to specific needs that have not been adequately addressed by the Leading Provider and/or concerns regarding compliance with the Doncaster Principles.

Within 3 months of the date of this PCA (or such other date as may be agreed for the area of the Integrated Services) the Leading Provider for each Integrated Service shall develop a delivery plan for the relevant Integrated Service for approval by the Provider Collaborative Group which shall identify the following:

- (a) the proposed commercial terms for the Integrated Service to be annexed to this Schedule 3 (Integrated Services) as a variation to the PCA once agreed by the Providers;
- (b) any agreed variations to the existing Services Contracts required to implement the delivery plan;
- (c) the key milestones for the delivery of the Integrated Services and the desired outcomes;
- (d) what employees will be required to work on the project;
- (e) whether any staff will need to be seconded from one Provider to another Provider; and if staff will require access to the premises or assets of another Provider.

Each delivery plan for Integrated Services must be approved by the Provider Collaborative Group prior to being implemented and will be annexed to this Schedule for reference purposes.

SCHEDULE 4

Payment Mechanism

The Providers will consider (i) the development of limited financial risk sharing for elements of the Integrated Services and (ii) a more integrated financial forum for discussion and resolution of system financial issues in respect of the Integrated Services following the execution of the PCA and (iii) the incentivisation model and transformation costs for changes to the Integrated Services but any changes to Service Contracts and this PCA will be subject to agreement between the Providers is to be developed by the Providers and inserted within this Schedule once agreed.

SCHEDULE 5

Dispute Resolution Procedure

- 1 Avoiding and Solving Disputes
 - 1.1. The Providers commit to working co-operatively to identify and resolve issues to mutual satisfaction so as to avoid so far as possible dispute or conflict in performing their obligations under this PCA. Accordingly, the Providers shall collaborate and resolve differences between them in accordance with Clause 6 (*Problem Resolution and Escalation*) of PCA prior to commencing this procedure.
 - 1.2. The Providers believe that:
 - 1.2.1. by focusing on the Doncaster Principles;
 - 1.2.2. taking decisions on a Best for Doncaster basis;
 - 1.2.3. being collectively responsible for all risks; and
 - 1.2.4. fairly sharing risk and rewards,they will reinforce their commitment to avoiding disputes and conflicts arising out of or in connection with the Integrated Services.
 - 1.3. The Providers shall promptly notify each other of any dispute or claim or any potential dispute or claim in relation to this PCA or the operation of the Integrated Services (each a "**Dispute**") when it arises.
 - 1.4. The Provider Collaborative Group shall seek to resolve any Dispute to the mutual satisfaction of each of the Providers.
 - 1.5. The Provider Collaborative Group shall deal proactively with any Dispute on a Best for Doncaster basis in accordance with this PCA so as to seek to reach a unanimous decision. If the Provider Collaborative Group reaches a decision that resolves, or otherwise concludes a Dispute, it will advise the Providers of its decision by written notice.
 - 1.6. The Providers agree that the Provider Collaborative Group, on a Best for Doncaster basis, may determine whatever action it believes is necessary including the following:

- 1.6.1. if the Provider Collaborative Group cannot resolve a Dispute, it may select an independent facilitator to assist with resolving the Dispute; and
- 1.6.2. the independent facilitator shall:
 - 1.6.2.1. subject to the provisions of this PCA, be provided with any information he or she requests about the Dispute;
 - 1.6.2.2. assist the Provider Collaborative Group to work towards a consensus decision in respect of the Dispute;
 - 1.6.2.3. regulate his or her own procedure and, subject to the terms of this PCA, the procedure of the Provider Collaborative Group at such discussions;
 - 1.6.2.4. determine the number of facilitated discussions, provided that there will be not less than three and not more than six facilitated discussions, which must take place within 20 Operational Days of the independent facilitator being appointed; and
 - 1.6.2.5. have its costs and disbursements met by the Providers involved in the Dispute equally or in such other proportions as the independent facilitator shall direct.
- 1.6.3. If the independent facilitator cannot resolve the Dispute, the Dispute must be considered afresh in accordance with this Schedule 5 and only after such further consideration again fails to resolve the Dispute, the Provider Collaborative Group may decide to:
 - 1.6.3.1. terminate the PCA; or
 - 1.6.3.2. agree that the Dispute need not be resolved.

COMPLETION CHECKLIST FOR PROVIDER COLLABORATION AGREEMENT
FOR THE DEVELOPMENT OF GREATER INTEGRATION OF SERVICES
ACROSS PROVIDER ORGANISATIONS IN DONCASTER UNDER THE DONCASTER PLACE PLAN

25th April 2018

Clause	Requirement	Action assigned to
Clause 12.4	Confidentiality and Competition Sensitive Information Agreements to be prepared	Post- Signature of the PCA
Schedule 1 – Commencement Date	To be confirmed once we know date of final signature / board approval	
Schedule 1 –Initial Term	Parties to confirm how long the PCA will continue initially – it will be possible to vary and amend the PCA in this period by agreement	HD suggest that this is 2 or 3 years initially
Schedule 2 (Parts 1 and 2)	Insertion of Terms of Reference for Provider Collaboration Group and Provider Operational Group	Amended terms circulated – to be confirmed
Schedule 3 – Integrated Services	Providers to agree the detail of these post signature for incorporation	Post- Signature of the PCA



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

Title	Process for Strategy Milestones		
Report to	Board of Directors	Date	30th April 2018
Author	Marie Purdue, Director of Strategy & Transformation		
Purpose		Tick one as appropriate	
	Decision (assurance process)	X	
	Assurance		
	Information (Lean update)	X	

Executive summary containing key messages and issues
This paper proposes the governance arrangements required for monitoring and reporting the implementation of the Trust's Strategic Direction 2017-2022 (including enabling strategies). A brief update on the NHSI Lean programme is also included
Key questions posed by the report
Does the Board agree that the proposed governance structure and process provides sufficient assurance on progress with implementation of the Strategic Direction 2017-2022 (including enabling strategies)?
How this report contributes to the delivery of the strategic objectives
This report identifies progress with implementation of the strategy.
How this report impacts on current risks or highlights new risks
The main risk is that we will not robustly implement 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 approve the proposed process for assurance and note the update on the NHSI Lean Programme.

1. Introduction

The purpose of this paper is to propose the governance arrangements required for monitoring and reporting the implementation of the Trust's Strategic Direction 2017-2022 (including enabling strategies). A brief update on the application to be in cohort one of the NHSI Lean Programme is also presented.

2. Monitoring

Key milestones have been identified by each of the strategy owners and these have been collated within the Strategy & Transformation Department. Quarterly monitoring of achievement of the milestones will also be undertaken by Strategy & Transformation and as part of this process relevant directors will be asked for quarterly update and to identify any reasons for slippage of any milestones if this is necessary.

Delivery of key strategic milestones will also be reviewed as part of Executive/Corporate Director annual and mid-year objective reviews.

3. Board Reporting

The reports collated above will be reported on an exception basis to relevant Board Committee, allocated as previously (see table below). The responsible Director will present the detail behind the exception report and any required mitigation.

Strategy	Sub-committee
Clinical Services	F&P and QEC
Information Management & Technology	F&P
Patient Experience & Engagement	QEC
Estates & Facilities	F&P
Governance & Assurance	QEC
Research & Development	QEC
Quality Improvement & Innovation	QEC
People & Organisational Development	F&P and QEC
Finance & Commercial	F&P

An exception report covering all strategies will be presented to Board having already been considered at QEC, F&P or both of these.

4. NHSI Lean Programme

The Trust has been successful in its application to be part of cohort one of the NHSI Lean Programme. On 16 May the Chief Executive has been invited to a meeting with the six other CEOs from cohort one Trusts and on the 17 May, the Chief Executive and others have been invited to a national conference to hear directly from senior healthcare leaders, from the UK and abroad, on the opportunities and challenges of embarking on a lean journey.

The Director of Strategy & Transformation and Head of Qii are working with NHSI colleagues and other Trusts in cohort one to prepare for the programme commencing in July 2018. Updates will be provided to Board as the preparation for the programme develops further.

Chair's Log - Finance and Performance Committee 24.4.18

Overview

A full meeting, again principally Finance focused. Two presentations were received – an overview of planned CIPs and a deep dive into preparations to deal with the new General Data Protection Regulation (GDPR). In terms of papers, in addition to the performance report, finance report and workforce report, we also received the detailed Annual plan, Financial Plan and Budget Setting paper on behalf of the full Board.

Assurance area – Performance

Performance Report

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

It was Pat Drake's first F+P meeting, but her professional knowledge and ability to interpret the data and question appropriately was evident and appreciated.

The performance 'At-a-glance' dashboard continues to improve with better developed peer and national comparisons aiding contextual understanding. It is our objective to develop contextual benchmarking data for all important indicators.

Catering update

The Director of Estates and Facilities gave an update in relation to the progress of the recently outsourced catering arrangements. A positive and improving picture was painted, with the opening of three principal facilities at DRI (Hot Kitchen, Costa and Subway) and an improving trend in relation to the quality and timeliness of patient meals. We will continue to track progress.

Assurance area – Workforce Management

We considered a report that addressed –

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

We received the first iteration of an 'At-a-glance' dashboard that enables us to see by principal job type the vacancy profile, agency spend and sickness levels side by side, enabling correlation and patterns to be more readily seen.

The Director of People and OD is bringing a paper to the next F+P with recommendations from executive colleagues on differential targets for vacancy levels and agency spend according to role type. It is our intention to include them on the Workforce 'At-a-glance' dashboard in future months.

There was nothing exceptional to report. The timing of the meeting meant that some data had not changed since the previous F+P, however there was a helpful further marginal reduction in Agency spend this month.

Assurance area – Overall Financial Picture and Closing the Financial Gap

The majority of F+P's time this month was spent considering financial issues.

Finance Report

Jon Sargeant reported the good news, expected but none the less welcomed, that we have met our control total. The Non-Exec and Governor members of the Committee asked Executive colleagues to pass on their thanks to Trust staff for the massive amount of work that has gone into making this happen. At times through the year it seemed beyond our grasp. The Executive Team are also to be congratulated for the leadership they have shown. It is no small achievement. A fuller report will be available to the Board.

The meeting also received the welcome news of bonus STF money totalling £3.9m. This money was a reward for delivering financial performance and all Trusts that accepted their control total for 17/18 received some of this money.

CIP Plan

Having celebrated the significant financial challenges we faced and met in the last year, we turned to look at the challenges for the year ahead. I think it is fair to say we have a mountain to climb. However, we stand the best chance of success if we plan carefully and mount a well organised, equipped and well-led expedition.

The CIP planning presentation we received gave us assurance that a robust and viable approach is being pursued. RAG rated schemes totalling £13.7m (Green - £4.93m, Amber - £3.99m, Red - £4.78m) were set out. David Pratt discussed in detail the progress to date, future schedule and mechanism for supporting and challenging budget holders.

Although there remains a gap between current foreseen CIP yield and that required to help meet this year's control total (see later), this is a far better position than we were in last year and the Board can be reassured that F+P will retain a sharp focus on this area. NEDs discussed how they could take a portion of CIPs each to quality assure and develop an area of expertise in relation to.

Contracts

The Director of Finance updated the meeting on the current position in relation to negotiations with CCG partners to set contract values for the year ahead. In essence, between our financial plan and our partners contractual intentions there remains a £4.5m gap. We firmly believe that our planning assumptions are correct, but a prudent reserve has been created by the D of F to offset, to some extent, adverse movement. Discussions continue with partners to track and monitor developments and build a fair costing model where both parties agree not to 'game' the system, whilst working to create an agreed contract to sustain, but not exceed current RTT performance levels. The committee approved the signing of the contract under delegated authority from the board.

Annual Plan, Financial Plan and Budget Setting

NEDs Alan Armstrong and Linn Phipps joined us for this item, which we discussed for over an hour. Full Board had already seen the principal papers for this item and asked F+P to finalise the decision making when additional information was available.

The core item was the decision to sign up to a control total deficit of £6.6m, which meant acknowledging the need for CIPs totalling £17.9m, along with a number of other assumptions which we sought assurance were prudent.

The matter was explored and debated constructively and in depth, before F+P agreed the paper's recommendations, including submission of the plan later this week in line with the NHSI deadline.

Assurance area – Governance and Risk

We held a deep dive into preparations to deal with the new General Data Protection Regulation (GDPR). The Chief Information Officer presented a detailed overview of the work in hand to ensure the Trust is positioned as best it is able to deal with the new legal provisions. The main Board will receive a detailed paper whose recommendations are now fully endorsed by F+P. We were impressed by the apparent thoroughness of preparation.

F+P received and noted the current risk register.

In preparation for regular receipt of Cash Committee minutes we familiarised ourselves with the terms of reference for that committee.

Neil Rhodes

Chair – Finance and Performance Committee

DBH Board 30.4.18

DBH Quality & Effectiveness Committee (QEC) 24.4.18 - Chair's report

Welcome: to Pat Drake, our new NED who is joining QEC.

Escalation

No new items for escalation to QEC or to the Board. (Issues were escalated from Care Groups to CGC around:

1. Patient transport between sites (there are delays in moving non-elective patients from BDGH to DRI)
2. Staff training to cope with aggressive patient/relatives

Action log/matters arising

The action log identifies clearly the actions completed, not yet due, agenda'd and to be reviewed. Key issues focussed on were:

- Item 9 Learning from Deaths: it is proposed that the main review of this be undertaken by QEC. See item on Strategic Discussion below.
- Item 12 Respiratory Unit: further Quality Summit planned c June, which will emphasise particularly a triangulation of quality metrics and staff experience; Pat invited to participate.

Meeting outputs and outcomes

Strategic thematic discussion: Learning from Deaths – avoidable deaths

Comprehensive and assuring report from Mandy Dalton. Noted the progress in extending structured judgement reviews. Discussed that there are concerns about timeliness of issue of death certificates and the operation of the Bereavement Office, which are being addressed. There has been a meeting with the Coroner concerning timeliness. A business case is being submitted for additional resourcing and the role of a medical examiner is proposed. Discussed the national concern raised re our identification of avoidable deaths, which has resulted in combining SJR and SI (serious incident) processes.

Possible BMA award is pending.

It is **proposed** that the main review of Learning from Deaths (avoidable deaths): be undertaken by QEC, and that to discharge the Board's legal responsibilities, the Board will receive:

- Quarterly statistics
- QEC minutes
- QEC Chair's report
- Escalation of any significant concerns/ exception reporting
- An annual report from QEC.

The Board is asked to **CONFIRM** that it is assured that these arrangements will discharge its legal duties in an optimal way.

Quality and Care: Assurance Report

This combines assurance from

- Quality dashboard
- Hard Truths (nursing staffing and quality metrics)
- Clinical Governance

The Medical Director demonstrated the Quality Dashboard and the range of data and constituent Dashboards which in contains, particularly the disaggregation to Care Group level. QEC considered how it and the whole Trust structure may best be able to interrogate the data in future, especially when intranet and real-time access are enabled.

The cover paper for this meeting combined all sections together for each of the 6 assurance questions, and assurances on each question were reviewed. It was appreciated that, whilst the CGC Minutes available to the Committee were for January/February, the Assurance report included assurance the discussions at the previous week's CGC. A range of questions were raised such as the extent to which our lower than average proportion of registered nurses may be a risk to care outcomes and patient experience; and our performance on Fractured Neck of Femur.

The QEC planning group will continue to consider the best way to present/interrogate the data in the report.

QEC reviewed a draft infographic which had been requested to represent the qualitative aspects of patient and public feedback; and to discharge our commitment in last year's Quality Accounts to create a Balanced Scorecard or similar to measure our improvement on qualitative measures of quality. It was noted that the draft infographic focussed on information from NHS choices and that a wider range of sources had been discussed previously. A further meeting would be held to review information sources and options.

It was noted that this report contained a number of areas where there are concerns (and these are QEC's natural areas of focus). It was AGREED that the Lead Directors will review all of the areas of concern flagged in this and the subsequent reports, to ensure that they have been risk assessed and appear appropriately in the risk registers held at Care Group level etc.

QEC carried out a 4th "deep dive" **interrogation of a key risk** into Availability of Medicines. The scope focussed on how we can influence a national risk that we cannot control. The interrogation report was commended for its clarity, and is attached for info. Interrogation examined particularly whether we have articulated the risk rather than the issue ie how we define "adequately treating" patients. There was discussion of how the problems had arisen, which changes in the supply chain, and that staff are having to work very hard to find alternative supplies of medicines and in some cases, this means that the method of treatment has to change. It was noted that for the first time, we are experiencing an absolute inability to supply some medicines.

Leadership & improvement capability

Workforce and Education Assurance report

QEC commended the excellence and clarity of the cover paper and its coverage of the 6 assurance questions. The report included the Action Plan in response to last year's Staff Survey and it was noted that this year's Staff Survey would be reviewed imminently by the whole Board.

Maternity Services - staff culture and staff survey

It was noted that nearly all items in the original RCOG report had been actioned/ closed, however, QEC had previously flagged its wish to keep progress with the qualitative aspects of culture and behaviour under periodic review. The depth of the survey questions was acknowledged to be helpful while the responses are concerning. Noted that a Task Force is being convened, to develop an action plan on morale, There will be staff Listening events, and NEDs would be invited if available. The survey will be repeated 6-monthly to establish trends. It will be checked that we have risk assessed this, e.g. impact on recruitment and retention.

Governance & Risk

Board Assurance Framework / CRR

This report presented changes in risk ratings over the past year. The definition of "direction of travel" would be reviewed as currently this is historic information.

Minutes of sub-committees

CGC: It would be checked whether Duty of Candour metrics have been included in our Quality Dashboard.

Governor questions

Clive Tattley explored whether Care Groups, to be reduced in number, would have enough time to examine the Quality Dashboard fully. Peter Abell raised apparent discrepancies between Wards' own data on appraisals and data which has been logged on HR systems.

Meeting reflections – what have we learnt?

- Good quality of reports – thank you Directors and teams! enables us to focus on the right areas, the concerns and the risks, and the assurances
- Using a standard approach to interrogating risks – helps embed this approach
- Good discussions eg of Infographic – though we need to explore this item further
- Hard work of planning group to replan agenda when scheduled discussion item (Patient experience of the discharge process) was deferred at the last minute
- Flexibility of Director team in managing diaries to attend and present (eg Learning from Deaths, Medicines)
- Welcoming

- Assurance discussions align concerns with risks
- Input of real experience eg QAT visits
- QEC is evolving and establishing its place – between CGC and Board – providing strategic challenge – continue to work on being in this space
- Good connectivity of themes
- Evolving clarity of what F&P vs QEC focus on re Workforce
- Managed limit to 3 hours!
- Technology (ppt) failed but this was not a problem as we had precirculated the ppt

Future discussion items identified for Work plan include

- Patient experience of the discharge process
- Patient experience of the complaints process
- Learning from deaths – family and patient experience - revisit
- Staff retention (June 2018)
- New annual report on losses/compensation/CNST claims, premiums & trends
- BIR (Quality section) scope and QEC role in providing assurance to the Board
- Quality and qualitative metrics eg NQB metrics
- Risk interrogation
- CQC/progress on maternity – assurance on progressing the longer-term and “soft” changes such as teamwork and cultural change, and embedding good practices
- What we mean by “Effectiveness”
- Duty of Candour – assurance on how the process is working (e g the chain of command for follow-through) and impact (eg whether staff feel able to speak up).
- Monitoring the Enabling strategies – milestones etc
- Reviewing the new R&D strategy asap – special QEC?

Linn Phipps

Chair Quality & Effectiveness Committee

28 4 18

Appendix 1

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?

Appendix 2

Risk Interrogation – Availability & Supplies of Medicines

Purpose of paper

This paper seeks to interrogate the risk associated with medicine shortages experienced by the trust using the risk interrogation template.

Risk interrogation questions

1. Have we captured the risk rather than the issue?

The issue of shortages in the medicines supply chain is an international one but one which carries significant risk for Doncaster & Bassetlaw Teaching Hospitals NHS Foundation Trust. Unavailability of medicines could potentially have a direct impact on patient care and patient pathways (including those that cross care boundaries), certain operational elements for the hospital, patient satisfaction and the reputation of the organisation and the NHS. The nature of supply and demand and having to source medicines from abroad carries financial risk. Medicines shortages are being managed at national and regional levels in the NHS by the Department of Health and regional procurement hubs but ultimately organisations are responsible for managing local impacts and risks while recognising they cannot control or influence the supply chain upstream from them. Stock efficiency initiatives as a result of the Carter Review may be having an untoward effect on the organisation's capability to absorb and manage stock shortages. This is compounded by the introduction of procurement rationing by the Department of Health which prevents organisation from hedging stock.

2. What are the key elements of the risk (this may include impact on business continuity)?

The key elements of this risk are:

- Patient care – unable to provide certain treatments or optimal treatments. Risk of negative impact on patient pathways.
- Delays to hospital operations and commitment of extra resources to find solution and provide supporting information.
- Patient satisfaction may be negatively affected and there might be a loss of confidence in the organisation carrying reputational risk.
- Increases in cost due to having to procure non-contract products or products from overseas which can increase costs with overheads and currency volatility. Non-payment or slow payment of invoices can damage relationship with supplier and potentially but supply chain on-hold reduce access to medicines and having to seek medicines from other suppliers at increased costs. Potential safety risks with having to use imported products that are unlicensed in the UK and contain information in a different language

3. Using the 5 x 5 matrix what is the initial risk score?

The initial score has been assessed as 15 – Likelihood of 5 and Impact of 3

4. What are the key milestones in mitigating the risk?

5. What actions are in place/needed and what is the expected impact of each action in mitigating the risk?

Adoption of a regional procurement online tool to track, manage and communicate supply shortages that the trust is experiencing. Access to tracking tool has been pushed out to Pharmacy teams to proactively identify shortages and for communication to clinical teams. It allows us to feed intelligence back to the regional and national team on current and future problems and potential solutions.

CMU of the Department of Health and regional procurement consortium are actively monitoring the pharmaceutical market for shortages and signs of strains on the supply chain. Regular email are received from these teams, assessed for local relevance and can lead to a request for support and/or an action plan to mitigate any known relevant risks

A weekly report has been established to track non-delivery or late delivery of medicines to flag actual and or future shortages.

A weekly supply shortages meeting takes place between senior procurement managers to identify issues, risk assess them and set up an action and communication plan if relevant. Significant issues are documented and tracked.

Shortages are communicated and escalated formally through care group management or clinical governance structures. This allow for a timely and reliable cascade of information and a local, joined-up response.

Updated workflows, process and procedures are under development to ensure that internal communication and engagement is optimised, collaboration is enhanced and action plans and solutions are documented better. This will improve the trusts response to future shortages

Failure to supply against contract lines and the cost of sourcing alternatives is being monitored by Pharmacy Procurement Teams. Rebates can be claimed against non- supply after a certain period and tracking allows us to make claims for compensation which can mitigate the financial risks.

Non-compliance with supplier payment terms and associated complaints are being monitored and escalated to senior pharmacy management to flag with Finance and seek quick resolution.

Support is sought from Regional QA teams to help quality assure imported or unlicensed medicines. This allows us to mitigate some of the risk by identifying ‘best alternatives’ and suppliers that can add value in terms of providing translations and meet demand.

6. Will the risk be fully mitigated within the resources currently available?

No. Despite the initiatives currently DBTH cannot fully mitigate with the resources currently available. Many variables are potentially outside the control, influence and scope of the trust and increased resources may not improve this.

7. If no to question 6 above detail what more could be done and what further resources are required?

Increased resources within the pharmacy procurement team would improve the responsiveness and agility of the trust to monitor, respond to and manage supply shortages but could not mitigate the risk fully. A temporary increase in administration

staff would streamline processes and ensure the correct training and skill mix is in place to allow for more dedicated efforts to manage efforts. A local IT solution (database) would allow better tracking, documentation and communication of local shortages while improving responsiveness and building organisation memory to deal with future problems.

8. What corporate action, if any, is necessary?

Help raise awareness of the problem and provide support for increased resources to help manage the system. Ensure that invoices are paid strictly against creditor's terms and conditions.

9. Who needs to know about the risk and the mitigation plans?

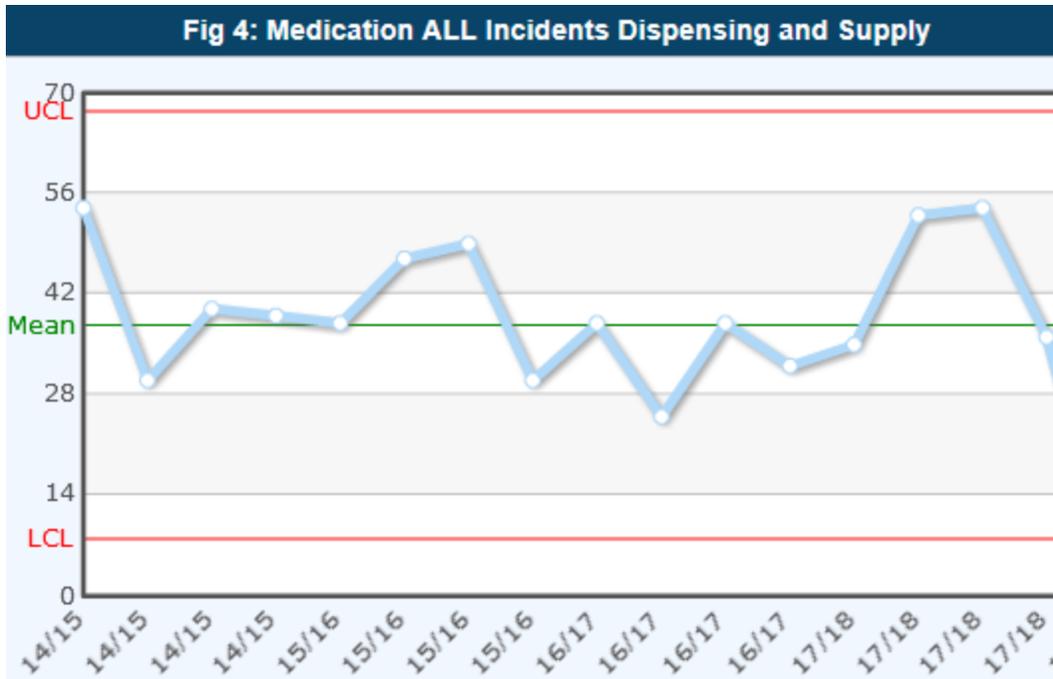
All Care Group triumvirate leadership teams and corporate leadership teams and cascaded down to relevant clinical and operational team and individual practitioners.

10. If any, what are the key areas outside of the scope of the action plan that impact on mitigating the risk?

Medicine shortages can occur for a number of reasons that are outside the control of DBTH and the NHS as a whole. The UK pharmaceutical market is controlled by the government to keep prices and profits down to ensure the best value for money for UK tax payers. However, Pharmaceutical companies operate internationally and can access markets where controls are lighter and profit margins higher and scarce stock can be diverted from the UK which can exacerbate the issue.

11. What evidence is there that the risk is under control?

The number of significant shortages cascaded through care groups and that could not be managed by pharmacy alone have reduced in 2018. Some lines that had been rationed at the end of 2017 are now available to meet DBTH's demand. There is greater input from the Department of Health to help manage shortages on a national level. The number of Datix incidents reported as supply problems has reduced in the last quarter of 2017 from a peak in quarter 3.



Despite all this, the nature of the problem means that while there may be indications of improvements in the pharmaceutical supply chain for certain issues this is not predicative of future capability to control. Greater data is required to help quantify the extent of the problem and apply greater control

12. What is the timetable for reviewing progress on mitigating the risk?

Monitoring is conducted weekly and updates are reported monthly to QEC.

13. What areas of the Assurance Framework does this risk link to?

This risk links to the strategic objective related to Patients, demonstrating that we CARE and are committed to quality and continuously improving patient experience. We are working with partners to prevent any disruption to patient care, support care-givers and patients and minimise the clinical, operational, reputational and financial risk identified

14. Further comments by the risk reviewer. 15. Comments made by QEC.

To be completed following discussion at QEC in April 2018.

16. Which Committee will take the lead in reviewing the risk? QEC

17. Using the 5 x 5 matrix what is the intermediate risk score?

Based on the interventions now in place it would be reasonable to review the position in 3 month's (July 2018) to determine if the improvement is sustained. It is recommended that the intermediate risk score is assessed as 12, Likelihood of 4 and Impact of 3

18. Using the 5 x 5 matrix what is the final/residual risk score?

There are a number of structural variables and future uncertainty with the UK pharmaceutical industry that limit control and mitigation at an organisational level and therefore the short to medium term final target could reduce to 9; Likelihood of 3 and Impact of 3.



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

Title	Financial Performance – March 2018		
Report to	Trust Board	Date	30 April 2018
Author	Alex Crickmar – Deputy Director of Finance Jon Sargeant - Director of Finance		
Purpose	To update the Board on the financial position for the month of March 2018.	Tick one as appropriate	
	Decision		
	Assurance		
	Information	X	

Executive summary containing key messages and issues

The Trust's surplus for month 12 (March 2018) was £4,337k, which is a favourable variance against plan in month of £4,593k. Year to date the Trust has a favourable variance of £4,123k against plan, thereby delivering the Trust's control total.

STF funding has been confirmed by NHS I which takes account of not achieving the A&E target in March (£1.2m) however this is offset by the additional bonus STF of £5.1m received at year end. Thereby additional STF income of £3.9m has being included within the year end position.

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

- Identify the most effective care possible
- Assist in the control and reduction of the cost of healthcare
- Assist in developing responsibly and delivering the right services with the right staff

How this report impacts on current risks or highlights new risks

Update relating to delivery of 2017/18 financial plan.

Recommendation(s) and next steps

The Board is asked to note:

- That the in-month I&E financial position was ahead of plan by £4,593k.
- The year to date I&E position at Month 12 of £11,962k deficit and thereby delivering the Trust's control total (£16,084k deficit).
- The year-end position includes additional STF of £3.9m.



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

FINANCIAL PERFORMANCE

P12 March 2018

DONCASTER AND BASSETLAW TEACHING HOSPITALS NHS FOUNDATION TRUST

P12 March 2018

1. Income and Expenditure vs. Forecast									2. CIPs									
Performance Indicator	Monthly Performance			YTD Performance		Annual Plan	Forecast	Performance Indicator	Monthly Performance			YTD Performance	Annual Plan	Forecast				
	Actual	Variance to budget	Variance to Forecast	Actual	Variance				Actual	Variance	Actual				Variance to budget	Variance to Forecast	Actual	Variance
		£'000	£'000															
I&E Perf Exc Impairments	(4,337)	(4,593) F	(3,330) F	11,693	(4,796) F	16,489	16,070	Employee Expenses	960	1,133 A	272 A	7,351	1,914 A	9265	7,351			
Income	(31,010)	(5,633) F	(5,748) F	(374,127)	(11,831) F	(361,892)	(367,541)	Drugs	5	(3) F	(1) F	39	(9) F	30	39			
STF Incentive	(1,347)	0	0	(11,547)	0	(11,547)	(11,547)	Clinical Supplies	104	230 A	234 A	706	241 A	947	706			
STF Adjustment 16/17	0	0	0	(419)	(419) F	0	(419)	Non Clinical Supplies	0	25 A	0 A	0	100 A	100	0			
Donated Asset Income	0	0	0	150	(254) F			Non Pay Operating Expenses	572	(249) F	(465) F	1,309	30 A	1340	1,309			
Operating Expenditure	33,013	1,522 A	2,066 A	384,606	7,514 A	377,092	382,646	Income	91	137 A	243 A	897	(173) F	724	897			
Pay	21,716	900 A	(11) F	258,327	5,718 A	252,610	257,974	Total	1,732	1,273 A	283 A	10,304	2,102 A	12,406	10,304			
Non Pay	11,298	622 A	2,077 A	126,279	1,797 A	124,483	124,672											
I&E Perf Exc 16/17 STF and Donated Asset Income	(4,337)	(4,593) F	(3,330) F	11,962	(4,123) F	16,489	16,489											
F = Favourable A = Adverse																		
Financial Sustainability Risk Rating				Plan	Actual													
UOR				4	3													
CoSRR				1	2													
3. Statement of Financial Position									4. Other									
All figures £m									Monthly Performance		YTD Performance		Annual		Forecast			
									Plan	Actual	Plan	Actual	Plan	Forecast	Plan	Forecast		
									£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000		
Cash Balance									1,900	11,866	1,900	11,866	1,900	1,900	1,900	1,900		
Capital Expenditure									635	3,178	3,942	7,537	6,481	8,265	8,265	8,265		
3. Statement of Financial Position									5. Workforce									
All figures £m									Opening Balance	Current Balance	YTD Performance		Annual		Forecast			
									01.04.17	30.11.17	Plan	Actual	Plan	Forecast	Plan	Forecast		
									£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000		
Non Current Assets									196,907	209,108	196,907	209,108	196,907	196,907	196,907	196,907		
Current Assets									33,612	65,683	33,612	65,683	33,612	33,612	33,612	33,612		
Current Liabilities									(31,967)	(68,230)	(31,967)	(68,230)	(31,967)	(31,967)	(31,967)	(31,967)		
Non Current liabilities									(79,348)	(88,292)	(79,348)	(88,292)	(79,348)	(79,348)	(79,348)	(79,348)		
Total Assets Employed									119,204	118,269	119,204	118,269	119,204	119,204	119,204	119,204		
Total Tax Payers Equity									119,204	118,269	119,204	118,269	119,204	119,204	119,204	119,204		
									Funded WTE	Actual WTE	YTD Performance		Annual		Forecast			
											Bank WTE	Agency WTE	Total in Post WTE		Under / (over)			
Current Month									6,037	5,572	145	129	5,846	191	191	191		
Previous Month									6,041	5,612	217	113	5,942	99	99	99		
Movement									4	40 0	72	(16) 0	96	92	92	92		

1. Context/Background

The year to date month 12 position is a deficit of £11,693k. After removal of the 2016/17 STF adjustment and the variance relating to donated assets, this is restated to a deficit of £11,962k.

2. Executive Summary

The Trust's surplus for month 12 (March 2018) was £4,337k, which is a favourable variance against plan in month of £4,593k. Year to date the Trust has a favourable variance of £4,123k against plan, thereby delivering the Trust's control total. (Note: This position excludes the impact from the consolidation of charitable funds).

STF funding has been confirmed by NHS I which takes account of not achieving the A&E target in March (£1.2m) however this is offset by the additional bonus STF of £5.1m received at year end. Thereby additional STF income of £3.9m has being included within the year end position.

In month 12, additional winter funding of £1.3m was received from NHS Improvement with the YTD Trust position including a total of £2.5m non-recurrent funding for winter pressures. In month 12 inpatient income was less than plan including emergency, however this is linked to the significant increase in un-coded activity in the position. In month clinical income overall is £2,462k favourable against plan including the winter monies received of £1.3m.

The cumulative income position at the end of Month 12 is £12,504k favourable to plan (this includes £2.5m of non-recurrent winter funding and additional STF funding as outlined above).

Income Group	Annual Budget	In Month Budget	In Month Actual	In Month Variance	YTD Budget	YTD Actual	YTD Variance
Commissioner Income	-302,553	-25,975	-28,601	-2,626 F	-302,553	-308,374	-5,820 F
Drugs	-22,601	-2,048	-1,885	164 A	-22,601	-23,739	-1,138 F
STF	-11,547	-1,347	-5,243	-3,896 F	-11,547	-15,862	-4,315 F
Trading Income	-36,737	-2,987	-2,832	155 A	-36,737	-37,968	-1,230 F
Grand Total	-373,439	-32,357	-38,560	-6,203 F	-373,439	-385,943	-12,504 F

The expenditure position to the end of March was £7,514k higher than budgeted levels, with a £1,522k adverse variance in month. This mainly relates to unachieved CIPs on non-pay.

Subjective Code	In Month Budget	In Month Actual	In Month Variance	In Month Forecast	In Month Variance to forecast	YTD Budget	YTD Actual	YTD Variance	Annual Budget	Forecast
1. Pay	20,816	21,716	900 A	21,726	-11 F	252,610	258,327	5,718 A	252,610	260,930
2. Non-Pay	9,705	11,730	2,025 A	8,520	3,210 A	115,700	131,304	15,604 A	115,700	122,466
3. Reserves	970	-432	-1,402 F	516	-948 F	8,783	-5,024	-13,807 F	8,783	-750
Total Expenditure Position	31,492	33,013	1,522 A	30,763	2,251 A	377,092	384,606	7,514 A	377,092	382,646

Capital expenditure YTD is £7.537m which is £728k behind the revised forecast of £8.265m.

The cash balance at the end of March was £11.9m against a plan of £1.9m. The closing balance was higher than plan due to winter funding received (£2.5m), Q3 STF paid in March (£3.5m), NHS organisations settling a number of outstanding balances, and payments relating to over performance on income being received from Commissioners.

3. Conclusion

The Trust's year-end financial position at Month 12 is £4,123k favourable to plan, thereby delivering the Trust's control total. The position reported in this paper is prior to review by external audit.



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

Title	Business Intelligence Report		
Report to	Board of Directors	Date	30th April 2018
Author	David Purdue, Chief Operating Officer Sewa Singh, Medical Director Moira Hardy, Director of Nursing, Midwifery and AHPs 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 62 day classic, 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

Diagnostics performance against 14 key tests

Infection control measures, CDiff and MRSA Bacteraemia

The Quality report highlights the ongoing work with Care Groups and external partners to improve patient outcomes and a focus on mortality rates.

The Workforce report identifies vacancy levels, agency spend and usage, sickness rates, appraisals and SET training.

Key questions posed by the report
<p>Is the Trust maintaining performance against agreed trajectories with NHSi?</p> <p>Is the Trust providing a quality service for the patients?</p> <p>Are Governors assured by the actions being taken to maintain a quality service?</p>
How this report contributes to the delivery of the strategic objectives
<p>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.</p>
How this report impacts on current risks or highlights new risks
<p>The corporate risks supported by this report are related to NHSi single oversight framework, especially in line with quality, patient experience, performance and workforce.</p>
Recommendation(s) and next steps
<p>That the report be noted.</p>

Performance Executive Summary Board of Directors April 2018

The performance report is against operational delivery in January, February and March 2018.

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 remains below the target at 89.1% in March, which is a deterioration from February and the worst position in the year.

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

Key issues relate to internal capacity to meet demand in the system. The Trust have purchased a modeling tool called Gooroo to more accurately model activity requirements over the year. The care group general managers are working jointly with the finance team to standardize the demand and capacity requirements for the year.

NHSI are aware of the current capacity shortfalls and trajectories to improve the position over 2018/19. This is dependent on the outcomes of the final contract with the CCGs.

Key to performance is the need to be maintaining contracted activity. March saw an improvement in theatre utilisation in GI, ENT and T&O.

The Elective Steering Board is reviewing theatre lists on all 3 sites to ensure that all lists are utilised effectively. The Elective Development Programme is looking at 3 specialties, Cardiology, ENT and Urology to maximise the efficient use of out-patients.

Diagnostics

The diagnostic target was achieved at 99.1%

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.

March Performance

Trust 93.3%, including alternative pathways **94.1%**.

Quarter 4, 90%, 91.2% with alternative pathways

Year to date 91.5%, excluding alternative pathways, 91.7 with alternative pathways

The key issues for breaches remains internal ED waits to see or be reviewed by a doctor. Potential improvements are expected after reviewing a number of processes within the dept.

The identification of the EPIC (Emergency Physician in Charge) and standardised operating protocols for escalation and shop floor management.

15% of patients at DRI were streamed to UCC from FDASS.

NHSI Additional Reporting Requirements

- 18.3% of all of DRI discharges take place at a weekend and 15.2% at BDGH.
- If the rest of the week was at the same level as Mondays then we would see an extra 153 patients a week at DRI and an extra 108 patients at BDGH
- A&E attendances on a Monday at DRI account for 15.4% of weekly activity rising to 15.9% at BDGH
- Non Elective Admissions on a weekday that GP admissions account for is 20.5% of all Emergency Admissions on a weekday at DRI but only 8.7% at BDGH.
- When we move into the weekend this drops to 11.3% at DRI and 2.7% at BDGH

Cancer Performance

February

62 day performance 85%, TWW performance 93.1%

The key issue for 62 day performance, remains in Urology, due to the number of patients requiring treatment. There were also a number of delays in complex pathways within Head and Neck and Gynaecology.

As part of the Cancer Alliance Work Programme, a series of deep dive meetings around cancer waiting times standards have taken place. The Doncaster and Bassetlaw place based meeting occurred on 12 February and feedback has now been received and an action plan developed.

Stroke Performance

January patients discharged with a diagnosis of stroke 55

Performance against the scan within 1 hour standard continues to be maintained above 48% at 63%. This is the best performance in the past 2 years

The 4 Hour Direct Admissions standard is still not being achieved by the Trust at 56.4%. however 80% of patients were directly admitted within 5hrs. The key issue in month was delays in the pathway access to beds on the stroke unit did not affect the performance.

David Purdue Chief Operating Officer April 2018

PERFORMANCE REPORT – March 2018

Cancer Performance

The following information relates to Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust performance in February.

February Performance

Standard	Local Performance %	National Performance %
TWW	93.1%	95.2%
31 day	98.4%	97.6%
62 day	85 %	80.8%
31 day Sub – Surgery	100%	95.4%
31 day Sub – Drugs	100%	99.6%
31 day Sub – Other	100%	100%
62 day Screening	90%	88%
62 day Con Upgrades	63.3%	87%
Breast Symptomatic	93.2%	94.1%

62 day Cancer performance

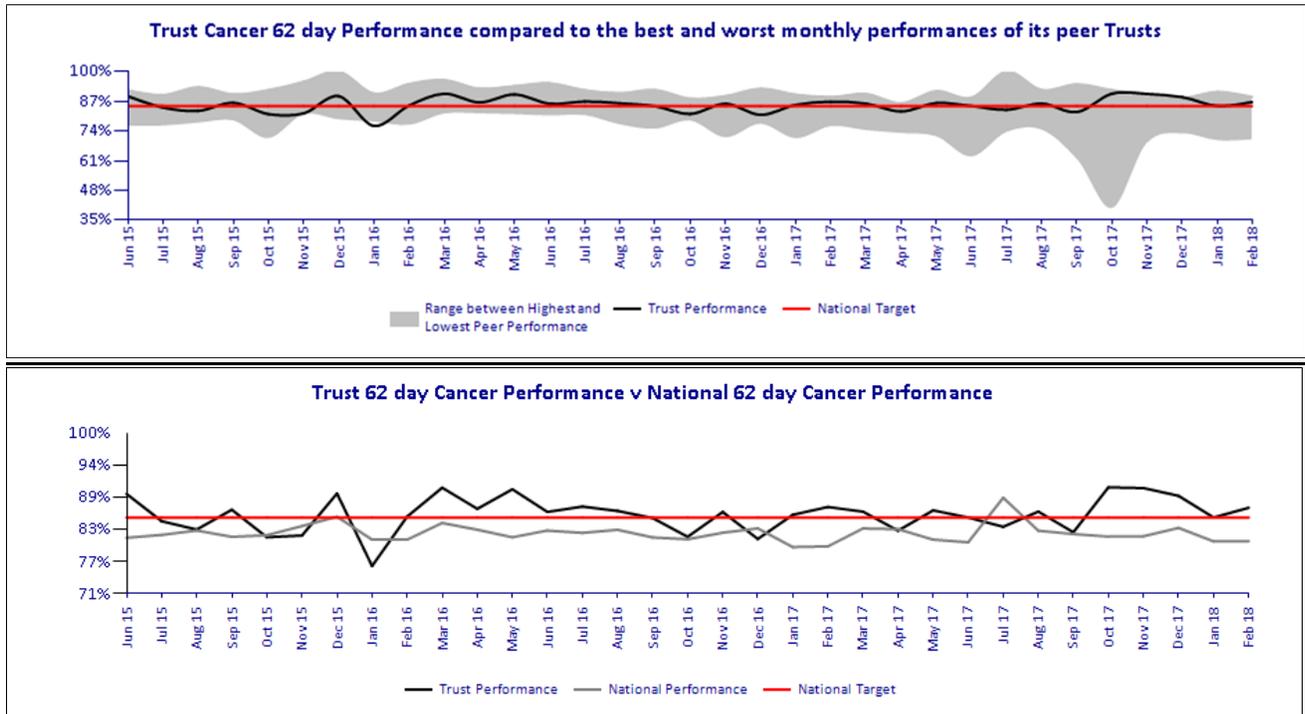
The 62 day standard was achieved by the Trust in February at 85%. Doncaster CCG performance was 89.23% and Bassetlaw CCG was 73.68%. Although below the 85% standard, this demonstrates an improvement for Bassetlaw CCG compared with January.

The key issue remains in Urology, due to the number of patients requiring treatment. There were also a number of delays in complex pathways within Head and Neck and Gynaecology.

As part of the Cancer Alliance Work Programme, a series of deep dive meetings around cancer waiting times standards have taken place. The Doncaster and Bassetlaw place based meeting occurred on 12 February and feedback has now been received.

PERFORMANCE REPORT – March 2018

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



Two Week Wait Performance

The February position for two week wait was 93.1% which was compliant with the national target of 93%. This is an improvement on January's position. Doncaster CCG saw a local performance of 92.9% with Bassetlaw CCG at 96.4%.

The Capacity and Demand tool continues to be developed, providing a planning tool based on previous referral trends, activity and capacity. Care groups have begun to use the tool proactively to plan two week wait capacity.

Weekly PTL meetings have now commenced with each specialty to track individual patient booking, pathways and to review breaches. The cancer management team meets regularly with the CCGs to review the information given in primary care which supports the two week wait position.

PERFORMANCE REPORT – March 2018

	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	98.7%	93.9%	100%	100%	100%		91.9%	90%	
Gynaecology	94.1%		50%				40%		
Haematology	90%		100%		100%	100%	100%		
Head & Neck	96%		100%				66.7%		
Lower GI	100%		100%	100%	100%		100%		0%
Lung	93%		100%				100%		60%
Other			100%				50%		
Skin	90.9%		100%				100%		
Upper GI	88.9%		100%	100%	100%		100%		
Urological	86.5%		96.7%	100%	100%	100%	65.9%		100%

The reasons for breaches in relation to two week wait appointments can be seen in the table below.

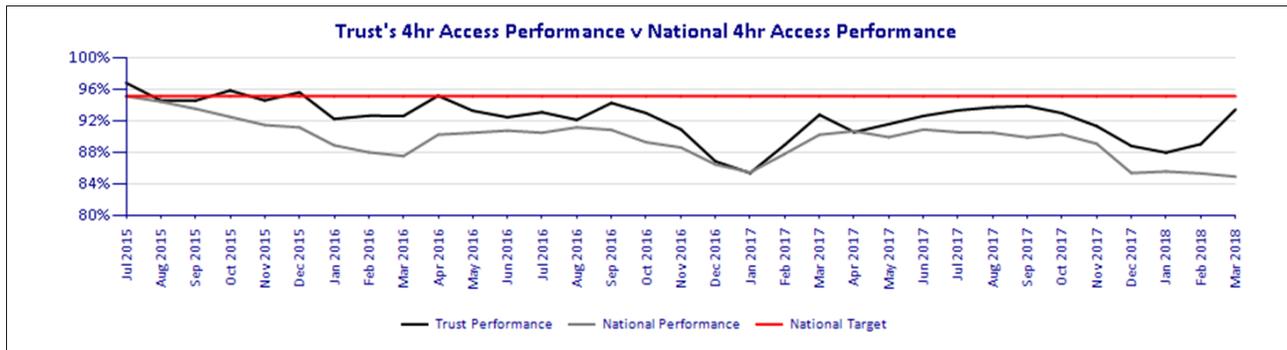
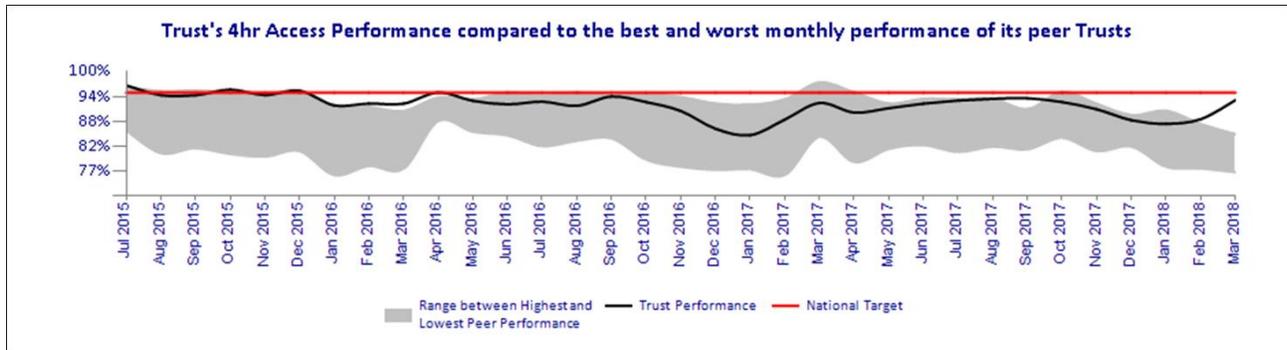
CWT Standard	Tumour Group	Performance against CWT standard	High Level View
Two Week Wait	Haematology	90%	1 breaches – patient choice
	Lower GI	90.3%	17 patients – 5 patient choice, 6 capacity, 6 administrative delay, 1 hospital cancellation
	Skin	90.9%	18 patients – 7 patient choice, 5 capacity, 3 administrative delay, 3 hospital cancellations
	Upper GI	88.9%	11 breaches – 6 patient choice, 3 capacity, 1 administrative delay 1 hospital cancellation
	Urology	86.5%	21 breaches – 5 patient choice, 11 capacity, 1 administrative delay, 4 hospital cancellations
31 day	Gynaecology	50%	1 patient – medical reasons impacted on delay
62 day	Gynaecology	40%	2 patients – both shared care - 1 medical reasons, 1 pathway delays
	Head & Neck	66.7%	2 patients – both shared care - 1 complex planning pathway, 1 pathway delays
	Other	50%	2 patients – both shared care - both complex diagnostic pathway
	Urology	65.9%	9 patients – 4 shared pathway – 1 patient choice, 3 Pathway delays around diagnostics . 5 local pathways , 2 equipment failure (bone scan), 2 capacity issues, 1 medical reason
62 day Consultant Upgrade	Lower GI	0%	2 patients – both shared care, 1 patient choice , 1 pathway delay
	Lung	60%	2 patients – both shared care – 1 pathway delay, 1 OPD capacity for treatment planning @ STH

PERFORMANCE REPORT – March 2018

4hr Access Target

The Trust achieved 93.3% in March 2018 against the 4hr access standard of 95%. Quarter 4 position ended at 90%, with the year to date performance at 91.5%. Nationally, the Trust have been ranked 13 which is still within the top quartile.

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



In March, 926 patients failed to be treated in 4hrs, with a total of 13770 patients attending ED. The main breach reason was wait to see ED doctor/ ED review which accounted for 593 of the 926 breaches. 107 breaches were due to bed pressures.

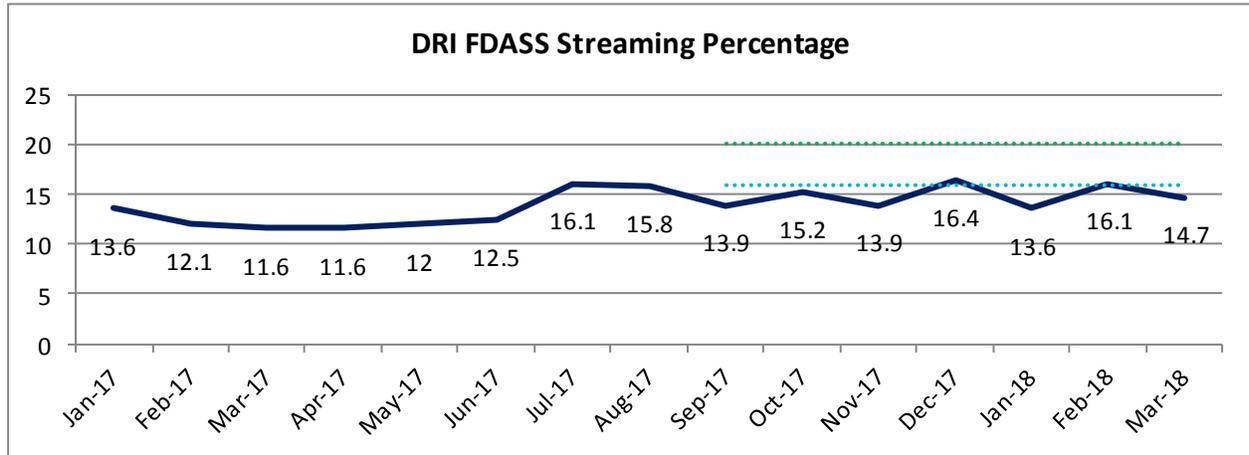
NHSI are delivering a further Action on A+E Programme which commences on 10 May 2018. This will bring together Urgent and Emergency Care partners from across Doncaster and Bassetlaw to jointly agree priority areas of opportunity and to plan improvement work.

PERFORMANCE REPORT – March 2018

Streaming

Doncaster FDASS

The number of patients streamed directly from the front door reduced slightly in March. The graph below shows the percentage of patients streamed each month.



Bassetlaw

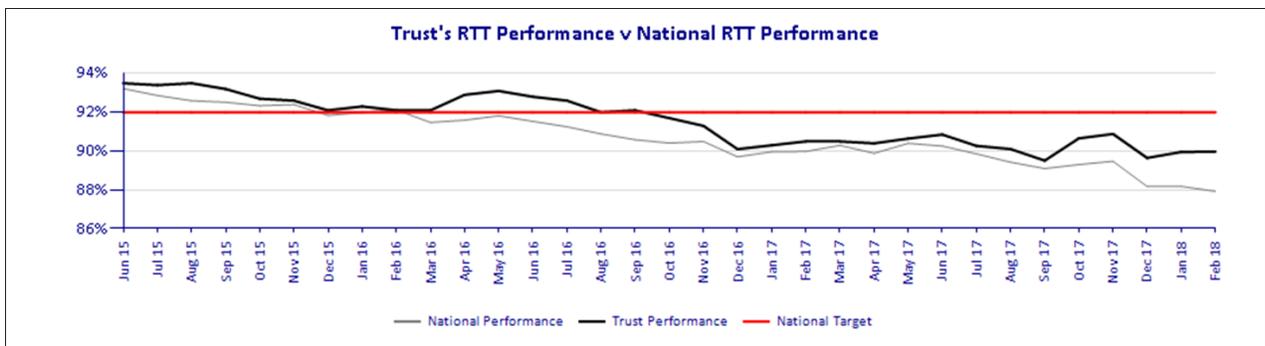
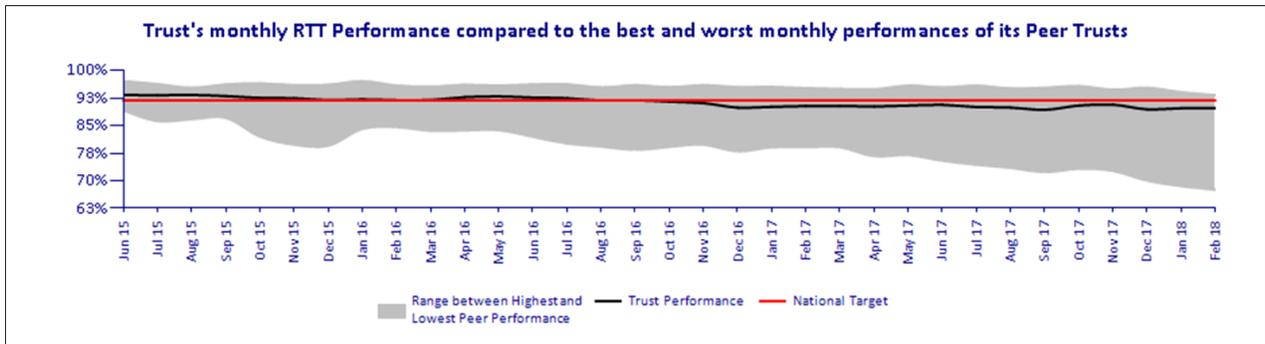
Streaming commenced at Bassetlaw on 1 October 2017. The % streamed has consistently been between 6-12%.

PERFORMANCE REPORT – March 2018

Referral to Treatment (RTT)

Incomplete pathways for March ended in an improved position at 89.1% against the 92% standard.

The graphs below show Doncaster and Bassetlaw’s performance compared with the National picture.



At the end of March 2018 there were two Incomplete Pathways over 52 Weeks. These pathways have been validated with agreed dates for treatment.

Weekly PTL meetings take place with all Care Groups where Delivery Plans are discussed to bring performance levels back in line with commissioned activity and meeting RTT. Advanced fortnightly monitoring meetings are in place with a number of specialty areas; *Orthopaedics, ENT, Ophthalmology and General Surgery.*

Ongoing challenges remain with accommodating elective patients due to beds across the two main sites, workforce and capacity to meet demand. Mitigations are identified short and long term to manage patient care.

PERFORMANCE REPORT – March 2018

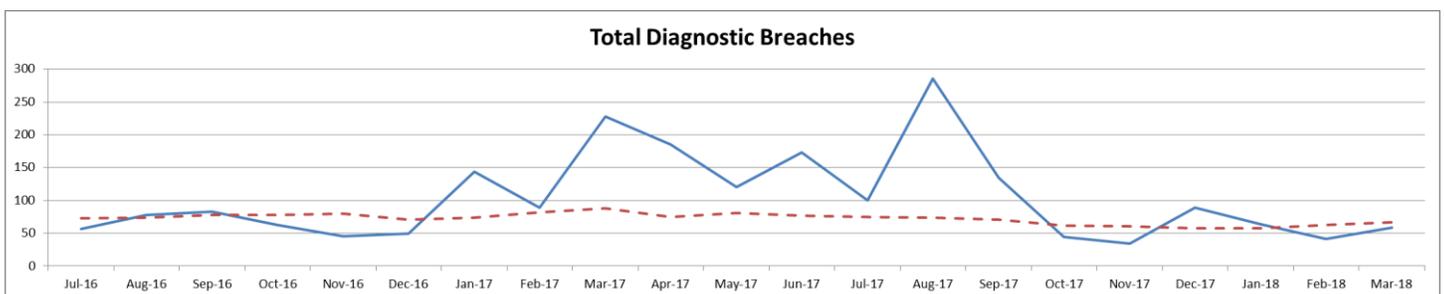
Specialty level RTT performance 92% in March can be found in the table below:

Specialty Group	Percentage
General Surgery	86.2%
Urology	91.9%
T&O	86.2%
ENT	89.0%
Ophthalmology	85.4%
Oral Surgery	93.7%
General Medicine	88.9%
Cardiology	88.9%
Dermatology	91.4%
Thoracic Medicine	94.5%
Rheumatology	75.8%
Geriatric Medicine	95.2%
Gynaecology	93.9%
Others	94.3%
Trust Total	89.1%

Diagnostics

The Trust has achieved the Diagnostic performance standard of 99% in March at 99.13%. In March there were 41 breaches overall compared with 64 breaches in February.

Audiology diagnostic performance improved further in March with 17 breaches compared with 23 breaches in February.



PERFORMANCE REPORT – March 2018

Stroke

Performance in January

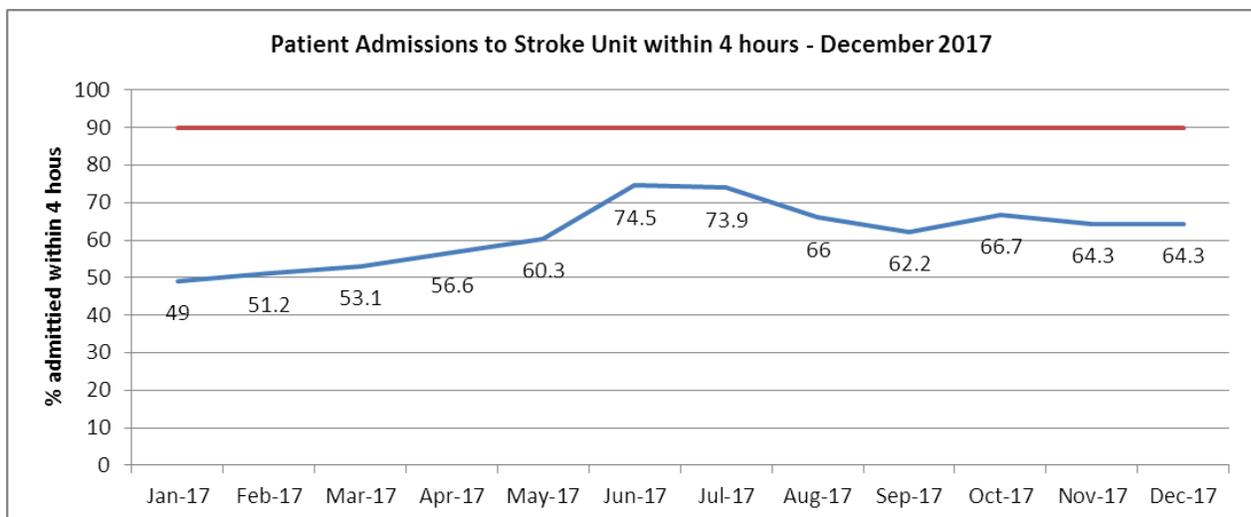
Performance against the scan within 1 hour standard continues to be maintained above 48% at an improved position of 63 % compared with December.

The 4 Hour Direct Admissions standard is still not being achieved by the Trust and January saw a slightly worse position compared with the previous months at 56.4%.

Validation of the breaches by the Stroke Nurse Practitioner team indicates that the majority of breaches were related to specific pathway issues. Increased bed pressures during the March did not adversely impact on admission to the stroke unit.

Direct admissions within 4hrs, target 90%

Direct Admission within 4 Hours	CCG			Total	Category	Sub Category	Total
	Bassetlaw	Doncaster	Other		Organisational	Beds	3
Yes	7	20	4	31		Pathway	16
No	5	19	0	24		Staff Availability	2
Grand Total	12	39	4	55	Clinical	Patient Presentation	2
Performance	58.3%	51.3%	100.0%	56.4%		Patient Needs	1
					Patient Choice	Declined	
					Awaiting further validation		



PERFORMANCE REPORT – March 2018

Scan within 1hr, target 48%

	CCG				Category	Sub Category	Total
Scan 1 hr	Bassetlaw	Doncaster	Other	Total	Organisational	Scanner	2
Yes	7	23	4	34		Pathway	7
No	4	16	0	20		Staff Availability	
Grand Total	11	39	4	54	Clinical	Criteria	
Performance	63.6%	59.0%	100.0%	63.0%		Patient Needs	
Note: 1 patient did not need a scan, having had an MRI at clinic previous day						Patient Presentation	11
					Patient Choice	Declined	
					Awaiting further validation		

Cancelled Operations

In March, 1.54% of Trust operations were cancelled. This demonstrates reduced performance compared with the previous month with 76 patients cancelled out of a total of 4951. 59 patients were cancelled for theatre reasons and 17 for non theatre reasons.

The year-end position for cancelled operations is 1.13%.

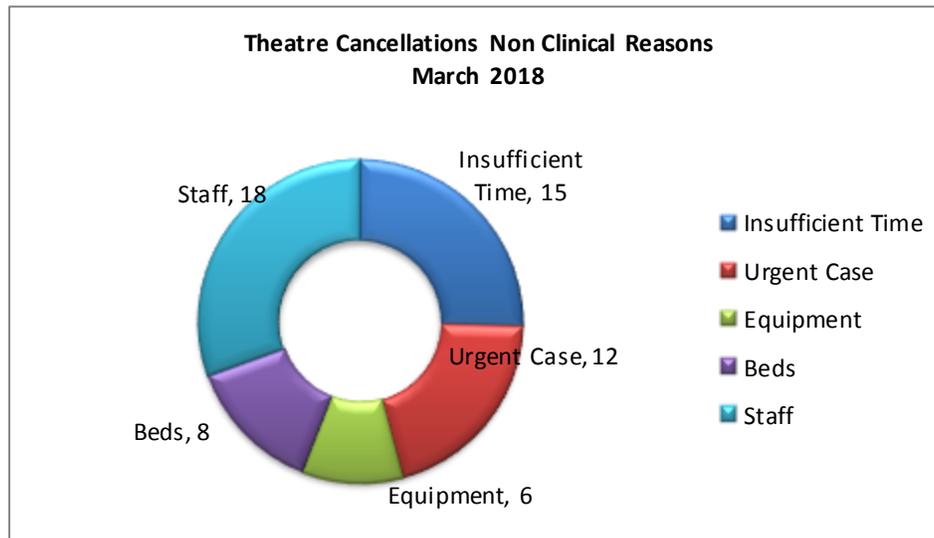
Indicator	Standard	Jan-18	Feb-18	Mar-18	YTD
Cancelled Operations (Total)	0.8%	0.87%	1.36%	1.54%	1.13%
Cancelled Operations (Theatre)		0.77%	1.25%	1.19%	0.91%
Cancelled Operations (Non Theatre)		0.10%	0.11%	0.34%	0.22%
Cancelled Operations-28 Day Standard	0	5	1	3	

Out of these overall cancellations, 30 patients were cancelled at Doncaster, 17 at Bassetlaw and 12 at Mexborough.

3 patients were cancelled on the day of admission and waited over the 28 day standard for their surgery to be rearranged.

PERFORMANCE REPORT – March 2018

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



DNA and CNA Rates

Indicator	Jan 18	Feb 18	March	
Outpatients: DNA Rate Total	9.85%	9.38%	10.33%	
Outpatients: Hospital cancellation Rate	5.2%	5.96%	5.96%	194

In March, the overall DNA rate across the Trust increased compared with the previous month's position at 10.33%.

It is recognised that the overall Trust DNA rate is higher in some specialties than the National picture.

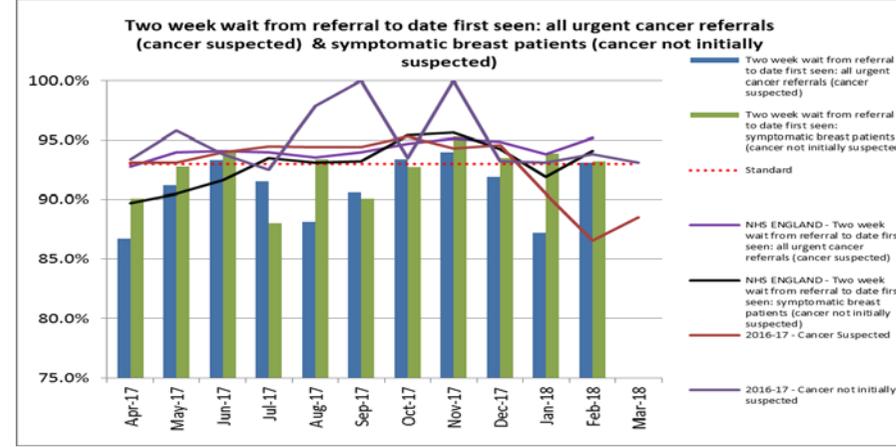
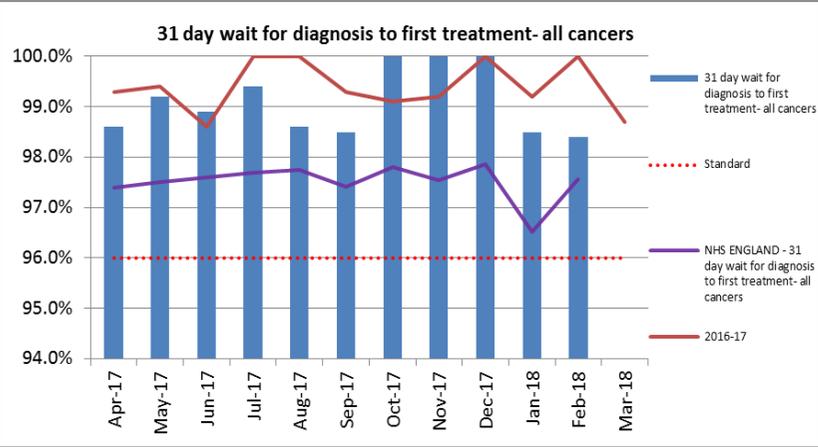
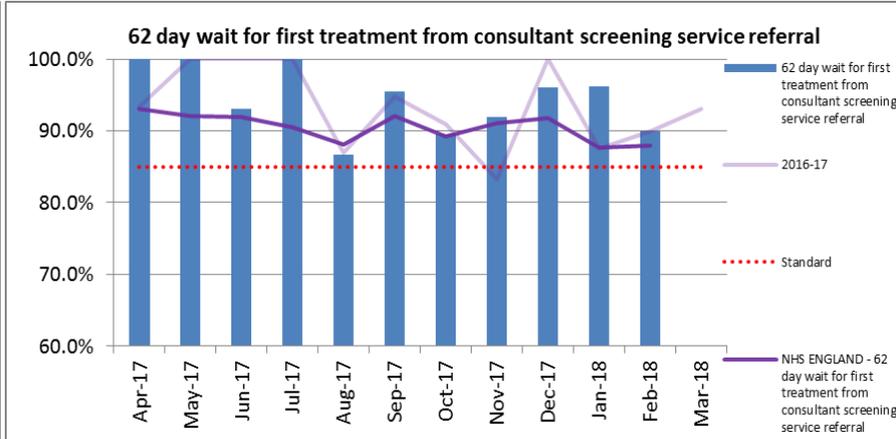
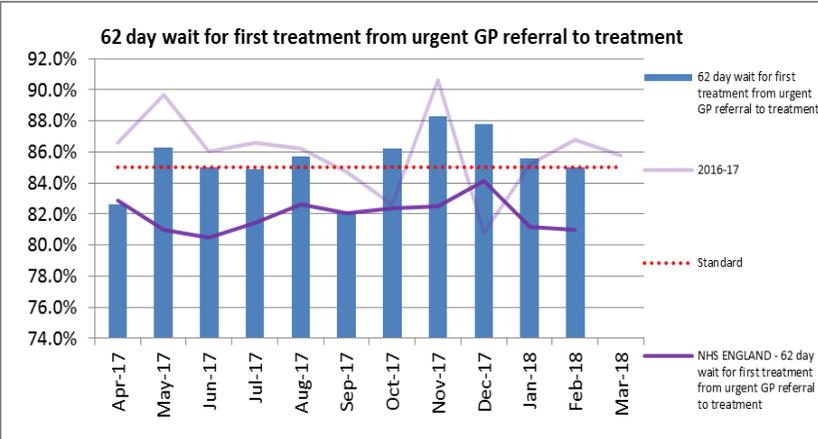
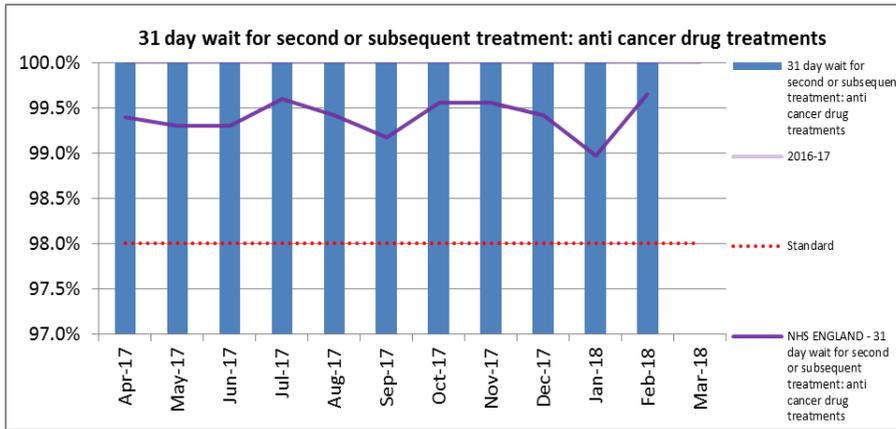
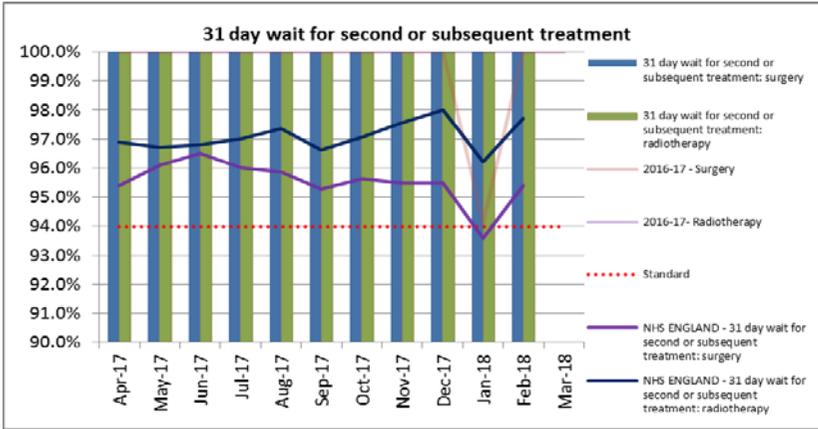
Work is ongoing to improve attendance within those specialties with the highest DNA rates.

At a Glance -March 2018 (Month 12)

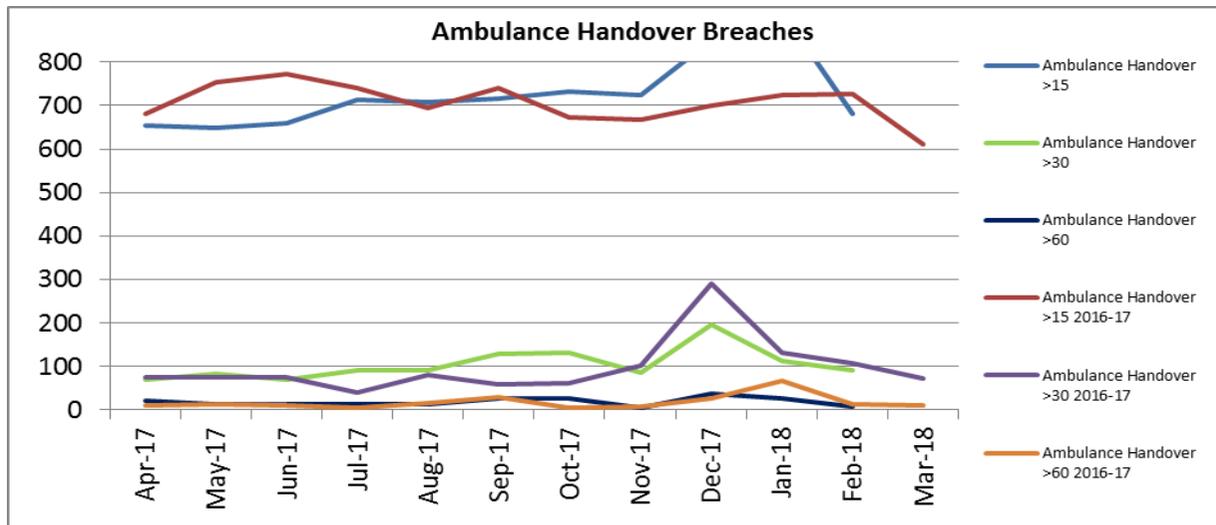
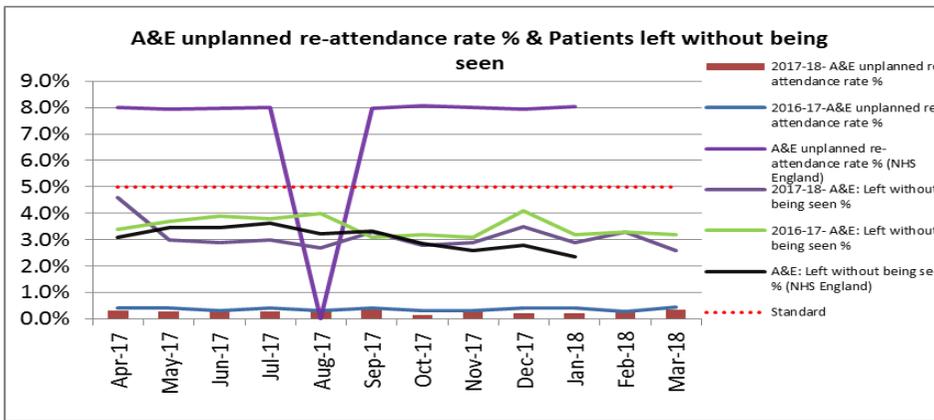
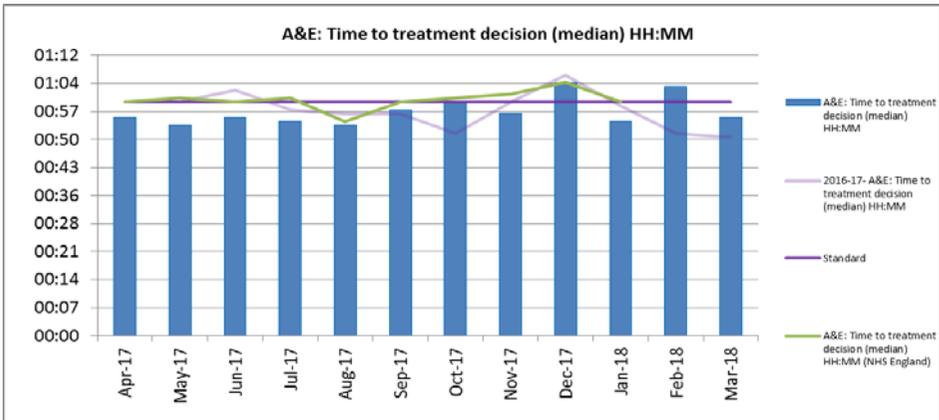
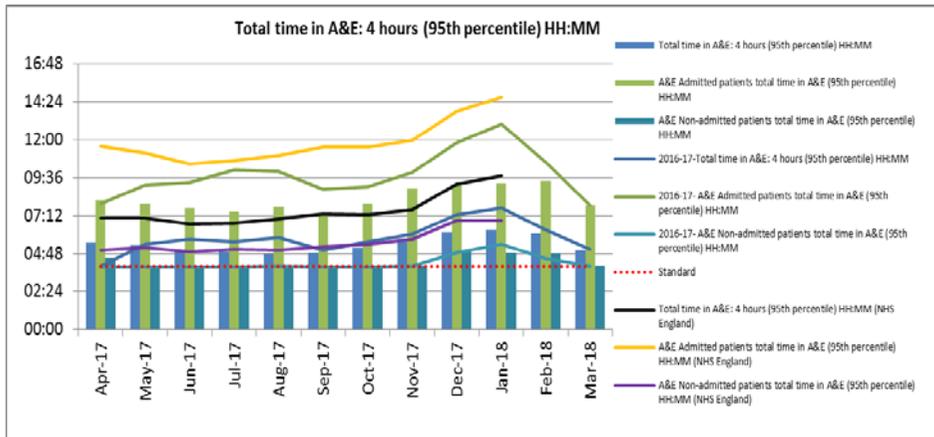
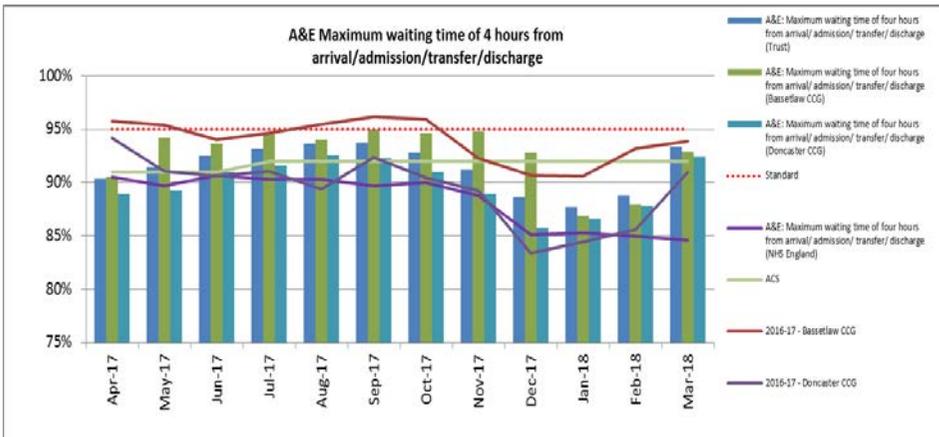
Doncaster & Bassetlaw Teaching Hospital NHS Foundation Trust					NHS England Benchmarking			Peer Group Benchmarking		
Indicator	Standard	Current Month	Month Actual	Direction of travel compared to previous Month	NHS England %	DBTHFT	Month	Peer Groups %	DBTHFT	Month
31 day wait for second or subsequent treatment: surgery	94.00%	February	100.00%	↔	93.60%	100.00%	February	93.70%	100.00%	February
31 day wait for second or subsequent treatment: anti cancer drug treatments	98.00%		100.00%		99.00%	100.00%		99.70%	100.00%	
31 day wait for second or subsequent treatment: radiotherapy	94.00%		100.00%		96.20%	100.00%		Not Available	100.00%	
62 day wait for first treatment from urgent GP referral to treatment	85.00%		85.00%	81.20%	85.00%	80.10%		85.00%		
62 day wait for first treatment from consultant screening service referral	90.00%		90.00%	87.70%	90.00%	89.40%		90.00%		
31 day wait for diagnosis to first treatment- all cancers	96.00%		98.40%	96.50%	98.40%	97.40%		98.40%		
Two week wait from referral to date first seen: all urgent cancer referrals (cancer suspected)	93.00%		93.10%	93.80%	93.10%	89.70%		93.10%		
Two week wait from referral to date first seen: symptomatic breast patients (cancer not initially suspected)	93.00%		93.20%	91.90%	93.20%	93.80%		93.20%		
A&E: Maximum waiting time of four hours from arrival / admission / transfer / discharge (Trust)	95.00%		March	93.30%	↗	84.60%		93.30%	March	
Maximum time of 18 weeks from point of referral to treatment-incomplete pathway	92.00%	March	89.10%	↘	87.90%	90.00%	February	82.85%	90.00%	February
% of Patients waiting less than 6 weeks from referral for a diagnostics test	99.00%	March	99.13%	↘	98.40%	99.35%	February	96.72%	99.35%	February
Ambulance Handover Times					No Benchmarking available					
Ambulance Handovers Breaches -Number waited over 15 & Under 30 Minutes		February	682	↘						
Ambulance Handovers Breaches-Number waited over 30 & under 60 Minutes			90	↘						
Ambulance Handovers Breaches -Number waited over 60 Minutes			8	↘						
Stroke					Still looking @ data sources for obtaining this information					
Proportion of patients scanned within 1 hour of clock start (Trust)	48.00%	January	63.00%	↘						
Proportion of patients directly admitted to a stroke unit within 4 hours of clock start (Trust)	90.00%		56.40%	↘						
Percentage of eligible patients (according to the RCP guideline minimum threshold) given thrombolysis (Trust)	20.00%		7.30%	↘						
Percentage of patients treated by a stroke skilled Early Supported Discharge team (Trust)	40.00%		63.60%	↘						
Percentage of those patients who are discharged alive who are given a named person to contact after discharge (Trust)	95.00%		84.10%	↘						
Implementation of Stroke Strategy - TIA Patients Assessed and Treated within 24 Hours	60.00%	March	64.10%	↗						
Theatres & Outpatients					No Benchmarking available					
Cancelled Operations	0.80%	March	1.54%	↘						
Cancelled Operations-28 Day Standard	0		3	↘						
Out Patients: DNA Rate			10.33%	↘						
Out Patients: Hospital Cancellation Rate			5.96%	↘						
Effective					Still looking @ data sources for obtaining this information					
Emergency Readmissions within 30 days (PbR Methodology)		January	6.50%	↗						

Indicator	Current Month	Month Actual (TRUST)	Month Actual (DRI)	Month Actual (BDGH)	Data Quality RAG Rating
% of patients achieving Best Practice Tariff Criteria	Mar-18	62.9%	62.7%	63.3%	
Best Practice Criteria					
36 hours to surgery Performance	Mar-18	63.6%	60.4%	72.1%	
72 hours to geriatrician assessment Performance		92.1%	93.4%	88.4%	
% of patients who underwent a falls assessment		99.0%	99.0%	99.0%	
% of patients receiving a bone protection medication assessment		100.0%	100.0%	99.0%	
Mortality-Deaths within 30 days of procedure		4.09%	3.00%	6.30%	
Safe					
Indicator	Standard (Local, National Or Monitor)	Current Month	Month Actual	Data Quality RAG Rating	
Infection Control C.Diff	4 Per Month - 45 full year M	Mar-18	1		
Infection Control MRSA	0 L		0		
HSMR (rolling 12 Months)	100 N	Jan-18	Unavailable		
Never Events	0 L	Mar-18	0		
VTE	95.0% N	Feb-18	95.0%		
Pressure Ulcers	12 Per Month 144 full Year L		3		
Falls that result in a serious Fracture	2 Per Month 23 full Year L		0		
Catheter UTI	Snap shot audit	Mar-18	0.42%		
Complaints & Claims					
Indicator	Current Month	Month Actual	Data Quality RAG Rating		
Complaints received (12 Month Rolling)		429			
Concerns Received (12 Month Rolling)	Mar-18	601			
Complaints Performance		67.0%			
Clinical Negligence Scheme for Trusts (CNST)		9			
Liabilities to Third Parties Scheme (LTPS)		2			
Claims per 1000 occupied bed days		0.37			
Workforce					
Indicator	Current Month	YTD (Cumulative)	Data Quality RAG Rating		
Appraisals	Mar-18	68.15%			
SET Training		78.68%			

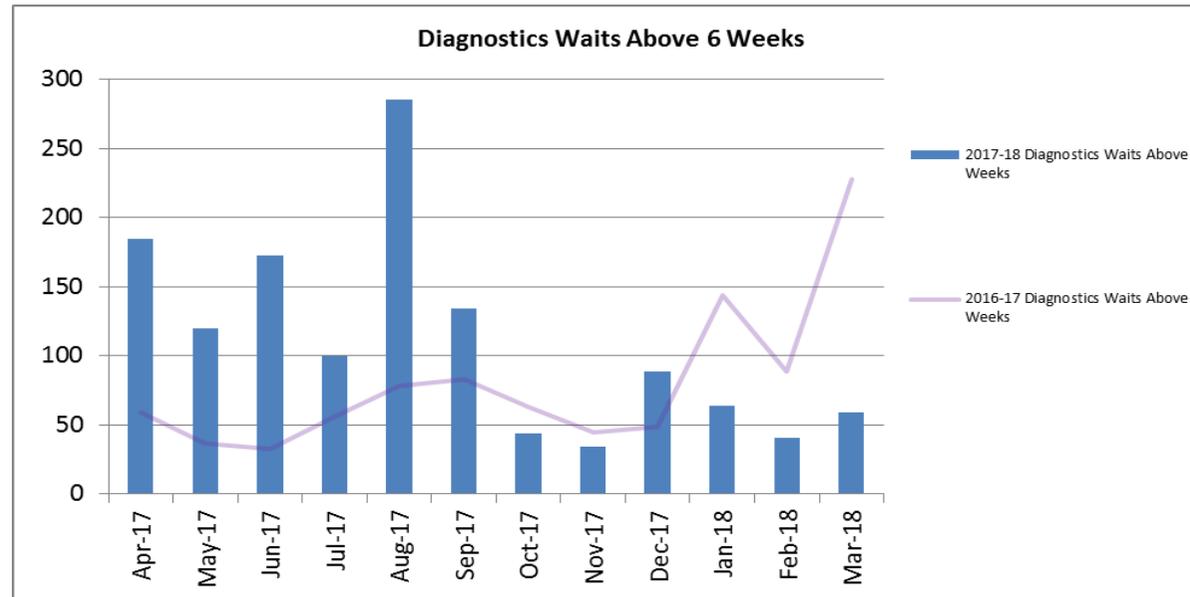
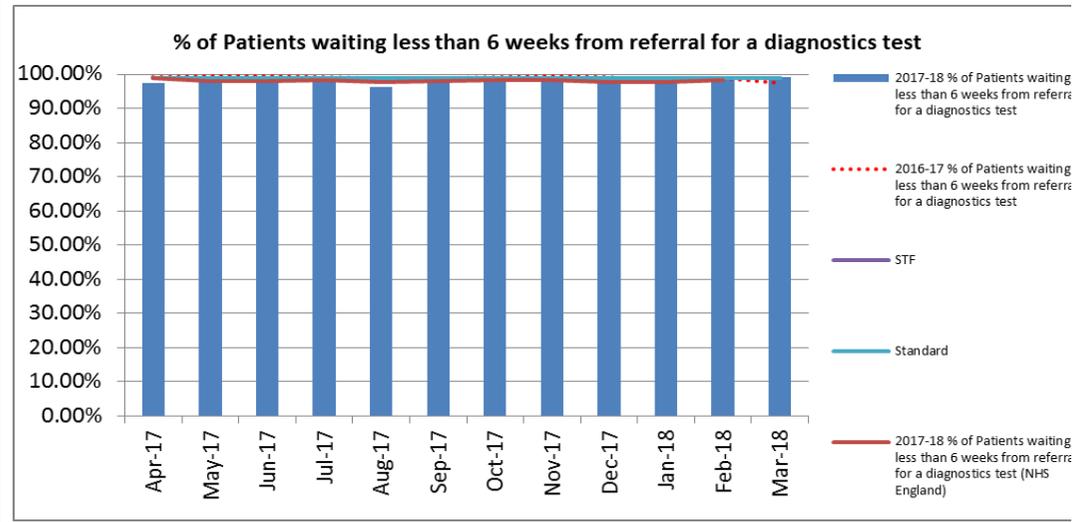
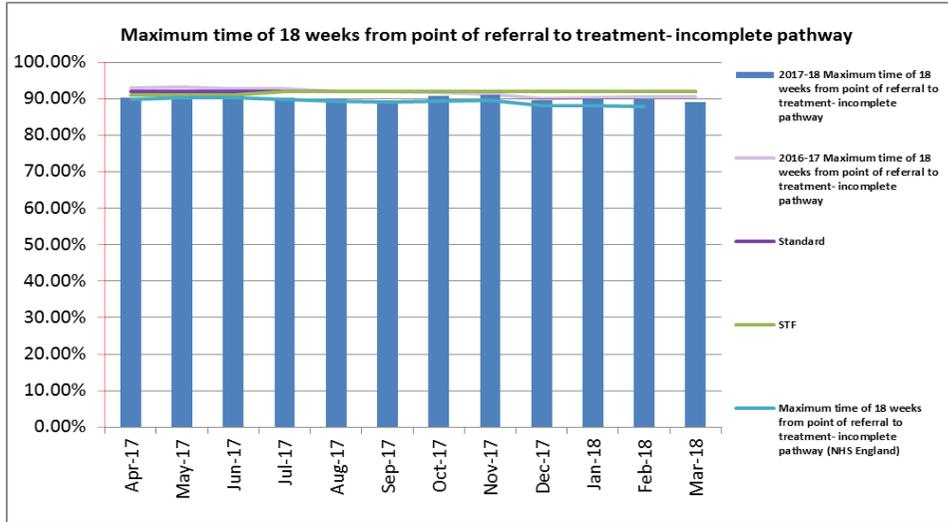
Monitor Compliance Framework: Cancer - Graphs - February 2018 (Month 11)



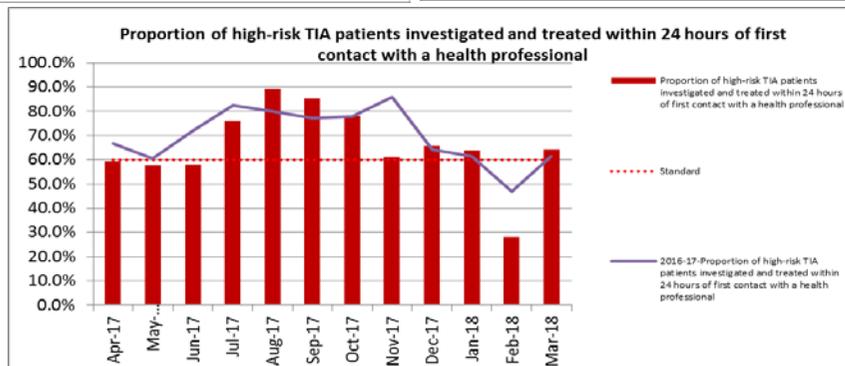
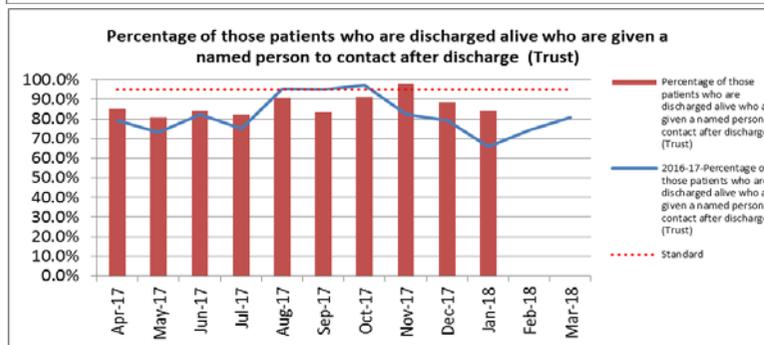
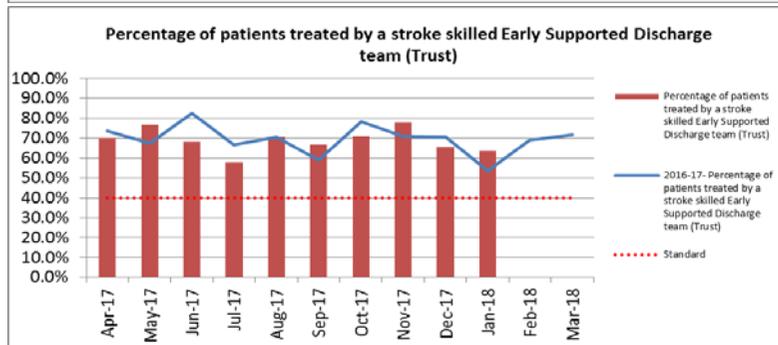
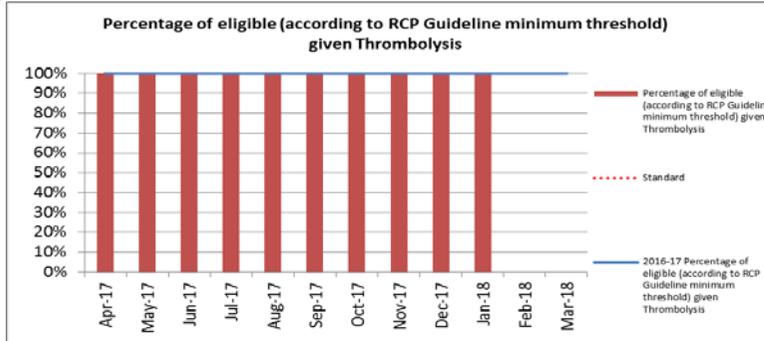
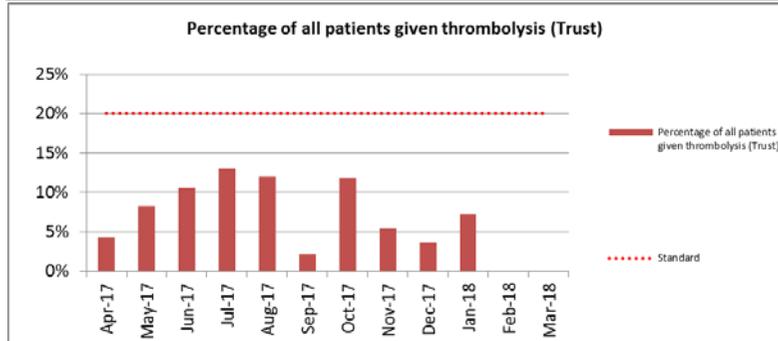
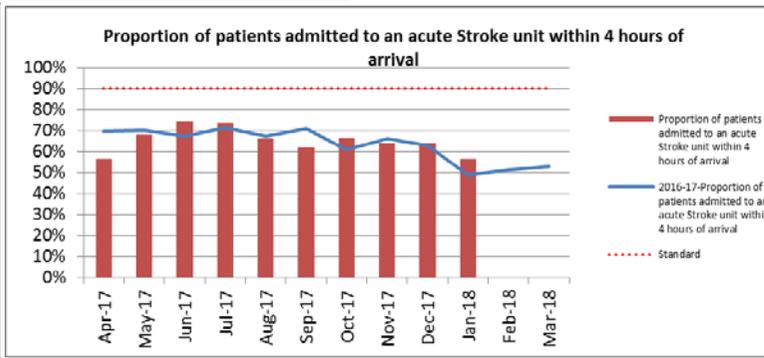
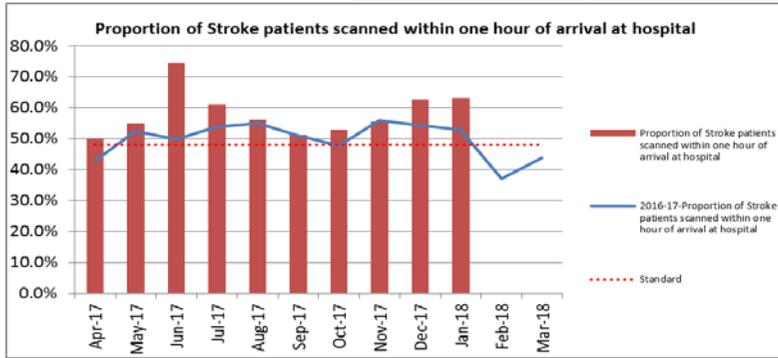
Monitor Compliance Framework: A&E - Graphs - March (Month 12)



Monitor Compliance Framework: 18 Weeks & Diagnostics - March (Month 12)



Stroke - Graphs January 2017 (Month 10)





Executive Summary - Safety & Quality - March 2018 (Month 12)

HSMR: Despite a raised crude mortality, HSMR for the month of January was 85.1 giving us a rolling 12 month HSMR of 89, which remains better than expected

Fractured Neck of Femur: On Fractured Neck of Femur, achievement of best practice tariff remains at about 60% whilst risk adjusted mortality continues to improve on both sites.

Serious Incidents: We have reported 10 Serious Incidents in month which is more than usual. 5 of these were HAPU and are being scoped. The other 5 are being investigated but do not appear to share any common themes.

Executive Lead:

Mr S Singh

C-Diff We have met the national target of having no more than 40 cases of C Diff in 17/18; however we missed the internal target of reducing the number of cases of C Diff for 17/18, ending the year with 2 more cases than the previous year

Fall resulting in significant harm: There were no cases of falls resulting in significant harm during March. Performance for 17/18 is the same as the previous year.

Hospital Acquired Pressure Ulcers: Three hospital acquired pressure ulcers have been declared in March, lower than at the same time last year. Currently there has been a 11.5% reduction in Category 3,4 and ungradeable hospital acquired pressure ulcers in 17/18

Complaints and concerns: There has been a reduction in the complaints response timeframe during March. This has in part been due to some resource issues. Weekly complaints tracking meetings with Heads of Nursing and with the Director of Nursing, Midwifery & AHPs continue.

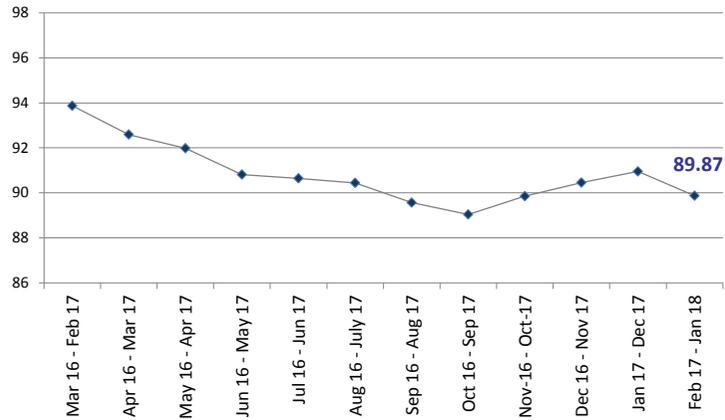
Friends & Family Test: Response rate and positivity of responses are higher than the national average with the exception of response rates for ED.

Executive Lead:

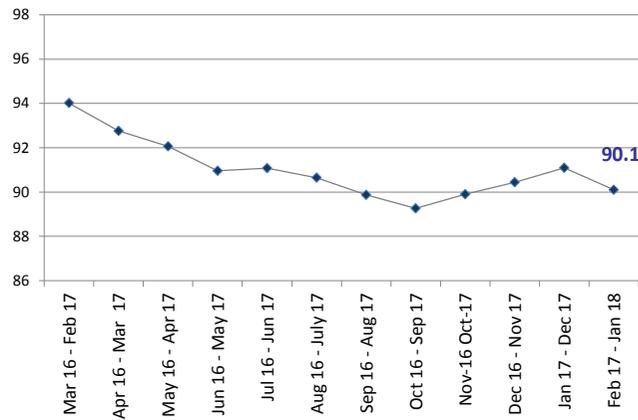
Mrs M Hardy

Hospital Standardised Mortality Ratio (HSMR) - January 2018 (Month 10)

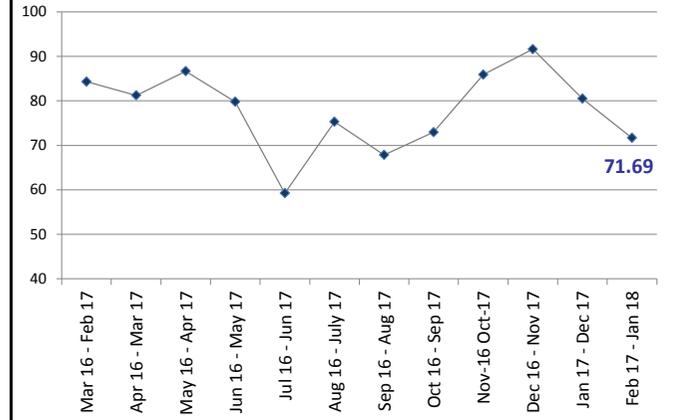
Overall HSMR (Rolling 12 months)



HSMR - Non-elective Admission (Rolling 12 months)



HSMR - Elective Admission (Rolling 12 months)

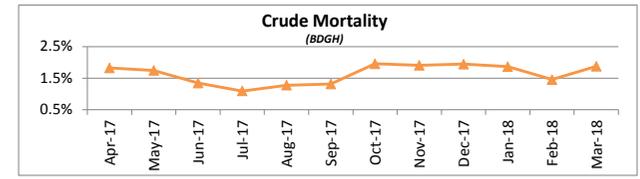
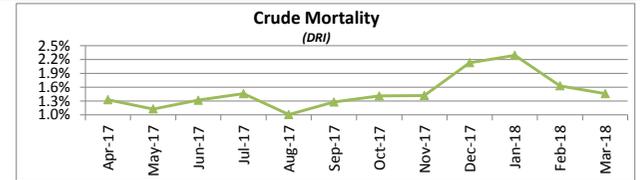
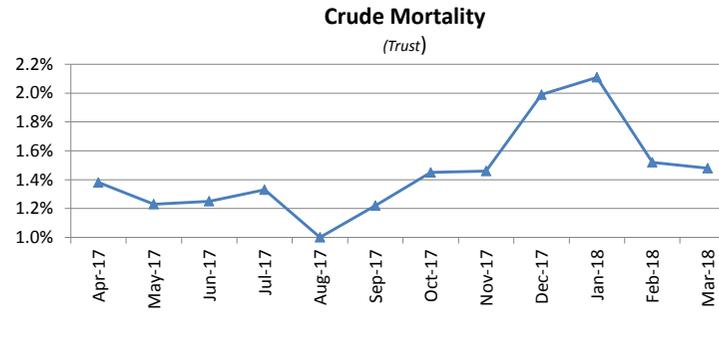


HSMR Trend (monthly)

	2015	2016	2017	2018
January	116.80	99.21	94.86	85.09
February	99.94	97.73	105.44	
March	90.54	97.37	82.66	
April	105.91	88.50	83.32	
May	101.15	96.60	83.14	
June	80.27	93.67	91.44	
July	92.56	97.73	95.57	
August	100.27	87.52	74.96	
September	90.26	95.34	88.34	
October	90.29	88.66	99.07	
November	88.98	82.30	89.13	
December	82.30	93.52	98.89	

Crude Mortality (monthly) - March 2018 (Month 12)

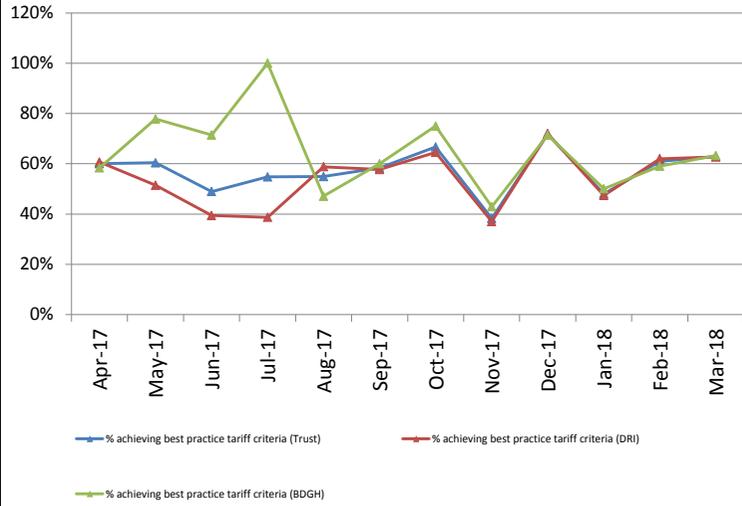
(number of deaths/number of patient discharged)



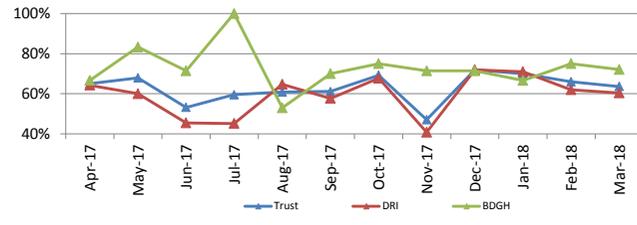
	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
Trust	1.38%	1.22%	1.25%	1.33%	1.01%	1.22%	1.45%	1.46%	1.99%	2.11%	1.52%	1.48%
Doncaster	1.33%	1.13%	1.32%	1.46%	1.01%	1.28%	1.41%	1.42%	2.13%	2.29%	1.63%	1.46%
Bassetlaw	1.82%	1.74%	1.34%	1.09%	1.27%	1.31%	1.95%	1.90%	1.94%	1.86%	1.45%	1.87%

NHFD Best Practice Pathway Performance - March 2018 (Month 12)

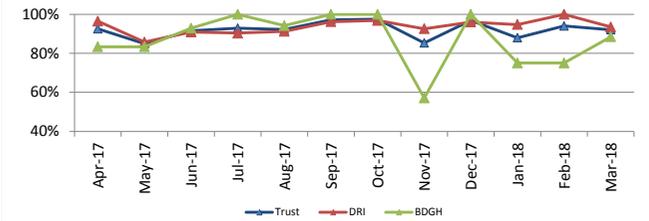
Best Practice Criteria Performance



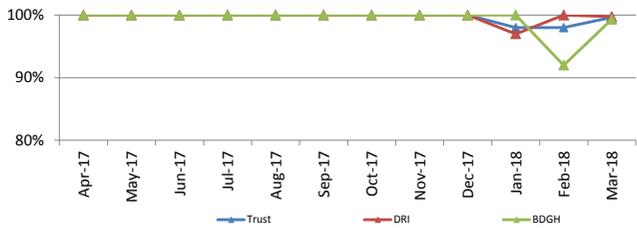
36 Hours to Surgery Performance



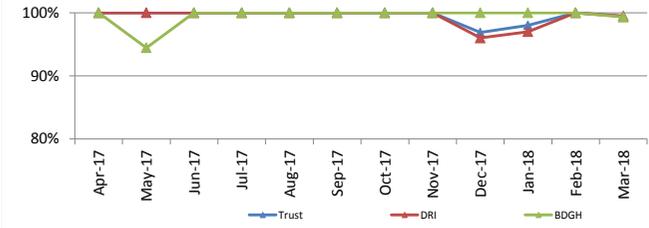
72 hours to Geriatrician Assessment Performance



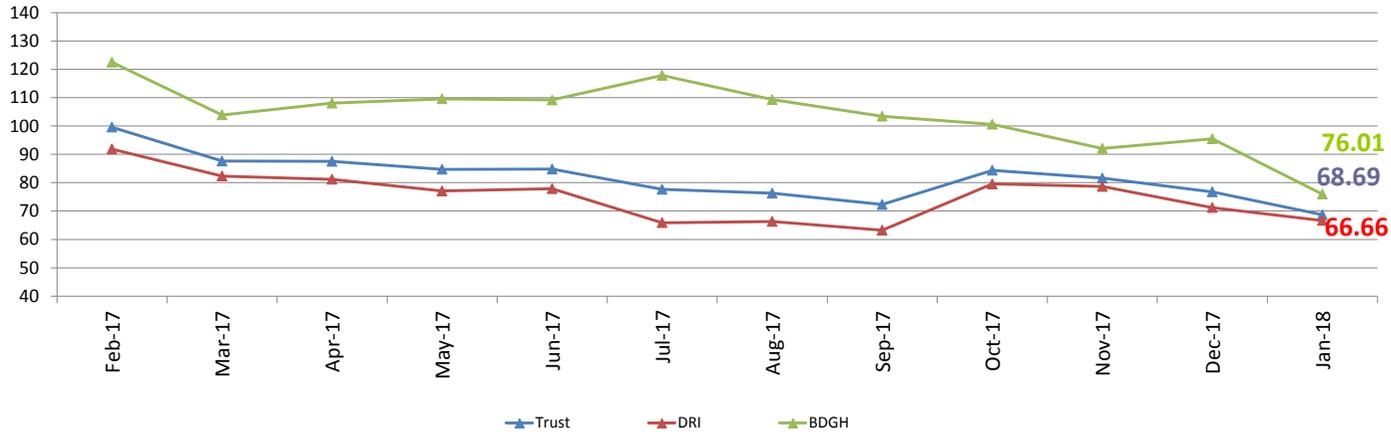
Bone Protection Medication Assessment



Falls Assessment Performance



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



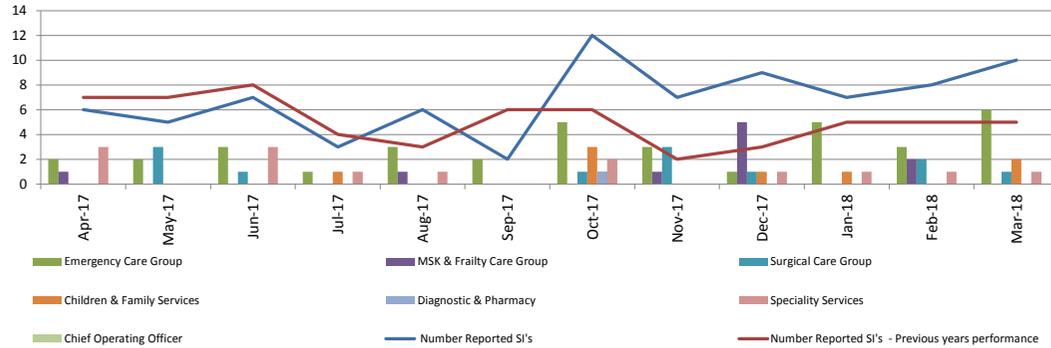
Serious Incidents - March 2018 (Month 12)

(Data accurate as at 16/04/2018)

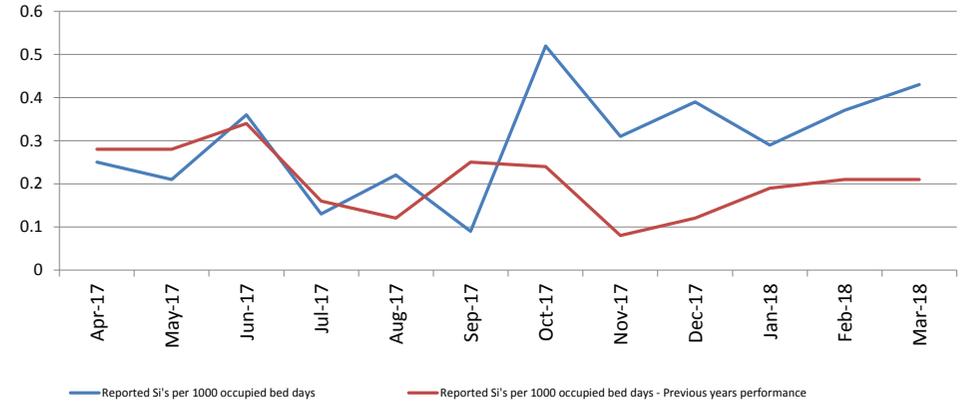
Please note: At the time of producing this report the number of serious incidents reported are prior to the RCA process being completed.

Overall Serious Incidents

Number Serious Incidents Reported (Trust & Care Group)



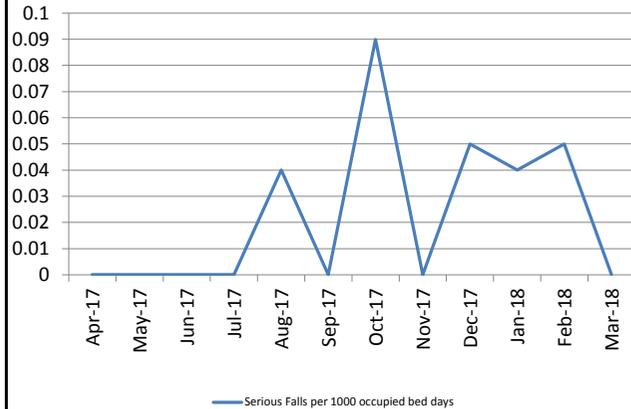
Serious Incidents per 1000 occupied bed days



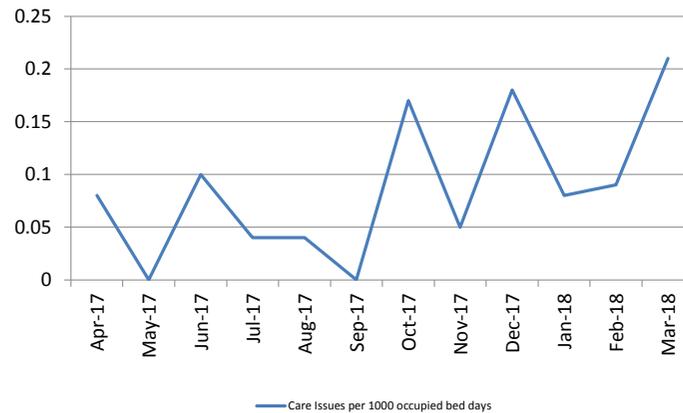
Current YTD reported SI's (Apr 17-Mar 18)	82	Number reported SI's (Apr 16-Mar 17)	63
Current YTD delogged SI's (Apr 17-Mar 18)	29	Number delogged SI's (Apr 16-Mar 17)	14

Themes

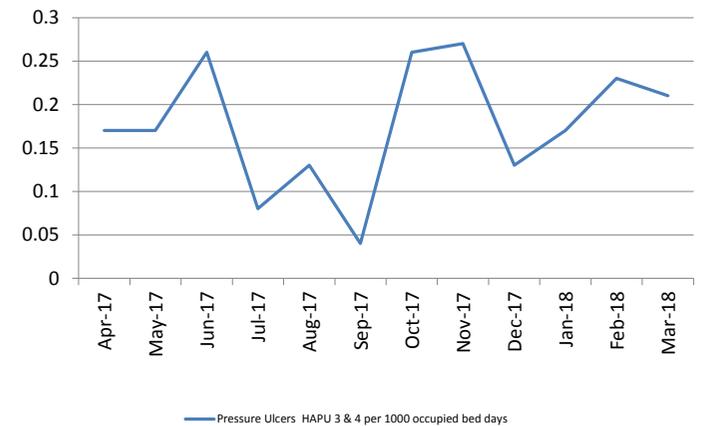
Serious Falls



Care Issues



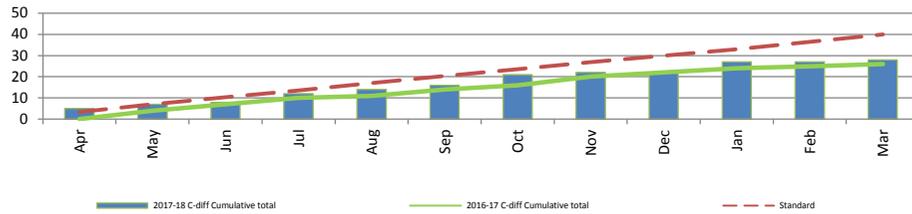
Pressure Ulcers - Category 3 & 4 (HAPU)



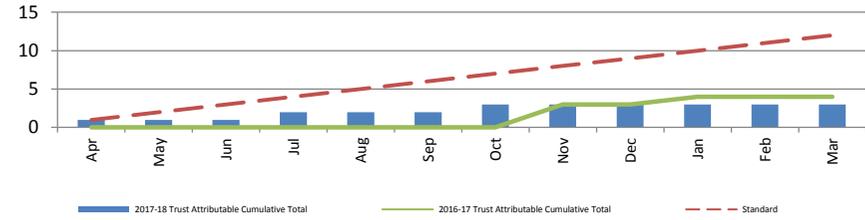
Monitor Compliance Framework: Infection Control C.Diff - March 2018 (Month 12)
(Data accurate as at 16/04/2018)

	Standard	Q1	Q2	Q3	Jan	Feb	Mar	Q4	YTD
2017-18 Infection Control - C-diff	40 Full Year	8	8	6	5	0	1	6	28
2016-17 Infection Control - C-diff	40 Full Year	7	7	8	2	1	1	4	26
2017-18 Trust Attributable	12	1	1	1	0	0	0	0	3
2016-17 Trust Attributable	12	0	0	3	1	0	0	1	4

C-diff 2017-18



Trust Attributable C-diff 2017-18



Pressure Ulcers & Falls that result in a serious fracture - March 2018 (Month 12)
(Data accurate as at 16/04/2018)

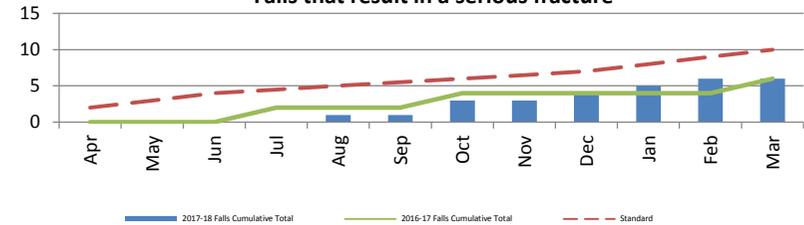
	Standard	Q1	Q2	Q3	Jan	Feb	Mar	Q4	YTD
2017-18 Serious Falls	10 Full Year	0	1	3	1	1	0	2	6
2016-17 Serious Falls	19 Full Year	0	2	2	0	0	2	2	6

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

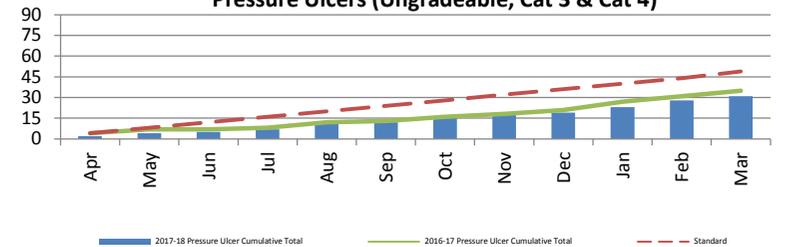
	Standard	Q1	Q2	Q3	Jan	Feb	Mar	Q4	YTD
2017-18 Pressure Ulcers	34 Full Year	5	7	7	4	5	3	12	31
2016-17 Pressure Ulcers	60 Full Year	7	6	8	6	4	4	14	35

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

Falls that result in a serious fracture



Pressure Ulcers (Ungradeable, Cat 3 & Cat 4)



Hard Truths - March 2018 (Month 12)

(Data accurate as at 18/04/2018)

Care Group	Matron	Ward	No of Funded Beds	Planned v Actual		Safe	Effective	Caring	Responsive	Well Led	Profile	
				CHPPD	Variance	Total score	Total score	Total score	Total score	QM total score	Work-force	Quality
Surgical	NS	B6	16	8.6	110%	2.5	0.0	2.0	2.0	6.5		
	NS	20	27	5.0	98%	2.5	1.0	1.0	0.5	5.0		
	NS	21	27	5.0	102%	0.5	1.0	0.0	0.5	2.0		
	LM	S12	20	5.1	100%	2.5	0.0	1.0	2.5	6.0		
	RF	SAW	21	7.1	96%	2.0	2.0	1.0	2.0	7.0		
	LC	ITU DRI	20	23.6	96%	2.5	1.0	0.0	1.5	5.0		
	LC	ITU BDGH	6	25.3	94%	2.5	0.0	0.0	2.0	4.5		
					99%							
MSK and Frailty	SS	A4	24	5.8	100%	0.5	0.5	0.0	0.5	1.5		
	SS	B5	30.7	6.5	99%	0.0	1.0	0.0	1.5	2.5		
	AH	St Leger	35	6.3	98%	2.0	2.5	2.0	1.0	7.5		
	AH	1&3	23	7.9	99%	1.0	0.0	0.0	1.0	2.0		
	SS	Mallard	16	8.9	108%	1.5	0.5	2.0	0.0	4.0		
	SS	Gresley	32	5.8	100%	1.0	1.5	0.0	1.0	3.5		
	SS	Stirling	16	8.0	105%	1.0	1.5	1.0	1.5	5.0		
	KM	Rehab 2	19	6.2	114%	0.0	0.0	0.0	1.0	1.0		
	KM	Rehab 1	29	4.1	101%	1.0	0.0	0.0	2.0	3.0		
					102%							
Specialty Service	JP	18	12	7.5	104%	3.5	0.5	0.0	2.0	6.0		
	JP	18 CCU	12	7.2	97%	0.0	0.0	0.0	2.0	2.0		
	AW	32	18	6.7	100%	3.0	1.0	2.0	1.5	7.5		
	AW	16	24	8.1	112%	3.0	1.5	1.0	0.5	6.0		
	RM	17	24	5.9	98%	2.0	1.0	1.0	1.0	5.0		
	JP	CCU/C2	18	6.7	105%	3.0	0.0	0.0	2.0	5.0		
	RM	S10	20	5.2	96%	1.5	0.0	1.0	1.5	4.0		
	RM	S11	19	5.8	99%	0.0	0.0	0.5	1.0	1.5		
					102%							
Emergency	MH	ATC	21	8.3	96%	2.0	0.5	0.5	2.5	5.5		
	SS	AMU	40	7.8	101%	2.5	1.5	1.0	1.5	6.5		
	MH	C1	16	6.1	99%	1.5	1.0	0.0	1.5	4.0		
	SC	24	24	6.4	105%	2.0	1.5	1.5	1.5	6.5		
	SC	25	16	7.2	100%	3.0	1.0	1.0	1.0	6.0		
	SC	Respiratory unit	56	5.9	97%	5.5	1.5	4.0	1.5	12.5		
					100%							
Children and Families	AB	SCBU	8	18.1	100%	0.0	0.0	0.0	0.0	0.0		
	AB	NNU	18	8.9	99%	0.5	0.0	0.0	1.0	1.5		
	AB	CHW	18	7.7	99%	1.0	0.0	0.0	0.0	1.0		
	AB	COU/CSU	21	9.0	97%	1.5	0.0	1.0	0.5	3.0		
	SS	G5	24	6.9	91%	2.0	1.0	2.5	1.5	7.0		
	SS	M1	26	7.8	82%	2.0	1.5	1.5	1.0	6.0		
	SS	M2	18	8.6	75%	1.0	1.0	2.0	1.0	5.0		
	SS	CDS	14	26.4	87%	0.5	0.0	1.0	0.5	2.0		
	SS	A2	18	10.2	93%	0.0	1.0	1.0	1.0	3.0		
	SS	A2L	6	26.5	97%	1.0	0.0	0.0	1.0	2.0		
					92%							

The workforce data submitted to UNIFY provides the actual hours worked in March 2018 by registered nurses/midwives and health care support workers compared to the planned hours. The Trusts overall planned versus actual hours worked was 99% in March 2018, similar to recent months.

The data for March 2018 demonstrates that the actual available hours compared to planned hours were:

- Within 5% 28 wards (70%) 2 less than February
- Between 5-10% 7 wards (17.5%) The same as February
- Surpluses over 10% 2 wards (5%) 2 more than February
- Deficits over 10% 3 wards (7.5%) The same as February

The wards where there were deficits in excess of 10% of the planned hours in March 2018, are Wards M1, M2 and Central Delivery Suite (CDS). When there have been lower levels of bed occupancy these areas have supported CDS and Labour Ward (Bassetlaw) with providing safe staffing levels. There has also been an issue in Maternity services with the management of annual leave over the year, while having more vacancies. This has been identified through the weekly e-roster support and challenge meetings, which has impacted on March rosters, but is projected to be improved on the rosters in coming weeks. Safe staffing has been achieved with no internal maternity diverts during March 2018

Quality and Safety Profile

The Quality Metrics data has highlighted that the Respiratory Unit have triggered Red for quality in March 2018. A quality summit is being planned.

Care Hours Per Patient Day (CHPPD) - March 2018 (Month 12)

(Data accurate as at 18/04/2018)

Utilising actual versus planned staffing data submitted to UNIFY and applying the CHPPD calculation the care hours for March 2018 are shown below

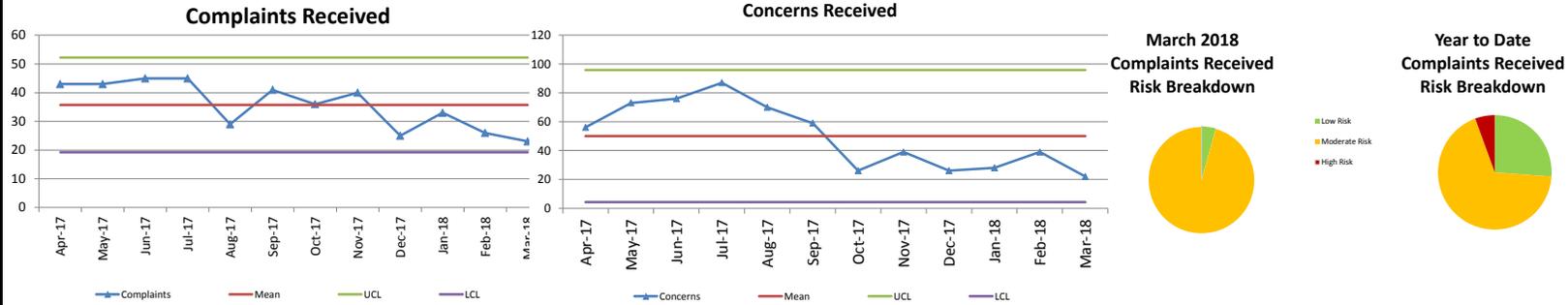
Site Name	Registered midwives/ nurses	Care Staff	Overall
BASSETLAW HOSPITAL	4.7	3.5	8.2
DONCASTER ROYAL INFIRMARY	4.2	3.2	7.4
MONTAGU HOSPITAL	2.3	2.6	4.9
TRUST	4.2	3.2	7.4

The rates are similar to last month. These rates benchmark as being similar to peers overall, but slightly lower for registered nurses and midwives, and slightly higher for care staff. There is a slight rise in the overall rate from 7.2 in January 2017 (corrected an anomaly in previously reported data) to 7.4 in March 2018.

Complaints & Claims - March 2018 (Month 12)

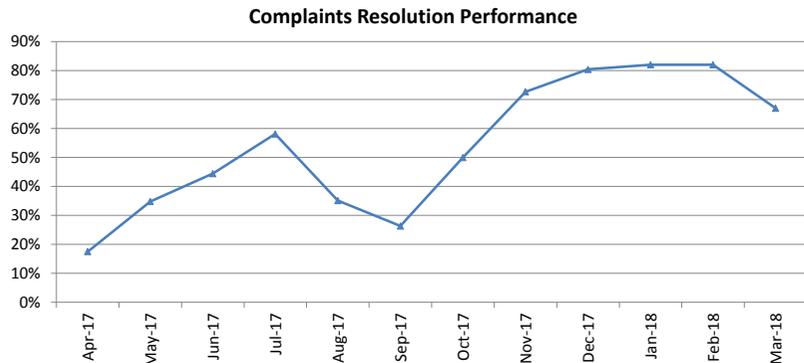
(Data accurate as at 16/04/2018)

Complaints



Complaints - Resolution Performance

(% achieved resolution within timescales)



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

Parliamentary Health Service Ombudsman (PHSO)

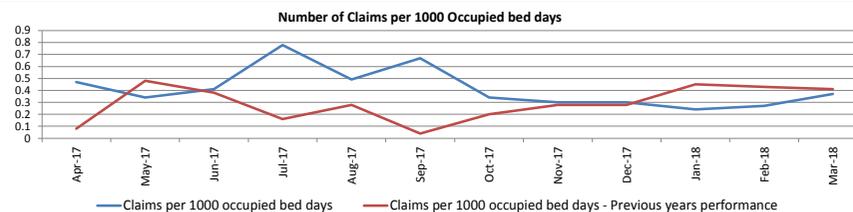
Month	Number of cases referred for investigation	Number Currently Outstanding
Mar-18	0	6

Year	Number referred for investigation YTD	Outcomes YTD	
		Outcome	Count
2016/17	8	Fully / Partially Upheld	2
		Not Upheld	4
		No further Investigation	0
		Case Withdrawn	0
2017/18	7	Fully / Partially Upheld	2
		Not Upheld	1
		No further Investigation	0
		Case Withdrawn	0

Claims

	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	YTD
Clinical Negligence Scheme for Trusts (CNST) Not including Disclosures	11	8	8	18	11	15	8	9	7	6	6	9	116
Liabilities to Third Parties Scheme (LTPS)	2	3	1	1	1	1	1	3	1	2	2	2	20

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

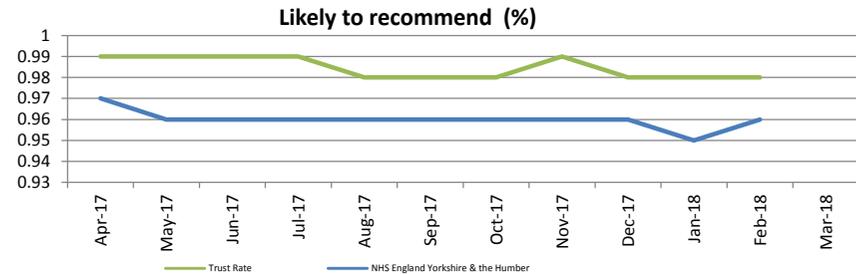
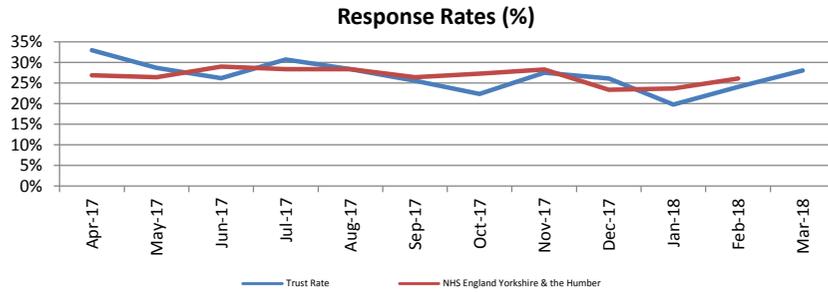


Friends & Family - March 2018 (Month 12)

(Data accurate as at 13/04/2018)

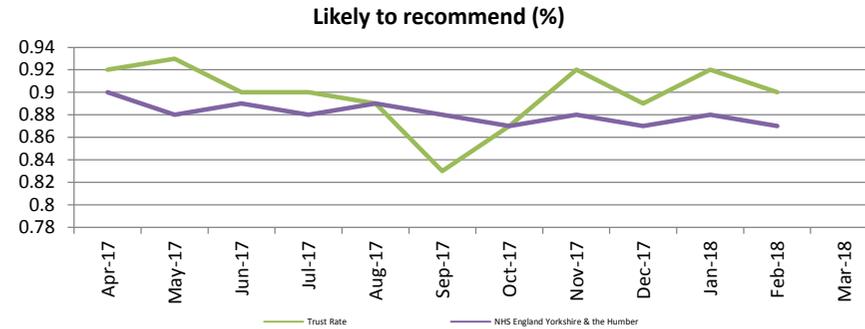
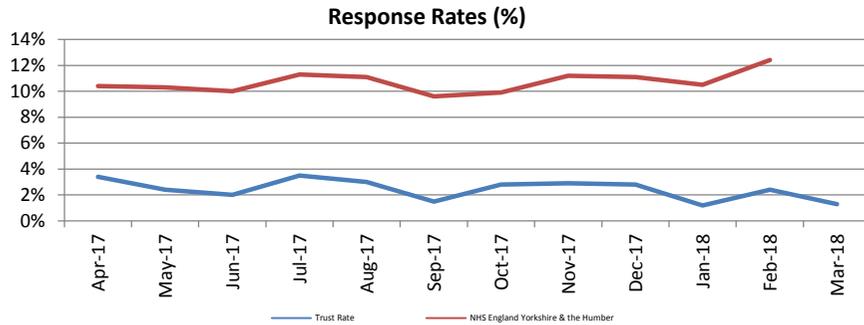
Inpatients

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



Accident & Emergency

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





Executive summary - Workforce - March 2018 (Month 12)

Sickness absence

Following the increases in sickness rates in December and January and the reduction in February, we have seen a further reduction in March - in month to 4.13% resulting in a year end figure of 4.51% which is similar to the rates in 2016/17. There has been a reduction in episodes of absence associated with absences in excess of 6 months and between 1 and 6 months. There have been a further reduction in short term absence rates with the long term rate remaining constant.

Appraisals

The Trusts appraisal completion rate has continued to see a further rise to 68.15% which is the fifth month of improvement since April 2017. The transition to a 3 month appraisal season has now commenced.

SET

We have seen a further rise in compliance with Statutory and Essential Training in February to 78.68% ; further analysis is taking place regarding the SET topics we require staff to undertake.

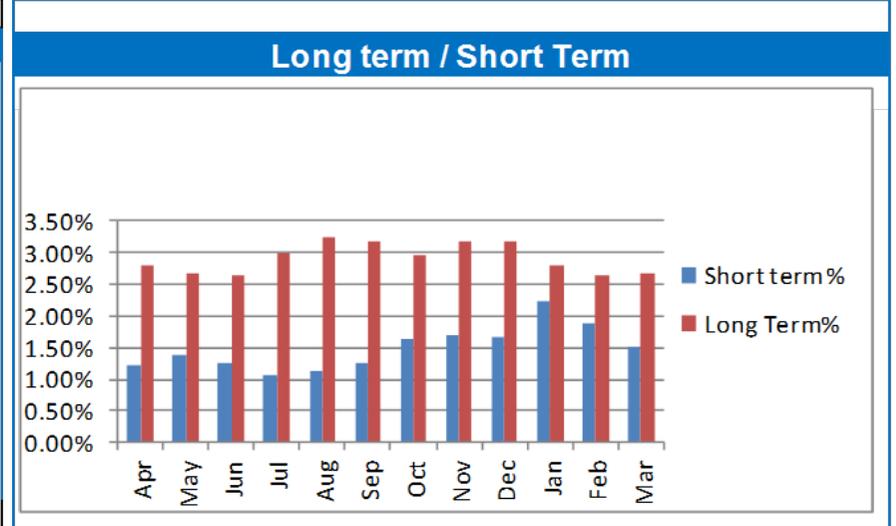
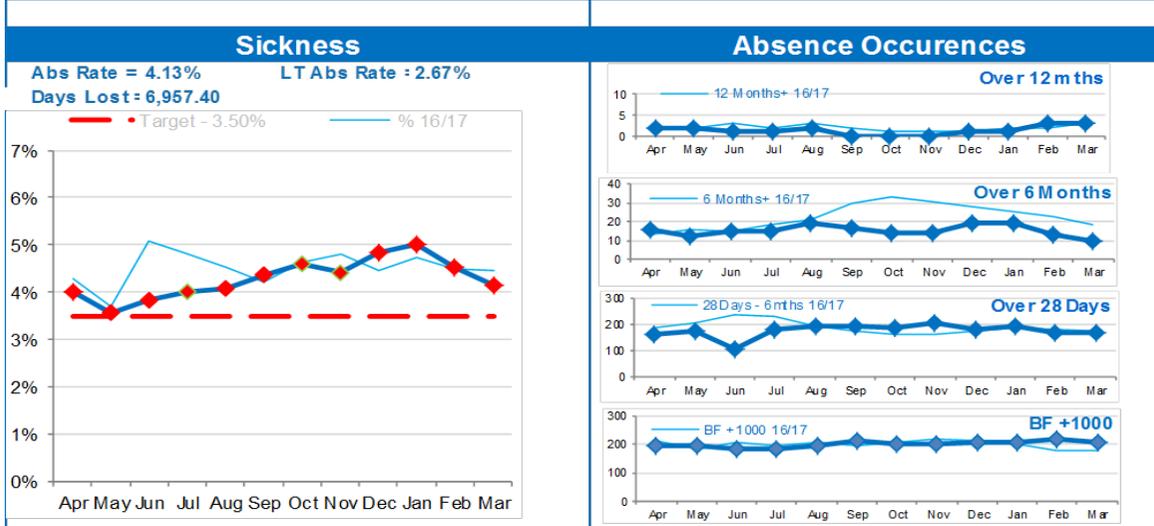
Staff in post

Please see attached tab covering staff in post by staff group. Vacancy rates are provided to both Finance & Performance and Quality & Effectiveness Committees.

Workforce: Sickness Absence - March (Month 12)

CG & Directorate Sickness Absence - Mar 2018 (Q4)

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

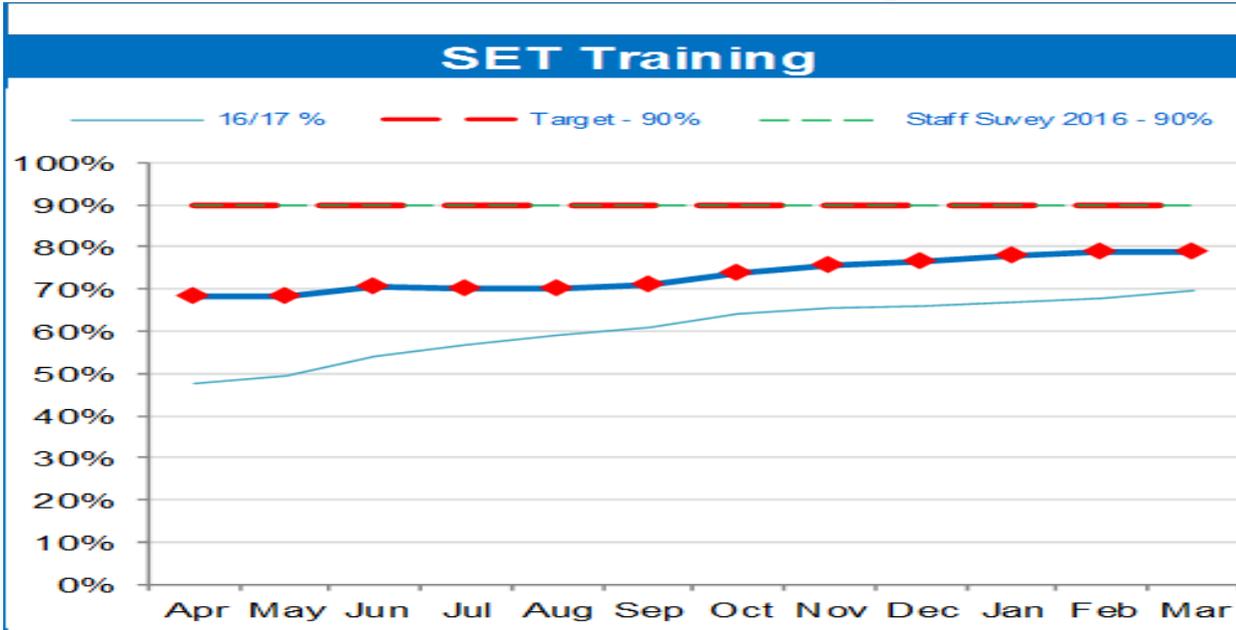


	Apr-17		May-17		Jun-17		Jul-17		Aug-17		Sep-17		Oct-17		Nov-17		Dec-17		Jan-18		Feb-18		Mar-18		Cumulative	
	Days Lost	% Rate	Days Lost	% Rate																						
Doncaster & Bassetlaw Teaching Hospitals NHS FT	6616.12	4.01%	5563.89	3.26%	5770.06	3.50%	6862.34	4.02%	7025.61	4.12%	7200.57	4.37%	7903.72	4.60%	7326.55	4.41%	8265.71	4.83%	8488.28	5.02%	6891.49	4.54%	6957.40	4.13%	90,292.83	4.51%
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%	0.00	0.00%	0.00	0.00%	0.91	0.10%	0.00	0.00%	0.00	0.00%	4.00	0.41%	43.60	0.41%
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%	763.22	4.03%	856.60	4.67%	1142.73	6.02%	1201.55	6.40%	808.35	4.76%	775.90	4.11%	10,248.46	4.74%
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%	674.27	3.66%	558.20	3.13%	491.55	2.68%	481.25	2.66%	460.63	2.82%	579.71	3.21%	8,107.86	3.74%
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%	12.09	2.12%	14.19	2.58%	29.75	5.23%	8.75	1.59%	8.03	1.64%	5.49	1.02%	103.48	1.71%
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%	1157.35	5.20%	1027.26	4.77%	1232.19	5.65%	1119.71	5.16%	810.96	4.12%	885.32	4.08%	12,362.37	4.78%
Estates & Facilities Directorate	1105.83	6.50%	892.26	5.09%	1014.74	6.00%	1182.10	6.78%	1277.73	7.33%	1128.03	6.71%	1136.25	6.55%	1038.68	6.17%	1335.00	7.71%	1134.78	7.21%	941.32	6.99%	926.27	6.26%	13,012.12	6.58%
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%	20.00	1.00%	30.00	1.69%	0.00	0.00%	1.00	0.06%	0.00	0.00%	0.00	0.00%	73.00	0.38%
Finance & Healthcare Contracting Directorate	43.60	2.00%	13.40	0.60%	93.41	4.35%	92.04	4.20%	113.64	5.05%	82.60	3.86%	78.00	3.56%	60.80	2.90%	117.96	5.46%	213.38	9.83%	176.33	8.76%	124.44	5.48%	1,310.02	5.01%
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%	132.09	3.86%	51.65	1.59%	151.50	4.49%	181.34	5.36%	122.20	4.01%	37.33	1.12%	1,431.87	3.62%
MSK & Family Care Group	722.98	3.00%	681.04	2.71%	751.38	3.06%	699.74	3.52%	795.62	3.11%	759.90	3.07%	799.37	3.10%	786.33	3.08%	1126.06	4.39%	1136.10	4.44%	814.65	3.53%	970.53	3.82%	10,739.24	3.58%
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%	0.90	0.41%	0.00	0.00%	0.00	0.00%	0.00	0.00%	20.91	18.21%	7.33	5.77%	50.57	2.22%
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%	55.01	3.07%	70.60	4.06%	75.35	4.27%	55.15	3.09%	87.85	5.49%	65.06	3.61%	848.87	4.12%
People & Organisational Development Directorate	42.28	1.55%	34.00	1.18%	66.08	2.40%	102.05	3.60%	102.00	3.73%	57.75	2.13%	51.99	1.78%	35.68	1.26%	36.08	1.21%	63.69	2.10%	111.88	4.08%	153.56	5.03%	1,073.20	3.15%
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%	208.00	3.49%	156.93	2.89%	204.45	3.63%	241.03	4.29%	236.72	4.78%	217.84	3.96%	2,415.73	3.42%
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%	935.86	5.14%	923.46	5.23%	789.67	4.30%	1056.13	5.71%	850.19	5.04%	793.58	4.22%	10,225.75	4.73%
Surgical Care Group	1266.77	4.21%	1080.28	3.48%	1165.05	3.87%	1490.53	4.84%	1515.67	4.91%	1602.85	5.34%	1889.32	6.02%	1736.07	5.70%	1532.52	4.87%	1594.41	5.08%	1441.47	5.09%	1411.03	4.51%	18,242.69	4.97%
Trust Funds (included in Finance)	0.00	0.00%	0.00	0.00%	0.00	0.00%	0.00	0.00%	NULL	NULL	4.00	4.84%														

Workforce: SET Training - March (Month 12)

CG & Directorate SET Training - Mar 2018 (Q4)

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

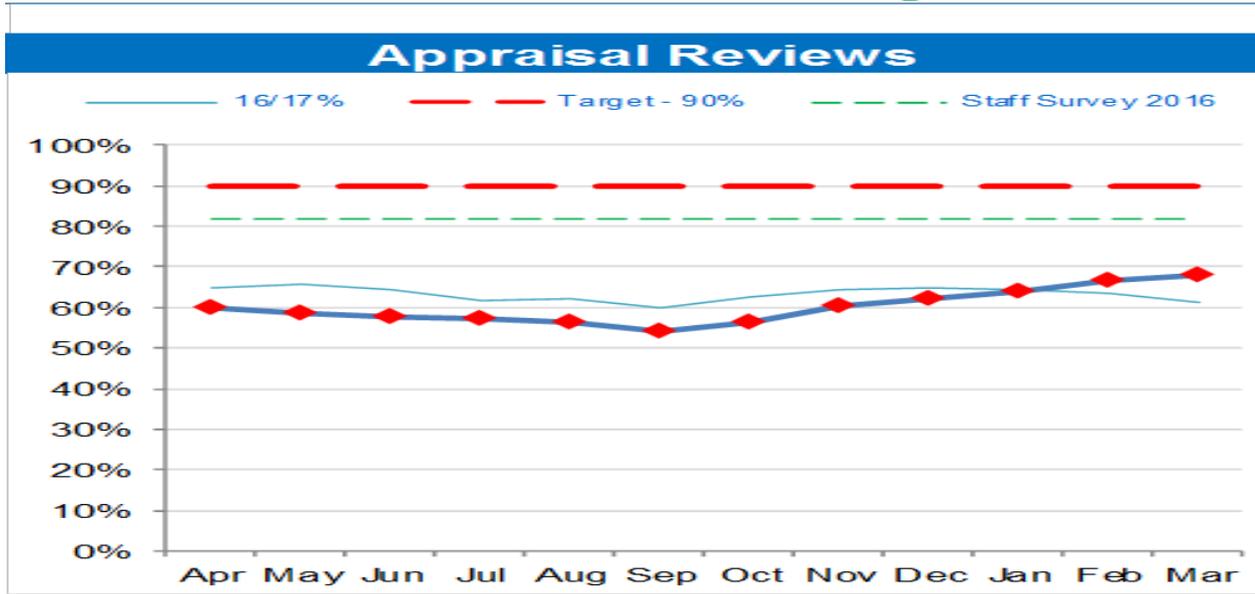


	% Compliance
Doncaster & Bassetlaw Teaching Hospitals NHS FT	78.68%
Chief Executive Directorate	86.11%
Children & Family Care Group	82.33%
Diagnostic & Pharmacy Care Group	87.01%
Directorate Of Strategy & Improvement	98.04%
Emergency Care Group	67.60%
Estates & Facilities	73.76%
Finance & Healthcare Contracting Directorate	94.35%
IT Information & Telecoms Directorate	92.98%
MSK & Frailty Care Group	84.33%
Medical Director Directorate	75.00%
Nursing Services Directorate	84.14%
People & Organisational Directorate	94.78%
Performance Directorate	77.96%
Speciality Services Care Group	73.42%
Surgical Care Group	76.25%

Workforce: Appraisals - March (Month 12)

CG & Directorate Appraisals - Mar 2018 (Q4)

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



Trust Total

	% Completed
Doncaster & Bassetlaw Teaching Hospitals NHS FT	68.15
Chief Executive Directorate	41.94
Children & Family Care Group	78.65
Diagnostic & Pharmacy Care Group	63.44
Directorate Of Strategy & Improvement	84.62
Emergency Care Group	50.36
Estates & Facilities	91.67
Finance & Healthcare Contracting Directorate	87.50
IT Information & Telecoms Directorate	74.77
MSK & Frailty Care Group	75.96
Medical Director Directorate	0.00
Nursing Services Directorate	75.38
People & Organisational Directorate	82.95
Performance Directorate	63.14
Speciality Services Care Group	66.29
Surgical Care Group	56.86

Workforce: Staff in post - March (Month 12)

	FTE	Headcount																						
Staff Group	Apr-17		May-17		Jun-17		Jul-17		Aug-17		Sep-17		Oct-17		Nov-17		Dec-17		Jan-18		Feb-18		Mar-18	
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	171.90	187.00	171.47	187.00	170.77	185.00	173.47	189.00	172.47	189.00	172.21	189.00
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	1,123.63	1,361.00	1,118.74	1,357.00	1,106.22	1,340.00	1,128.45	1,364.00	1,126.47	1,363.00	1,131.05	1,367.00
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	1,085.93	1,323.00	1,067.20	1,300.00	1,057.48	1,287.00	1,068.60	1,301.00	1,060.57	1,291.00	1,064.98	1,296.00
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	333.98	385.00	334.55	386.00	333.48	385.00	333.95	386.00	336.83	389.00	331.95	385.00
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	567.59	826.00	569.05	828.00	564.44	820.00	492.84	701.00	492.83	701.00	488.71	695.00
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	125.30	139.00	124.90	139.00	122.70	137.00	126.30	141.00	129.10	143.00	125.70	141.00
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	505.78	637.00	504.89	628.00	500.29	597.00	504.54	598.00	509.05	601.00	509.11	600.00
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	1,580.79	1,831.00	1,577.99	1,829.00	1,559.68	1,809.00	1,603.22	1,862.00	1,598.79	1,859.00	1,598.70	1,861.00
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	8.36	9.00	6.56	7.00	5.56	6.00	3.92	4.00	1.92	2.00	1.92	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	5,503.26	6,698.00	5,475.34	6,661.00	5,420.61	6,566.00	5,435.28	6,546.00	5,428.03	6,538.00	5,424.31	6,536.00

Q2 (17/18) LEARNING FROM DEATHS REPORT

1.0 Background and Introduction

This is the second quarterly report produced since the publication of the “**National Guidance on Learning from Deaths**” in March 2017 by the National Quality Board.

The Trust has also published its policy, **Learning from Deaths: CORP/RISK 32** in August 2017 and data collection is ongoing as follows:

- Number of in hospital deaths, by site and specialty
- Number of deaths in the A&E department
- Number of deaths of patients with a learning disability/severe mental health issue
- Number of patients on end of life IPOCs at time of death
- Cause of death
- Quality of care at each phase of the patients hospital stay
- Quality of the documentation within the patient record
- Number of cases screened
- Number of cases reviewed using a standardised methodology
- How many deaths were more likely than not to have been due to problems in care delivery.

2.0 Current position.

During Quarter 2 there have been 416 in hospital deaths, including 34 deaths across both hospital A&E departments. 264 (64%) of these cases have been screened/reviewed and of those screened just 2 cases went on to have a full structured judgement review.

The mortality monitoring group (MMG) monitors on a monthly basis each specialties mortality review activity. The following table illustrates how each specialty is performing in relation to the requirements set out in the policy.

Care Group	Specialty	JULY			AUGUST			SEPTEMBER		
		No. of Deaths	No. Reviewed	% complete	No. of deaths	No. Reviewed	% complete	No. of deaths	No. reviewed	% complete
Specialty Services	Cardiology	3	3	100%	3	3	100%	2	2	100%
	Diabetes/endocrinology	1	1	100%	1	1	100%	3	0	0%
	Haematology	0	0	N/A	4	4	100%	3	2	66%
	Renal	0	0	N/A	0	0	N/A	4	0	0%
	Stroke	9	9	100%	13	10	77%	8	6	75%
	Urology	1	1	100%	3	2	66%	0	0	N/A
	Vascular	0	0	N/A	1	1	100%	1	1	100%
	Breast	0	0	N/A	0	0	N/A	0	0	N/A
	Dermatology	0	0	N/A	0	0	N/A	0	0	N/A
Children & Families	Gynaecology	0	0	N/A	0	0	N/A	0	0	N/A
Surgical	ENT	1	1	100%	0	0	N/A	0	0	N/A
	General Surgery	18	10	100%	2	2	100%	4	2	50%
	Ophthalmology	0	0	N/A	0	0	N/A	1	1	100%
MSK & Frailty	T&O	1	1	100%	3	2	67%	6	6	100%
	Care of the Elderly	23	10	100%	11	5	45%	12	10	83%
	Rheumatology	0	0	N/A	0	0	N/A	0	0	N/A
Emergency (S) = screened SJR = Structured judgement review	Respiratory	5	5	100%	12	8	58%	24	11(S) 6(SJR)	71%
	Gastroenterology	4	3	75%	4	0	0%	11	6	54%
	General Medicine	65	38(S) 6(SJR)	83%	59	22(S) 5(SJR)	45%	51	19(S) 5(SJR)	47%
	Emergency Department	13	13	100%	16	16	100%	13	13	100%
	Total:	150	101	67%	132	81	61%	143	90	63%

3.0 Actions taken throughout Quarter 2 to assist specialties with compliance:

- Last quarter I reported that the End of life team were screening all deaths within general medicine and stroke when the patient was on an EOL care plan. This is no longer sustainable for the end of life team due to high numbers and the need to maintain their reviews within their own specialty. The Matron for general medicine has introduced a specific emergency care group multi-disciplinary mortality meeting, however as numbers are so high in this care group, this will still not ensure all deaths are scrutinised. A solution will be reached if the recent business case for permanent full time resource to lead on the mortality review work is agreed. Each case will then be screened within the bereavement office.
- Diabetes/endocrinology have been unable to locate the notes to enable them to undertake their reviews. It has been decided that the notes, wherever possible, will be made available to them in CDC following the completion of coding.
- The renal department have contacted me for further training for their staff to ensure that the reviews will then be completed within 6 weeks.
- Trauma and Orthopaedics have identified one of their advanced clinical practitioners to lead on this work.

4.0 Findings and themes

- No death during Q2 was judged to be more likely than not due to problems in care
- There has been 1 death of a patient with a learning disability (LD). This has been reported to the CCG and reviewed with input from the LD liaison nurse. No issues with care and treatment plan identified.
- 96% of case notes reviewed contained excellent/good documentation.
- 4% of case notes were difficult to review due to the poor documentation and in particular, legibility of handwriting. There was also an issue raised with regards the poor quality of case note filing at BDGH
- 97% of cases reviewed received excellent or good care overall, 2% received adequate care and 1% poor care.
- Of those concluded to have received “poor care” the following 3 themes were identified;
 - Poor fluid balance monitoring and antibiotic administration
 - Unnecessary hospital and ward transfers
 - Some lack of knowledge in recognising the dying chronically ill patient resulting in unnecessary interventions and treatment.

5.0 Ongoing work and developments:

- Since the National case note review programme made the decision to remove the “avoidability of death” score from the data collection form, we have amended the terms of reference of the Mortality case Note review group (MCNRG) Whenever a tier 1 review indicates a score of 1, 2 or 3 as an “overall assessment score” this case is brought along to the MCNRG for a multidisciplinary review. A decision is then made on whether the case fits the Serious Incident Criteria or what further action and learning is required.
- A further training session has been held, bringing our total of mortality review trained staff to 100.
- The first regional patient and public involvement meeting was held in November. The aim of this group is to reflect on the current practice, in place in some NHS Trusts in the Yorkshire and Humber region, including families and carers’ views into their local mortality review programme.
To explore ways of standardising the embedding of the families/carers’ voice into trusts’ mortality review processes in order to increase organisational learning from problems in care.
To develop a flexible framework on how families/carers could be involved in mortality review programmes in care settings such as acute and mental health.

6.0 Conclusion

The overall trend throughout this quarter for number of reviews undertaken has not been quite as good as quarter 1. This may be due to the summer months with more staff being on holiday and so not available to undertake the reviews.

The continuous monitoring by the mortality monitoring group (MMG) of each specialty activity ensures that any issues with compliance are identified quickly and solutions put in place.

A business case for 1.2 WTE has been submitted. If this is accepted then the resource will be used to ensure that the timely screening of deaths within the emergency care group is undertaken. It will also be used to engage more with the families and carers of those patients who die in order to address any care issues they may have raised.

This report will be tabled at the December MMG meeting, Clinical Governance Committee and Board of Directors.

Mandy Dalton
November 2017

LEARNING FROM DEATHS REPORT : Q3 17/18

Report to: Board of Directors and Clinical Governance Committee March 2018

Introduction

The Trust published its Learning from Deaths Policy in September 2017. There is a requirement to publish the data collected as a result of the processes outlined within the policy every quarter as a standing agenda item at a public Board meeting from Q3 2017/18.

As we had been collecting the data prior to this, this is the third quarterly report. However, in this report you will find a different layout and further information on the quality of care assessments.

The National Mortality Record Review (NMCRR) data collection proforma is used for the Structured Judgement Reviews (SJR). This is a validated methodology available from [National Mortality Case Record Review \(NMCRR\) programme resources | RCP London](#). The Trust has a number of clinicians within every specialty trained to undertake the SJRs using the proforma and further training is planned. The methodology is based upon the principle that clinicians use explicit statements to comment on the quality of healthcare in a way that allows a judgement to be made that is reproducible. Examples of good and poor care are highlighted.

For those patients who die following an elective admission, a structured judgement review of case notes is undertaken within the Mortality case note review meeting and discussed directly with the deputy Medical Director. There are occasions when what was coded as an elective admission was actually an emergency admission following an elective outpatient procedure. Clinical coding will adjust the coding whenever required.

All deaths of patients with a learning disability or severe mental health problem are referred to the national LeDeR programme. This is a multi-agency programme for review of deaths in patients with learning disabilities, commissioned by NHSE.

All specialties with 10 or fewer deaths are expected to undertake a structured judgement review of all the cases and this process is monitored via the Mortality Monitoring group (MMG). Whenever possible, and ideally, the clinician will not have been involved in the care of the patient who died.

For specialties with greater than 10 deaths a month, namely general medicine, respiratory and care of the elderly, a random selection of 10 deaths will be reviewed and the intention is to screen all of the other deaths.

Screening of case notes, using a screening tool approved by MMG, is currently undertaken by the Mortality review lead and the end of life team. The goal is to ensure all other notes, not fitting the criteria above, are screened. This has not yet been entirely achieved but once further resource is available, improvements in this process and an increase in the number screened will be seen.

Specific focused reviews of patients who have a primary cause of death of the following have been undertaken:

- Sepsis
- Pneumonia
- AKI

Results.

During Quarter 3 there have been 566 in hospital deaths, 148 more than last quarter. 95 (17%) of these cases have been screened and 239 (43%) have had a structured judgement review. Therefore, 334 (60.5%) of in hospital deaths have been scrutinised.

This is 4% less than quarter 2.

There are a two main reasons why there has been a slight fall in the numbers:

- Increased hospital activity throughout January and February has meant that clinicians have not had the time to complete the reviews.
- Operational/process issues in the bereavement office has resulted in the mortality review lead assisting to ensure that medical cause of death certificates are completed in a timely way. As a consequence, the number of notes being screened has fallen slightly, and the usual chasing of staff to complete reviews has not been as constant.

The Mortality monitoring group has acknowledged that the process issues within the bereavement office are of great concern and that they will receive a monthly update on the situation.

Assessment of care provided

239 structured judgement reviews have been undertaken this quarter. The chart below demonstrates the scores for each phase of care.

	Good or excellent care (score 4-5)	Adequate care (score 3)	Very poor/Poor care (score 1-2)	N/a	Not recorded
Admission and initial management	203	24	3	0	0
On-going care	135	43	1	60	0
Care during procedure	63	3	0	173	0
Peri-operative care	66	0	0	173	0
End of life care		3	3		0
Overall assessment of care received	233	3	3	0	0
Overall assessment of patient record	208	4	2	0	0

***Adequate care = where treatment has been appropriate but in the process of delivering care some lapses have been identified. Whilst these could not have contributed to the ultimate outcome, nonetheless, it is important that these apparent deficiencies are addressed**

The SJR proforma has recently been amended at a National level to remove the “avoidability of death” section and to add a section that enables the identification of problems in care by the following categories:

- Problems in assessment, investigation, diagnosis
- Problems with medication/IV fluids/oxygen
- Problems related to treatment and management plan
- Problems with infection management
- Problem related to operation/invasive procedure
- Problem in clinical monitoring
- Problem in Resuscitation

The earlier version of the proforma did not contain this section and therefore a significant proportion of the case reviews undertaken this quarter did not include this data. Q4 will include a full analysis of these problems in care.

This quarter there were 3 cases where clinical assessment on admission failed to initiate the sepsis IPOC and 9 cases when an end of life decision could have been made more swiftly. The 3 cases where the sepsis IPOC was judged not to have been initiated at the correct time went on to have a second review to determine whether the death was avoidable. Each case was in relation to patients with many co-morbidities and in fact in 2 of the cases the sepsis HAD been initiated correctly but the documentation was lacking. None of the deaths were judged to have been avoidable.

Other specific learning points identified (though not directly causing death)

1. Stopping unnecessary medications close to end of life
2. More consistent use of advanced care plans
3. Timely blood culture taking
4. Ensure antibiotics are administered at the time of prescribing

Reflection and Learning

In general the reviews were of good quality with numerous detailed descriptions of good practice. In a very small proportion of cases, examples of where practice could have been improved were documented. The great majority of these are in connection with early recognition of the dying patient and though not affecting the outcome, may well have affected the quality of end of life care. Having said that, the number of patients put onto end of life care plans continues to rise and in fact since this process has been underway we have seen a 22% rise in timely decision to commence an end of life care plan.

Whilst screening notes in the bereavement office at DRI, to ensure a more timely decision on whether or not a SJR is required, it has become apparent that the systems and processes within the office require a review.

The two main areas of concern are:

- Bereaved relatives waiting too long for a medical cause of death certificate (MCCD)
- GP's not being notified of the death of their patients in a timely way.

These 2 areas are now part of a quality improvement programme which will be reported on in future reports.

Mandy Dalton
March 2018



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

Title	Staff Survey Action Plan		
Report to	Board of Directors	Date	April 2018
Author	Karen Barnard, Director of People & OD		
Purpose			Tick one as appropriate
	Decision		X
	Assurance		
	Information		

Executive summary containing key messages and issues

In February we received the feedback from the 2017 staff survey. Whilst we have seen some small improvements which on the whole mirror the feedback we received in 2014 the Trust continues to benchmark badly against other acute Trusts. Our overall score for staff engagement was 3.66, as it was last year but below the average of 3.79 for all acute trusts, which was itself down on the previous year. We have again made increasing levels of engagement across DBTH one of the key priorities for 2018 and already begun the process of local action planning.

Most encouragingly, we saw a 3% increase in staff recommending the Trust as a place to work, and as a place to receive treatment (however still in the lowest 20% of acute Trusts).

Care Groups and directorates have been asked to develop action plans for their key priorities but just as important they have been tasked with including how they intend to share the results, proposed actions and progress against those actions during the year. A recent audit conducted by KPMG, our internal auditors, found that, in terms of last year's local action plans, staff had little knowledge of the work that was being undertaken by leadership teams despite there being action plans in place. Key areas of attention at Trust level will be the development of the Trust's leaders and managers, involvement of staff in Qii projects, focus on translating the Trust's values into action and demonstrating to staff our achievements in relation to the care we provide to patients.

Key questions posed by the report

Are members assured that the actions identified within the action plan will deliver improvements to the staff survey results in 2018?
Do the enabling strategies of People & OD, Communications & Engagement and Qii support the work needed to improve our staff survey results and demonstrate to staff that WE CARE

How this report contributes to the delivery of the strategic 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

How this report impacts on current risks or highlights new risks

Staff morale – the actions contained within the report look to provide assurance that the Trust is taking steps to to improve staff morale.

Recommendation(s) and next steps

The Board of Directors is asked to note the report and approve the action plan

WE CARE for our staff

Whilst our staff survey results improved slightly following a significant deterioration the previous year the Trust benchmarks poorly against other Acute Trusts. It is vital therefore that we demonstrate to our staff that WE CARE for members of Team DBTH and make the most of our achievement in becoming a Teaching Hospital. The Trust's People & Organisational Development, Communications & Engagement and Quality Innovation & Improvement strategies detail much of the work needed to achieve improvements in our staff survey results. However we must condense these strategies into a meaningful action plan which we can share with members of Team DBTH and demonstrate our commitment to improving their working lives within the Trust. In addition we have seen variation in the feedback from across the Care Groups/Directorates and across staff groups. Therefore areas have been tasked with developing their own SMART action plans which will also detail how they will involve their teams and communicate the progress against those plans.

Headline data

Care of patients is my organisation's top priority – improvement of 3% to 71% but average for acute figures is 76%

I would recommend my organisation as a place to work – improvement of 3% to 51% but average for acute Trusts is 61%

If friend or relative needed treatment I would be happy with the standard of care provided by this organisation – improvement of 3% to 62% but average for acute Trusts is 71%

These combine into a single key finding of staff recommendation of the organisation as a place to work or receive treatment – DBTH saw an improvement from 3.54 to 3.58 but the average for acute Trusts is 3.76

The Trust's overall staff engagement score remained static at 3.66 with the national average being 3.79. This figure is made up of the above score for staff recommending the Trust plus the scores for staff motivation at work (3.81) and staff ability to contribute towards improvements at work (65%)

COMPARATIVE SCORES – Staff FFT – At a glance

	2015-16				2016-17				2017-18			
	Q1	Q2	Q3 SS	Q4	Q1	Q2	Q3 SS	Q4	Q1	Q2	Q3 SS	Q4
Care or Treatment	80	78	64	72	76	73	59	80	76	76	62	79
Place to work	73	77	60	66	60	58	48	79	59	59	51	76

The above table details the comparative differences between the scores relating to recommending the Trust between the staff survey results (Q3) and the quarterly Staff Friends and Family test – please note that Q4 is a small survey directed towards any new starters who miss the main staff survey due to their start date being after the data submission.

Members will recall from the 2017 survey results that the Trust did not benchmark well with other acute Trusts nationally despite seeing some small improvements in many of our scores as compared with 2016. The results have been reviewed within Care Groups and Directorates and across the Trust as a whole. Despite the Trust performing well across a range of performance and quality indicators it is disappointing that only 62% of our staff feel happy with the standard of care provided by the Trust. When analysing that data further it appears that fewer staff within some corporate areas feel able to recommend the Trust for treatment and in addition when comparing the data by staff group it is predominantly our non-clinical staff who are least likely to recommend the Trust for treatment. Having reflected on this with the Medical Director and Director of Nursing, Midwifery and AHPs we have recognised that much of our communication regarding quality and performance across the Trust is either directed mainly towards clinical staff or is focused on our continued improvement journey rather than celebrating our achievements. In terms of staff believing that care of patients is our top priority the data indicates that in the main clinical areas agree with this statement, although there are exceptions. Therefore in developing messages that we communicate to our teams we must ensure that there is a balanced focus between patient care and finances.

Most positive scores

The Trust was in the best 20%/better than average in the following key findings:

- Percentage of staff working extra hours
- Percentage of staff experiencing discrimination at work in the last 12 months
- Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months
- Percentage of staff witnessing harmful errors, near misses or incidents in the previous month
- Percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months
- Percentage of staff experiencing physical violence from staff in the last 12 months (but the Trust benchmarked in the worst 20% for violence from patients, relatives or the public)

Staff motivation at work saw a further deterioration from last year (3.81 from 3.86 – the national acute average being 3.92 and the best being 4.07) – this key finding comprises questions on looking forward to going to work, enthusiasm about their job and whether time passes quickly. The least positive scoring question across the Trust was on looking forward to going to work and as with many other questions we have seen a variation amongst certain staff groups which has then contributed to the variation between directorates and care groups. This along with the variation in scores for effective team working and staff satisfaction with level of responsibility and involvement I would expect to see within Care Group and Directorate action plans as relevant to them.

At Quality & Effectiveness Committee I was asked there were any difference in the results by location; a specific report was requested from our survey provider – this has indicated there was

little variation in the main. At Montagu Hospital all appraisal questions scored better than whole Trust figures; fewer staff reported instances of violence and harassment but also experienced fewer instances of errors/incidents which could affect staff and patients. Staff at Bassetlaw Hospital scored slightly lower than the other sites for recommending the Trust as a place to work. At both Bassetlaw and Montagu Hospitals there was less positive feedback about senior managers in terms communication and involving staff in decisions affecting them. Through the review of Director portfolios, Care Group restructure and buddying of Directors with Care Groups the alignment of Directors to each location will also be considered.

Communications

As mentioned above Care Groups and Directorate have been asked to explicitly include within their plans how they will share their results and action plans with their teams and how they will continue to brief their teams of the ongoing progress. We have also developed a trust-wide communication plan which is detailed below.

Updated Staff Survey posters around sites – similar to last year, highlighting achievements in 2017/18 and positive actions taken forward the communications team will draft and spotlight certain improvements and examples of listened and taken action.

General communications – an update from the initial piece which has been published regarding our results. Further communications need to be separated into a number of pieces, with messages from both Richard Parker and also Karen Barnard, further explaining our results and also promoting what we are doing with the data we now have. This will include a forward plan in general Trust terms but also a update what this means locally. This needs to stay service specific rather than Care Group in order to future-proof it in anticipation of structure changes.

A poster template has been created for services, with potential to looking at further supporting materials to ensure that areas are fully communicating their Staff Survey results and taking positive actions to address them.

The majority of this work will be delivered via the Buzz, Trust Intranet/New Extranet, as well as staff Facebook group and Staff Brief. There is potential to put this information into small film projects, communicating the top line bits of information, making it really clear and concise how we are advancing this work. We anticipate that this information should be rolled out over a number of weeks and months, with updates coming right up until the launch of the next Staff Survey. To inform this work, Communications will develop a plan, detailing dates and what work needs to be completed.

Topic for staff experience group – Facilitated by Communications and P&OD colleagues, a run-down of the results, what this means for the Trust and how we intend to positively improve. There needs to be some sense of how the group can steer this work, and also some focus on increasing the uptake, especially in less-engaged areas.

Re-launch of Ask the Boss and Care Group specific mailboxes – there is the potential to run this alongside communications for the Staff Survey, this will be another example of how we have listened and taken action. The Communications team will need sign-up from the senior team to answer requests as a matter of importance and will be another way for members of staff to engage and help to influence positive change. Care Group specific mailboxes will be launched when the structure changes.

Care Group and Directorate action plans

At a Trust level the attached action plan has been drafted. As detailed above relevant sections from the Communications and Engagement and Qii strategy actions plans will be included within this overarching action plan.

Care Groups and Directorates have been tasked with developing their own action plans to address their priority areas. Progress against these action plans will be monitored through the accountability meetings and fed through to WEC and QEC. Having reviewed those action plans the themes arising from them are:

- Flexible working
- Opportunity for staff to undertake Qii projects/improvement team approach
- Team communications
- Visibility of leadership teams
- Immediate line manager visibility and support
- Health and wellbeing/pressure to come to work when unwell
- Survey response rates
- Training plans/Appraisal training/CPD
- Incident reporting/feedback from incidents and patient feedback
- Conflict resolution/lone working
- Recognition/celebrating achievements

The Trust level action plan is attached for consideration by the Board of Directors. This action plan is supported by the People & OD, Communications & Engagement and Qii enabling strategies with key components of each of those action plans being added into this action plan for sharing with Team DBTH.

Staff survey action plan 2018

Area of focus	Actions	Addressing staff survey question/ area	Success measure
Overall staff experience/engagement programme	Refresh the staff experience group and review the membership to ensure we have a cross section of staff groups and Care Group/Directorate representation. Agree topics of discussions with the group and invite senior leaders to attend those discussions.	Response rate Recommendation as place to work and receive treatment Staff engagement score	Improved response rate Improvement in recommendation of DBTH as place to work and to receive care Improvement in staff engagement score
	Review how we demonstrate the achievements of the Trust in relation to quality and performance and communicate to all staff. Regular celebration of our achievements.	Key finding 1: Staff recommending the Trust as a place to receive treatment and work (including whether staff believe patient care is a top priority for the Trust)	Improvement in key finding
Opportunity for employee voice and involvement	Introduce a formalised approach to the collation of staff feedback received during a specific period through the existing channels. Timely analysis of the number of comments/ feedback and the tone (to act as a morale barometer, supplementing the Staff FFT work). This would provide the Board with an understanding of staff reaction to certain updates/changes Introduction of appraisal season giving staff the option for maintenance or developmental appraisals. Review of appraisal process for 2019/20 to incorporate greater reference to the Trust's values	Key finding 3: percentage of staff agreeing their role makes a difference to patients/ service users (6b) Key finding 5: recognition and value of staff by organisation and managers (5a,5f,7g) Key finding 6: Percentage of staff reporting good communication between senior management and staff (81-d)	Improvements in scores in relevant key findings Reduced number of grievances
	Demonstrate a clearer 'you said' 'we did' approach so employees see the value in having a voice and provide shared learning about where that has been done well.	Key finding 7: Percentage of staff able to contribute towards improvements at work (4a,4b,4d)	Improvements in scores of relevant key findings

	<p>Responses to be formed based on insights gathered through champions and the staff experience group as well as all staff feedback (including the staff survey).</p> <p>Develop case studies around staff survey improvements for Care Groups/ Corporate Directorates using the 'you said we did' approach. Care Group/Directorate action plans to be developed in conjunction with staff to ensure the priorities meet their needs.</p> <p>Reference to Qii action plan to be included and Lean programme</p>	<p>Key finding 3: percentage of staff agreeing their role makes a difference to patients/ service users (6b)</p>	<p>Improvements in morale measured through regular barometers</p> <p>Increase in service improvement projects led by front line services</p>
<p>Communicating vision/strategy</p>	<p>Clearer representation/ visibility of executive team- especially within their senior teams communicating the 'future'. Alignment of Executive Directors with Care Groups and sites.</p> <p>Create a programme of engagement opportunities and engagement KPIs for the executive teams including presentation of staff brief, STAR awards presentations, back to the floor exercises and bespoke Q/A forum sessions with a wide ranging group of staff (such as CEO breakfast sessions with medics).</p>	<p>Key finding 5: recognition and value of staff by organisation and managers (5a,5f,7g)</p> <p>Key finding 6: Percentage of staff reporting good communication between senior management and staff (81-d)</p>	<p>Key finding 5: recognition and value of staff by organisation and managers (5a,5f,7g)</p> <p>Key finding 6: Percentage of staff reporting good communication between senior management and staff (81-d)</p>
	<p>Deliver a series of staff engagement events (big health conversation/ let's talk DBTH) supported by additional digital engagement.</p> <p>Ensure senior staff/ line managers can support staff to make sense of their role within the context of the organisational strategy.</p>	<p>Key finding 7: Percentage of staff able to contribute towards improvements at work (4a,4b,4d)</p> <p>Key finding 8: Staff satisfaction with level of responsibility and involvement (3a,3b,4c,5d,5e)</p> <p>Key finding 3: percentage of staff agreeing that their role makes a difference to patients/ service users (6b)</p>	<p>Key finding 7: Percentage of staff able to contribute towards improvements at work (4a,4b,4d)</p> <p>Key finding 8: Staff satisfaction with level of responsibility and involvement (3a,3b,4c,5d,5e)</p> <p>Key finding 3: percentage of staff agreeing that their role makes a difference to patients/ service users (6b)</p> <p>Number of contributions/ suggestions made by staff</p>

	<p>Develop a communications and engagement champions model, with key representatives from all Care Group/ Corporate Directorates committed to attendance at key events to hear and feedback (including staff brief, annual members meeting, transformation workshops).</p> <p>Review the membership of the ‘staff experience group’ which will also include senior members of staff, staff side and governors.</p> <p>Continue to deliver pro-active communications campaigns making use of varied media.</p>	<p>Key finding 7: Percentage of staff able to contribute towards improvements at work (4a,4b,4d)</p> <p>Key finding 8: Staff satisfaction with level of responsibility and involvement (3a,3b,4c,5d,5e)</p>	<p>Improvements to key findings</p> <p>Key finding 7: Percentage of staff able to contribute towards improvements at work (4a,4b,4d)</p> <p>Key finding 8: Staff satisfaction with level of responsibility and involvement (3a,3b,4c,5d,5e)</p> <p>Improved attendance at Staff Brief</p> <p>Continued increase in use of social media. Alternative means of communication identified through engagement with staff</p>
Supporting and engaging with managers	<p>Improve current intranet provision in order to provide line managers with all the key information, guidance and policies they need to manage staff enabling a self-service approach.</p>	<p>Key finding 10: Support from immediate managers (5b, 7a-e)</p>	<p>Improvement in key findings</p> <p>Key finding 10: Support from immediate managers (5b, 7a-e)</p> <p>Measure use of intranet site</p>
	<p>Develop a line manager bulletin/ blog/ portal to include support and guidance on key people issues. Contents could include:</p> <ul style="list-style-type: none"> - Steps to delivering quality appraisals including key messages to staff (video of a good appraisal) - Effective team working - The importance of supporting health and wellbeing of staff with particular focus on mental wellbeing and resilience (links to CQUIN for 2017/18) - Sickness absence management best practice 	<p>Key Finding 9. Effective team working (4h-j)</p> <p>Key finding 10: Support from immediate managers</p> <p>Key finding 11: Percentage of staff appraised in the last 12 months (20a)</p> <p>Key finding 12: Quality of appraisals (20b-d)</p> <p>Key finding 13: Quality of non-mandatory training,</p>	<p>Improvements in key findings</p> <p>Reduced sickness absence rates</p> <p>Improved appraisal rates</p> <p>Reduced grievances</p>

		<p>learning or development (18b-d)</p> <p>Key Finding 19: Organisation and management interest in and action on health and wellbeing (7f, 9a)</p>	
	<p>Adopt a line manager first approach for all communications involving significant change. This will enable managers to understand the reasons for change and to feel equipped to support their staff and help them to make sense of their roles in the change.</p> <p>Ensure all Care Groups and Directorates understand and share staff survey feedback – engaging with staff to understand the results and develop actions to address areas for concern in their survey results.</p> <p>Explore with the senior leadership team across the Trust how best to communicate with them</p>	<p>Key finding 10: Support from immediate managers</p> <p>Key finding 7: Percentage of staff able to contribute towards improvements at work (4a,4b,4d)</p>	<p>Improvement in key findings</p> <p>Line managers questionnaire as part of the launch of the bulletin/blog/portal</p> <p>Staff survey engagement events taken place in Care Groups</p>
	<p>Develop a leadership strategy and programme for the organisation to include talent management and succession planning</p>	<p>Key finding 8: Staff satisfaction with level of responsibility and involvement (3a,3b,4c,5d,5e)</p>	<p>Improvement in key findings</p> <p>Strategy in place and programmes identified</p>
	<p>Review DBTH management programme to ensure managers are equipped to manage people issues appropriately with specific reference on team working and resilience</p>	<p>Key finding 10: Support from immediate managers</p> <p>Key finding 9: Effective team working</p>	<p>Improvement in key findings</p> <p>Positive evaluation of programme</p>
Supporting staff	<p>Visual campaign to ensure that everyone working, visiting or receiving treatment within the Trust is aware of acceptable behaviours towards members of Team DBTH.</p>	<p>Key findings 22 & 23: Percentage of staff experiencing violence</p>	<p>Reduced incidence of violence</p>

	Regular reminders to all staff on the importance of reporting incidents of violence, harassment, bullying or abuse. Promote wider circulation of Risky Business to non-clinical staff.	Key findings 24 & 27: Percentage of staff reporting most recent experience of violence, harassment, bullying or abuse	Improvement in reporting of incidents
	Campaign to reinforce the Trust's values; inclusion of the Trust's values and behaviours in appraisal process for 2019/20	Key finding 1: Staff recommending the Trust as a place to work and receive treatment	Improvement in key findings Reduced vacancy rates Improved retention and turnover figures
	Develop workplans from the We Care for our Junior Doctors Forum and the Specialty and Associate Specialist Doctor Forum. To be monitored via WEC and JLNC	Key finding 26: Percentage of staff experiencing bullying, harassment or abuse from staff	Improvement in key findings



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

Title	Annual Estates & Facilities Performance Report		
Report to	Board of Directors	Date	30th April 2018
Author	Kirsty Edmondson-Jones		
Purpose			Tick one as appropriate
	Decision		
	Assurance		X
	Information		

Executive summary containing key messages and issues

The annual Estates and Facilities performance report provides Board of Directors with the first annual review of performance for 2017/18, ahead of new quarterly performance reports to Board in 2018/19.

The report also includes the annual declaration of Trust compliance performance against the Department of Health (DOH) NHS Premises Assurance Model (NHS PAM) for 2017/18.

The Performance Data provided demonstrates the significant improvements to the quality and efficacy of E&F services achieved in 2017/18.

Building on the improvements made, further work is required in 2018/19 to:

- further improve staff survey results and increase uptake
- review BDGH cleaning to assess potential for learning from DRI LEAN Zonal model
- work with wards/departments to reduce delays which adversely impact Portering performance
- improve MTS average response times by introducing a new KPI of 4 days
- work with P&OD to reduce long-term sickness and to manage short-term sickness.

Key questions posed by the report

Are Board of Directors assured of progress made over 2017/18 to improve the performance of Estates and Facilities services, including Trust Compliance against NHS PAM?

How this report contributes to the delivery of the strategic objectives
The paper updates BOD in the wider Corporate Risk (F&P4) relating to the failure to ensure a suitable estates infrastructure is in place.
How this report impacts on current risks or highlights new risks
Recommendation(s) and next steps
Board of Directors are asked to note the content of this paper and progress made.



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

Annual Estates and Facilities Performance Report - April 18



Become a Trust member and make a difference to the care our hospitals provide.
Email foundation.office@dbh.nhs.uk or visit www.dbh.nhs.uk for more information about membership.

Estates and Facilities Annual Performance Report April 2017 – March 2018

1. Executive Summary

This performance report provides Board of Directors with an annual review against the performance of Estates and Facilities Services (E&F) for 2017/18, ahead of quarterly performance reports to Board in 2018/19. The report also includes the annual declaration of Trust compliance performance against the Department of Health (DOH) NHS Premises Assurance Model (NHS PAM) for 2017/18. The NHS Pam ensures the Trust meets the Care Quality Commission (CQC) Essential Standards of Quality and Safety Guidance 2015, updated in June 2017 to the Key Lines of Enquiry (KLOE). The full annual DBTH NHS PAM assessment is attached at appendix 1.

The content of this report provides Board of Directors with assurance of the significant improvements achieved to many areas of E&F services during 2017/18.

At A Glance

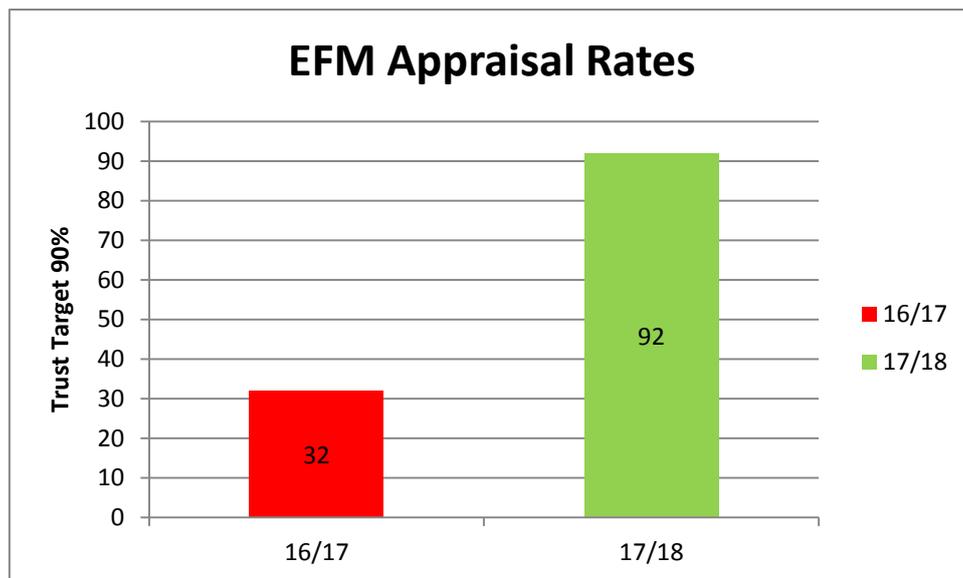
Performance Measure	KPI/Target	Actual	Variance	RAG		Comments
Appraisal	90%	92%	2%	 		
SET	90%	74%	-16%	 		Green Rag will be 90% by end Q1
Sickness	3.50%	6.56%	3.06%	 		Working with P&OD to manage sickness
Staff Survey	Greens	N/A	N/A	 		69% responses improved
Compliance	Good	80%	N/A	 		Increase of 18%
Cleaning DRI	90%	96%	6%	 		
Cleaning BDGH	90%	88%	-2%	 		Review potential to extend DRI LEAN Zonal
Cleaning MMH	90%	90%	0%	 		
Portering DRI	Complete within 30m	64%	N/A	 		
Portering BDGH	Complete within 30m	90%	N/A	 		
Portering MMH	Complete within 30m	62%	N/A	 		
Estates PPM DRI/MMH	Increase Completion	5,297 more		 		
Estates PPM BDGH	Increase Completion	880 more		 		
Estates Reactive DRI/MMH	90% Cat 1	94%	4%	 		Increase of 18%
Estates Reactive BDGH	90% Cat 1	100%	10%	 		increase of 8%
MTS DRI	100%	100%	0%	 	N/A	
MTS BDGH	100%	100%	0%	 	N/A	
MTS MMH	100%	0%	100%	 	N/A	recruitment in progress

Status Legend Reference		
Status	Value	Icon
Worse	-1	
Same	0	
Improve	1	
Worse than target	Red	
Better than target	Green	

2. Management Information

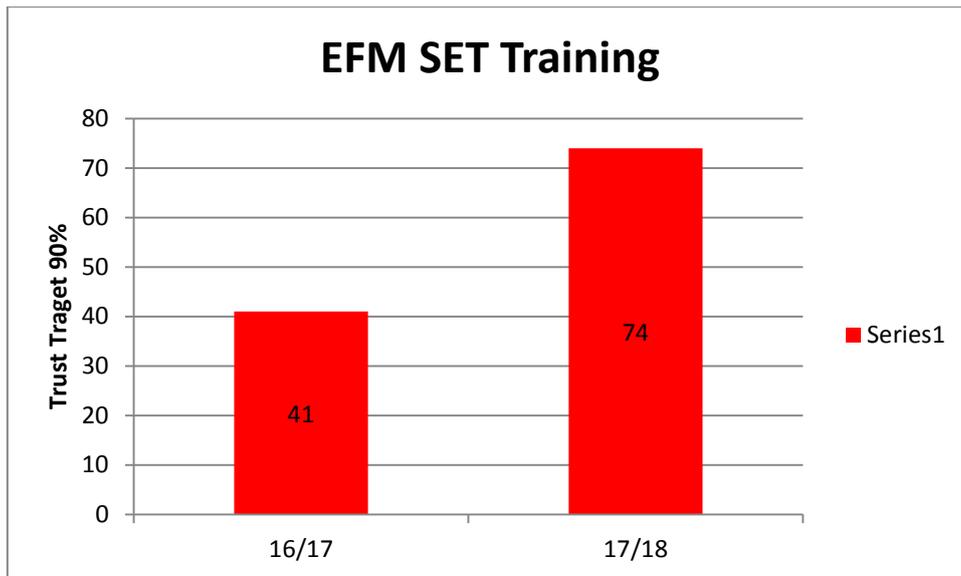
2.1 Appraisal

Having previously been a significant outlier with the lowest appraisal scores in the Trust, the Directorate has achieved the Trust target of 90% for the first time in a number of years.



2.2 Statutory and Essential Training (SET)

Whilst significant improvements have also been made to SET training, work continues to ensure E&F achieve 90% SET by end of Q1 18/19.



2.3 Sickness

E&F continues to be an outlier with average sickness percentages for 2017/18 being 5.02% in Estates and 7.03% in Facilities, with an overall cumulative total of 6.56% against a Trust target of 3.5%. Work continues to resolve long-term sickness and to effectively manage short-term sickness.

2.4 Staff Survey

Estates and Facilities staff survey results for 2017/18 showed a significant improvement when compared to 2016/17 with 69% of the 88 questions showing improved scores, some with significant improvements of up to 12%. The Directorate now have 6 scores that are significantly better than the Trust average, 2 of which are now the highest scores in the Trust, as shown at table 1.

Table 1. Scores Significantly Better than Trust Average/Trust Highest Score

Q number	Question	Trust Average	Estates & Facilities
10c	Don't work any additional unpaid hours per week for this organisation, over and above contracted hours	48	71 Highest in the Trust
11b	In the last month, have not seen any errors/near misses/incidents that could hurt patients	76	85 (up 5%)
14a	Not experienced physical violence from patients/service users, their relatives or other members of the public	81	92 (up 3%)

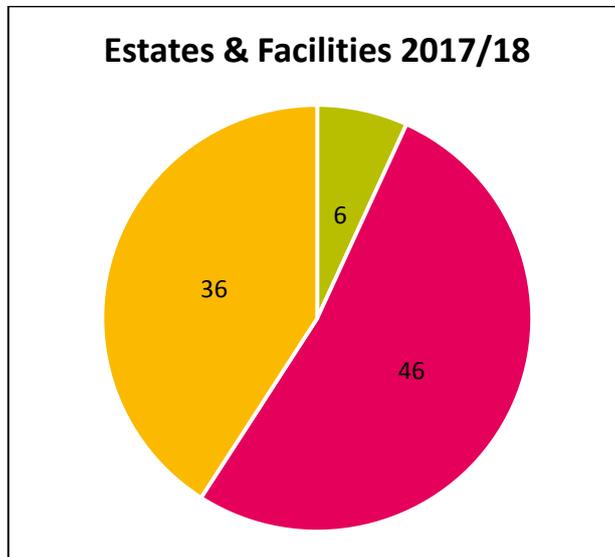
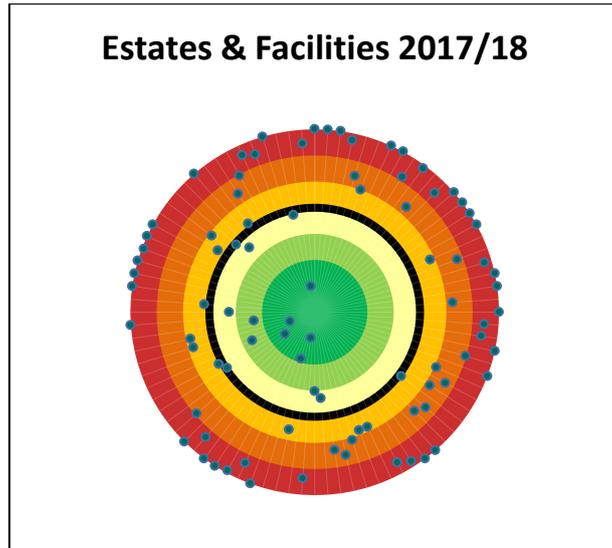
14d+	Last experience of physical violence reported	63	69 Highest in the Trust
15a	Not experienced harassment, bullying or abuse from patients/service users, their relatives or other members of the public	74	89 (up 5%)
17a	Not experienced discrimination from patients/service users, their relatives or other members of the public	96	99 (up 4%)
22c+	Feedback from patients/service users is used to make informed decisions within the directorate/department	49	64 (up 12%)

Other scores that have significantly improved in 2017/18 include many of the Organisation scores, as shown in table 2.

Table 2. Additional Most Improved Scores

Q number	Question	Trust Average	Estates & Facilities
18a+	Had training, learning or development in last 12 months	68	45 (up 8%)
20d	Appraisal/performance review: definitely left feeling work is valued	26	26 (up 9%)
21a	Care of patients/service users is organisations top priority	71	66 (up 7%)
21b	Organisation acts on concerns raised by patients/service users	69	61 (up 9%)
21c	Would recommend organisation as place to work	51	41 (up 9%)
22b+	Receive regular updates on patient/service users feedback in my directorate/department	51	52 (up 12%)

Despite these significant improvements, the Directorate has further work to do to improve scores within 46 questions where scores are significantly worse than the Trust average.



Estates and Facilities is:

- Significantly BETTER than average on 6 question(s)
- Significantly WORSE than average on 46 question(s)
- The scores were average on 36 question(s)

The sample size increased marginally in 17/18 to 24% from 22% in 16/17. The use of electronic surveys continues to deter our non-office based staff from completing the survey, despite releasing them from duties and providing computer rooms. In order to increase completion rates, the Directorate is working with P&OD to procure a survey facilitator that offers a paper-based option for 2018/19.

3 Estates and Facilities Compliance

The NHS PAM has been developed, with the support of the Department of Health (DOH) and industry bodies, to assist Trusts in reviewing their compliance management structures and processes in a consistent manner, bringing together:

- Compliance with Quality and Safety Standards, and
- Efficiency

The intention is to safeguard that one is not delivered at the expense of the other, helping to deliver a financially sustainable NHS that takes Quality and Safety as its organising principle, meeting the CQC Essential Standards of Quality and Safety Guidance 2015, updated in June 2017 to the Key Lines of Enquiry (KLOE).

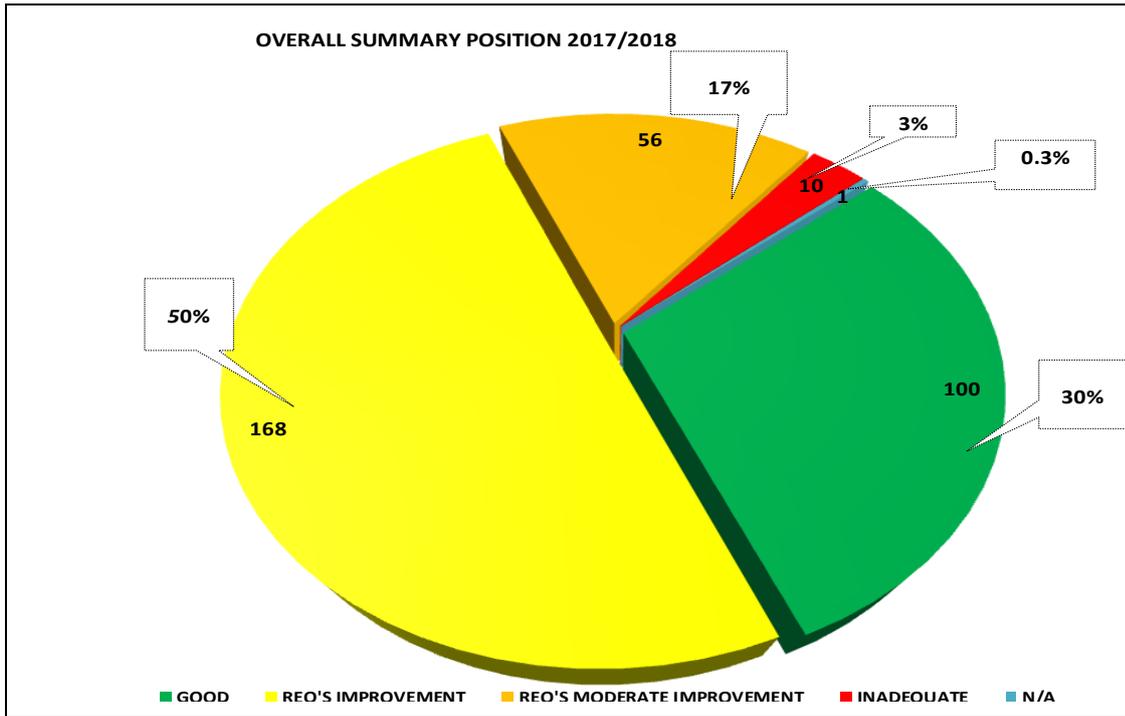
The Assessed Domains are:

- Efficiency
- Safety
- Effectiveness
- Patient Experience
- Organisational Governance

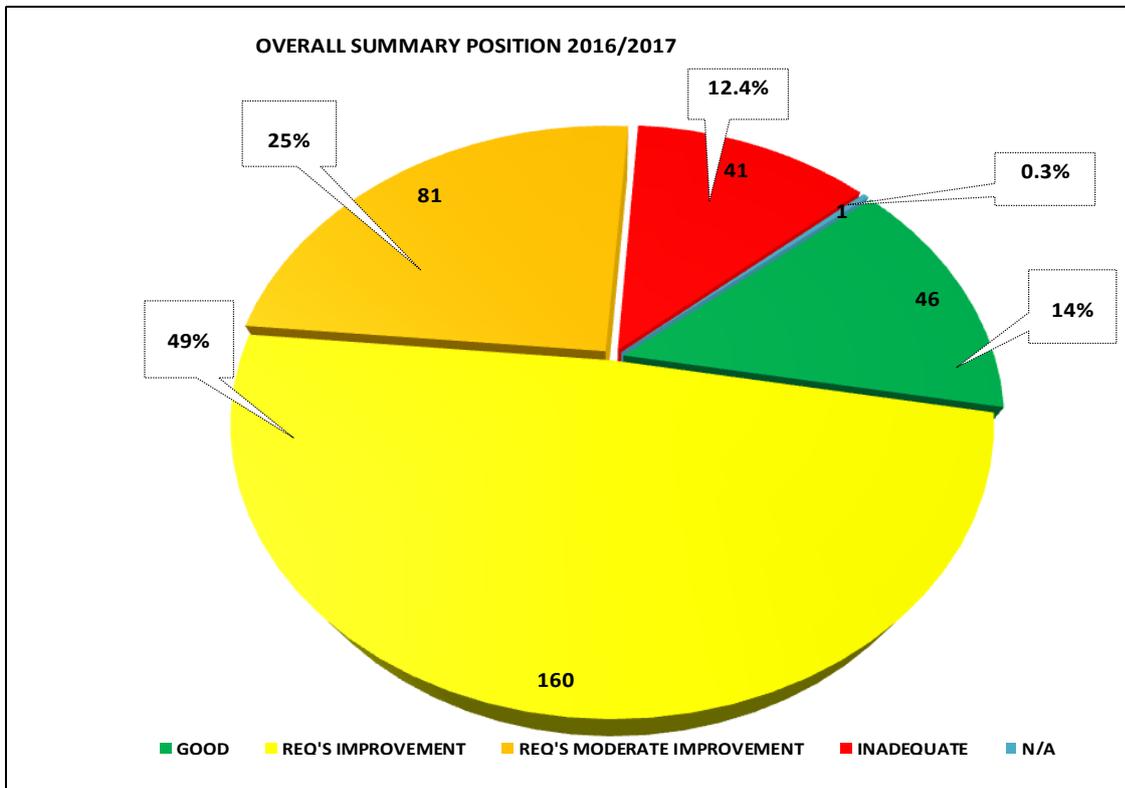
The first four Domains cover the main areas where E&F services impact on Safety and Efficiency. The Organisational Governance Domain acts as an overview of how the other four Domains are managed as part of the internal governance of the organisation. Its objective is to ensure that the outcomes of the Domains are reported to NHS Boards and embedded in internal governance processes to ensure actions are taken where required.

The NHS PAM overall summary position for DBTH has improved in all 5 Domains during 2017/18 by a total of 18% increasing the Trust overall rating to 80% 'Good/Requires Minimal Improvement', with 'Inadequate' ratings reducing to 3% from 12.4%. The majority of actions required moving forwards to improve the Trust scores further are linked to Capital Investment and are part of the draft 7 year EFM Capital Investment Programme which accompanies the 5 year EFM Strategy.

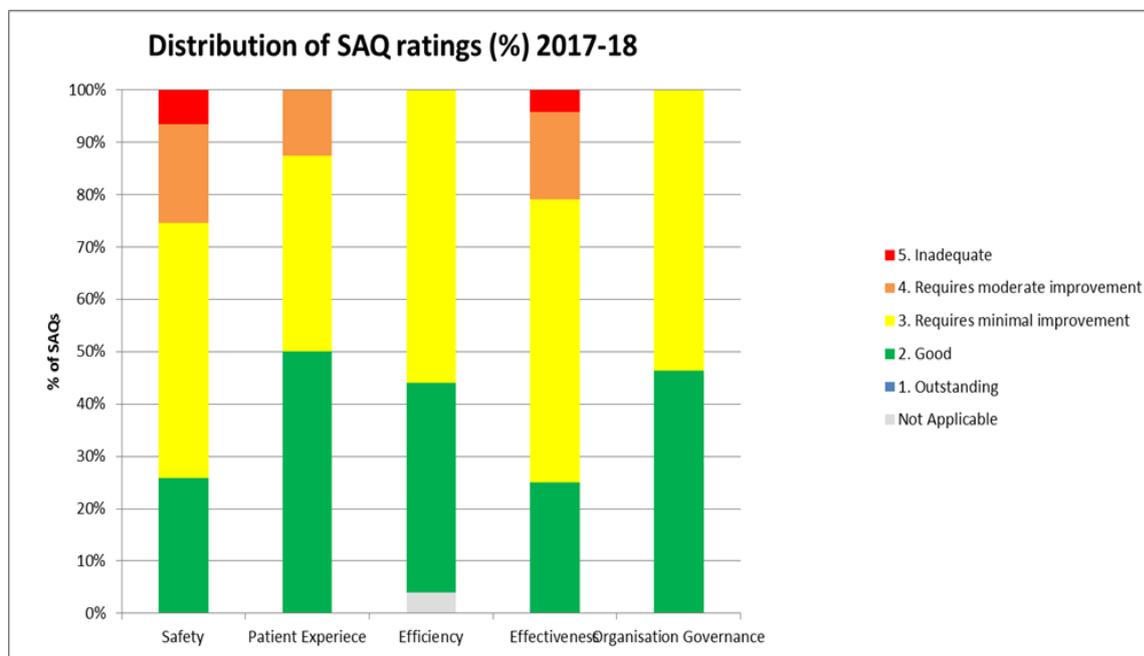
DBTH PAM Overall Summary Position for 2017/2018



DBTH Overall Summary Position for 2016/2017



NHS PAM DBTH Overall Summary Distribution of SAQ Ratings (%) for 2017-2018.



Legend

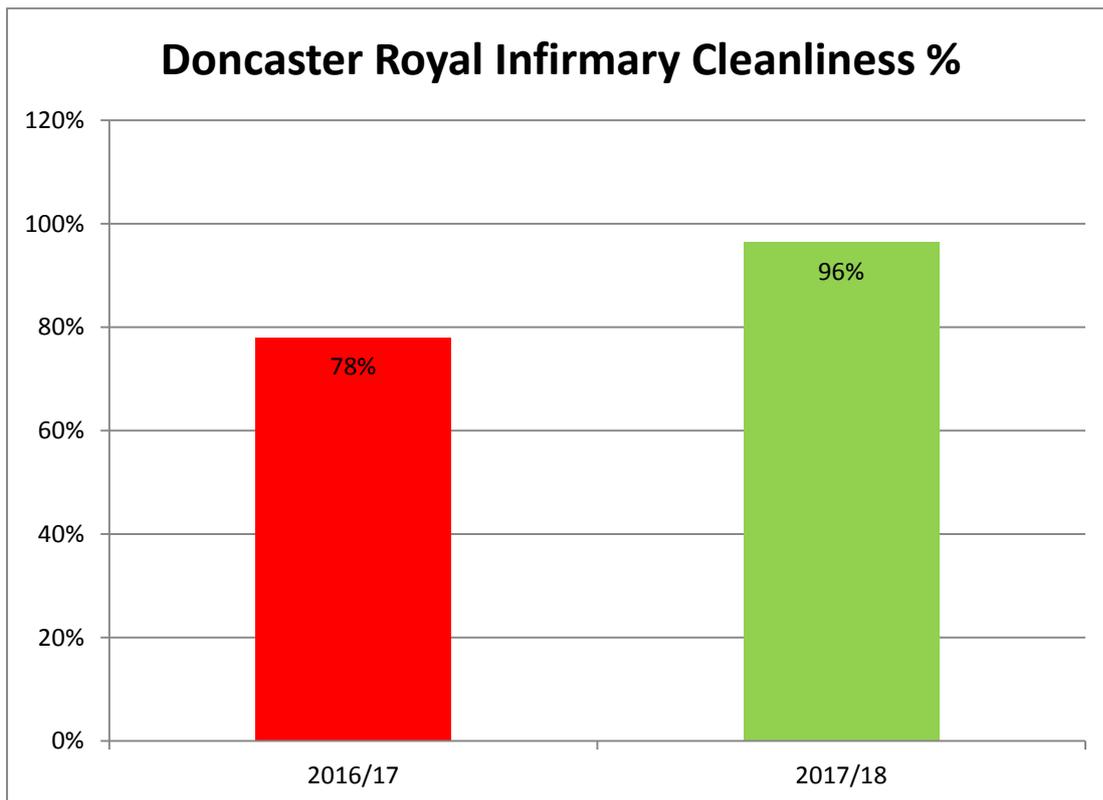
Domain	Domain statement
Safety	The organisation provides assurance for Estates, Facilities and its support services that the design, layout, build, engineering, operation and maintenance of the estate meet appropriate levels of safety to provide premises that supports the delivery of improved clinical and social outcomes.
Patient experience	The organisation ensures that patient experience is an integral part of service provision and is reflected in the way in which services are delivered. The organisation will involve patients and members of the public in the development of services and the monitoring of performance.
Efficiency	The organisation provides assurance that space, activity, income and operational costs of the estates and facilities provide value for money, are economically sustainable and meet clinical and organisational requirements.
Effectiveness	The organisation provides assurance that its premises and facilities are functionally suitable, sustainable and effective in supporting the delivery of improved health outcomes.
Organisation governance	How the organisations board of directors deliver strategic leadership and effective scrutiny of the organisations estates and facilities operations. How the other four Domains are managed as part of the internal governance of the NHS organisation. Its objective is to ensure that the outcomes of the Domains are reported to the NHS Boards and embedded in internal governance and assurance processes to ensure actions are taken where required.

4 Facilities Performance

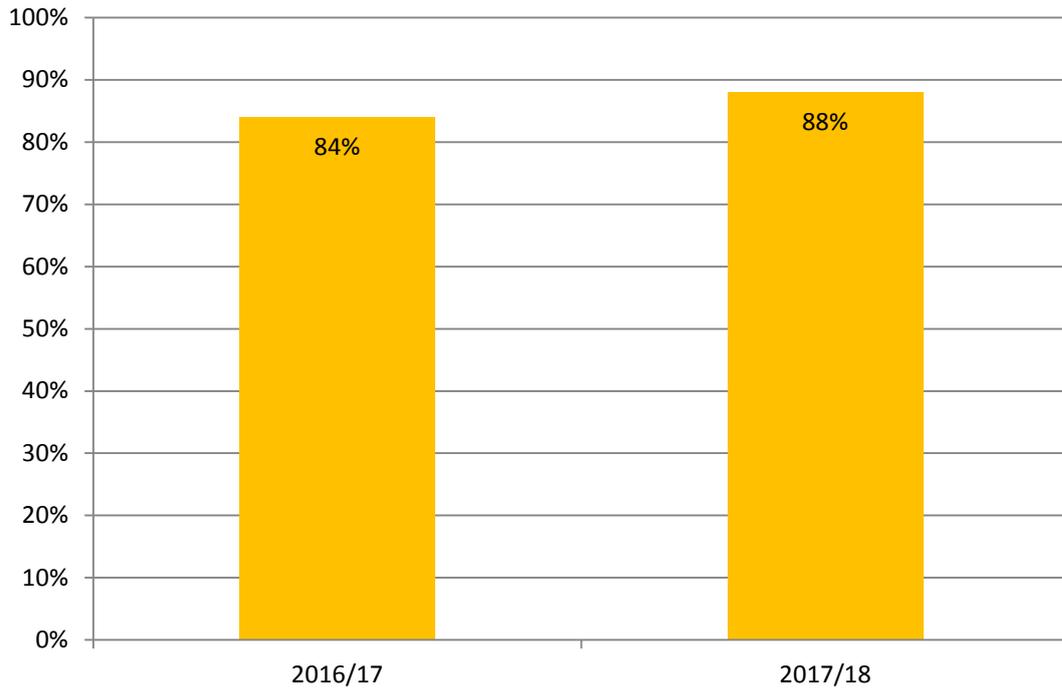
4.1 Hospital Cleanliness

Ratings of cleanliness by Patients in the National Patient Survey 17/18 rated cleanliness for the organisation with a highest score of 1, with DBTH being better than the National Average.

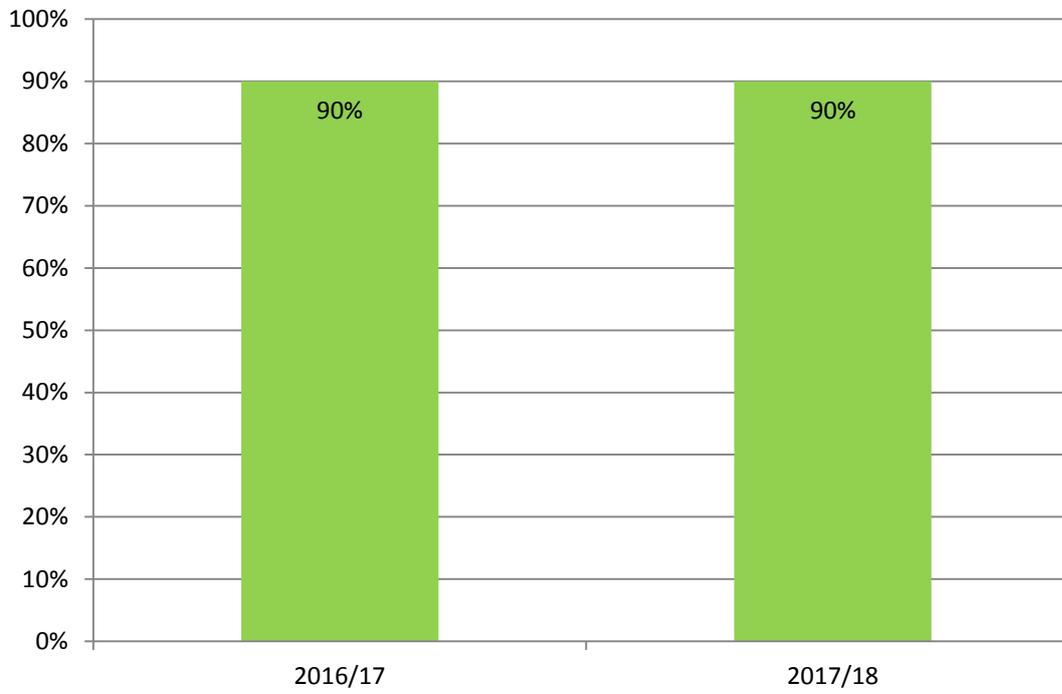
Following the implementation of a new LEAN Zonal service model at DRI in February 2017 there has been a significant improvement in average cleanliness scores, exceeding the Trust internal standard of 90%. MMH has continued to achieve the Trust standard of 90%, however despite a small improvement of 4%, BDGH has continued to fall below the Trusts internal standard scores. Following the Post Project Implementation Review of the DRI LEAN project in March 18, there will now be a review of the BDGH site to establish if quality standards can be improved by adopting the same LEAN Zonal Model as DRI.



Bassetlaw Cleanliness %

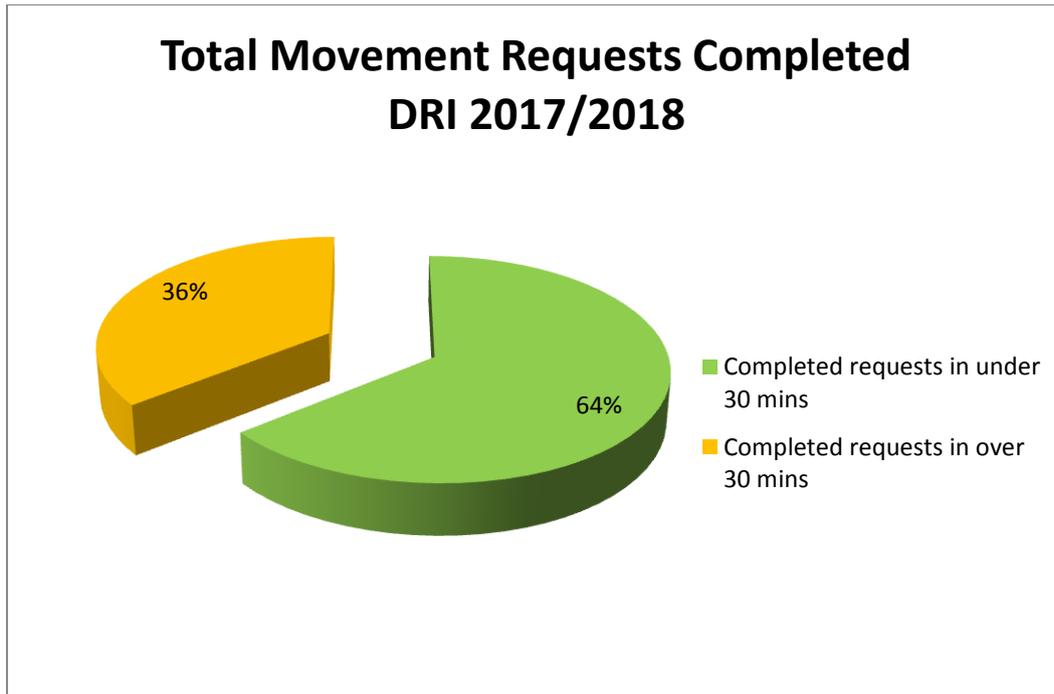


Montagu Cleanliness %

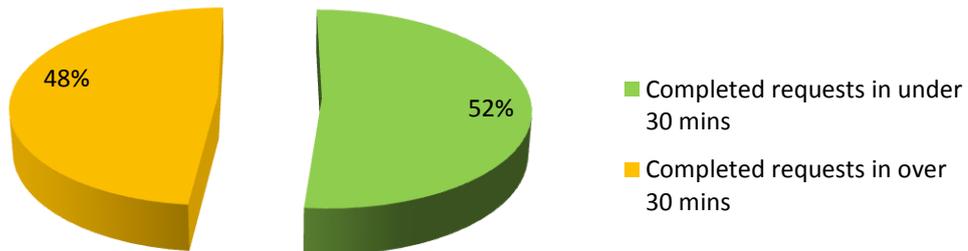


4.2 Portering Response

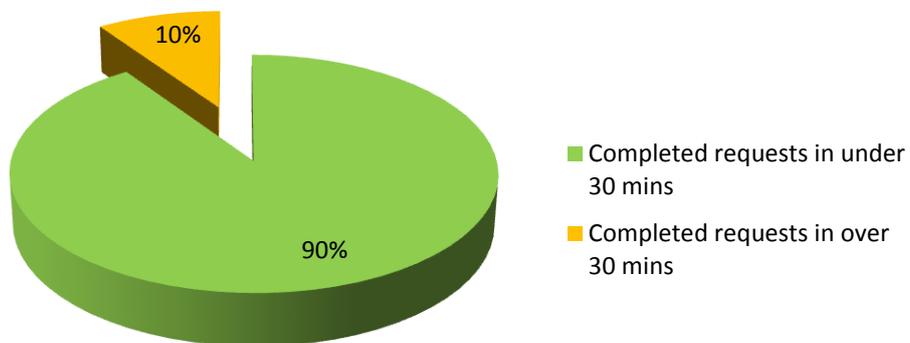
In addition to improving cleanliness scores at DRI, the new LEAN Zonal model also improved portering response times by 12% at DRI. However, delays in the system (patient not ready, no wheelchair, nurse related etc) led to 36% of jobs being completed outside of the Trust target of 30mins at DRI, and by 38% at MMH. These delays do not impede performance to the same extent at BDGH, and work continues to identify and share best practice between sites and to work with wards and departments to reduce delays in order to improve performance.



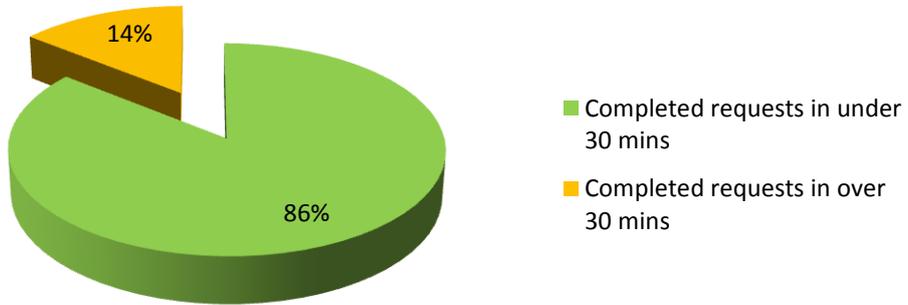
Total Movement Requests Completed DRI 2016/2017



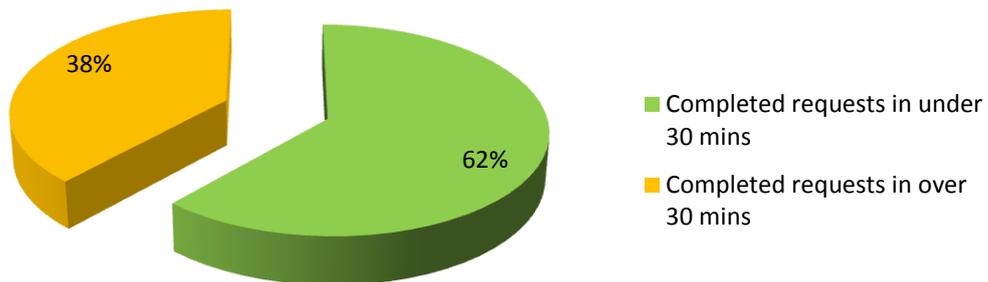
Total Movement Requests Completed BDGH 2017/2018



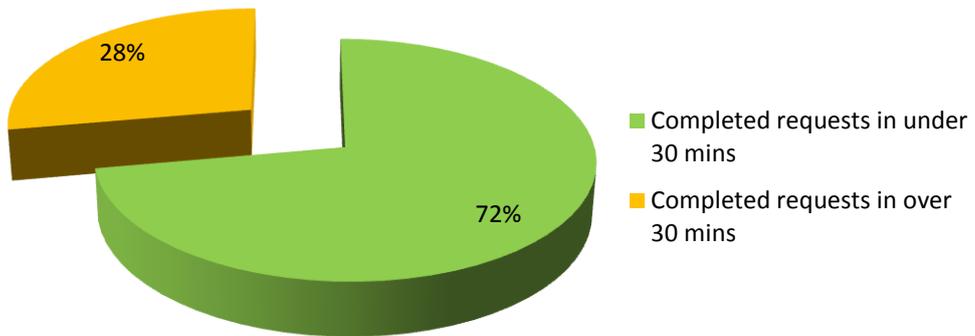
Total Movement Requests Completed BDGH 2016/2017



Total Completed Movement Requests MMH 2017/2018



Total Completed Movement Requests MMH 2016/2017



Examples of Facilities Dashboards

Central Service KPI Report Update March 2018

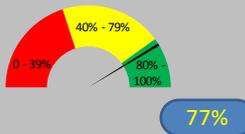
Total Number of Dispatches Per Month



Average Number of Jobs Per Hour

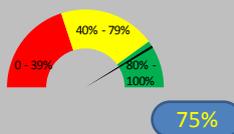


% Productive January



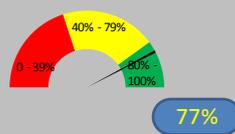
Percent of productive hours for the department during the reporting month

% Productive February



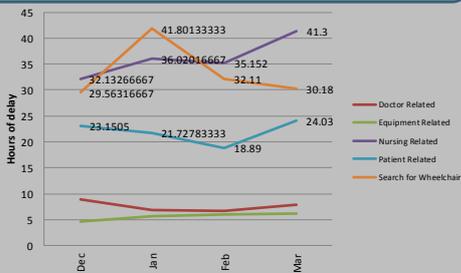
Percent of productive hours for the department during the reporting month

% Productive March

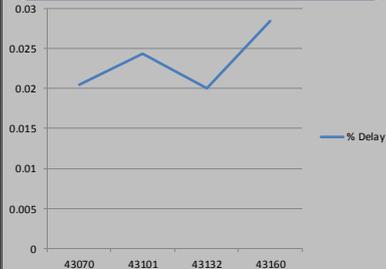


Percent of productive hours for the department during the reporting month

Hours of Delay Top 5 Reason Code Per Month



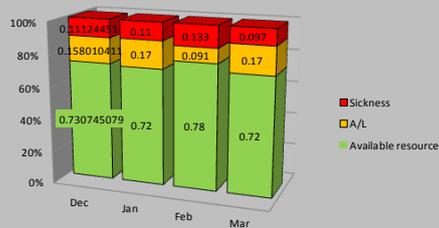
Percent of Portering Staff Lost Due to Delays Per Month



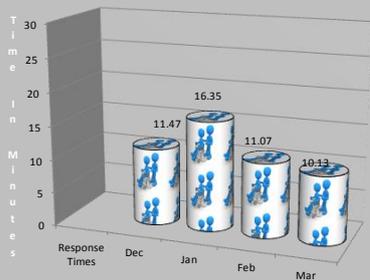
Percent of Wheelchairs, Beds & Trolleys used for patient movement by month



Resource Availability Breakdown

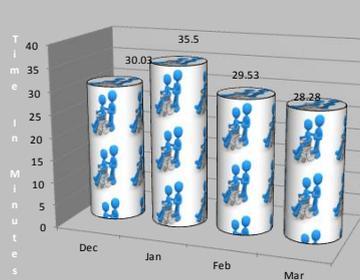


Average Pending Time (Patient Moves Only) (Request to Porter Allocated)



Average Minutes a patient job is waiting for porters to be allocated to the job. Our Pending Time target is 15 mins or less

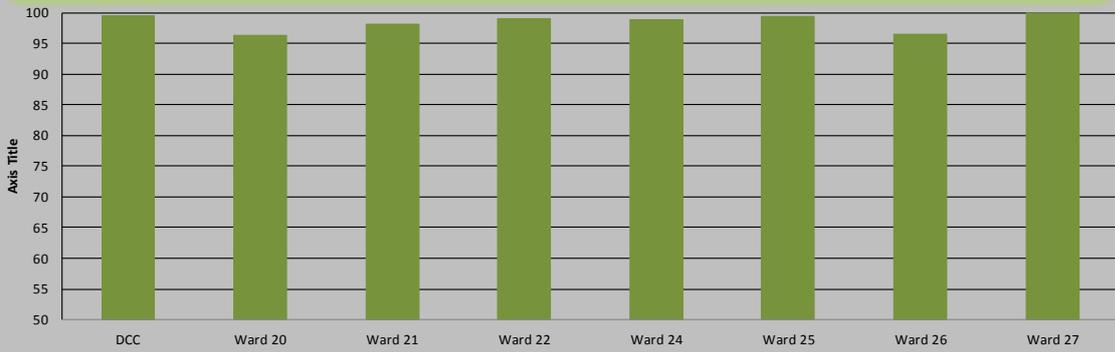
Average Trip Time (Patient Moves Only) (Porter Requested to Complete)



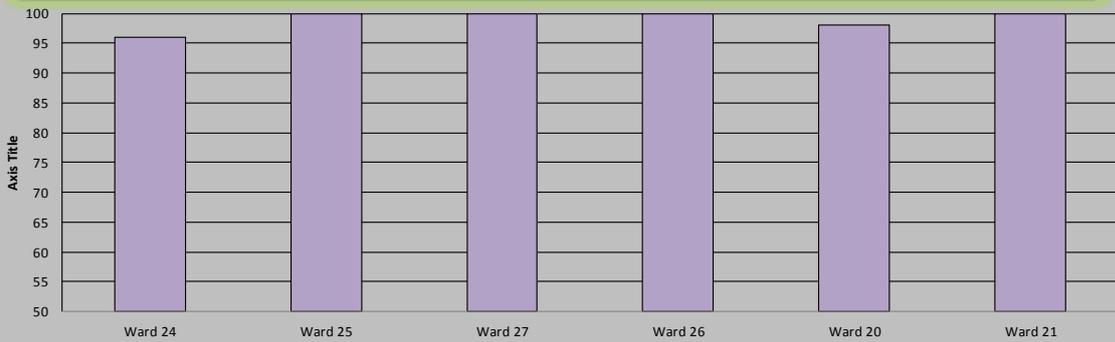
Average Minutes a patient job takes from being requested to being completed. Our Trip Time Target is 30 mins or less

Zone 3 KPI Report Update March 2018

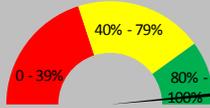
MiC4C Cleanliness Audit Scores March



IPC Cleanliness Audit Scores 2017/18



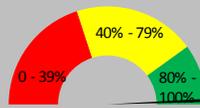
% S.E.T. Compliance



96.5%

Percent of staff completed statutory & essential training

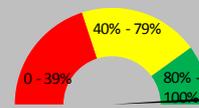
Annual Leave Usage YTD



98.2%

% planned annual leave used YTD -Resource Management-

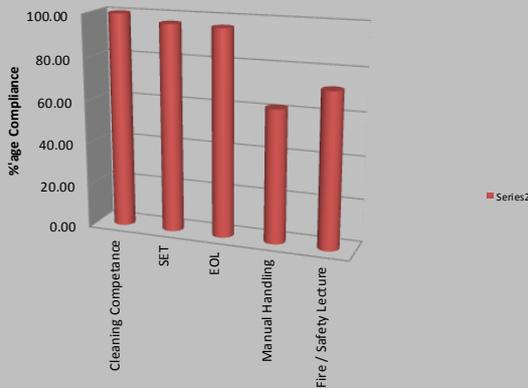
% Resource Input Hours



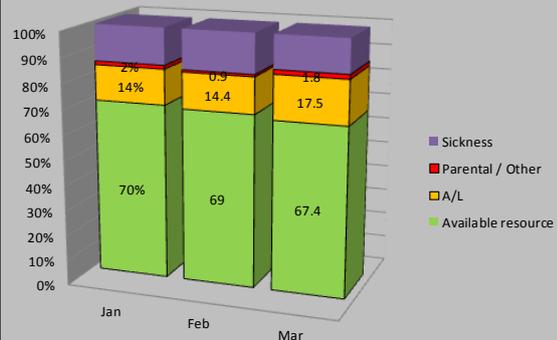
97.9%

Hours input as a % of hours planned during the reporting month

Staff Training Compliance %



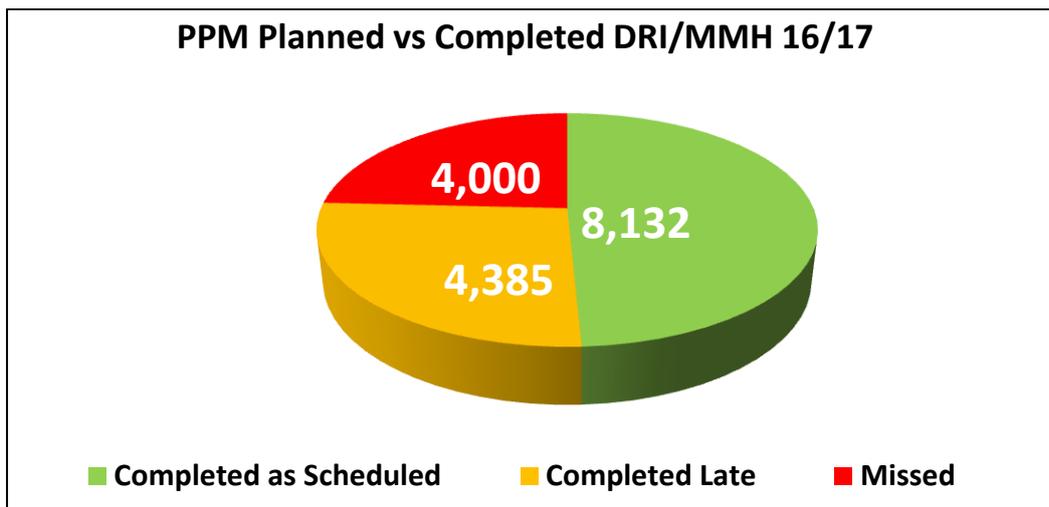
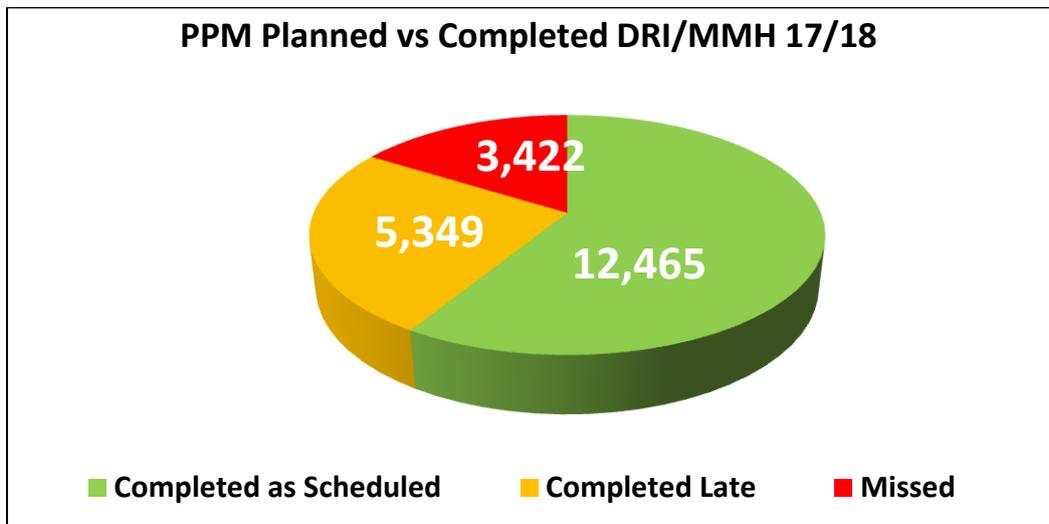
Resource Availability Breakdown



5 Estates Performance

5.1 Planned Preventative Maintenance (PPM) DRI/MMH

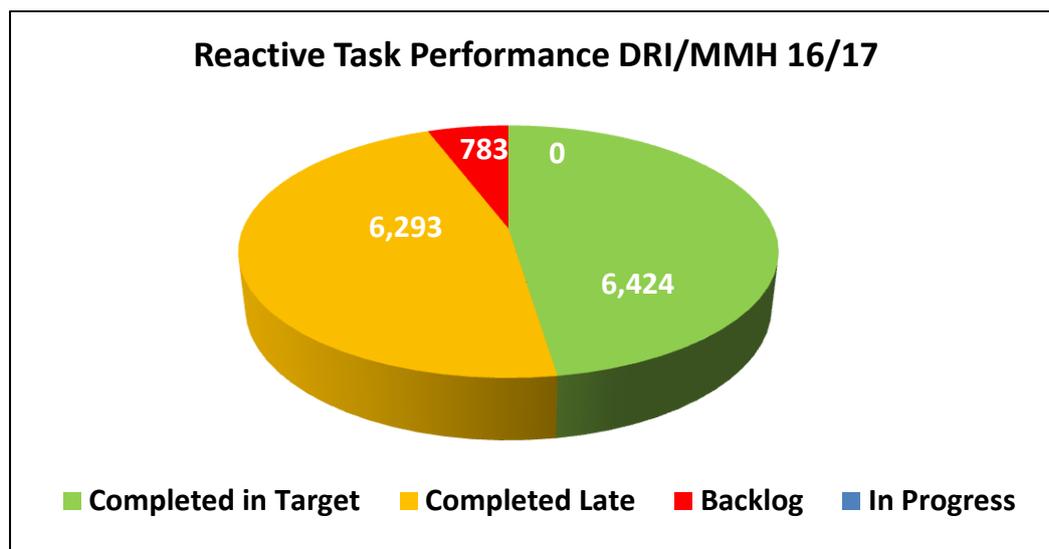
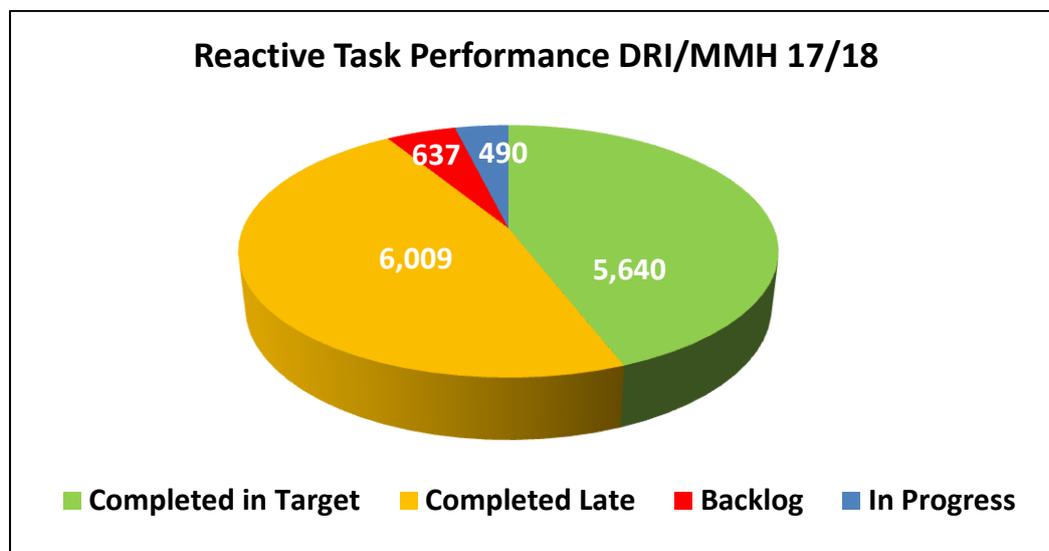
Completion of PPM's significantly improved in 2017/18 at DRI/MMH with 4,333 more PPM's being completed as scheduled, and a total of 5,297 more PPM's being completed in 17/18 compared to 16/17. There were also 578 less missed PPM's, despite a PPM review and an increase of 4,719 additional PPM's being added to the Planet system in 17/18 in order to improve safety and compliance.

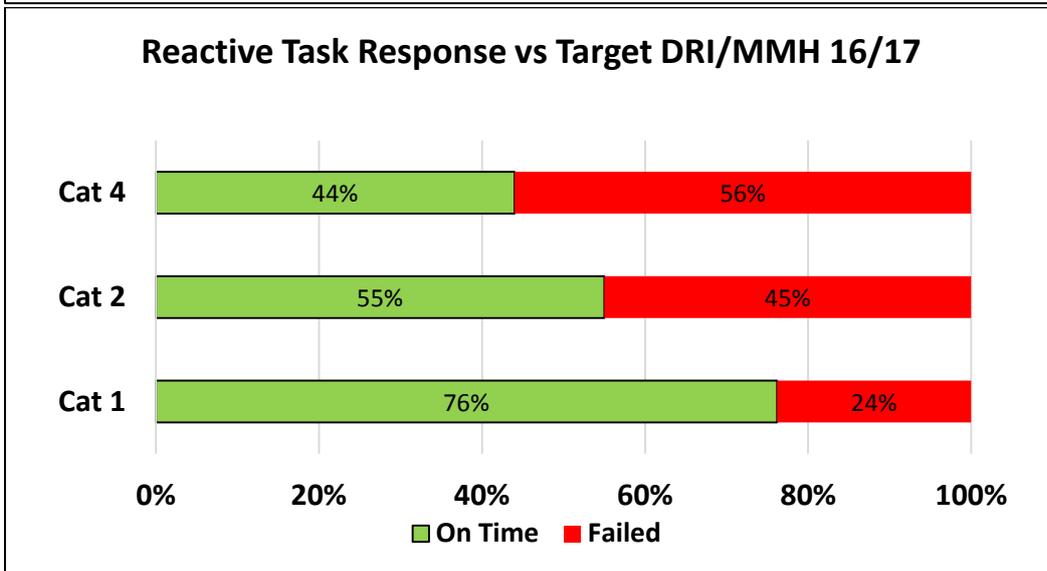
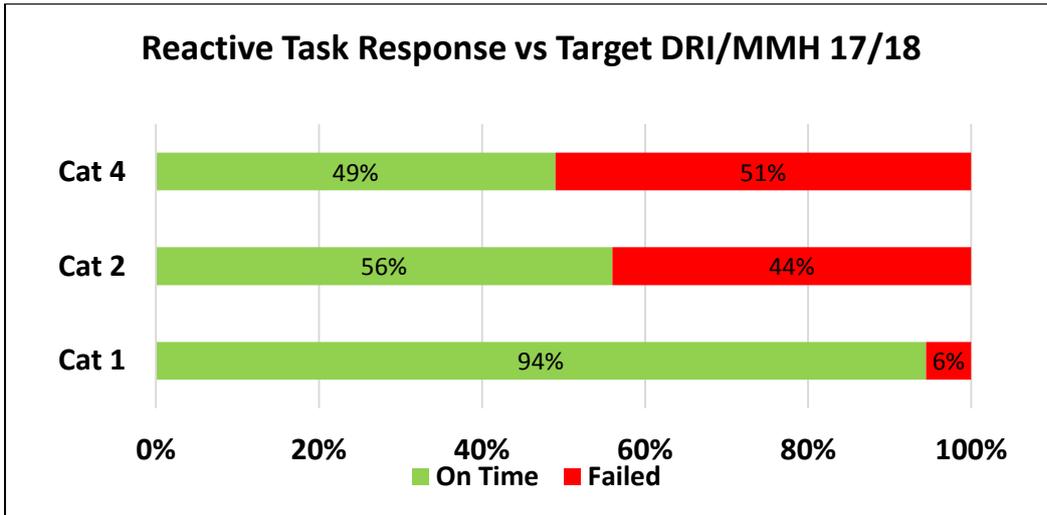


5.2 Reactive Maintenance DRI

Completion of Reactive Maintenance tasks significantly improved in Q1 and Q2 with no jobs being outstanding on the system at DRI/MMH. However, due to the need to manage services within budget in Q3 and Q4, jobs undertaken were contained to the most urgent 'must do'. This led to a build-up of 637 outstanding jobs on the system by the end of the year.

In terms of overall performance, despite the rationing of job completion in Q3 and Q4, the data shows that 18% more Category 1 jobs were completed on time.

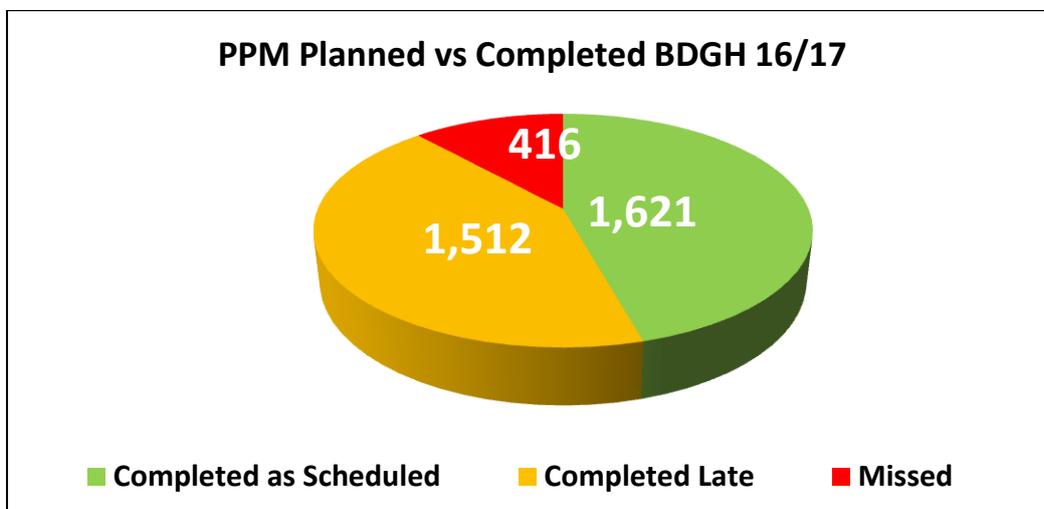
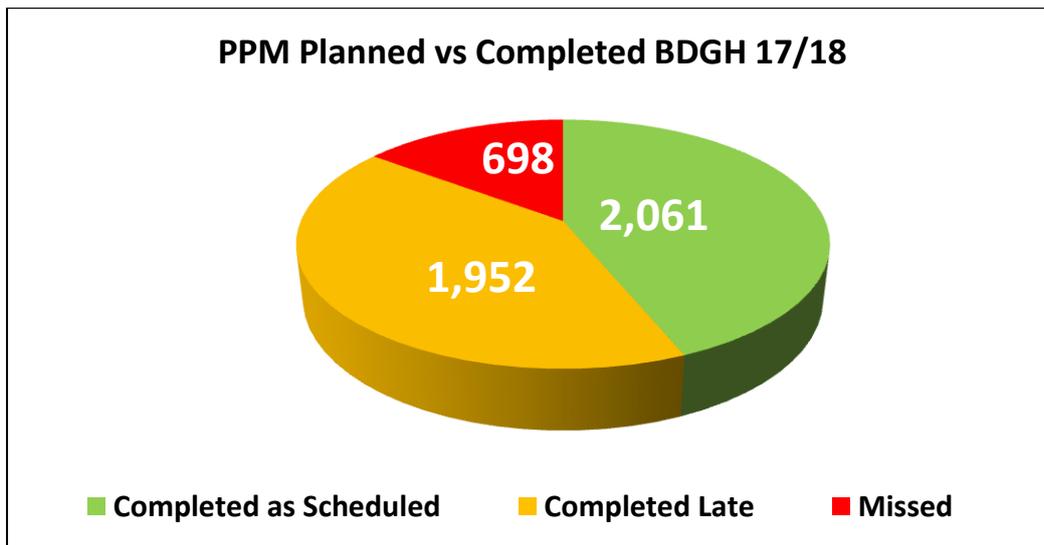




CATEGORY 1 (EMERGENCY) RESPONSE = ATTEND WITHIN 1 HOUR - RESOLVE WITHIN 8 HOURS
CATEGORY 2 (URGENT) RESPONSE = ATTEND WITHIN 8 HOURS - RESOLVE WITHIN 12 HOURS
CATEGORY 3 = STATUTORY/MANDATORY/ESSENTIAL PPM
CATEGORY 4 (NON-URGENT) RESPONSE = ATTEND WITHIN 5 WORKING DAYS RESOLVE WITHIN 10 WORKING DAYS

5.3 Planned Preventative Maintenance BDGH

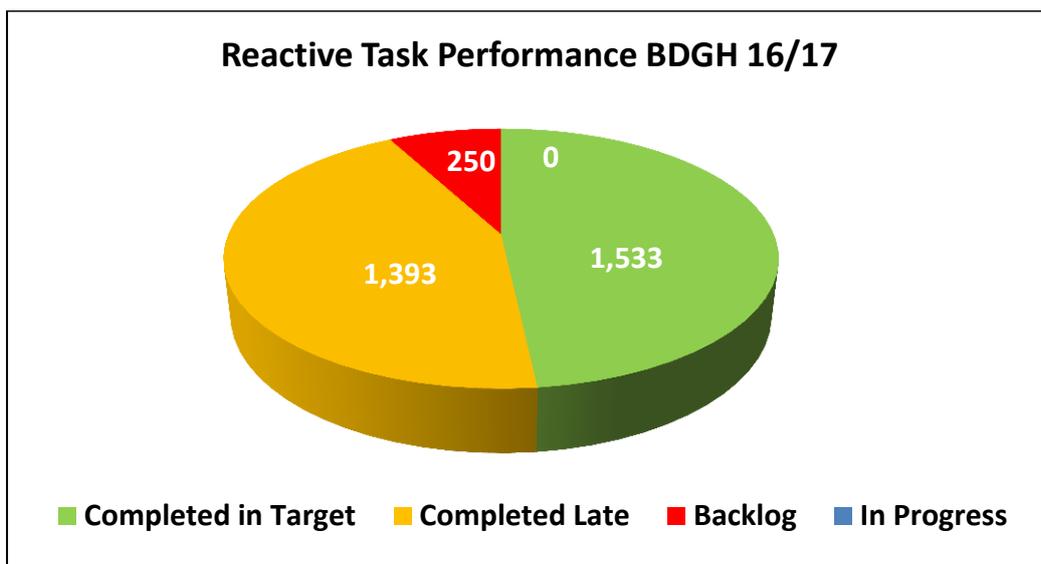
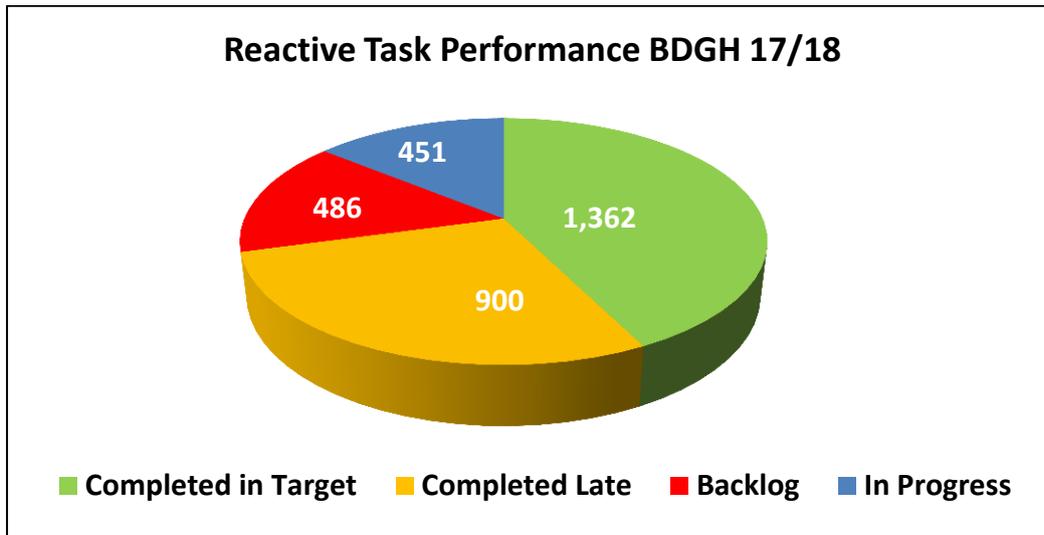
At BDGH 440 more PPM's were completed as scheduled, and a total of 880 more PPM's were completed in 17/18 compared to 16/17. There was an increase of 282 missed PPM's, although performance had still improved as a PPM review increased the overall PPM schedule by 1,162 in order to improve safety and compliance.

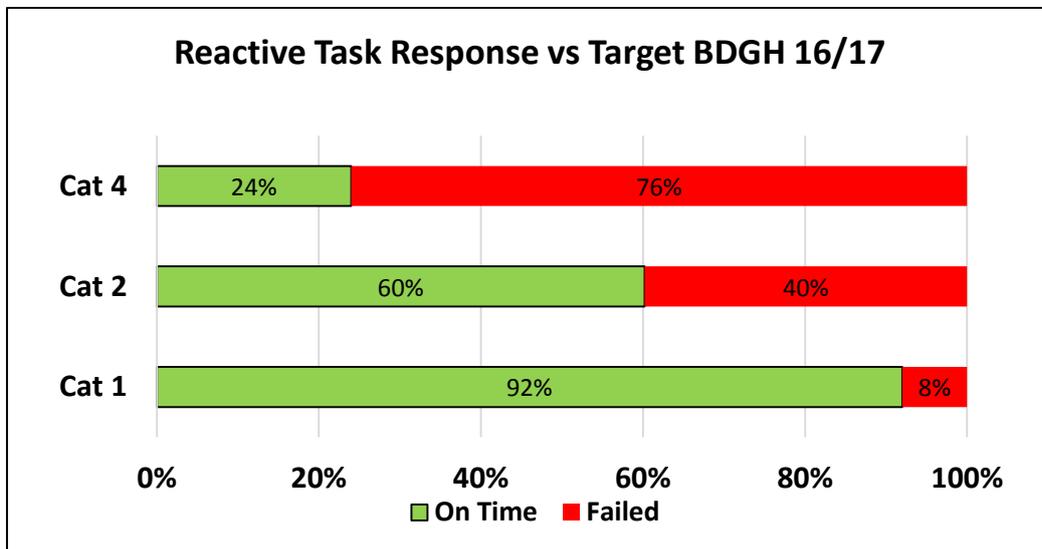
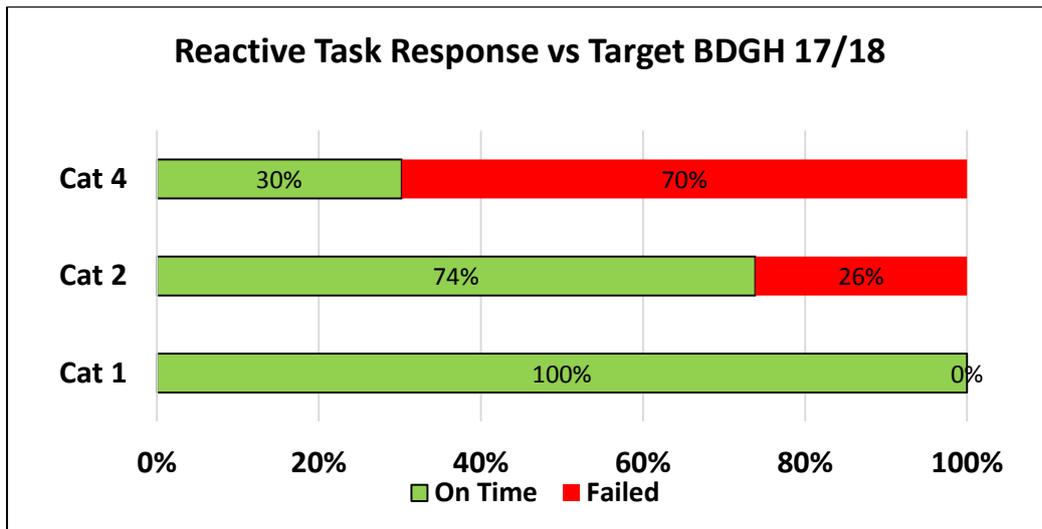


5.4 Reactive Maintenance BDGH

Completion of Reactive Maintenance tasks significantly improved in Q1 and Q2 with very few jobs being outstanding on the system at BDGH. However, due to the need to manage services within budget in Q3 and Q4, jobs undertaken were contained to the most urgent 'must do'. This led to a build-up of 451 outstanding jobs on the system by the end of the year.

In terms of overall performance, despite the rationing of job completion in Q3 and Q4, the data shows that 100% of Category 1 jobs were completed on time, an increase of 8%.





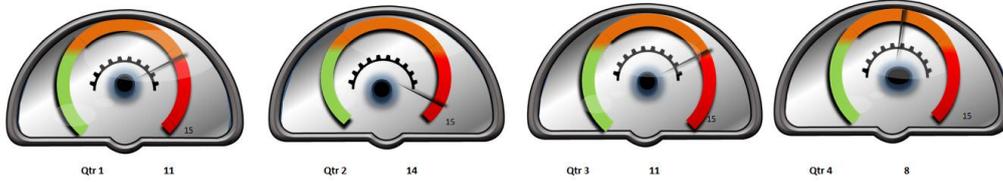
6 Medical Technical Services (MTS) - Annual Dashboard

Due to an upgrade of database in 2016/17 it has not been possible to provide a comparison of performance between 16/17 and 17/18. The MTS dashboard shows that 100% of condition monitoring jobs were completed as planned at DRI and BDGH, although some slippage was experienced at MMH this is now planned for Q1 18/19.

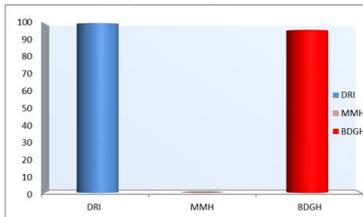
Average response times range over the quarters from 8 to 14 days, a new internal response target has been set for 2018/19 of 4 days.

MTS KPI Dashboard '17/18'

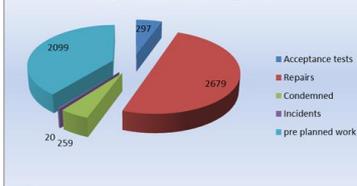
Average response times, in days for all work activity - Target for 18/19 is 4 days



Condition Monitoring program % of areas completed

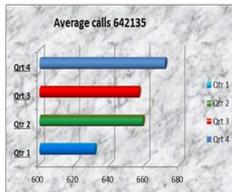


17/18 MTS Work spread



Appraisals in 2017/18	100%
SETS completed in 2017/18	100%
Sickness level in 2017/18	3.32%

Montagu hospital condition monitoring has slipped in the 17/18 program and is scheduled for early May 18



Average calls to MTS reception



Average answer time Target 10 secs

Medical Technical Services (MTS)

MTS carry out management and maintenance services to the trusts wide range of medical devices. This includes provision of medical gas to the trust, operation of the equipment library, Condition monitoring, being ward and department based inspections of equipment. Repairs, servicing and calibration. We also manage external contracts with specialist support companies. In addition MTS offers advice on , procurement, maintenance, training, and disposal of equipment.

Notes

In 17/18 MTS replaced its master equipment database and as a result some data transfer issues were identified. This has resulted in 2016/17 data being unreliable. Average work activity response times are higher than the target of 4 days due to key staff movement in year.

7 Conclusion and Recommendations

The Performance Data provided demonstrates the significant improvements to the quality and efficacy of E&F services achieved in 2017/18.

Further work is now required to build upon the improved staff survey results, and to increase uptake of the survey. A review of BDGH cleaning is required to assess potential for learning from the LEAN Zonal model at DRI, and also to work with wards and departments to reduce delays which adversely impact Portering performance. MTS wish to improve their average response times with a new KPI of 4 days being introduced in 18/19. The Directorate will continue to work with colleagues in P&OD to reduce long-term sickness and to manage short-term sickness.

The Board of Directors is asked to note the content of this E&F Performance report and the progress made.



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

NHS Premises Assurance Model (PAM) Assessment 2017/2018



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Executive Summary

The NHS Premises Assurance Model (NHS PAM) has been developed, with the support of the Department of Health (DOH) and industry bodies, to assist Trusts in reviewing their management structures and processes in a consistent manner, bringing together:

- Compliance with Quality and Safety Standards, and
- Efficiency

Safeguarding that one is not delivered at the expense of the other and helping to deliver a financially sustainable NHS that takes Quality and Safety as its organising principle, meeting the CQC Essential Standards of Quality and Safety Guidance 2015, updated in June 2017 to the Key Lines of Enquiry (KLOE).

The objectives behind the NHS PAM support the NHS constitution pledge:

“to provide services from a clean and safe environment that is fit for purpose based on national best practice” and the current regulatory requirements to ensure that “service users are protected against risks associated with unsafe and unsuitable premises”.

In simple terms the NHS PAM is a complex spreadsheet that can be used to collect a snapshot of the organisation’s fitness for purpose at a point in time. It does this through a series of Self-Assessment Questions (SAQ’s) and produces a summary report that can be used to demonstrate the overall state of the organisation to its service users, commissioners and regulators. Its purpose is to support the organisational aim of ensuring that the premises and associated services are safe.

The NHS PAM has been utilised by a small number of Trusts for several years with DBTH commencing participation in 2013 through PAM working groups and collaboration locally. A major revision released in May 2014 and updated more recently in January 2016 radically altered the extent of the PAM package reflecting changes in Policy, Strategy, Regulations and Technology. This version is built around 5 Domains and a series of common questions.

The Domains are:

- **Efficiency**
- **Safety**

- **Effectiveness**
- **Patient Experience**
- **Organisational Governance**

The first four Domains cover the main areas where Estates and Facilities (E&F) impacts on Safety and Efficiency. The Organisational Governance Domain acts as an overview of how the other four Domains are managed as part of the internal governance of the NHS organisation. Its objective is to ensure that the outcomes of the Domains are reported to NHS Boards and embedded in internal governance processes to ensure actions are taken where required.

The following report provides an overview of PAM and the process and methodology utilised by the DBTH E&F team when undertaking the PAM assessment. The report provides information from the PAM assessment for 2017/2018 and covers all 5 PAM Domains, illustrating areas of improvement made by the Trust from the previous year's 2016/2017 PAM assessment providing a basis for comparison annually. The report also outlines areas of deficiency that require further improvement, and in some cases investment to bring the Trust up to an all-round Good rating.

1. Introduction

The NHS PAM is designed to provide an overview for Board level assurance purposes of the organisational management of the Trust as a whole, split into 5 Domains (with the Safety Domain sub split into Hard and Soft), and does not function based on Property or Divisional splits within an organisation.

This assessment of the DBTH PAM has been undertaken using the current model and reflects the Trust's position as at 2017/2018. The methodology utilised has been developed by a number of other Trusts, information obtained from the Grovenbridge Academy (GA), and in conjunction with the identified responsible Trust management members of the DBTH PAM working Group.

This methodology takes the PAM SAQ's into a working group Evidence File and records responsibilities by named post holder along with evidence and commentary provided by the responsible Trust staff members against each of the SAQ working group documents.

Within the evidence file the SAQ responses have been split to reflect these disparate functionalities, and an overview taken as to the Organisational position in relation to the evidence provided from the different functional areas. This allows a Trust wide position to be established for the PAM responses.

The end scores and grading of the assessments are conditional upon the views taken by the individuals and team members conducting the assessments. For this reason, and to deliver consistency, the Evidence File approach allows for the same view across multiple years ensuring ongoing PAM assessments will be consistent with the initial assessment undertaken by the DBTH PAM working Group.

The following section of the report provides an overview of the PAM process undertaken by DBTH, and explains what constitutes evidence for the PAM working groups and DBTH PAM report.

2. The PAM Assessment Process

Initially a number of large PAM working groups were undertaken with various members of the E&F team, and a number of stakeholders including Clinical Leads, Infection, Prevention and Control (IPC) Leads, and General Managers across the Trust. These large working groups included a series of presentations explaining PAM and the process that the Trust was undertaking to complete the PAM assessments. From these large working groups, smaller working groups were established to prime the PAM Evidence File and identify key names and contact details for each of the PAM SAQ's. The objective was to target the most Senior Manager who had direct responsibility for the area of the SAQ to avoid dispersing the evidence collection across too many staff members. The Evidence File was then broken down into staff based working group documents which were sent individually to each responsible staff member for them to complete and return.

Once the Evidence File was considered to be complete, a review of the returns was conducted and each SAQ element given a score within the pre-determined 'Inadequate, Requires Moderate Improvement, Requires Minimal Improvement, Good and Outstanding' grades given within the PAM working document. There is also a Not Applicable (N/A) grade but with a Trust the size of DBTH it was agreed at the outset that there were no SAQ areas that would be classified as this, apart from the Efficiency Domain F2 – *'does the Trust have a well-managed approach to the running of PFI and LIFT contracts'* as the Trust does not currently run PFI or Lift contracts.

At various points in the process the PAM working group Evidence File scores were manually transferred into the working copy of NHS PAM and the report produced and shared with the E&F Senior Management Team by way of a PAM summary report for review. The outcome from the summary report review provides feedback to the PAM working group members, reinforcing the requirement for prompt evidence submission for the assessment year.

2.2 What Constitutes Evidence

PAM calls for documented evidence of robust policies and procedures. Rather than collect a full batch of physical policy documents that would become outdated through the anticipated lifecycle of the PAM exercise, it was agreed to accept evidence of these documents existence from each individual Responsible Person, with adhoc audit. Within the working group Evidence File staff submit the Approved Procedural Document (APD) details linked to the Trust Intranet and procedures stored on the DBTH Shared drive locations of relevant documentation. Approval,

Review and Expiry dates are also provided to enable an auditing process through the PAM working group Evidence file.

All other required documentation evidence is uploaded into individual working group folders by the responsible members of the individual working groups and transferred onto the Trust Micad Computer Aided Facilities Management (CAFM) System for transparency and assurance.

2.3 The Report

The report provides information from the PAM assessment for 2017/2018 and covers all 5 PAM Domains including an Overall Summary Position for DBTH, illustrating areas of improvement made by the Trust from the previous year's 2016/2017 PAM assessment as a basis for comparison. The Trust Overall Summary Position for 2017/2018 is 80% Good/Requires Minimal Improvement compared to 2016/2017 score of 62%. The report also outlines areas of deficiency that require further improvement, and in some cases investment, to achieve compliance with Legislation, Approved Codes of Practice (ACOP's) and Guidance, to bring the Trust up to an all-round Good rating.

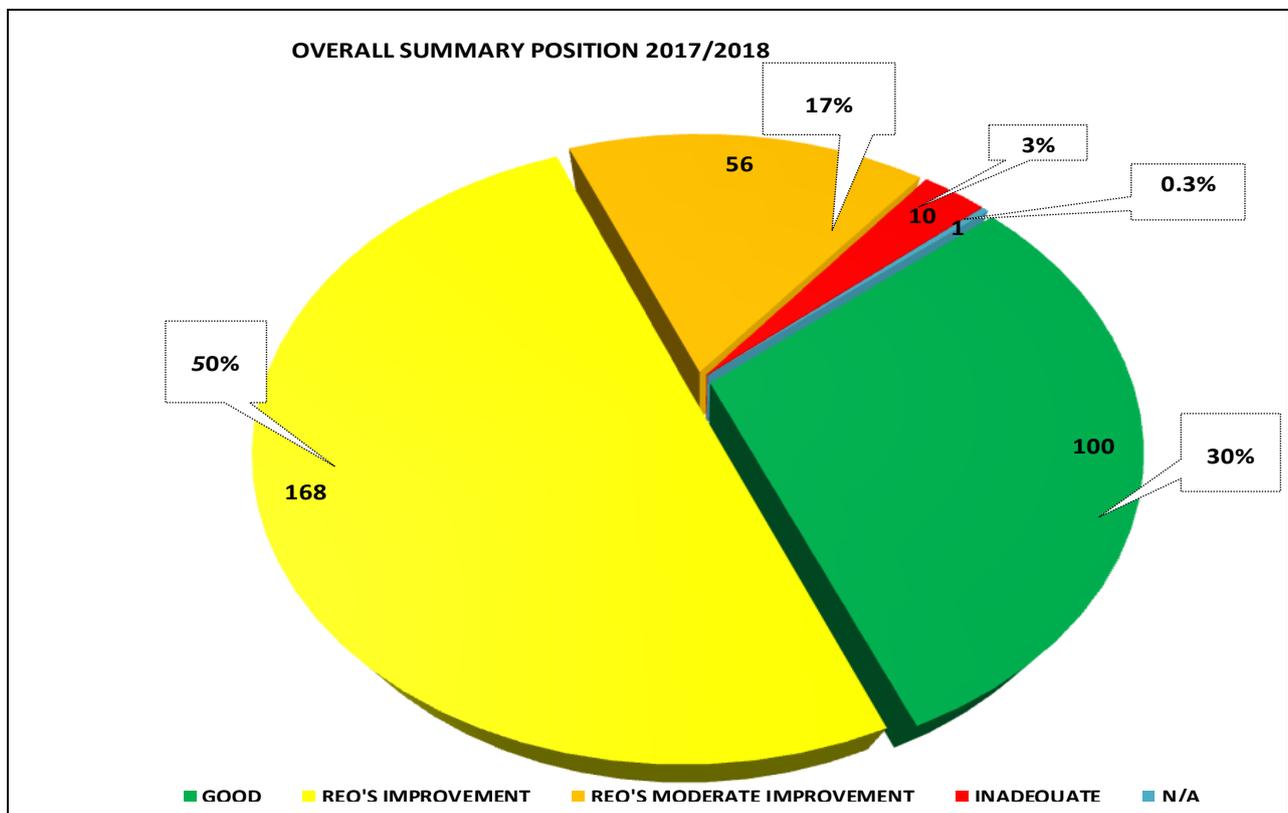
The reporting features of PAM as issued by the DOH are somewhat limited and because of the complexity of the spreadsheet within which the responses are held, it is difficult to add custom reports. Therefore the following report for DBTH 2017-2018 draws on the reports that are available within the PAM working documents and the commentary provided by the PAM working group exercises undertaken.

3. Overall Summary Position for PAM 2017-2018

The PAM Distribution of SAQ Ratings for 2017-2018 shows DBTH to be Good in 100 elements, requiring Minimal Improvement in 168 elements, requiring Moderate Improvement in 56 elements, Inadequate in 10 elements and N/A in one individual element. The evidence gained during the PAM assessment process has identified the need for Minimal Improvement in the majority of sections within the individual PAM SAQ's. These will be picked up in detail within the review of each individual Domain through the PAM working group process for 2018/2019 with action plans and review dates presented to individual responsible managers.

The PAM Overall Summary Position for DBTH has improved in all 5 Domains rating DBTH 80% Good/Requires Minimal Improvement compared to 2016/2017 score of 62%. Figure 1 illustrates the breakdown of the PAM Self-Assessment Question (SAQ) score ratings for the assessment year 2017/2018, with Figure 2 showing the previous year's 2016/2017 Overall Summary for comparison. Figure 3 shows the PAM distribution of SAQ ratings for 2017/2018 including individual Domain statement, with Figure 4 providing the average scores for the 2017/2018 overall summary position

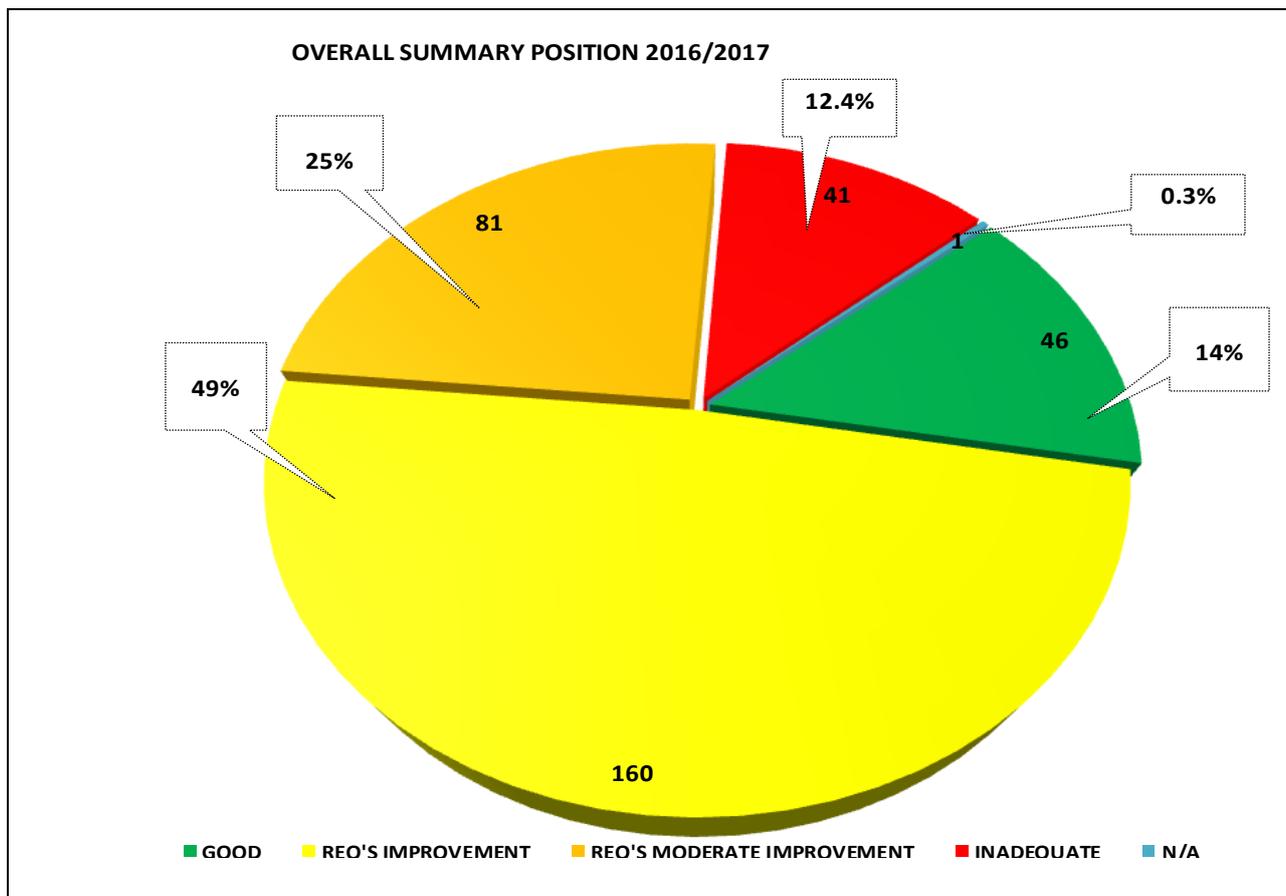
Figure 1: DBTH PAM Overall Summary Position for 2017/2018



Numerical breakdown of DBTH Overall PAM SAQ scores for 2017-2018 are as follows:

Outstanding	= 0
Good	=100
Requires Minimal Improvement	= 168
Requires Moderate Improvement	= 56
Inadequate	=10
Not Applicable	= 1

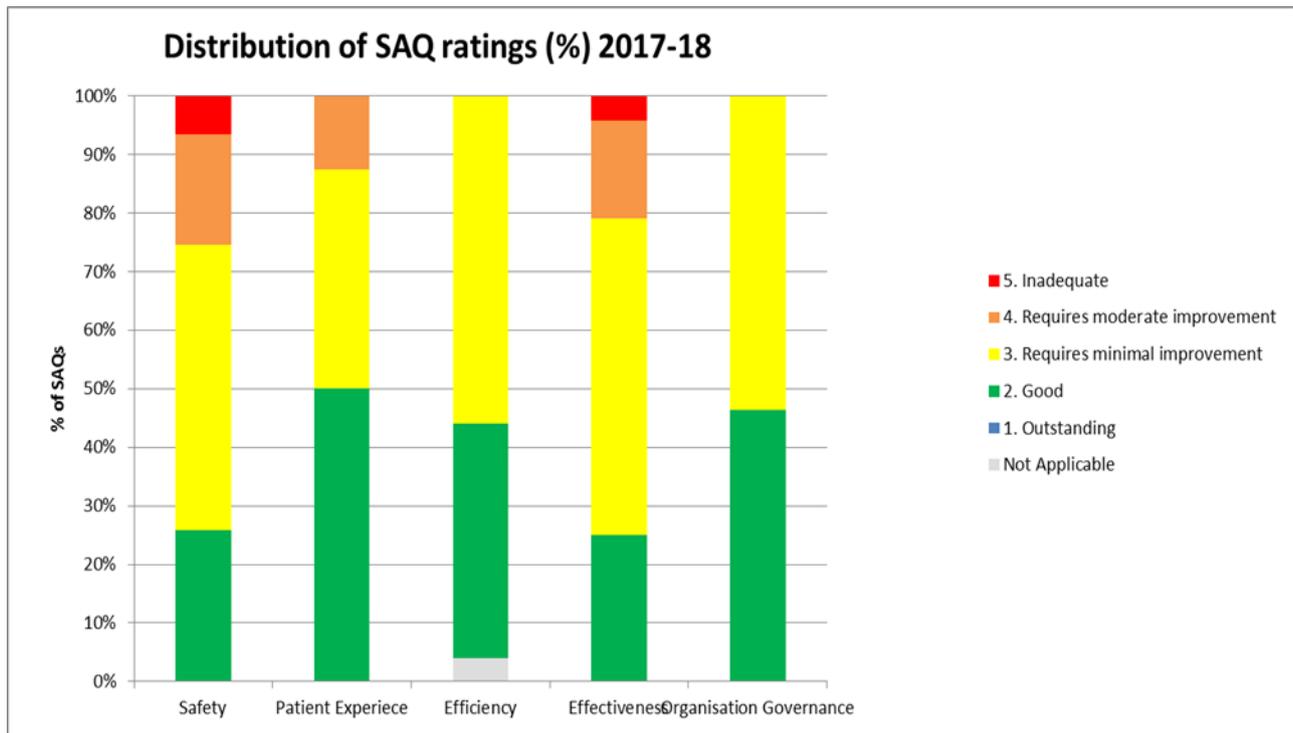
Figure 2: DBTH Overall Summary Position for 2016/2017



Numerical breakdown of DBTH Overall PAM SAQ scores for 2016-2017 are as follows:

Outstanding	= 0
Good	= 46
Requires Minimal Improvement	= 160
Requires Moderate Improvement	= 81
Inadequate	= 41
Not Applicable	= 1

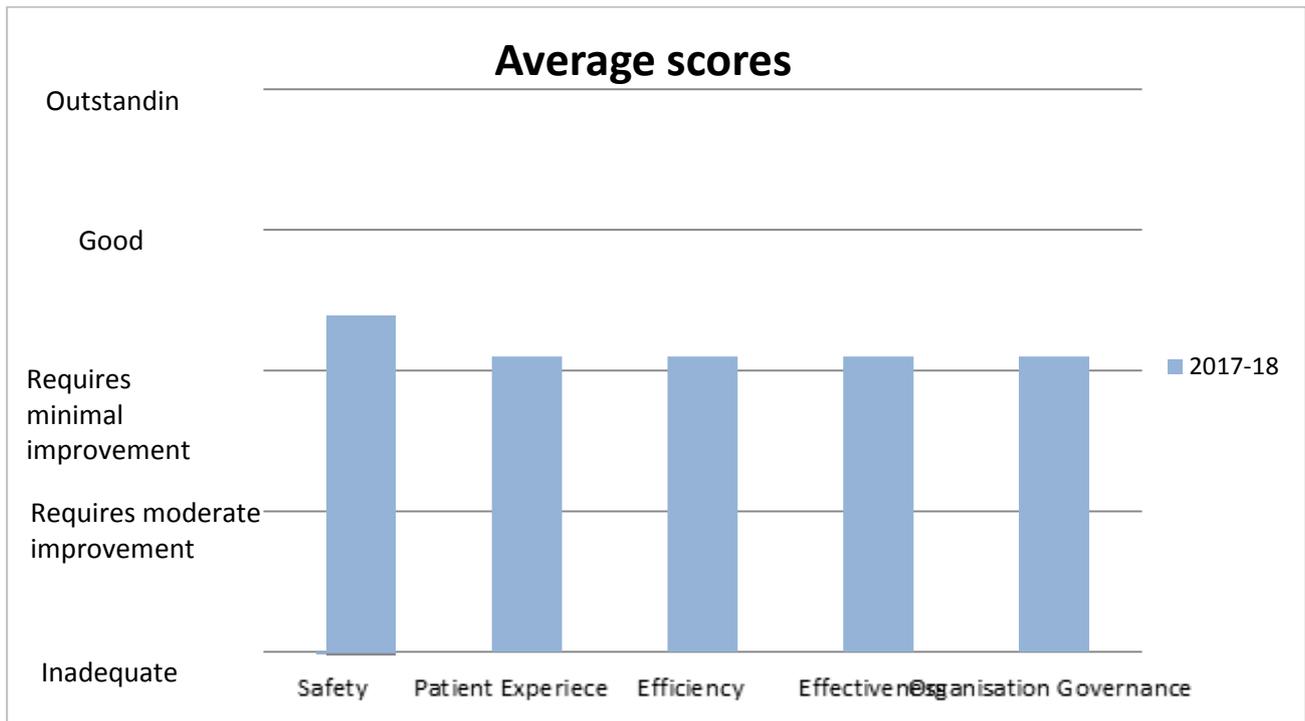
Figure 3: PAM DBTH Overall Summary Distribution of SAQ Ratings (%) for 2017-2018.



Legend

Domain	Domain statement
Safety	The organisation provides assurance for Estates, Facilities and its support services that the design, layout, build, engineering, operation and maintenance of the estate meet appropriate levels of safety to provide premises that supports the delivery of improved clinical and social outcomes.
Patient experience	The organisation ensures that patient experience is an integral part of service provision and is reflected in the way in which services are delivered. The organisation will involve patients and members of the public in the development of services and the monitoring of performance.
Efficiency	The organisation provides assurance that space, activity, income and operational costs of the estates and facilities provide value for money, are economically sustainable and meet clinical and organisational requirements.
Effectiveness	The organisation provides assurance that it's premises and facilities are functionally suitable, sustainable and effective in supporting the delivery of improved health outcomes.
Organisation governance	How the organisations board of directors deliver strategic leadership and effective scrutiny of the organisations estates and facilities operations. How the other four Domains are managed as part of the internal governance of the NHS organisation. Its objective is to ensure that the outcomes of the Domains are reported to the NHS Boards and embedded in internal governance and assurance processes to ensure actions are taken where required.

Figure 4: PAM DBTH Distribution of Overall Summary Average Position Scores for 2017-2018



For the areas requiring improvement in the overall PAM assessment, PAM allows for the entry of “Capital Costs for Compliance” and “Revenue Consequences”. As PAM is a review of the management Policies and Procedures there should be no Capital Costs – as this would imply change to the physical structure of the Estate and if this is required it will be identified through the 7 Facet Condition Surveys, Strategic reviews and Operational procedures. Should PAM have highlighted that these reviews or procedures are not functioning correctly within the Organisation, then the correction is to the processes and the resultant Capital Costs should be embedded within the DBTH Capital Programme and not reported through PAM, which would have the potential to generate double accounting. However, there will be Revenue Consequences for changes within management processes for DBTH, and reviewed by the E&F Senior Management team through the review of the individual Domain summaries and resultant score.

The following section of the report is split into the 5 individual PAM Domains providing a summary for each section including the distribution of SAQ’s, Questions, Average Scores and Overall Summary for the 2017/2018 Domain. To enable comparison and illustrate improvements achieved by the Trust, the previous year’s PAM 2016/2017 Overall Summary for each Domain is included.

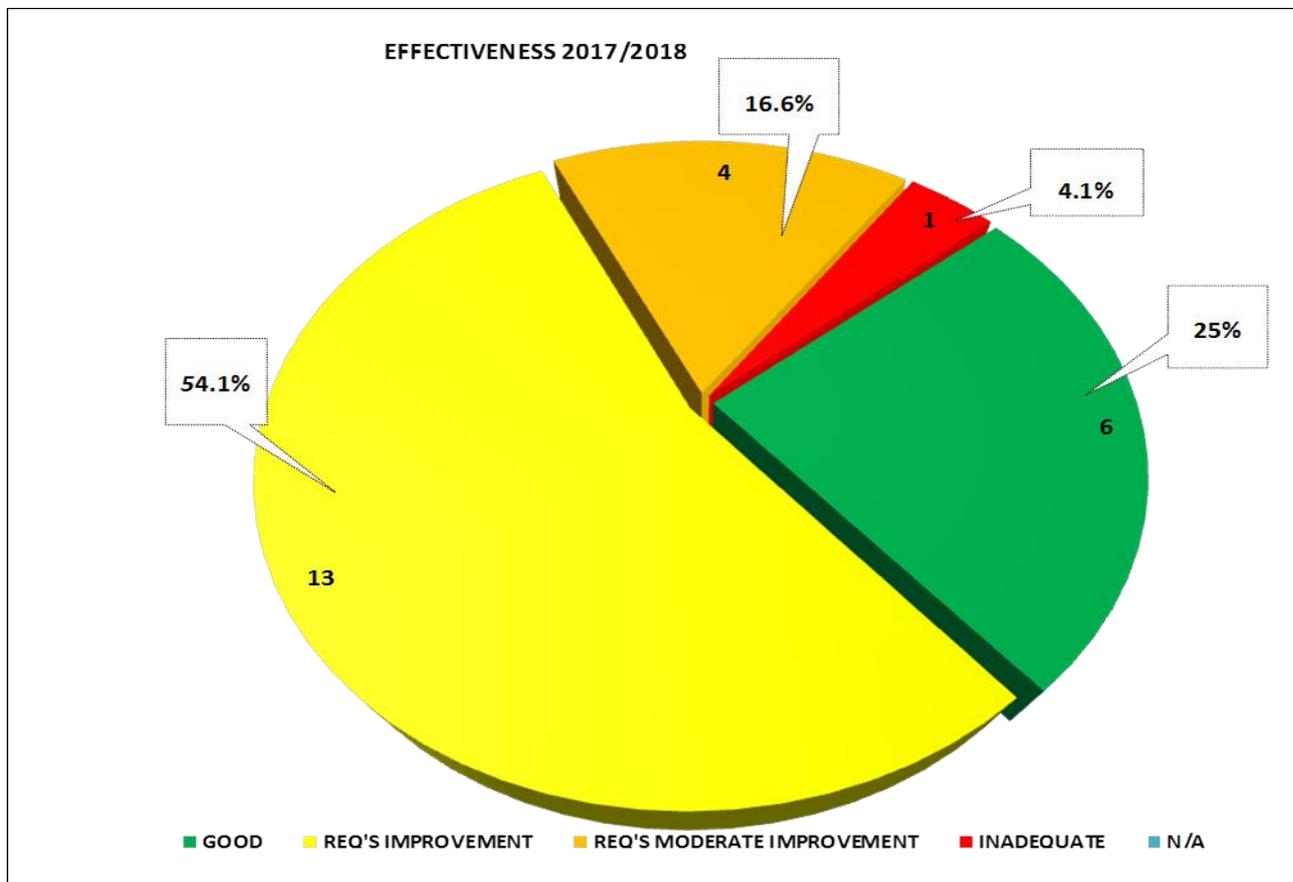
4. Domain Reviews for PAM 2017-2018

4.1 Effectiveness

The PAM Distribution of SAQ Ratings for Effectiveness shows DBTH to be Good in 6 elements, requiring Minimal Improvement in 13 elements, requiring Moderate Improvement in 4 elements and Inadequate in 1 element. The evidence gained during the PAM assessment process has identified the need for Minimal Improvement in the majority of SAQ's within this individual Domain.

The PAM Effectiveness Summary Position for DBTH demonstrates progressive improvement, with Figure 5 illustrating the breakdown of the PAM SAQ score ratings for the assessment year 2017/2018, and Figure 6 showing the previous year's 2016/2017 Effectiveness summary for comparison. Figure 7 shows the PAM distribution of Effectiveness SAQ ratings for 2017/2018 including individual Domain statement, with Figure 8 providing the average scores for the 2017/2018.

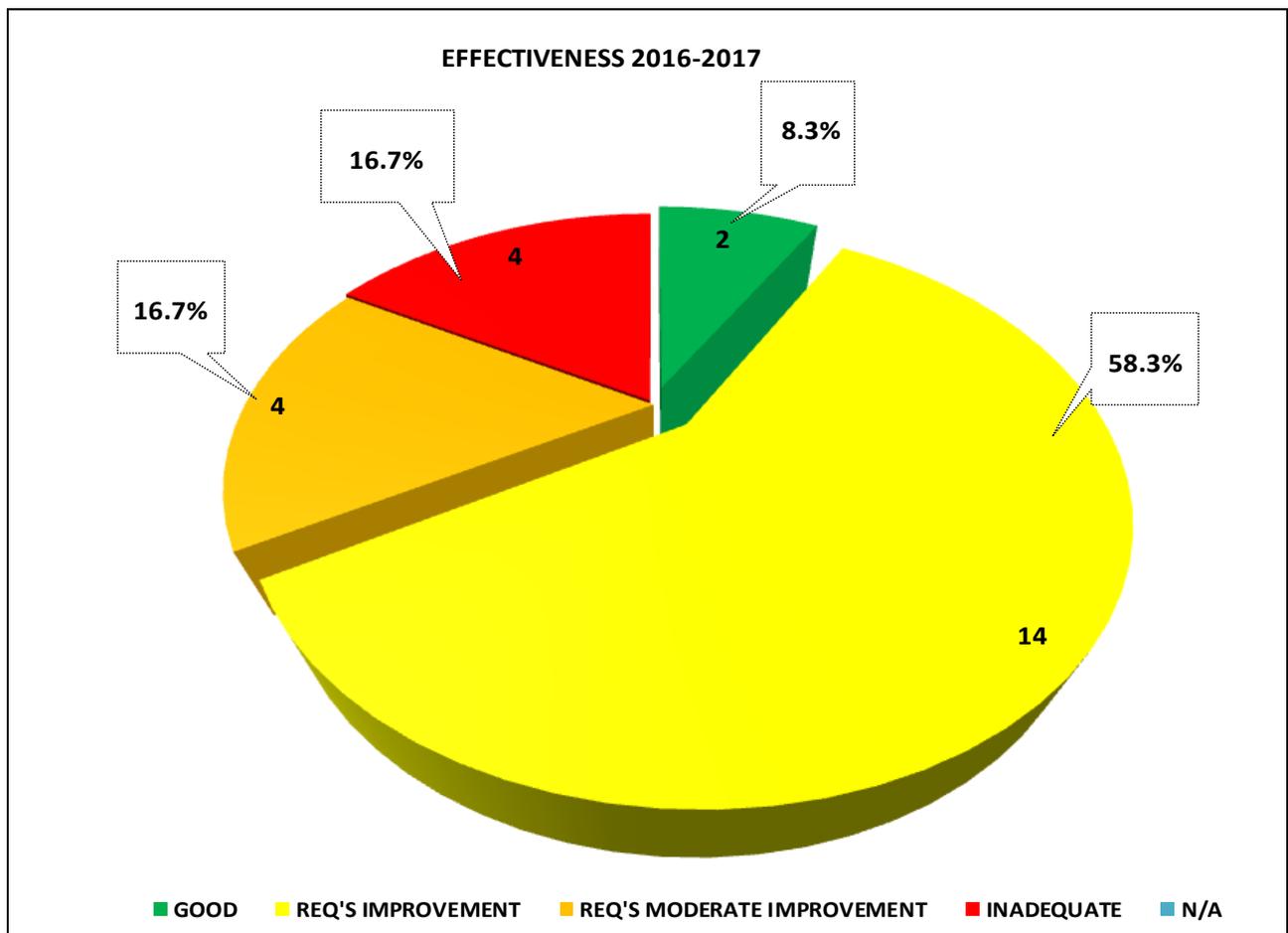
Figure 5: DBTH PAM Effectiveness Domain Summary Position for 2017/2018



Numerical breakdown of DBTH Overall Effectiveness SAQ scores for 2017-2018 are as follows:

Outstanding	= 0
Good	= 6
Requires Minimal Improvement	= 13
Requires Moderate Improvement	= 4
Inadequate	= 1
Not Applicable	= 0

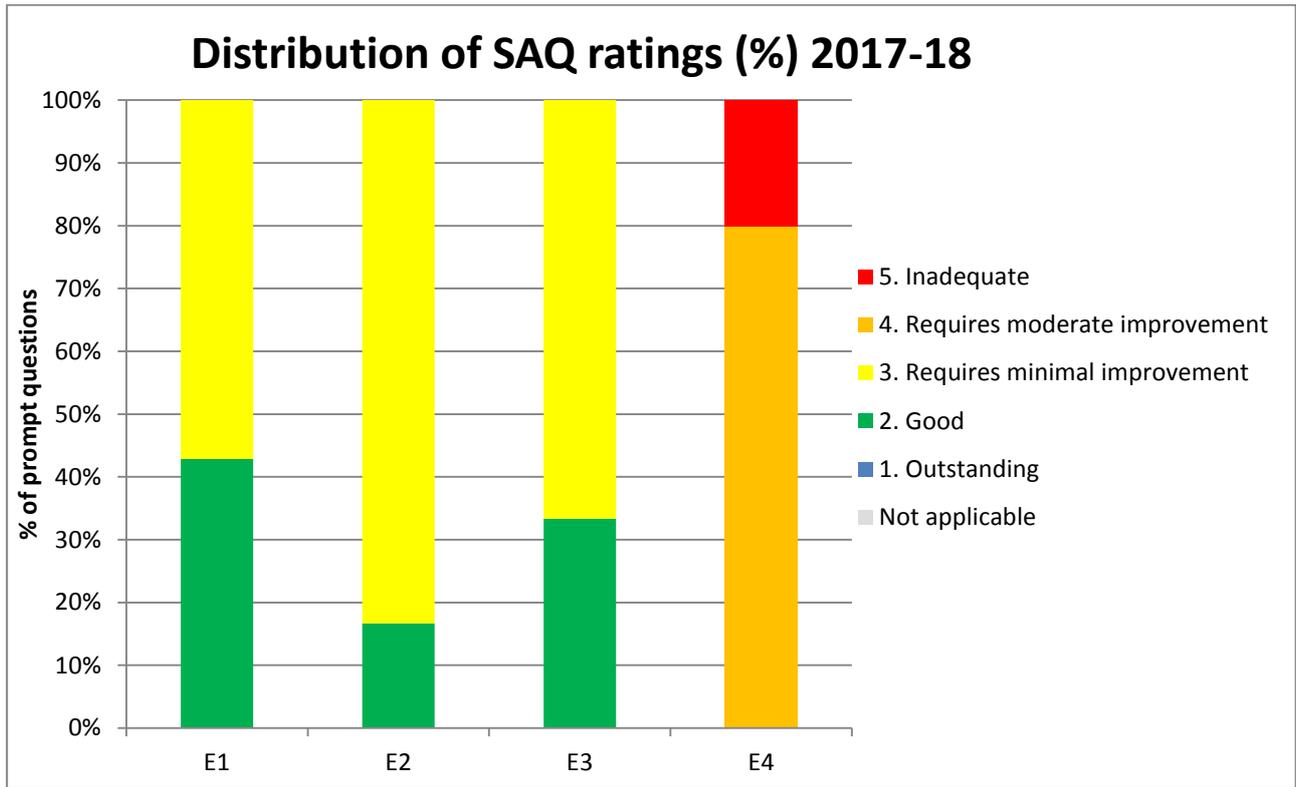
Figure 6: DBTH PAM Effectiveness Domain Summary Position for 2016/2017



Numerical breakdown of DBTH Overall Effectiveness SAQ scores for 2016-2017 are as follows:

Outstanding	= 0
Good	= 2
Requires Minimal Improvement	= 14
Requires Moderate Improvement	= 4
Inadequate	= 4
Not Applicable	= 0

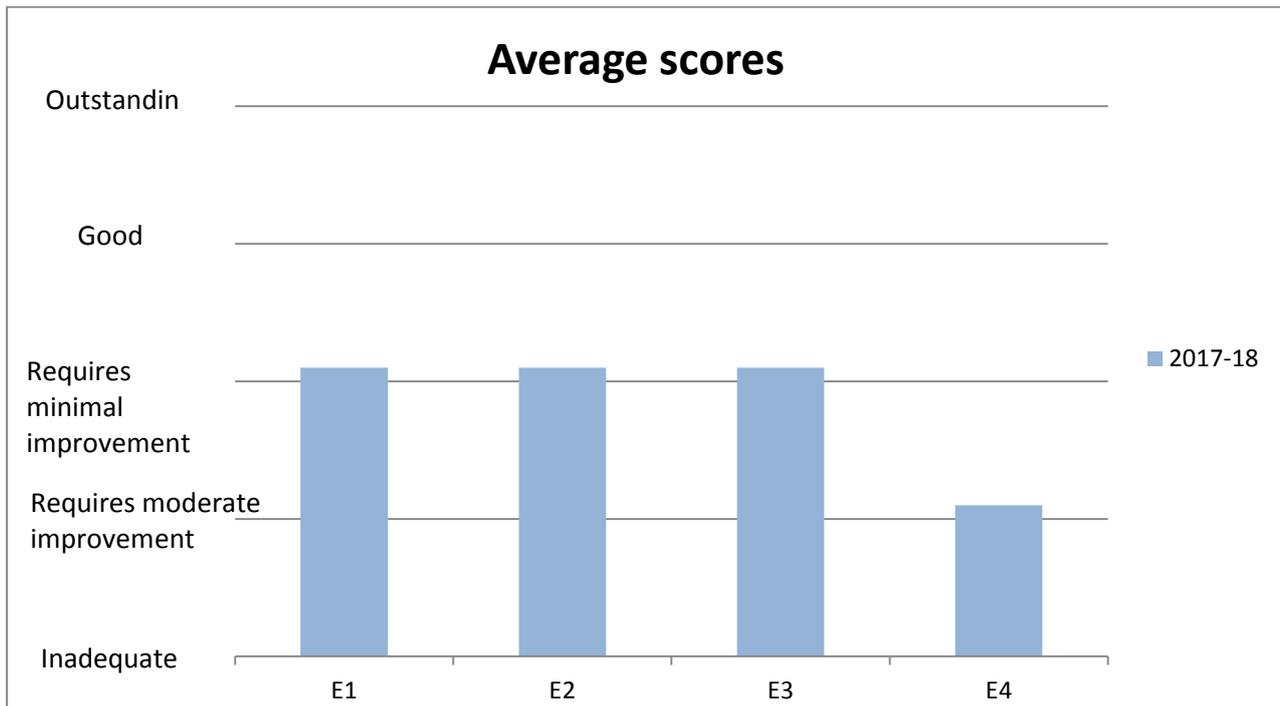
Figure 7: DBTH PAM Distribution of SAQ Ratings (%) for Effectiveness 2017/2018



Legend

SAQ code	Self Assessment Question - Does your Organisation/site:
E1	A clear vision and a credible strategy to deliver good quality Estates and Facilities services
E2	A well-managed approach to town planning
E3	A well-managed robust approach to management of land and property
E4	A well-managed annually updated board approved sustainable development management plan

Figure 8: DBTH PAM Average Scores for Effectiveness 2017/2018



SAQ elements showing improvement within the Effectiveness Domain are in E1:

E1. Sections 2, 3 and 6 Strategy, Development and Progress – Improvement have been made with the development of the Estates 5 year Strategy which 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 delivering E&F services can add by enabling an organisation to achieve its objectives and to continuously improve its performance.

The majority of the Effectiveness Domain requires minimal improvement with E4 requiring Moderate improvement in all areas also identifying inadequate in E4.5 costed Action Plans.

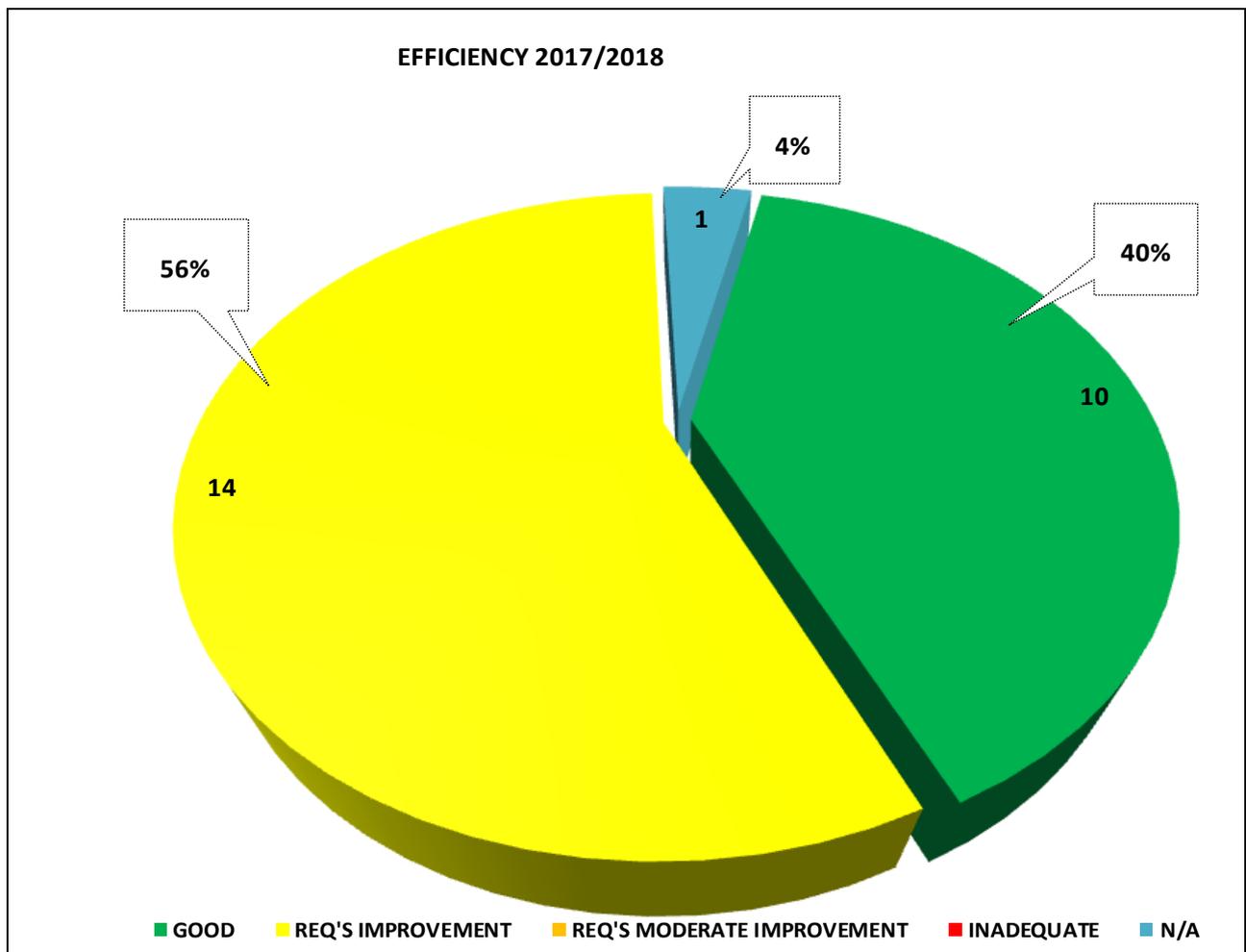
E4. Sections 1 to 4 require the Trust to have a Sustainable Development Plan, including Action Planning, Monitoring, Reporting and Governance. This area has been identified by the F&F Senior Management team as requiring improvement and is discussed in the annual plan. The new Total Waste Management contract has been identified as an area where improvements in waste segregation, recycling and reduction in carbon footprint will deliver marked improvements across the Trust.

4.2 Efficiency

The PAM Distribution of SAQ Ratings for Efficiency shows DBTH to be Good in 10 elements, requiring Minimal Improvement in 14 elements and N/A in 1 element. The evidence gained during the PAM assessment process has identified the need for Minimal Improvement in the majority of SAQ's within this individual Domain.

The PAM Efficiency Summary Position for DBTH demonstrates progressive improvement, with Figure 9 illustrating the breakdown of the PAM SAQ score ratings for the assessment year 2017/2018 and Figure 10 showing the previous year's 2016/2017 Efficiency summary for comparison. Figure 11 shows the PAM distribution of Efficiency SAQ ratings for 2017/2018 including individual Domain statement, with Figure 12 providing the average scores for the 2017/2018.

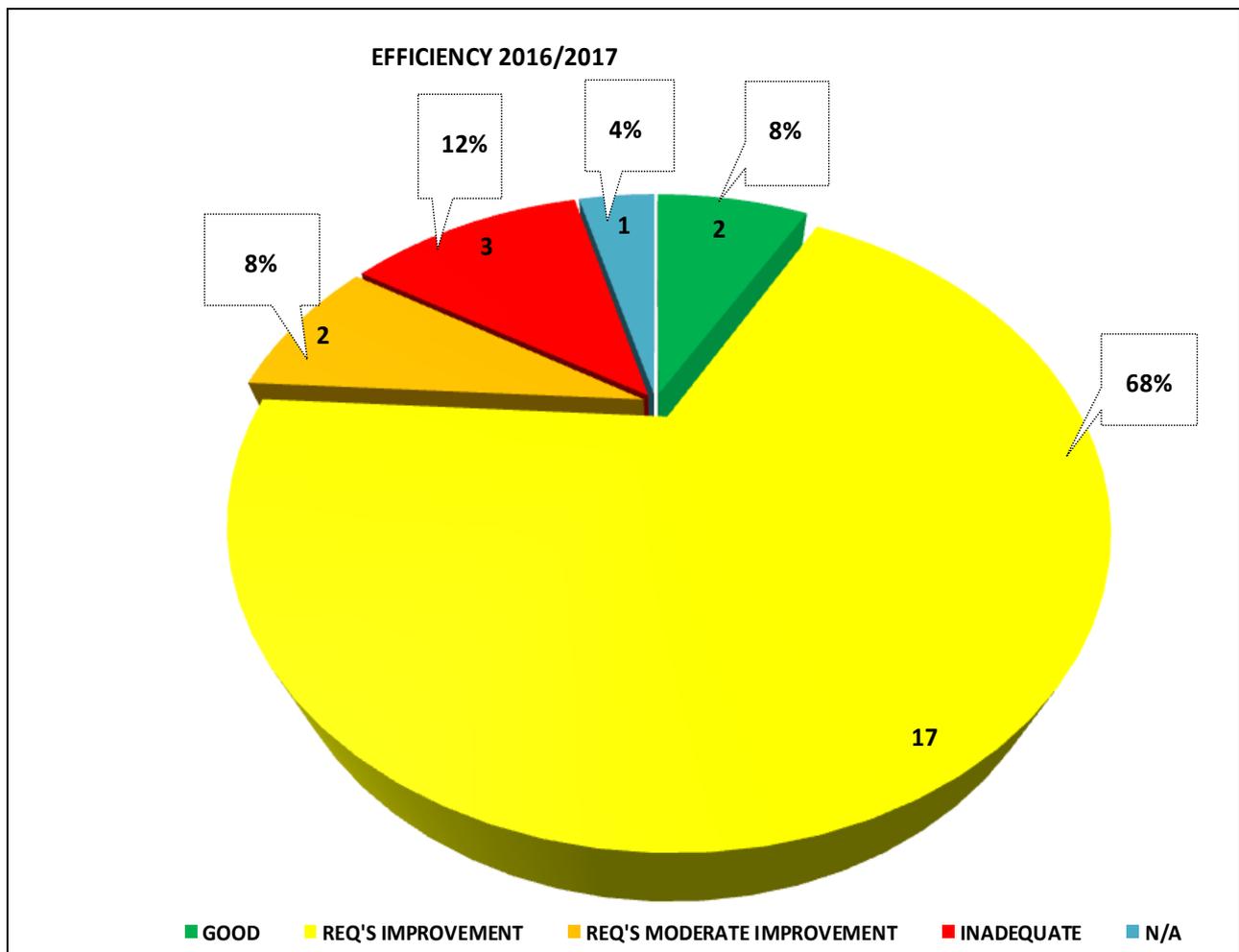
Figure 9: DBTH PAM Efficiency Domain Summary Position for 2017/2018



Numerical breakdown of DBTH Overall Efficiency SAQ scores for 2017-2018 are as follows:

Outstanding	= 0
Good	= 10
Requires Minimal Improvement	= 14
Requires Moderate Improvement	= 0
Inadequate	= 0
Not Applicable	= 1

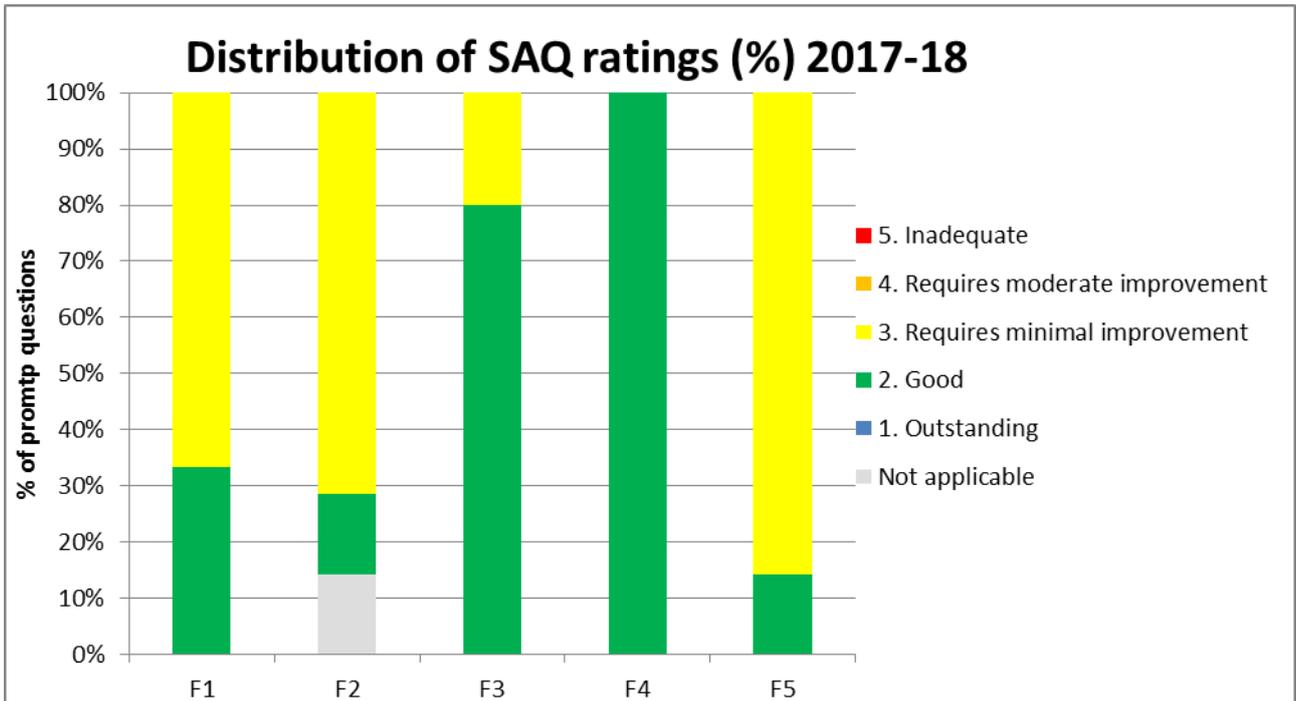
Figure 10: DBTH PAM Efficiency Domain Summary Position for 2016/2017



Numerical breakdown of DBTH Overall Efficiency SAQ scores for 2016-2017 are as follows:

Outstanding	= 0
Good	= 2
Requires Minimal Improvement	= 17
Requires Moderate Improvement	= 2
Inadequate	= 3
Not Applicable	= 1

Figure 11: DBTH PAM Distribution of SAQ Ratings (%) for Efficiency 2017/2018



Legend

SAQ code	Self Assessment Question - Does your Organisation/site have a well-managed approach to achieving value for money and cost improvements in relation to:
F1	A well-managed approach to performance management of the estate and facilities operations?
F2	A well-managed approach to improved efficiency in running estates and facilities services?
F3	Improved efficiencies in capital procurement, refurbishments and land management?
F4	A well-managed and robust financial controls, procedures and reporting?
F5	An Estates and Facilities services are continuously improved and sustainability ensured?

Figure 12: DBTH PAM Average Scores for Efficiency 2017/2018



SAQ elements showing improvement within the Efficiency Domain are in F1, F2 and F3:

F1. Section 2 Benchmarking – Improvements in benchmarking through ERIC, PAM metrics, Health Estates and Facilities management Association (HEFMA), National Performance Advisory Group (NPAG), Cater, Naylor and the Model Hospital.

F2. Sections 5 The use of New Technology – Improvements in maximising the benefits from new technology are obtained through the E&F Computer Aided Facilities Management (CAFM) systems, including Micad, Planet, MIC4C, and Teletracking. The E&F also utilise two BMS systems for energy management across the Trust.

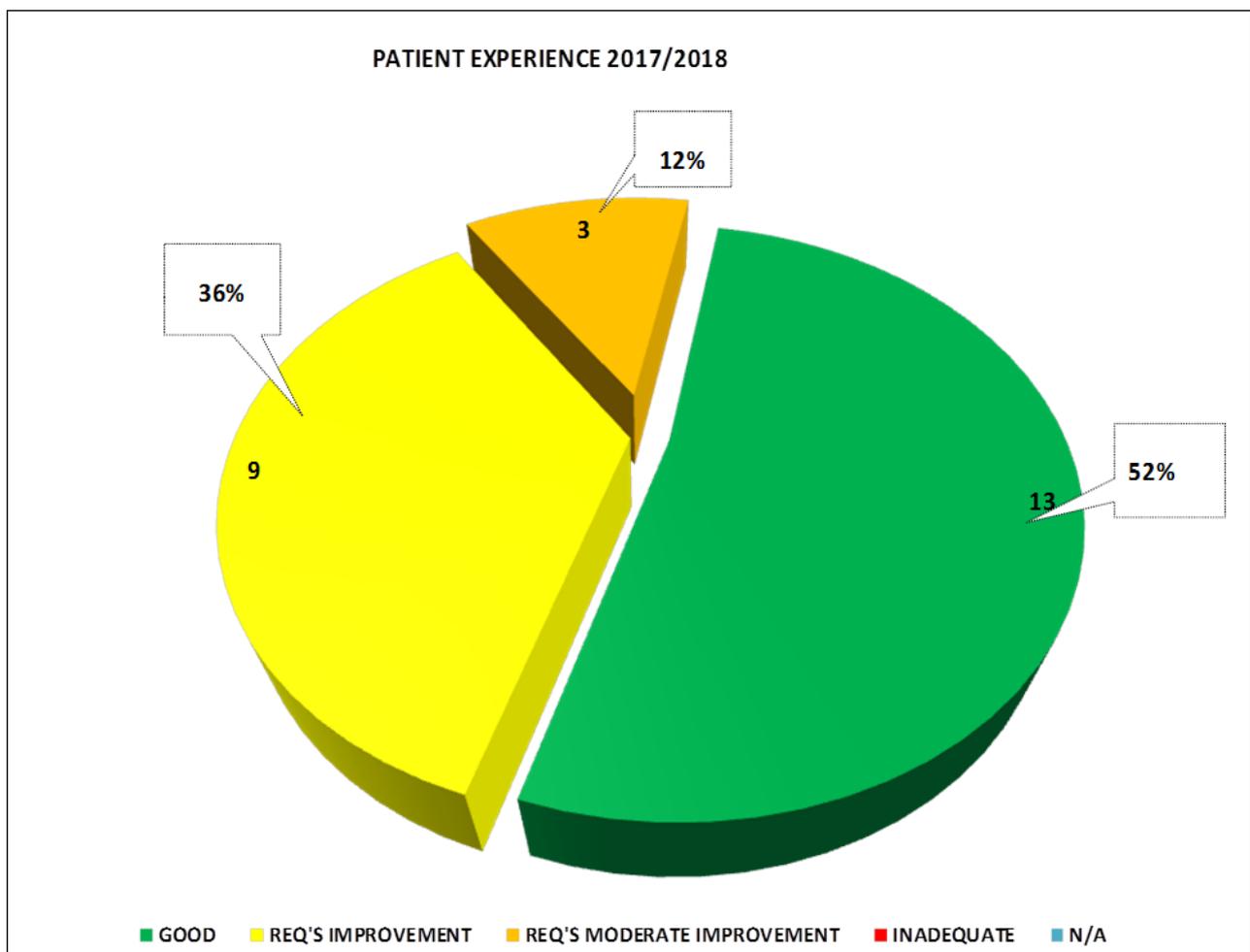
F3. Sections 1, 2, 3 and 5 Improved Efficiencies in Capital procurement, refurbishments and land management – This is evidenced through the utilisation of external procurement vehicle including P21+ with the Trust preferred Partner IHP. The use of an external cost advisor, contract with new preferred legal consultants and other health service frameworks including SBS.

4.3 Patient Experience

The PAM Distribution of SAQ Ratings for Patient Experience shows DBTH to be Good in 13 elements, requiring Minimal Improvement in 9 elements and requiring Moderate Improvement in 3 elements. The evidence gained during the PAM assessment process has identified the need for Minimal Improvement in the majority of SAQ's within this individual Domain.

The PAM Patient Experience Summary Position for DBTH demonstrates minimal improvement, with Figure 13 illustrating the breakdown of the PAM SAQ score ratings for the assessment year 2017/2018 and Figure 14 showing the previous year's 2016/2017 Patient Experience summary for comparison. Figure 15 shows the PAM distribution of Patient Experience SAQ ratings for 2017/2018 including individual Domain statement, with Figure 16 providing the average scores for the 2017/2018.

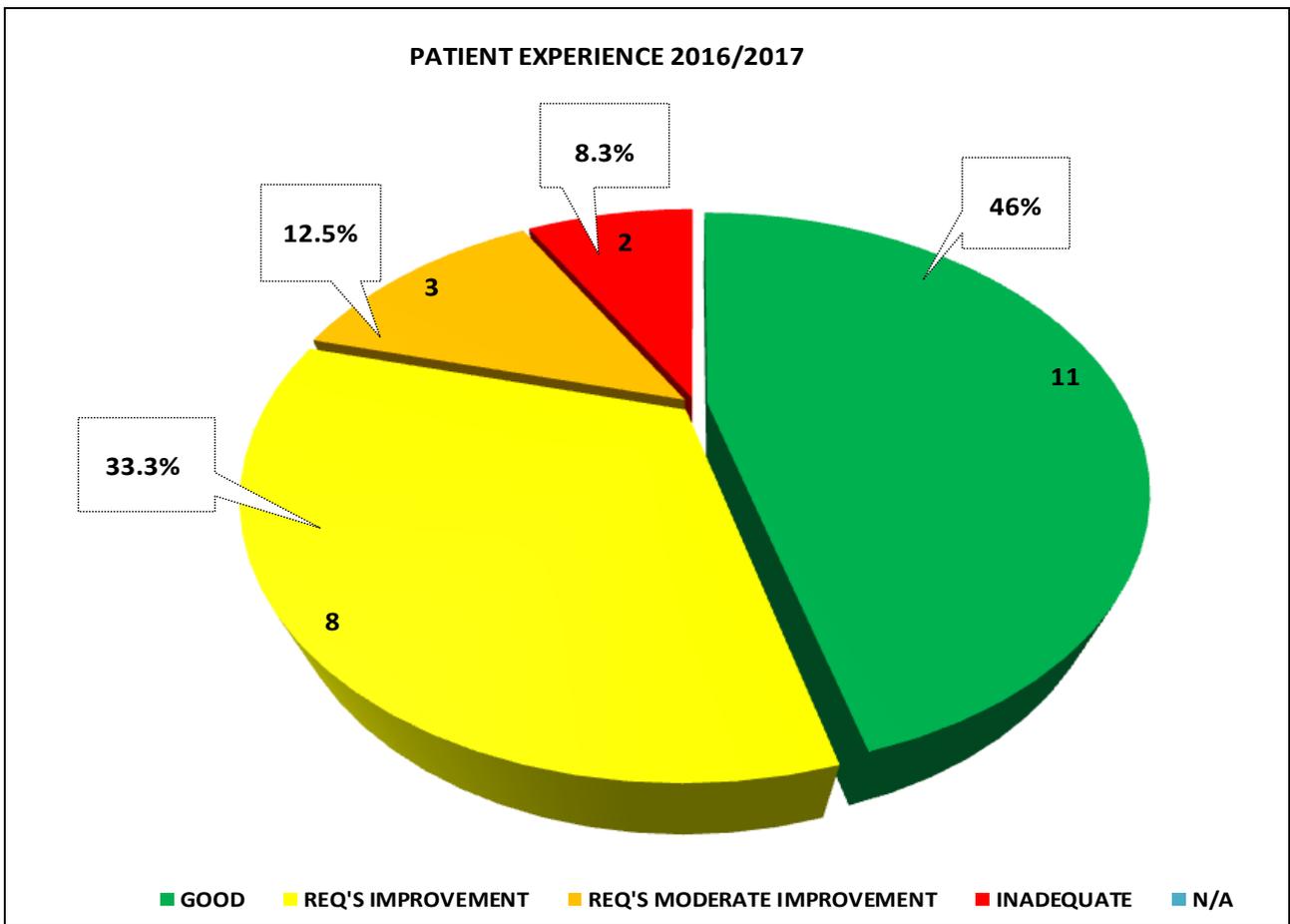
Figure 13: DBTH PAM Patient Experience Domain Summary Position for 2017/2018



Numerical breakdown of DBTH Overall Patient Experience SAQ scores for 2017-2018 are as follows:

Outstanding	= 0
Good	= 13
Requires Minimal Improvement	= 9
Requires Moderate Improvement	= 3
Inadequate	= 0
Not Applicable	= 0

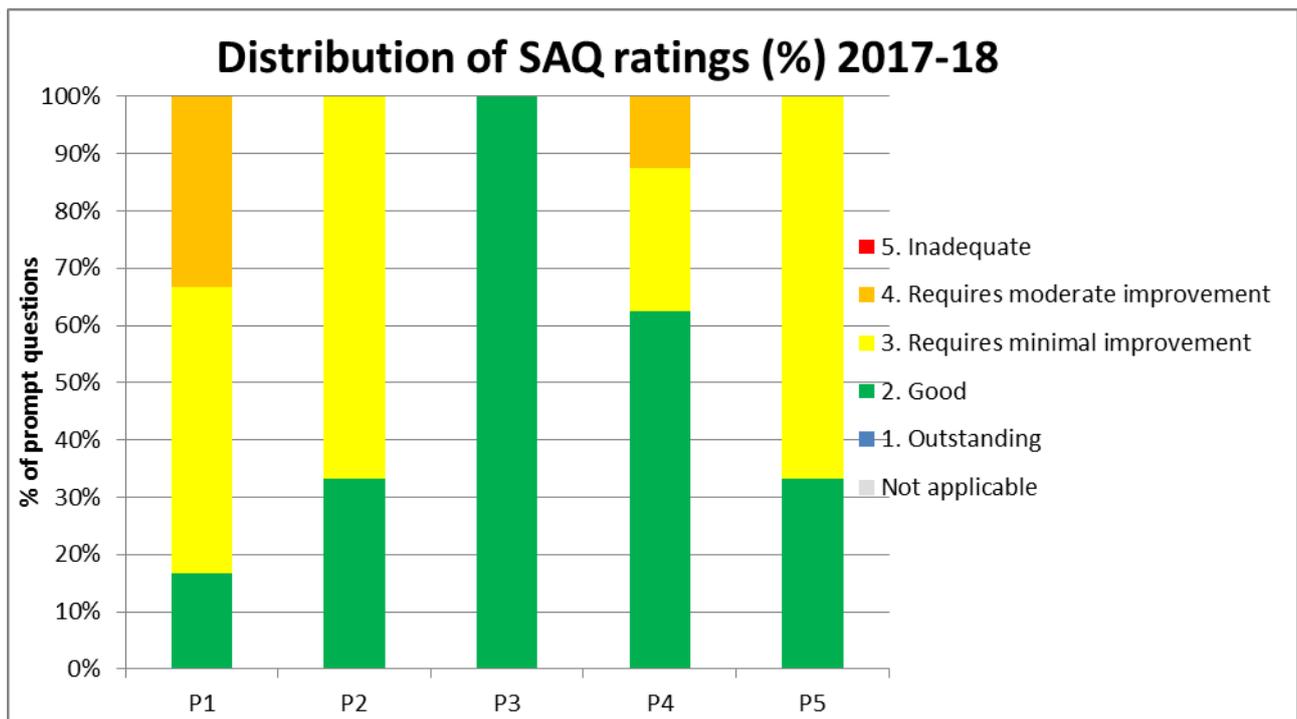
Figure 14: DBTH PAM Patient Experience Domain Summary Position for 2016/2017



Numerical breakdown of DBTH Overall Patient Experience SAQ scores for 2017-2018 are as follows:

Outstanding	= 0
Good	= 11
Requires Minimal Improvement	= 8
Requires Moderate Improvement	= 3
Inadequate	= 2
Not Applicable	= 0

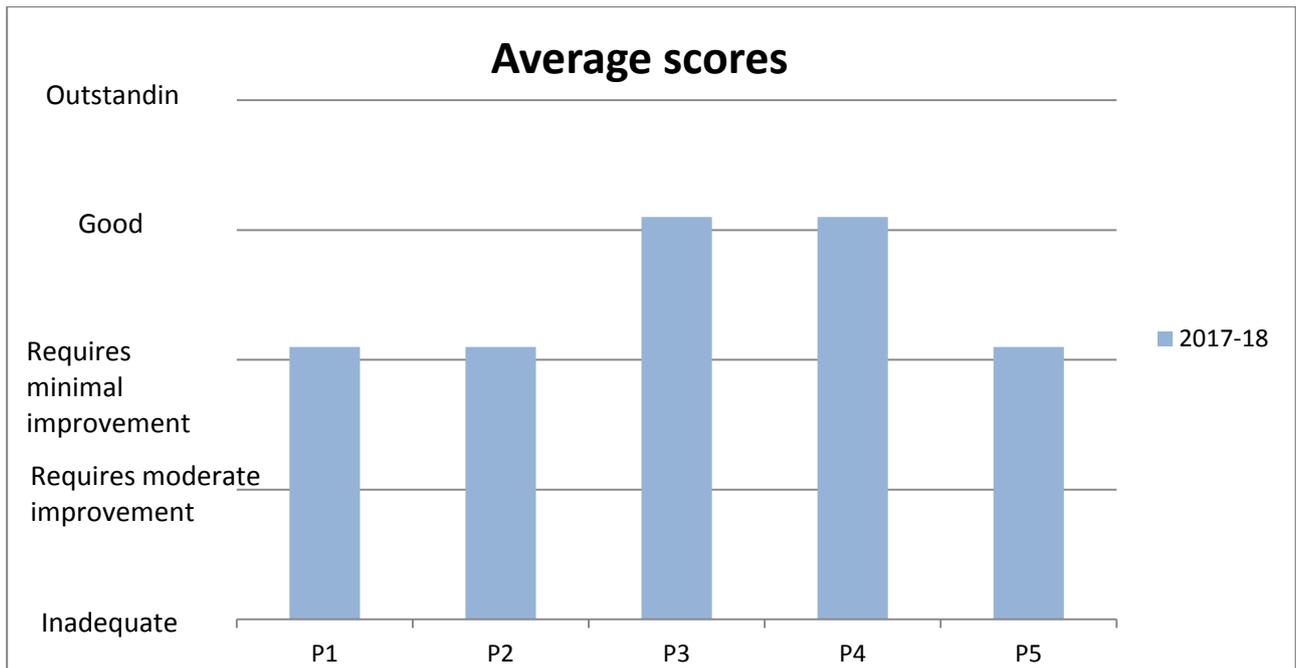
Figure 15: DBTH PAM Distribution of SAQ Ratings (%) for Patient Experience 2017/2018



Legend

SAQ code	Self Assessment Question - Does your organisation:
P1	How are people who use estates and facilities services, the public and staff engaged and involved?
P2	Ensure that patients, staff and visitors perceive that the condition, appearance, maintenance and privacy and dignity of the estate is satisfactory?
P3	Ensure that patients, staff and visitors perceive cleanliness to be satisfactory?
P4	Ensure that NHS Catering Services provide adequate nutrition and hydration through the choice of food and drink for people to meet their diverse needs?
P5	Ensure that access and car parking arrangements meet the reasonable needs of patients, staff and visitors and are effectively managed at all times?

Figure 16: DBTH PAM Average Scores for Patient Experience 2017/2018



SAQ elements showing improvement within the Patient Experience Domain are in P1:

P1. Section 5 Value – Do both Leaders and staff understand the value of staff raising concerns? Is appropriate action taken as a result of concerns raised? - Improvements achieved through the Patient Experience Group (PEG), Patient Experience Committee, Nursing & Quality Board Report, Complaints Policy, Staff survey and Trust strategic direction.

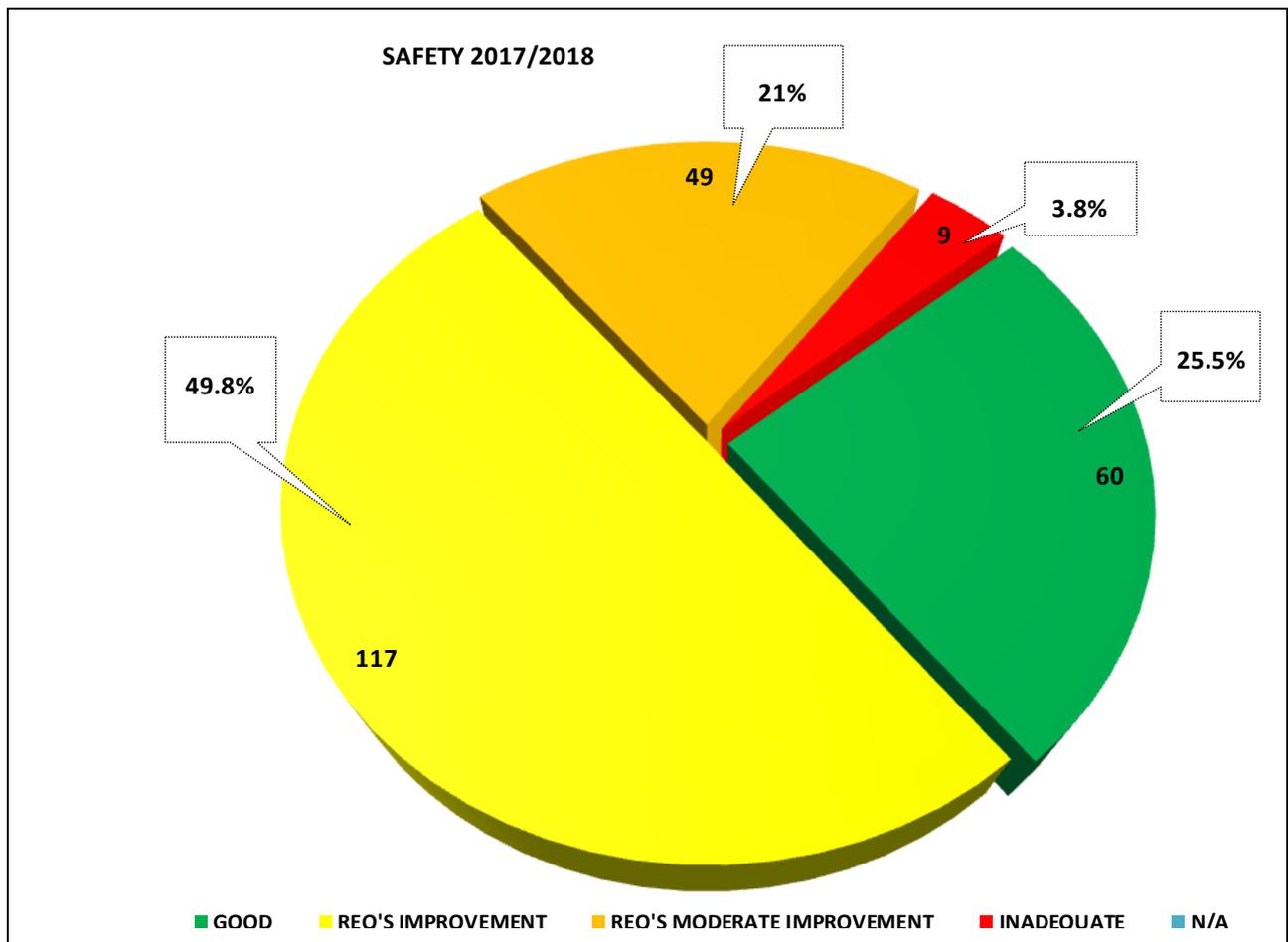
All other areas requiring Minimal and Moderate improvement will be through the PAM working group process for 2018/2019 with action plans and review dates presented to the individual responsible managers.

4.4 Safety

The PAM Overall Distribution of SAQ Ratings for the Safety Domain shows DBTH to be Good in 60 elements, requiring Minimal Improvement in 117 elements, requiring Moderate Improvement in 49 elements and Inadequate in 9 elements. The evidence gained during the PAM assessment process has identified the need for Minimal Improvement in the majority of SAQ's within this Domain, which is split into two sections; Safety Hard 'Hard FM' and Safety Soft 'Soft FM'.

The Overall PAM Safety Summary Position for DBTH demonstrates progressive improvement, with Figure 17 illustrating the breakdown of the PAM SAQ score ratings for the assessment year 2017/2018 and Figure 18 showing the previous year's 2016/2017 Safety summary for comparison.

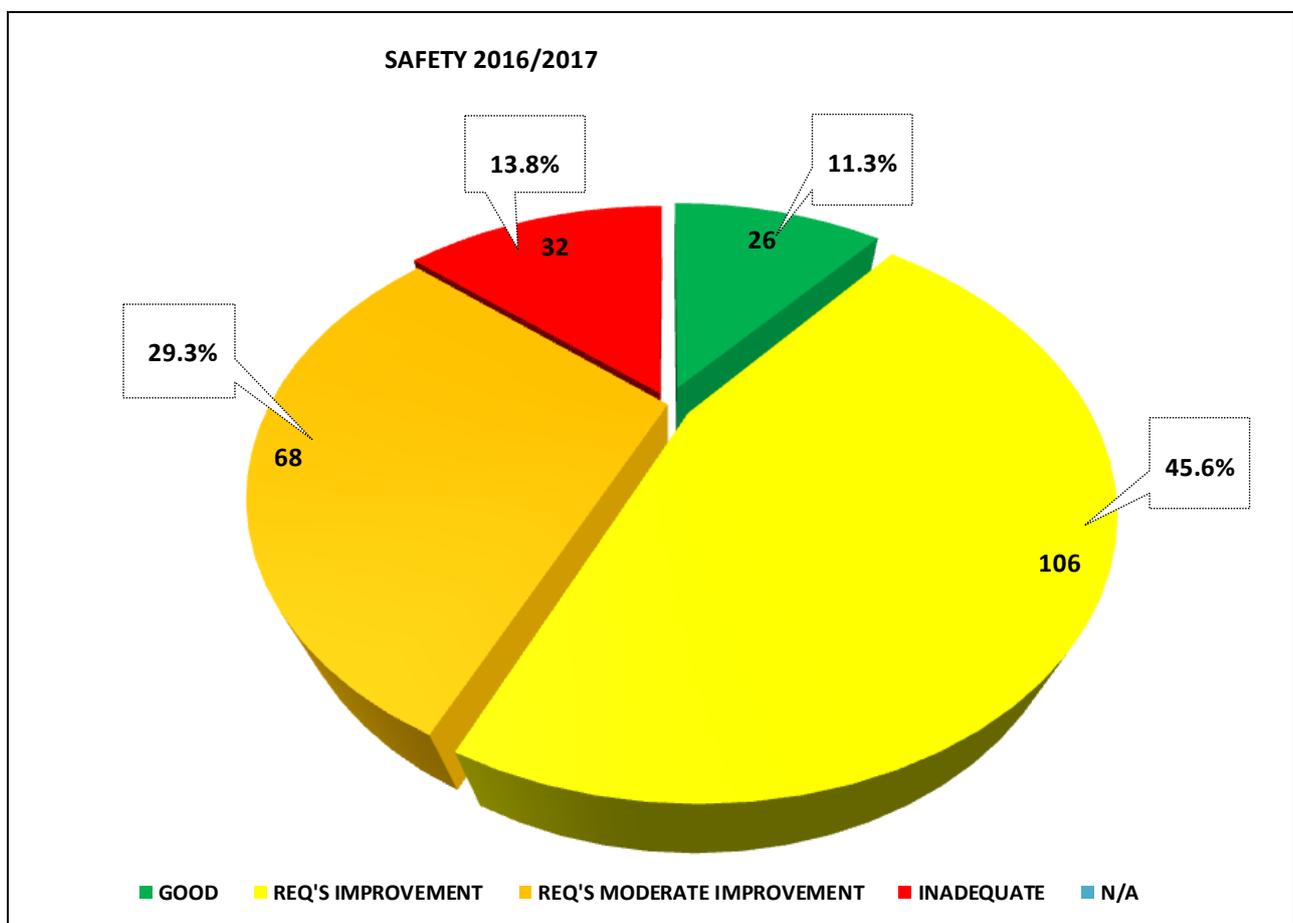
Figure 17: DBTH PAM Safety Domain Summary Position for 2017/2018



Numerical breakdown of DBTH Overall Safety SAQ scores for 2017-2018 are as follows:

Outstanding	= 0
Good	= 60
Requires Minimal Improvement	= 117
Requires Moderate Improvement	= 49
Inadequate	= 9
Not Applicable	= 0

Figure 18: DBTH PAM Safety Domain Summary Position for 2016/2017



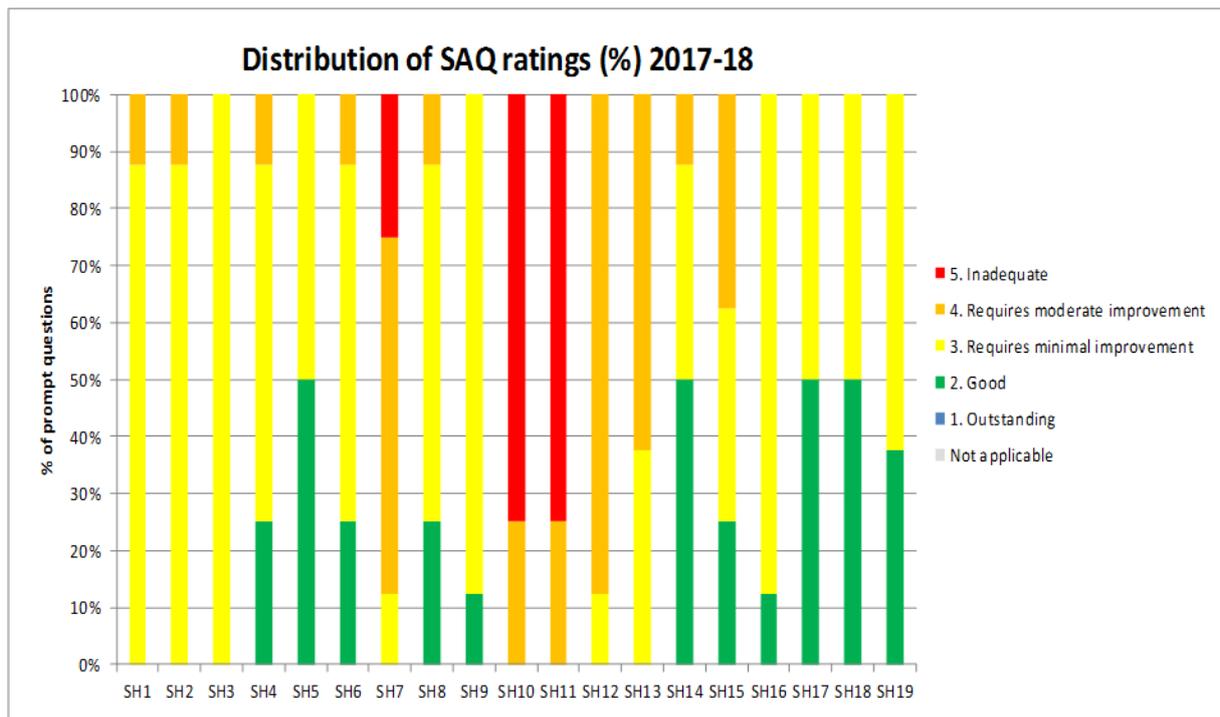
Numerical breakdown of DBTH Overall Safety SAQ scores for 2017-2018 are as follows:

Outstanding	= 0
Good	= 26
Requires Minimal Improvement	= 106
Requires Moderate Improvement	= 68
Inadequate	= 32
Not Applicable	= 0

4.4.1 Safety (Hard)

Figure 19 shows the PAM distribution of Safety Hard SAQ ratings for 2017/2018 including individual Domain statement, with Figure 20 providing the average scores for the 2017/2018.

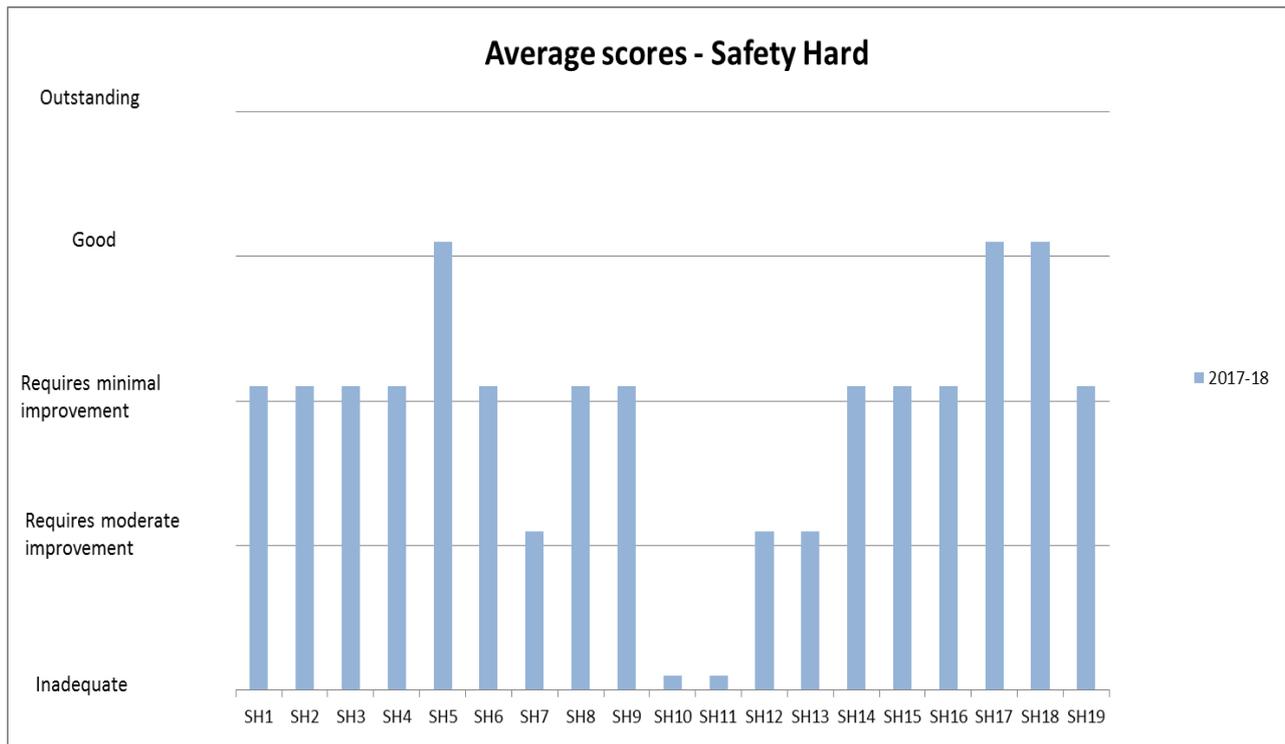
Figure 19: DBTH PAM Distribution of SAQ Ratings (%) for Safety Hard



Legend

SAQ code	Self Assessment Question - Is the Organisation/site safe and compliant with well managed systems in relation to:
SH1	Estates and Facilities Operational Management
SH2	Design, Layout and Use of Premises
SH3	Estates and Facilities Document Management
SH4	Health & Safety at Work
SH5	Asbestos
SH6	Medical Gas Systems
SH7	Natural Gas and specialist piped systems
SH8	Water Systems
SH9	Electrical Systems
SH10	Mechanical Systems e.g. Lifting Equipment
SH11	Ventilation, Air Conditioning and Refrigeration Systems
SH12	Lifts, Hoists and Conveyance Systems
SH13	Pressure Systems
SH14	Fire Safety
SH15	Medical Devices and Equipment
SH16	Resilience, Emergency and Business Continuity Planning
SH17	Reporting and implementing Premises and Equipment issues
SH18	Contractor Management
SH19	Safety and Suitability of Premises and Services

Figure 20: DBTH PAM Average Scores for Safety Hard 2017/2018



SAQ elements showing progressive improvement within the Safety Hard Domain are in SH4, SH5, SH6, SH7, SH14, SH15 and SH18:

The main improvements within the Safety Hard Domain SAQ’s have consisted of provision of Suitable and Sufficient Policies and Procedures, clearly defined Roles and Responsibilities including identification of Responsible Persons and specialist Authorised Engineers signed off by the Chief Executive and improved Risk Assessment processes and procedures.

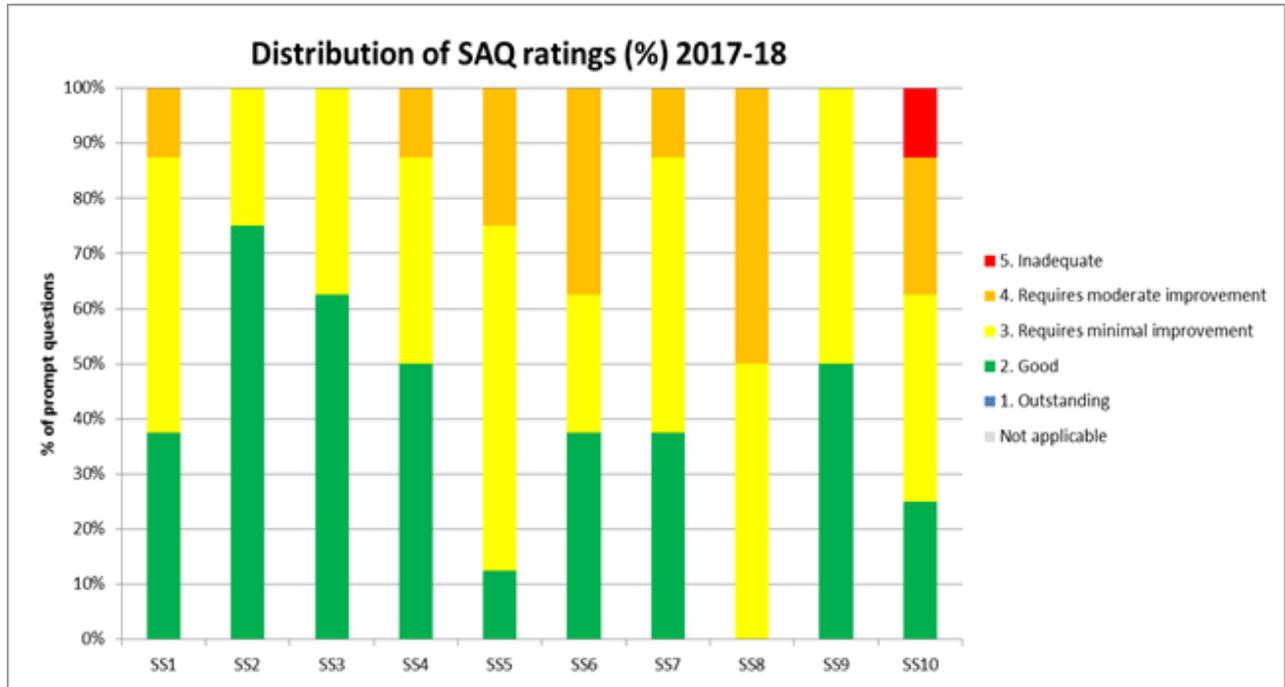
The two main areas of concern in this Domain are SH7 and SH10, scoring inadequate in a number of elements. The main elements of deficiency are the requirements for a Policy and Procedure, Identifying Roles and Responsibilities, Improving Training and Development and Review Processes. These deficiencies form part of the PAM SAQ working group action plan.

All other elements within this Domain requiring Minimal and Moderate improvement, as well as an overall requirement for further Training and Development to increase the number of Appointed Persons (AP’s) and Competent Persons (CP’s) throughout the Domain, will be reviewed through the PAM working group process for 2018/2019 with action and review dates presented to the individual responsible managers enabling the development of costed actions plans.

4.4.2 Safety (Soft)

Figure 21 shows the PAM distribution of Safety Soft SAQ ratings for 2017/2018 including individual Domain statement, with Figure 22 providing the average scores for the 2017/2018.

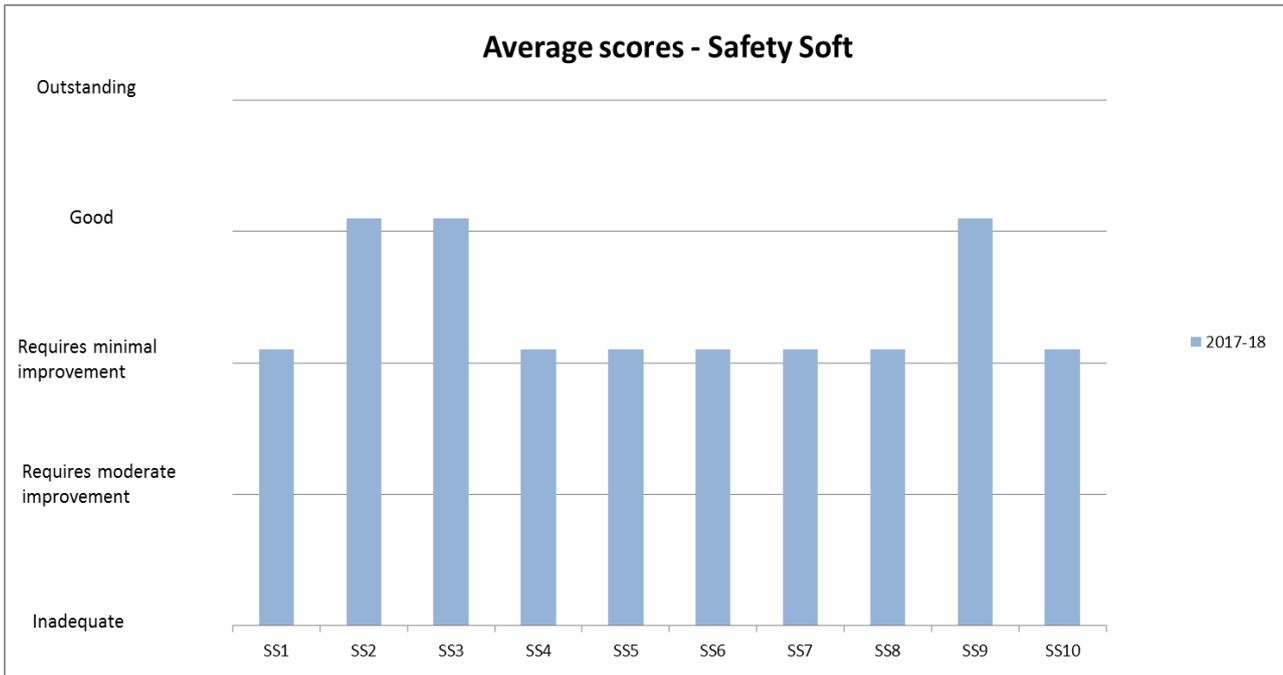
Figure 21: DBTH PAM Distribution of SAQ Ratings (%) for Safety Soft 2017/2018



Legend

SAQ code	Self Assessment Question - Is the Organisation/site safe and compliant with well managed systems in relation to:
SS1	Catering Services
SS2	Decontamination Processes
SS3	Waste and Recycling Management
SS4	Cleanliness and Infection Control
SS5	Laundry Services and Linen
SS6	Security Management
SS7	Transport Services and access arrangements
SS8	Pest Control
SS9	Portering Services
SS10	Telephony and Switchboard

Figure 22: DBTH PAM Average Scores for Safety Soft 2017/2018



SAQ elements showing progressive improvement within the Safety Soft Domain are in SS1, SS3, SS4, SS5, SS6 and SS9:

The main improvements in the Safety Soft Domain SAQ’s have consisted of provision of Suitable and Sufficient Policies and Procedures, Roles and Responsibilities which are clearly defined, including identification of Responsible Persons, Training and Development, improvements in Risk Assessments (Risk Assessment Procedures) and Review Processes.

There is only one element scored as inadequate, which is costed action plans for Telephony; this is being reviewed externally to the E&F department.

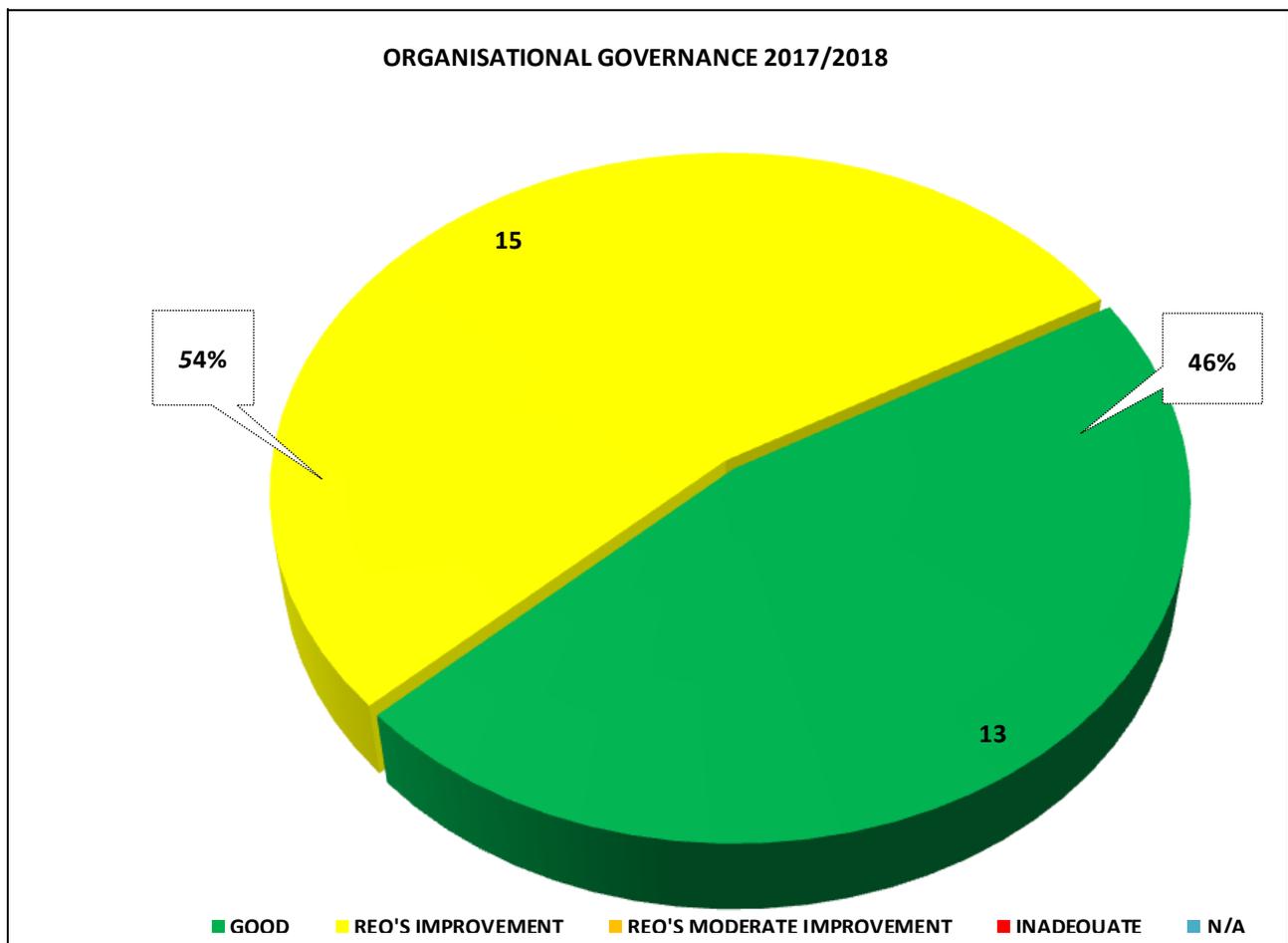
All other elements within this Domain requiring Minimal and Moderate improvement will be reviewed through the PAM working group process for 2018/2019 with action plans and review dates presented to the individual responsible managers.

4.5 Organisational Governance

The PAM Distribution of SAQ Ratings for Organisational Governance shows DBTH to be Good in 13 elements, requiring Minimal Improvement in 15 elements. The evidence gained during the PAM assessment process has identified the need for Minimal Improvement in the majority of SAQ's within this individual Domain.

The PAM Organisational Governance Summary Position for DBTH demonstrates increased improvement, with Figure 23 illustrating the breakdown of the PAM SAQ score ratings for the assessment year 2017/2018 and Figure 24 showing the previous year's 2016/2017 Organisational Governance summary for comparison. Figure 25 shows the PAM distribution of Organisational Governance SAQ ratings for 2017/2018 including individual Domain statement, with Figure 26 providing the average scores for the 2017/2018.

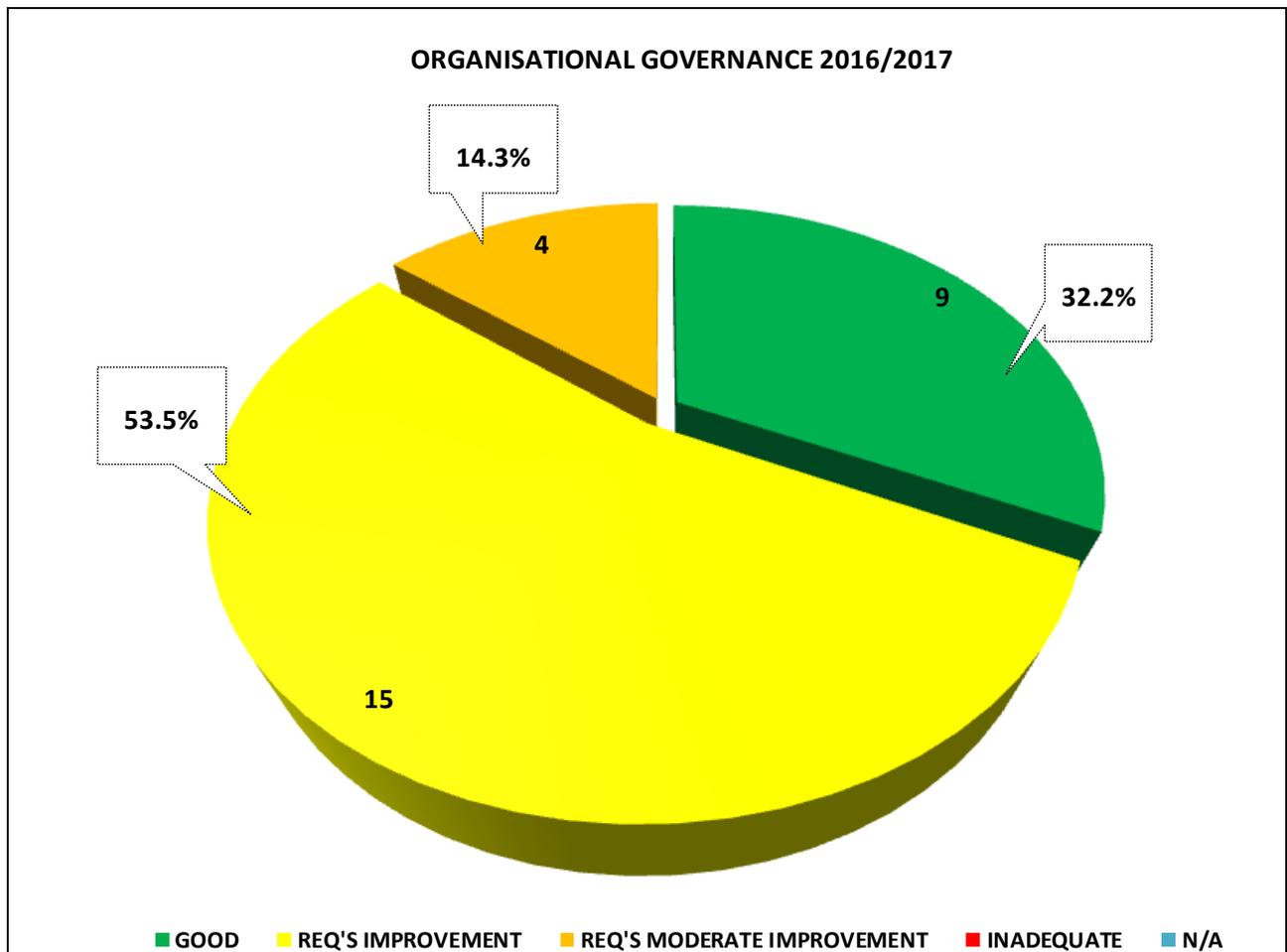
Figure 23: DBTH PAM Domain Organisational Governance Summary Position for 2017/2018



Numerical breakdown of DBTH Overall Organisational Governance SAQ scores for 2017-2018 are:

Outstanding	= 0
Good	= 13
Requires Minimal Improvement	= 15
Requires Moderate Improvement	= 0
Inadequate	= 0
Not Applicable	= 0

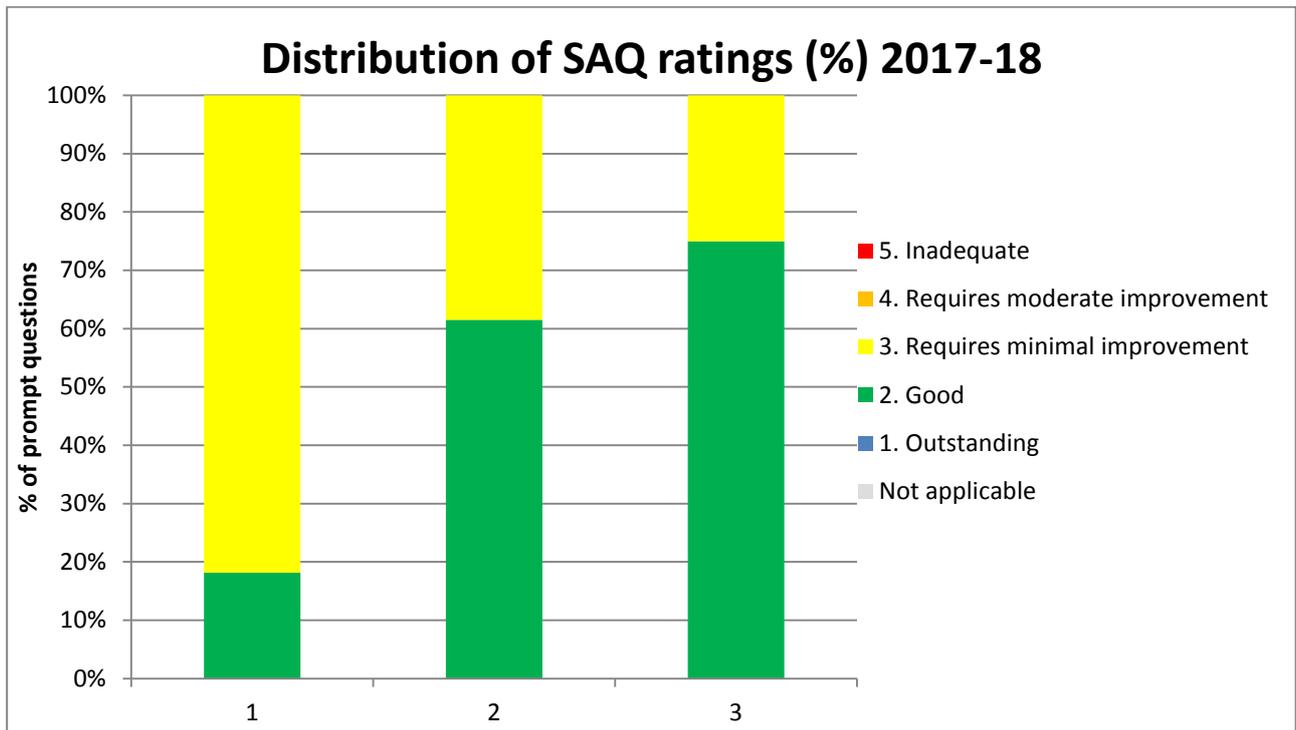
Figure 24: DBTH PAM Organisational Governance Domain Summary Position for 2017/2018



Numerical breakdown of DBTH Overall Organisational Governance SAQ scores for 2017-2018 are:

Outstanding	= 0
Good	= 9
Requires Minimal Improvement	= 15
Requires Moderate Improvement	= 4
Inadequate	= 0
Not Applicable	= 0

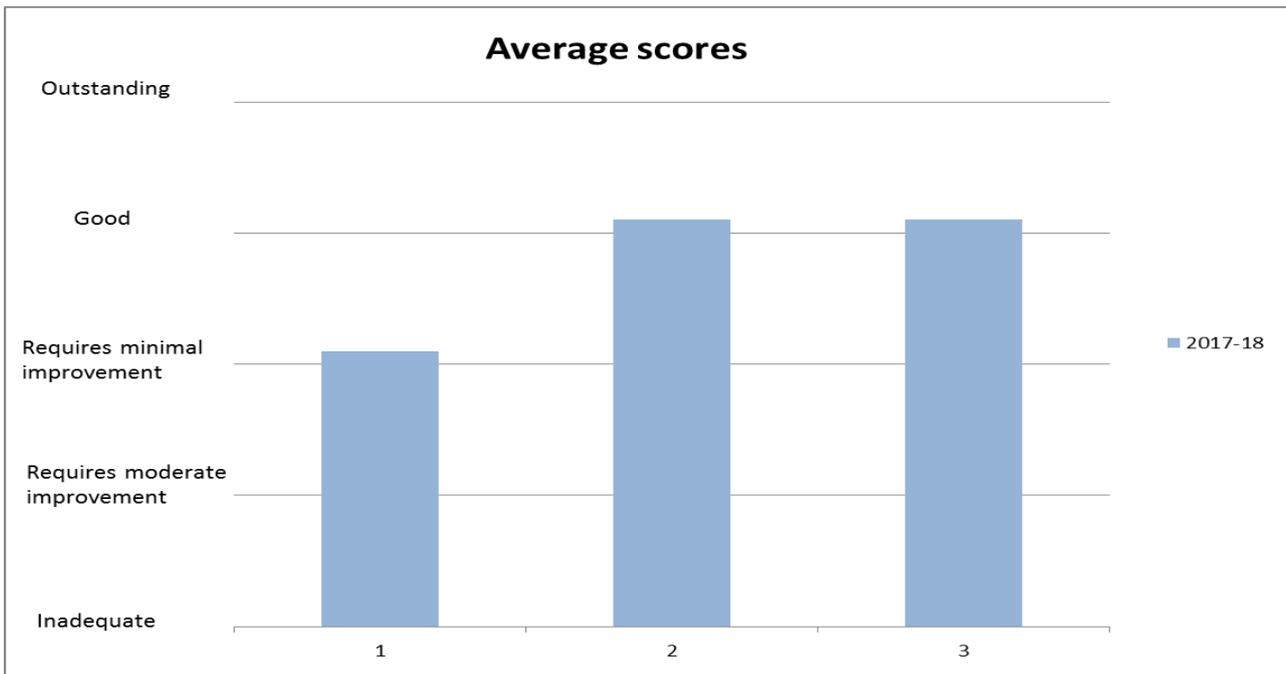
Figure 25: DBTH PAM Distribution of SAQ Ratings (%) for Organisational Governance 2017/2018



Legend

SAQ code	Self Assessment Question - Does your organisation:
G1	Does the Estates and Facilities governance framework have clear responsibilities and that quality, performance and risks are understood and managed?
G2	Does the Estates and Facilities leadership and culture reflect the vision and values, encouraging openness and transparency and promoting good quality estates and facilities?
G3	Does the Board have access to professional advice on all matters relating to Estates and Facilities assurance and linked to Regulators and Inspectors requirements?

Figure 26: DBTH PAM Average Scores for Organisational Governance 2017/2018



All three SAQ elements show evidence of progressive improvement within the Organisational Governance Domain: How the Organisations Board of Directors (BOD’s) delivers Strategic Leadership and effective scrutiny of the Organisations E&F operations:

The Director of E&F attends a number of Board and Executive meetings, including Finance and Performance which provide opportunity for Non-Executive Director (NED) challenges and Board assurance. The Director of E&F has regular 121 meetings with the Chief Executive and Chair of the Board, enabling the BOD’s to monitor the quality, performance of the E&F and its understanding of the risks associated with managing the Estate to provide a clean, safe, secure and suitable environment for its Patients, Staff and Visitors. The Director of E&F also chairs the Trust Health & Safety (H&S) Committee which reports to the Audit and Non-Clinical Risk Committee, providing direct feedback to Board.

Operationally the E&F hold monthly E&F Committee meetings and bi-monthly E&F H&S Committee meetings. The E&F have a document approach to Risk Management and a process for Operational Risk Escalation; Risks rated high 15-25 are fed into the Corporate Risk Register where a robust internal audit focused around key risk Corporate Risk provides Board assurance.

As with previous Domains in the PAM assessment all other elements within this Domain requiring Minimal and Moderate improvement will be reviewed through the PAM working group process for 2018/2019 with action plans and review dates presented to the individual responsible managers.

4.6 Conclusion and Recommendations

The report has provided information from the PAM assessment for 2017/2018 covering all 5 PAM Domains including an Overall Summary Position for DBTH and has been developed to deliver assurance for the Board on a consistent basis. The assessment has illustrated areas of improvement made by the Trust delivering a score of 80% Good/Requires Minimal Improvement compared to the 2016/2017 PAM assessment score of 62%, an 18% improvement. The report also outlined identified areas of deficiency that require further improvement, and in some cases investment, to achieve compliance with Legislation, ACOP's and Guidance to bring the Trust up to a target rating for 2018/2019 of 90% Good rating.

The PAM report bridges the gap between the Board and operational detail of the day to day E&F operations, providing opportunity to stimulate better-informed dialogue as to how the premises can be more efficiently and effectively managed, enabling the E&F to make a contribution to the overall strategic objectives of the organisation.

The Senior Management of DBTH E&F provided appropriate resources and support to the PAM working groups and have reviewed the process at key points providing additional resource and input as necessary to pick up deficiencies in the response from other staff.

A programme of review for PAM 2018/2019 is already in place and is progressing, this has placed the Trust in a good position following a recent correspondence from NHS Improvement (NHSI) who are suggesting the NHS PAM Assessment may become mandatory during 2018/19, rather than best practice. As a result of the effective deployment of NHS PAM at DBTH, E&F have recently been approached by NHSi to be involved in a new national PAM working group.

Board of Directors are asked to note the progress made in 2017/18 to increasing compliance ratings for the Trust against NHS PAM.



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

Title	Board Assurance Framework & Corporate Risk Register		
Report to	Board of Directors	Date	30 April 2018
Author	Matthew Kane, Trust Board Secretary		
Purpose		Tick one as appropriate	
	Decision		
	Assurance	X	
	Information		

Executive summary containing key messages and issues

The attached Corporate Risk Register and Board Assurance Framework present the end of Quarter 4 2017/18 position. Risk reviews will take place with executives over the coming weeks and ratings and controls will change accordingly.

Below is a presentation of the Q1 versus year end position in respect of the risks contained on the Board Assurance Framework (which highlights risks to strategic objectives) and the Corporate Risk Register (the top operational risks, scoring 15 or above).

No	Risk	Q1/initial score	End of year	Direction
F&P1 (CRR)	Failure to achieve compliance with financial performance and achieve financial plan	L3 x I5 = 15	L3 x I5 = 15	
QEC1	Failure to engage and communicate with staff and representatives in relation to immediate challenges and strategic development	L3 x I4 = 12	L3 x I4 = 12	
ANCR1	Risk of fraud	L2 x I4 = 8	L2 x I4 = 8	
F&P2	Failure to deliver accurate financial reporting underpinned by effective financial governance	L3 x I4 = 12	L2 x I4 = 8	

QEC2	Lack of adequate CT scanning capacity at DRI	L3 x I3 =9 (added May 17)	L3 x I3 = 9	
F&P3	Failure to deliver Cost Improvement Plans in this financial year	L4 x I4 = 16	L2 x I4 = 8	
QEC3	Inability to sustain the Paediatrics service at Bassetlaw	L2 x I2 = 4 (added May 17)	L2 x I2 = 4	
F&P4 (CRR)	Failure to ensure that estates infrastructure is adequately maintained and upgraded in line with current legislation, standards and guidance.	L4 x I5 = 20	L4 x I5 = 20	
Q&E4	Failure to ensure adequate medical records system	L3 x I3 = 9 (added May 17)	L3 x I3 = 9	
F&P5 (CRR)	Failing to address the effects of the medical agency cap	L3 x I4 = 12	L4 x I4 = 16	
Q&E5	Failure to engage with patients and staff around the quality of care and proposed service changes	L2 x I3 = 6 (added May 17)	L3 x I3 = 9	
F&P6 (shared with QEC) (CRR)	Failure to achieve compliance with performance and delivery aspects of the Single Oversight Framework, CQC and other regulatory standards	L4 x I4 = 16	L4 x I4 = 16	
Q&E6	Failure to improve staff morale	L3 x I4 = 12 (added May 17)	L3 x I4 = 12	
F&P7	Failure to sustain a viable specialist and non-specialist range of services	L2 x I2 = 4	L3 x I3 = 9	
Q&E7	Failure to adequately prepare for CQC inspection	L2 x I3 = 6	L2 x I3 = 6	
F&P8 (CRR)	Inability to recruit right staff and have staff with right skills	L4 x I4 = 16	L4 x I4 = 16	
Q&E8	Failure to achieve complaint reply performance standards	L5 x I2 = 10 (added Dec 17)	L3 x I2 = 6	
F&P9	Breakdown of relationship with key	L3 x I4 = 12	L3 x I4 = 12	

	partners and stakeholders			
Q&E9 (CRR)	Failure to adequately treat patients due to unavailability and lack of supply of medicines	L5 x I3 = 15 (added Mar 18)	L5 x I3 = 15	↔
F&P10	Failure to ensure business continuity / respond appropriately to major incidents	L2 x I4 = 8	L2 x I4 = 8	↔
F&P11 (CRR)	Failure to protect against cyber attack	L3 x I5 = 15	L3 x I5 = 15	↔
F&P12 (CRR)	Failure to ensure that estates infrastructure is adequately maintained and upgraded in accordance with the Regulatory Reform (Fire Safety) Order 2005 and other current legislation standards and guidance	L3 x I5 = 15 (added May 17)	L4 x I5 = 20	↑
F&P13 (CRR)	Inability to meet Trust's needs for capital investment	L4 x I4 = 16 (added May 17)	L4 x I4 = 16	↔
F&P14	Uncertainty over ACS financial regime including single financial control total	L3 x I4 = 12 (added Mar 18)	L3 x I4 = 12	↔
Q&E14	Reduction in hospital activity and subsequent income due to increase in community provision	L4 x I3 = 12 (added Sept 17)	L4 x I3 = 12	↔
F&P15	Commissioner plans do not come to fruition and do not achieve the required levels of acute service reduction	L3 x I3 = 9 (added Sept 17)	L3 x I3 = 9	↔
N/A	Risk from board leadership transition including new Chair and Chief Executive, Director of Finance and non-executive directors	L2 x I4 = 8	Removed May 17	↓
N/A	Failure to deliver accurate and timely performance information through CaMIS system	L3 x I4 = 12	Removed May 17	↓

In summary:

- Five risks saw their ratings reduced in the year

- Four risks saw their ratings decrease
- 19 stayed the same

In addition, the Trust has commenced work on a revised risk appetite statement which will be brought to Board shortly.

Key questions posed by the report

- N/A

How this report contributes to the delivery of the strategic objectives

The attached BAF highlights the key risks to the strategic objectives.

How this report impacts on current risks or highlights new risks

The report highlights all corporate and strategic risks to the Trust.

Recommendations

Board is asked to note the report.

Doncaster & Bassetlaw Teaching Hospitals Corporate Risk Register

No.	Description of Risk		Exec owner	Relevant committee	Original Risk Score 1:Low...5:Extreme		Overall Original Risk Score	Controls	Current Risk Score 1:Low 5:Extreme		Overall Current Risk Score	Direction of travel	Target Risk Score 1:Low 5:Extreme		New and developing controls	Owner and target date
	Source (Lack of...Failure to ...)	Consequences (Results in ...Leads to ...)			Like-likelihood	Impact			Like-likelihood	Impact			Like-likelihood	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. (xv) Support from BDO. (xvi) Appointment of suitably qualified Efficiency Director.	3	5	15	↔	2	5	Additional grip and control mechanisms as proposed through BDO	Ongoing
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) Independent Authorising Engineers appointed for key services, providing annual audits and technical guidance (v) Revised business planning process for all capital investments (vi) Estate condition and backlog maintenance assessment undertaken via 6-7 facet survey (vii) Progress and monitoring of actions undertaken through compliance committees e.g. health and safety committee (viii) Board level health and safety training undertaken, October 2017 (viii) Completion of in-depth high voltage scheme (June 2017)	4	5	20	↔	2	5	(i) Review and develop business continuity and disaster recovery plans (ii) Comprehensive review of Estates and facilities risk register and risk escalation process (iii) Seek additional funding to rectify condition and backlog maintenance issues	DP - Spring 2018 KEJ - Spring 2018 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) Teaching hospital status communicated through recruitment. (ii) Care Group to escalate recruitment difficulties to MD/COO. (iii) Use of Trust staff in first instance to address gaps wherever possible. (iv) Signed memo of understanding between all Trusts in the WTP to abide by a standard set of principles. (v) P&OD / Workforce reports to BoD. (vi) Workforce and Education Committee. (vii) Agency spend and breaches going to Exec Team and Finance and Performance. (viii) Better system around rate-to-fill and fill rates. (ix) Use of social media to attract new candidates. (x) Relationships with universities. (xi) GMC Survey. (xii) Medical agency locum panel. (xiii) BDO Grip & Control work. (xiv) Use of alternative workforce.	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.	KB/SS/DP - ongoing As above
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 processes. (xiii) Weekly review of A&E Action plan in accountability meeting chaired by COO. (xiv) Licence to Operate linked to SOF	4	4	16	↔	3	3	New accountability framework to go live	DP - Spring 2018
F&P8	Inability to recruit right staff and have staff with right skills	(i) Increase in temporary expenditure (ii) Inability to meet FYFV and Trust strategy (iii) Inability to provide viable services	Director of People & OD	Finance & Performance	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 - bolstered. (vii) Consultant appointment approval processes. (viii) NHS Professionals processes & management information. (ix) Pilot of Assistant Practitioner role. (x) Links with universities, increasing local placements. (xi) Developing bands 1-4 nursing roles. (xii) Nurse associate roles - exploration. (xiii) Increasing the attractiveness of the website, social media and open days.	4	4	16	↔	2	4	(i) Exploring recruitment with other partners and through other methods. (ii) Agency report development	MH - Nov 2017 KB - Sep-Nov 2017

F&P11	Failure to protect against cyber attack	(i) Trust becoming non-operational (ii) Inability to provide clinical services (iii) Negative impact on reputation	Chief Information Officer	Finance & Performance	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 (vii) All servers and systems patched to appropriate level (viii) Computers and network infrastructure get security patches automatically applied	3	5	15	↔	1	4	Controls proposed by recent cyber security audit	SM - January 2018
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 contained within this overarching entry. For further details please consult the EF risk register.	(i) Breaches of regulatory compliance could result in Enforcement or Prohibition notices issued by the Fire and Rescue Services (ii) Claims brought against the Trust (iii) Inability to provide safe services (iv) Negative impact on reputation	Director of Estates and Facilities	Finance & Performance	5	5	25	(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	3	5	15	↔	2	5	(i) Further review of Risk Based capital investment plans (ii) Comprehensive review of Estates and Facilities risk register and risk escalation process (iii) Seek additional funding to rectify condition and backlog maintenance issues	JS - Spring 2018 KEJ - Spring 2018 TBC
F&P13	Inability to meet Trust's needs for capital investment	(i) Inability to sustain improvements 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 structure - Corporate Investment Group and Capital Monitoring Group. (iii) Guidance and templates for investment and disinvestment. (iv) Proactive prioritisation of schemes.	4	4	16	↔	1	4	Clarity around process over STP capital projects.	TBC
Q&E9	Failure to adequately treat patients due to inavailability and lack of supply of medicines	(i) Impact on safety of patients (ii) Impact on patient experience (iii) Potential delays to treatment (iv) Impact on trust reputation (v) Increased workload in pharmacy procurement	Chief Operating Officer	Quality & Effectiveness	5	3	15	(i) Support from Regional Procurement Team (ii) Arrangement of substitute drugs and medicines (iii) Database of supply issues managed by RPT (iv) Daily updates on shortages (v) Holding to account of wholesalers for non-delivery of their contractual obligations and monitoring the performance of wholesalers in the region (vi) Local holding to account through account business managers (vii) Escalation measures to Deputy Chief Pharmacist for persistent and acute issues (viii) Logistics team communicating shortages to the ward and pharmacy team if stock not available for supply	5	3	15	NEW	2	3	TBC	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 NEGLECTIBLE	Negligible impact/delay/overspend/difficulty	Minor loss < £1,000	Trivial, very short-term single non-compliance	Insignificant injury (no intervention)	Low level public awareness/concern	Negligible impact/unnoticed by service users
2 MINOR	Small impact/delay/overspend/difficulty	Small loss £1,001-£10,000	Small, single, short-term non-compliance	Minor injury (local intervention)	Short-term local media coverage	Small impact/small inconvenience
3 MODERATE	Medium scale impact/delay/overspend/difficulty	Moderate loss £10,001 - £100,000	Sustained single or a few short-term non-compliances	Moderate injury (professional intervention)	Longer-term local media coverage	Medium level impact/moderate inconvenience
4 MAJOR	Significant impact/delay/overspend/difficulty	Significant loss £100,001 - £1,000,000	Multiple sustained non-compliances	Major injury (hospital stay)	Short-term national media coverage	Significant impact/serious inconvenience
5 CATASTROPHIC	Substantial impact/delay/overspend/difficulty	Substantial loss > £1,000,000	Multiple, long-term, significant non-compliances	Fatal injury	Longer-term national media coverage	Substantial/Complete service failure

Strategic Aim 1 - 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 Q3	Deputy Director of Finance substantively appointed with an estimated started date of March 5 2018. One resignation for the Head of Financial Accounts, but otherwise now fully established in Finance. PMO re-organisation underway and interim appointed for 6 months. Patient Experience and Engagement Strategy approved at BoD. Action plan to deliver the strategy to be presented to January Patient Experience & Engagement Committee. A significant amount of data has been collated from DBTH systems we can access routinely (i.e. CaMIS, Symphony, RIS etc.). Currently pursuing access to other data sources. The information team are currently evaluating the requirements for the BI tool with the aim of providing timely management information. Initial prototype components for the BI dashboard have been developed.						Direction 	
RISKS	LINK TO CRF	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 and Hospital Services Review (ii) Commissioner engagement (iii) Involvement/influence NHSE commissioning intentions (iv) R & D support for specialist services (v) Quarterly Executive discussions with STH (vi) Contribution to reconfiguration discussions	(i) Peer review programme outcome (9 June 2016) (ii) Patient outcome and service quality as published by National Registries (iii) Agreement with Sheffield over vascular services (iv) Publication of Hospital Services Review workstreams (September 2017) (v) Hospital Services Review list of priorities (vi) Participation in review of specialist services (vii) Decision on HASU	(i) Strategic review of specialised services in Y&H to be implemented supported by working group (ii) Outcomes of Hospital Services Review (iii) Final outcome on HASU	(i) HSR outcomes reported - April 2018 (ii) HASU (Spring 2018)	L2 x I2 = 4
Failure to protect against cyber attack leading to (i) Trust becoming non-operational (ii) Inability to provide clinical services (iii) Negative impact on reputation	F&P11	Chief Information Officer	L3 x I5 = 15	(i) Penetration test of systems to identify gaps and risks; (ii) Firewalls, passwords, anti-virus equipment. (iii) Policies and reinforcement through communication to staff; (iv) Staff awareness through Certified Security Professional course and other training; (v) Trigger alerts; (vi) Care Cert system at NHS Digital (vii) All servers and systems patched to appropriate level (viii) Computers and network infrastructure get security patches automatically applied	(i) Trust unaffected by cyber attack in May 2017 (ii) Governors briefing June, 2017 (iii) Cyber maturity audit and action plan reported via ANCR to Board, September 2017 (iv) Annual IT audit	Progress against Internal Audit action plan to be presented to ANCR every six months	To undertake the work from the cyber maturity audit and report through ANCR (Spring 2018)	L3 x I4 = 12
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 (iv) RFID System operational (v) IM&T Strategy	(i) Storage bays reviewed (ii) Presentation before Board in August 2017 on RFID (iii) RFID installed, October 2017	(i) Electronic Patient Record System (ii) Information Strategy	(i) Consideration of EPR in IM&T Strategy (ii) Draft Information Strategy presented to ET and due to come to Finance & Performance Committee in March 2018	L2 x I2 = 4
Failure to engage with patients and staff around the quality of care and proposed service changes leading to (i) Negative patient and public reaction towards the Trust (ii) Impact on reputation (iii) Impact on staff morale (iv) Risk of long-term recruitment issues (v) Risk of delay to any service changes	Q&E5	Director of Nursing, Midwifery and AHPs/ Medical Director	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 & Experience 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 (xi) Media & social media policy (xii) Governor/ NED briefings (xiii) MP briefings/ meetings (xiv) Governor training (xv) Meetings with local journalists (xvi) Face to face briefings with services (xvii) Staff engagement events, briefings and workshops (xviii) Communications with staff on Hospital Services Review (xix) Internal staff surveys	(i) Consultation on HASU and children's tier 2 surgery (ii) Consultation on new strategic direction (iii) Baseline Governors engagement work with the public (iv) Case law and advice taken in respect of service changes (v) F4H Strategy special, September 2017 (vi) Training on communication (vii) Communications team is responsive on traditional and social media (viii) New, engaging website (ix) Invested in strong relationships with local journalists and MPs (x) Ensuring internal and external communications are aligned and staff engagement is considered in external comms process (xi) Communications Strategy approved by Board, October 2017 (xii) Ongoing meetings with commissioners and primary care across the patch (xiii) Medical Director's discussions with governors	(i) ACS sessions with NEDs and local MPs and councillors	(i) ACP communications plan in development (Spring 2018) (ii) Further ACS sessions planned for 2018 with local politicians (23 March 2018) and NEDs (8 May 2018)	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	Director of Nursing, Midwifery and Allied Health Professionals	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) CQC internal audit (ii) IRMER inspection and action plan in place (iii) Reports to Board and QEC (iv) CQC Insights (v) PIR and self-assessment completed (vi) Action plan for Child Protection - Information Sharing (vii) Positive mock inspections	(i) Positive assurance from CQC (ii) Good inspection and self-assessment outcomes	(i) Final report from CQC inspection (expected March 2018)	L2 x I2 = 6

<p>Failure to achieve complaint reply performance standards</p> <p>leading to</p> <p>(i) Impact on reputation (ii) Impact on patient experience</p>	Q&E8	Director of Nursing, Midwifery and Allied Health Professionals	<p>L3 x 12 = 6 (new score)</p>	<p>(i) Live complaints tracker developed (ii) Weekly PET/CG meetings to monitor progress/review agreed timescales and manage the complainants expectations. (iii) Weekly meetings with the Head of Patient Safety & Experience, Deputy Director of Quality & Governance and DoN which includes escalation. (iv) Quality dashboard includes CG performance presented at Clinical Governance Committee on a monthly basis. (v) Monitored through Patient Experience & Engagement Committee.</p>	<p>(i) Patient Experience Strategy approved (ii) Positive Q3 results presented to Board in January 2018</p>	<p>(i) Improved performance in complaints handling</p>	<p>(i) Improvement plans in place and being implemented (Spring 2018)</p>	<p>L2 x 12 = 4</p>
<p>Failure to adequately treat patients due to unavailability and lack of supply of medicines</p> <p>leading to</p> <p>(i) Impact on safety of patients (ii) Impact on patient experience (iii) Potential delays to treatment (iv) Impact on trust reputation (v) Increased workload in pharmacy procurement</p>	Q&E9	Chief Operating Officer	<p>L5 x 13 = 15</p>	<p>(i) Support from Regional Procurement Team (ii) Arrangement of substitute drugs and medicines (iii) Database of supply issues managed by RPT (iv) Daily updates on shortages (v) Holding to account of wholesalers for non-delivery of their contractual obligations and monitoring the performance of wholesalers in the region (vi) Local holding to account through account business managers (vii) Escalation measures to Deputy Chief Pharmacist for persistent and acute issues (viii) Logistics team communicating shortages to the ward and pharmacy team if stock not available for supply</p>	<p>(i) Temporary improvements to the supply chain (ii) Updates from CMU (Commercial Medicines Unit of NHSE)</p>	<p>(i) Longer term improvements to supply chain (ii) Awareness amongst relevant staff</p>	<p>Gaps to be added to database (February 2018)</p>	<p>L2 x 13 = 6</p>

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)								
PROGRESS Q3	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.								
	Estates strategy agreed at Board of Directors in December 2017. Action plan tracking progress against implementation, KPMG audit of strategy and capital process Jan 10th. Three Steering Boards well established. Plans in place to improve utilisation of facilities on each of the three main sites. STF achieved for Quarter 3. Cancer 62 days currently on track. Diagnostics achieved in quarter. RTT being modelled with the CCGs to agree trajectories for the end of March. Work plans in place via the planned care board to ensure the appropriate movement of services. QII action plan being implemented all milestones met to date.							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 15 = 15	(i) Business and budget planning processes. (ii) Financial governance policies and procedures. (iii) Monthly monitoring of financial performance. (iv) Data analysis of trends and action to address deterioration. (v) Continued liaison with budget holders to identify risks to delivery. (vi) Demand and capacity planning processes. (vii) Detailed monitoring by Finance and Performance Committee. (viii) Budgets set on recurrent outturn resulting in a more robust financial plan. (ix) Budgets signed off by care groups and corporate departments. (x) Monthly monitoring at Board and directorate level. (xi) Uncommitted general contingency reserve. (xii) Regular finance meetings with budget holders. (xiii) Performance review meetings with NHSI. (xiv) All directorates signed up to control total. (xv) Support from BDO. (xvi) Appointment of suitably qualified Efficiency Director.	(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 (xi) BDO governance review (xii) Regular finance reports to F&P (xiii) Strong performance in month 10 (xiv) Significant assurance audit with limited number of improvements on core financial systems	(i) Consistent reporting of achievement against plan (ii) 2017/18 external audit	N/A	L2 x 15 = 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	L2 x 14 = 8 (new score)	(i) Checklist of control accounts reviewed by the Finance Director (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 (v) New deputy director of finance appointed	(i) Unqualified opinion on 2016/17 accounts (ii) Consistency of reporting over sustained period (iii) Internal audit reports show significant assurance with only minor improvements in respect of financial reporting (iv) M9 accounting position (v) Significant assurance audit with limited number of improvements on core financial systems	(i) Continued positive audits on financial reporting	N/A	L1 x 14 = 4	
Failure to deliver Cost Improvement Plans in this financial year leading to (i) Negative impact on Turnaround (ii) Negative impact on Trust's financial position (iii) Loss of STF funding	F&P3	Director of Finance	L2 x 14 = 8 (new score)	(i) Full Quality Risk Assessment and operational deliverability assessment of plans. (ii) Regular consideration of schemes by Management Board and Executive Team. (iii) Collaboration with other providers, to identify joint opportunities. (iv) CIP tracker developed to provide visibility of progress against plan. (v) Engagement in working together programme. (vi) PMO led by new Efficiency Director, 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. (ix) Regenerated E&E Committee. (x) CIP recovery meetings (fortnightly) with each group.	(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. (v) BDO governance review.	(i) Outstanding recurrent CIP target to be found	N/A	L1 x 14 = 4	

<p>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.</p> <p>leading to</p> <ul style="list-style-type: none"> (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 15 = 20	<ul style="list-style-type: none"> (i) Annual business plan supports identification of issues by Care Groups / Directorates (ii) Risk-based capital investment plans (iii) Maintenance and support service contracts (iv) Independent Authorising Engineers appointed for key services, providing annual audits and technical guidance (v) Revised business planning process for all capital investments (vi) Estate condition and backlog maintenance assessment undertaken via 6-7 facet survey (vi) Progress and monitoring of actions undertaken through compliance committees e.g. health and safety committee (vii) Board level health and safety training undertaken, October 2017 (viii) Completion of in-depth high voltage scheme (June 2017) 	<ul style="list-style-type: none"> (i) Presentations to Finance and Performance and Governors Briefings (ii) Catering contract agreed May 2017 (iii) New service assistants in post April 2017 (iv) Completed 6/7 facet survey (v) Asbestos and window surveys complete (vi) Asbestos management plan up to date (vii) Window risk assessments complete (vii) Water management protocols complete and progress commenced (ix) Electrical infrastructure surveys complete (xii) Waste contract completed and delivered (xiii) New catering contract signed (xiv) New gas main (xv) Continuously premise assurance model (xvi) Estates Strategy approved by Board and capital plan (xvii) Estates strategy audited (significant assurance) 	<ul style="list-style-type: none"> (i) Additional 6/7 facet work. (ii) Premises Assurance Model under development with first estates update to Board (iii) Capita programme to be agreed 	<ul style="list-style-type: none"> (i) MP developing capital schemes for ACS funding (Autumn 2017) (ii) New electrical supplier to site (iii) PAM to be brought to Board (Spring 2018) (iv) Capital programme to be agreed in April 2018 	L2 x 15 = 10
<p>Failing to address the effects of the medical agency cap</p> <p>leading to</p> <ul style="list-style-type: none"> (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 14 = 16	<ul style="list-style-type: none"> (i) Teaching hospital status communicated through recruitment. (ii) Care Group to escalate recruitment difficulties to MD/COO. (iii) Use of Trust staff in first instance to address gaps wherever possible. (iv) Signed memo of understanding between all Trusts in the WTP to abide by a standard set of principles. (v) P&OD / Workforce reports to BoD. (vi) Workforce and Education Committee. (vii) Agency spend and breaches going to Exec Team and Finance and Performance. (viii) Better system around rate-to-fill and fill rates. (ix) Use of social media to attract new candidates. (x) Relationships with universities. (xi) GMC Survey. (xii) Medical agency locum panel. (xiii) BDO Grip & Control work. (xiv) Use of alternative workforce. 	<ul style="list-style-type: none"> (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. (vii) Agency spend to F&P. (viii) Weekly flash reports and meetings. (ix) Bassetlaw@ (x) QIMET process 	<ul style="list-style-type: none"> (i) Develop new service model to mitigate medical staff shortage, working across the Trust. (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) Scrutiny of qualified nursing process to be put in place. (vi) Flexible use of staff across ACS system. (vii) Hospital Services Review (March 2018). (viii) Flash report on agency spend. (ix) Collaborative bank pilot (March 2018). 	<ul style="list-style-type: none"> (i) Hospital@ work (March 2018) (ii) In discussion with recruitment agencies to fill gaps (March 2018). (iii) Medical collaborative bank taking place (March 2018). (iv) Review of existing NHSP contract (Spring 2018). (v) Local Workforce Action Board work taking place. 	L3 x 12 = 6
<p>Failure to achieve compliance with performance and delivery aspects of the Single Oversight Framework, CQC and other regulatory standards</p> <p>leading to</p> <ul style="list-style-type: none"> (i) Regulatory action (ii) Impact on reputation 	F&P6	Chief Operating Officer	L4 x 14 = 16	<ul style="list-style-type: none"> (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 processes. (xiii) Weekly review of A&E Action plan in accountability meeting chaired by COO. (xiv) Licence to Operate linked to SOF 	<ul style="list-style-type: none"> (i) Full and unconditional registration with CQC (ii) Business Intelligence and Performance 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 Programme North - showcasing best practice (ix) System Perfect 	<ul style="list-style-type: none"> (i) CQC self-assessments and mock inspections (ii) CQC Inspection report (iii) Consideration of Trust's regulatory position in relation to its breach of licence 	<ul style="list-style-type: none"> (i) New accountability framework linked to SOF being put in place for care groups and corporate depts (Spring 2018) (ii) CQC Report expected April 2018 (iii) Consideration of breach position (April 2018) 	L3 x 13 = 9

<p>Failure to ensure that estates infrastructure is adequately maintained and upgraded in accordance with the Regulatory Reform (Fire Safety) Order 2005 and other current legislation standards and guidance.</p> <p>Note: a number of different distinct risks are contained within this overarching entry. For further details please consult the EF risk register.</p> <p>leading to</p> <p>(i) Breaches of regulatory compliance could result in Enforcement or Prohibition notices issued by the Fire and Rescue Services (ii) Claims brought against the Trust (iii) Inability to provide safe services (iv) Negative impact on reputation</p>	F&P12	Director of Estates and Facilities	L4 x 15 = 20	<p>(i) Regular external inspections from SVRS and Notts Fire Service (ii) Improved fire safety risk assessments and evacuation strategies (iii) Improved Fire Safety Training (iv) Programme upgrade of fire detection systems (v) Programme upgrade of structural fire precautions (compartments) (vi) External Audit Fire Authorised Engineer (vii) Fire safety training Trust Board and Exec Team (viii) Further Development of Fire Safety Response Team structure (ix) Risk based Capital Investment plans identified by estate condition and backlog maintenance assessments via 6 - 7 facet surveys (x) Progress and monitoring of actions undertaken through compliance committees eg health and safety committee</p>	<p>(i) Physical works to DRI and MMH (ii) Fire safety action plan (iii) Report to Board in June 2017 (iv) Fire safety training scheduled July 2017 (v) Staff trained in fire safety - June 2017 (vi) 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 (vii) Upgrade of existing, and provision of additional, fire alarm and detection systems at DRI and Montagu Hospital. (viii) Approval of evacuation strategies for W&Cs and East Block. (ix) HSE inspections of Women's Block (x) Montagu evacuation strategy approved, December 2017 (xi) Priority list for fire strategies presented to Board</p>	<p>(i) Full compliance with requirements of Fire Service (ii) Training on evacuation strategies (iii) Actions to address Deficiency Notice at Bassetlaw</p>	<p>(i) Training to be rolled out across 2017/18 (Rolling programme) (ii) Priority list in development (Spring 2018) (iii) Action plan to be developed for Bassetlaw Deficiency Notice (Spring 2018)</p>	L2 x 15 = 10
<p>Inability to meet Trust's needs for capital investment</p> <p>leading to</p> <p>(i) Inability to sustain improvements in Trust's estate. (ii) Negative impact on patient safety. (iii) Negative impact on reputation.</p>	F&P13	Director of Finance	L4 x 14 = 16	<p>(i) Finance reports to Board and Finance and Performance Committee. (ii) Capital governance governance structure - Corporate Investment Group and Capital Monitoring Group. (iii) Guidance and templates for investment and disinvestment. (iv) Proactive prioritiation of schemes.</p>	<p>(i) DBTH part of bidding process for ACS funds (ii) Five year review of capital requirements which have been prioritised</p>	<p>(i) Knowledge of possible funding remaining for ACS capital schemes. (ii) Clarity over external capital processes.</p>	<p>(i) MP developing capital schemes for ACS funding.</p>	L1 x 14 = 4
<p>Lack of adequate CT scanning capacity at DRI</p> <p>leading to</p> <p>(i) Negative impact on patient safety. (ii) Inability to safely manage the emergency and inpatient activity.</p>	Q&E2	Chief Operating Officer	L3 x 13 = 9	<p>(i) Allocation within 2017/18 capital programme. (ii) Engagement with care group directors.</p>	<p>(i) Business case cleared at CIG (ii) Initial discussions at F&P and ACS level (iii) Case approved at Board, February 2018 (iv) CT donation</p>	<p>(i) Consideration of case by NHSI</p>	<p>(i) Decision from NHSI (Spring 2018)</p>	L2 x 12 = 4
<p>Uncertainty over ACS financial regime including single financial control total</p> <p>leading to</p> <p>(i) Impact on Trust's finances and control total (ii) Negative impact on reputation</p>	F&P	Director of Finance	L3 x 14 = 12 (new risk)	<p>(i) Chair and exec attendance at ACS meetings. (ii) Leadership at ACS level. (iii) Developing governance structure.</p>	<p>(i) Ongoing discussions with ACS and at national level.</p>	N/A	N/A	L2 x 12 = 4
<p>Risk of fraud</p> <p>leading to</p> <p>(i) Impact on Trust's finance (ii) Negative impact on reputation</p>	ANCR1	Director of Finance	L2 x 14 = 8	<p>(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 (v) Staff fraud questionnaire.</p>	<p>(i) Quarterly and annual LCFS reports (ii) Achievement of satisfactory NHS Protect Quality Assessment outcome (iii) Full completion of 2016/17 operational fraud plan and 2017/18 plan in place (iv) Completion of fraud staff survey (vii) 79% completed fraud awareness training in 2017/18 (viii) NHS Protect assurance report to Board, October and November 2017</p>	N/A	N/A	L1 x 14 = 4

Strategic Aim 3 - We will increase partnership working to benefit people and communities.								
KEY STEPS		<p>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</p> <p>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.</p> <p>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</p> <p>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</p> <p>Evaluate the potential for Public/Private Partnerships, linked to the Trust strategic direction.</p>						
PROGRESS Q3		<p>Involved in Place Plan Doncaster. COO and CEO more involved at Bassetlaw. Working with DMBC colleagues to promote closer working with project teams. Milestones requested from Directors for development of summary and animation - work ongoing on this and aligned to place plans. DBTH actively involved in the hospital services review and in the key workstreams for ACS. Head of Medical Staffing has now commenced and will support improved delivery of recruitment, casework and productivity. Following a review of MD functions and staff, plans have been developed to enable changes to occur over the next two quarters. Gateshead NHS Trust commissioned to undertake a review of opportunity for WOS, report due 12th Jan to Director of Finance. CT/HASU business case costs provided by P21+ partner IHP by 11th Jan, full business case due at Board in February for submission to NHSI.</p>						<p>Direction</p> 
RISKS	LINK TO CRR	EXEC	CURRENT RR	CONTROLS	ASSURANCE	GAPS IN ASSURANCE	ACTION TO ADDRESS GAPS	TARGET RR
<p>Breakdown of relationship with key partners and stakeholders</p> <p>leading to</p> <p>(i) Negative impact on strategic objectives</p> <p>(ii) Negative impact on reputation</p>	F&P9	Chief Executive	L3 x14 = 12	<p>(i) Partnership working processes - Working Together, STP, Accountable Care Systems, HWB</p> <p>(ii) Engagement with commissioners & other local trusts</p> <p>(iii) Attendance at CCG governing body meetings</p> <p>(iv) CE meetings with NHS England</p> <p>(v) Regular briefings to Members of Parliament</p> <p>(vi) Partner Governor seats on the Board of Governors</p> <p>(vii) Regular item on Exec Team for feeding back</p>	<p>(i) CE Reports</p> <p>(ii) Updates on HWB activity</p> <p>(iii) Updates regarding Working Together and STP programme via CE report (BoD) (ii)</p> <p>(iv) Committees in common and STP MoUs</p> <p>(v) Support from commissioners</p> <p>(vi) Bassetlaw and Doncaster Place Plans endorsed.</p> <p>(vii) Well Led Governance Review reinforces the Trust's partnership arrangements.</p> <p>(viii) ACS Conference for Governors taken place, October 2017</p> <p>(ix) CIC meetings underway</p>	<p>(i) ACS events planned with MPs and councillors</p> <p>(ii) Outcome to legal challenges known</p>	<p>(i) ACS events taking place (March/May 2018)</p>	L2 x14 = 8
<p>Failure to ensure business continuity / respond appropriately to major incidents</p> <p>leading to</p> <p>(i) Negative impact on reputation</p> <p>(ii) Regulatory enforcement</p> <p>(iii) Negative impact on performance</p>	F&P10	Chief Operating Officer	L2 x14 = 8	<p>(i) Business continuity plans</p> <p>(ii) Business Continuity Policy</p> <p>(iii) Statement of Compliance against National Core Standards for EPRR</p> <p>(iv) BRSG which monitors BC planning progress</p> <p>(v) Business Continuity Group linked to operational structures</p> <p>(vi) Major Incident Plan</p> <p>(vii) Training of A&E staff on CBRN incidents</p> <p>(viii) Emergency response plans in place (annually reviewed)</p> <ul style="list-style-type: none"> - Evacuation of a hospital site - Mass Casualty Plan - Pandemic Influenza Plan - Severe Weather Plan - Prison Plan - CBRNE plan <p>(ix) Incident Control Rooms in line with EPRR Command and Control guidelines</p> <p>(x) Communications exercises undertaken twice yearly as required by statute</p> <p>(xi) Command & control training for BoD & senior managers on-call</p> <p>(xii) Revision of plans following test exercises.</p> <p>(xiii) On-call senior management trained - Leading in a crisis and public enquiry simulation</p>	<p>(i) Power outage testing Summer 2017</p> <p>(ii) Annual confirmation of compliance against National Core Standards for Emergency Preparedness, Resilience and Response (BoD, Nov 2016)</p> <p>(iii) Test exercises: Sickness, fuel (2016)</p> <p>(iv) Internal Audit follow-up review of business continuity arrangements</p> <p>(v) Risk assessment of major incident and business continuity plans with NHS England (2015)</p> <p>(vi) Y&H peer review of major incident plans 2016.</p> <p>(vii) External review of HAZMAT - compliant (September 2015)</p> <p>(viii) Hazardous Substances policy agreed by Board 29.11.2016</p> <p>(ix) Tabletop exercises undertaken, SY risk assessment completed and two power cuts</p> <p>(x) Working with Care Groups to develop relevant desktop exercises.</p> <p>(xi) Trust unaffected by system-wide cyber attack, May 2017</p> <p>(xii) Winter planning agreed by Board in July 2017</p> <p>(xiii) Compliance with Annual Statement of Compliance against the NHS Core Standards for Emergency Preparedness, Resilience and Response (2017/18)</p> <p>(xiv) Presentation to Board on Emergency Planning, November 2017</p> <p>(xv) Business continuity exercise (mostly completed), December 2017</p> <p>(xvi) Further review of processes following power outage (Winter 2018)</p> <p>(xvii) Cold weather plan tested</p> <p>(xviii) Escalation Policy for management of major incident - Trust/Council</p>	<p>(i) Business continuity plans reviewed</p> <p>(ii) Further testing of plans</p>	<p>(i) Emergency plans in process of review (Spring 2018)</p>	L2 x13 = 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 Q3	Joint Planned Care Board meets monthly, reviewing impact of PLCV and assessing activity against contract.							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 12 = 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 (v) CEO's presentation to Governors, September 2017 (vi) Decision taken by Bassetlaw CCG, October 2017	(i) Recruitment of medical and nursing staff	(i) Regular recruitment exercises	L2 x 12 = 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 13 = 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 and ACS	(i) Meetings taking place with Council and other partners to assess impact (ongoing)	L4 x 12 = 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 Officer	L4 x 13 = 12 (new score)	(i) Potential to dual run services (ii) Contractual negotiations (iii) External advice on contractual changes (iv) Consideration of changes through ACPs	(i) Active monitoring of position (ii) Place Plans in place (iii) Clinical services strategy in place	(i) Alignment of expectations between Trust and CCG	(i) Ongoing negotiations (Spring 2018)	L2 x 13 = 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	<p>Bassetlaw @ project group established to review the workforce model. Workforce planning planned as part of the business planning process. Confirm and challenge processes in place to review rostering and use of bank and agency staff. Successful recruitment to key vacancies, eg midwives, ED and Paediatric Consultants. DBTH key partner in the ACS workforce workstreams. Insights development workshop held for all senior managers (GM, HON, Deputy Directors). Action plan developed following that day. Insights development planned for Executive Team and Care Group Directors and Assistant Directors. Development of behaviour charter in progress. Head of Leadership and Organisational Development role being established. Staff experience group developed leadership behaviour expectations which is incorporated in leadership role job descriptions and included in delivery of management skills passport. Improvement in staff survey response rate to 49.9%. Survey monkey underway within maternity services to review progress following the RCOG review. Following the recruitment to the full complement of the Executive Team an Insights development workshop is being planned. Appraisal will include 360 degree feedback utilising the Helathcare Leadership model. Board development programme being finalised.</p>						<p>Direction</p> 	
RISKS	LINK TO CRR	EXEC	CURRENT RR	CONTROLS	ASSURANCE	GAPS IN ASSURANCE	ACTION TO ADDRESS GAPS	TARGET RR
<p>Inability to recruit right staff and have staff with right skills</p> <p>leading to</p> <p>(i) Increase in temporary expenditure (ii) Inability to meet FYFV and Trust strategy (iii) Inability to provide viable services</p>	F&P8	Director of People & OD	L4 x I4 = 16	<p>(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 - bolstered. (vii) Consultant appointment approval processes. (viii) NHS Professionals processes & management information. (ix) Pilot of Assistant Practitioner role. (x) Links with universities, increasing local placements. (xi) Developing bands 1-4 nursing roles. (xii) Nurse associate roles - exploration. (xiii) Increasing the attractiveness of the website, social media and open days.</p>	<p>(i) Increased fill-rate, above national averages in most areas. (ii) Recruitment report to Board, May 2017. (iii) Regular NHSI reporting which is reported to Exec Team, increased to bank as well as agency. (iv) Benchmarking work. (v) WTP work. (vi) New style agency report reported monthly to Exec Team. (vii) Work with ACS Local Workforce Action Board. (viii) Accountability arrangements embedded. (ix) Regular reports to F&P. (x) Review of cohort recruitment. (xi) Work on apprenticeships. (x) We care for junior doctors work. (xi) People & OD Strategy.</p>	(i) Leadership Strategy.	(i) P&OD structure - review being finalised (Spring 2018).	L2 x I4 = 8
<p>Failure to engage and communicate with staff and representatives in relation to immediate challenges and strategic development</p> <p>leading to</p> <p>(i) Deterioration in management-staff relationships (ii) Negative impact on performance (iii) Negative impact on reputation</p>	Q&E1	Director of People & OD	L3 x I4 = 12	<p>(i) Process to engage with LNC. (ii) Process to engage with Partnership Forum. (iii) HR policies and procedures. (iv) Staff engagement project strands. (v) Staff experience group. (vi) Listening events by CEO. (vii) E&E Committee communications plan. (viii) One-page strategy summaries.</p>	<p>(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. (viii) Delivery of engagement plan KPIs. (ix) Listening events (x) Buzz and social media interaction. (xi) Meetings with staff regarding Hospital Services Review. (xii) Staff survey action plan.</p>	<p>(i) Relationship with new chair of Partnership Forum. (ii) Release of staff representatives to do their role. (iii) Staff survey action plans to be revised (end of March).</p>	<p>(i) Care group action plans to be developed and implemented and monitored through accountability meetings. (ii) Development of staff side relationships (Spring 2018).</p>	L2 x I4 = 8
<p>Failure to improve staff morale</p> <p>leading to</p> <p>(i) Recruitment and retention issues (ii) Impact on reputation (iii) Increased staff sickness levels</p>	Q&E6	Director of People and OD	L3 x I4 = 12	<p>(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. (ix) 'Bugbears and bright ideas' approach. (x) Agreed approach to staffside - management meetings. (xi) Achievement of teaching hospital status.</p>	<p>(i) Feedback from Friends and Family Q2. (ii) Feedback from CEO's listening events and lunchtime meetings with consultants. (iii) Bugbears and bright ideas outcomes. (iv) Report to QEC and Board, June 2017, on staff survey action plan. (v) People and OD Strategy approved by Board in October 2017. (vi) Improvements in staff survey results.</p>	<p>(i) Consistent positive scores for staff Friends and Family Test. (ii) Refreshed P&OD Strategy action plan (various) (iii) Consistent positive scores for staff survey.</p>	<p>(i) Additional listening exercises. (ii) P&OD action plans (Various).</p>	L2 x I4 = 8



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

Title	Patient Experience and Engagement Quarterly Report – Q4 2017/18		
Report to	Board of Directors	Date	30th April 2018
Author	Moira Hardy, Director of Nursing, Midwifery and Allied Health Professionals Lisette Caygill, Acting Deputy Director of Quality and Governance		
Purpose			Tick one as appropriate
	Decision		
	Assurance		
	Information		✓

Executive summary containing key messages and issues
This report provides the Board of Directors with information relating to Quarter 4 performance using the information available from Datix and the learning points from the organisation and summarising the end of year activity. 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.
Key questions posed by the report
Does the current report information and the planned steps described provide the relevant information to enable the Board of Directors 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 is measured and monitored for effectiveness through the Patient Experience & Engagement Committee and Care Group activity.
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 FFT response and positivity data locally and nationally and predominantly >95% performance in ward based patient satisfaction surveys.
Recommendation(s) and next steps
The Patient Experience & Engagement Strategy milestones performance will be continue to be measured and monitored through the Patient Experience & Engagement Committee.

1. INTRODUCTION

This paper provides the Board of Directors with information relating to the Trusts performance against the standards identified in the Trusts policy; *complaints, concerns, comments and compliments; resolution and learning*. The data is produced directly from Datix. As Datix is a live system and is continually updated the report is accurate as per the report date and may not reflect the current status when viewed at the Board of Directors Meeting.

2. COMPLAINTS AND CONCERNS RECEIVED

The statistical process control (SPC) charts below show the trend in complaints and concerns in total and separately, from March 2016 to March 2018. These charts illustrate normal variation within expected limits with a significant reduction being demonstrated from October 2017 to date. No specific causes have been identified to account for this trend.

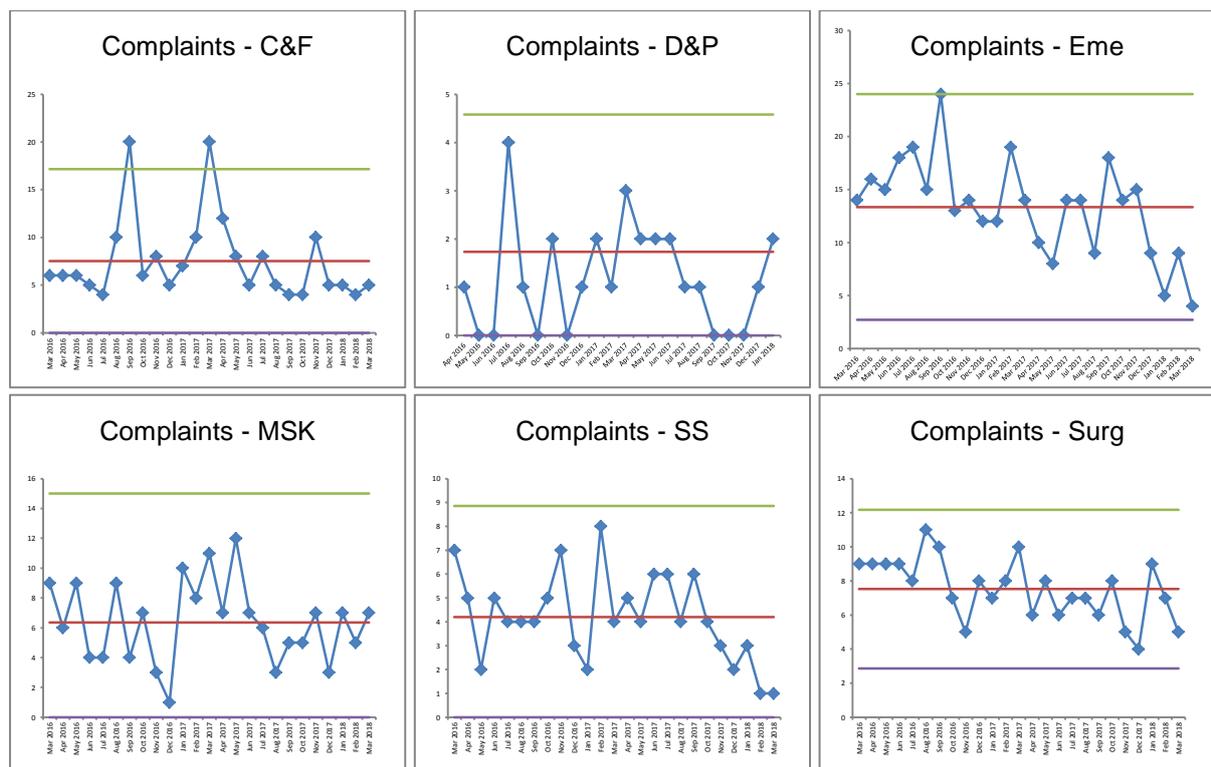


2.1. COMPLAINTS & CONCERNS BY MANAGEMENT TEAM

The table below shows the Care Group rate of complaints and concerns for the last quarter.

	Concern	Complaint
Children and Families Care Group	8	14
Diagnostic and Pharmacy Care Group	4	2
Emergency Care Group	17	18
MSK and Frailty Care Group	15	19
Surgical Care Group	14	21
Specialty Service Care Group	11	5
Chief Operating Officer	13	0
Directorate of Finance and Infrastructure (incl Estates)	5	1
Directorate of Nursing and Quality	2	2
Total	89	82

The charts below illustrate the trend for complaints within Care Groups and it is evident that there is normal variation over most Care Groups with the exception of Specialty Service Care Group who are reporting a decreasing trend in the complaints rate.



3. COMPLAINTS AND ENQUIRIES FROM MEMBERS OF PARLIAMENT

Members of parliament undertake representing their constituents and write to the Trust to obtain information and raise concerns and complaints. In Quarter 4 2017/18 there have been 7 occasions. The data is a subset of the overall complaint, concern and questions included in this report.

	Concern	Complaint	Advice, Comments and Questions	Compliment	Total
Apr 2017	2	3	1	0	6
May 2017	0	2	2	0	4
Jun 2017	5	5	0	0	10
Jul 2017	1	4	1	2	8
Aug 2017	1	2	1	0	4
Sep 2017	0	4	0	0	4
Oct 2017	1	5	0	0	6
Nov 2017	1	6	0	1	8
Dec 2017	0	2	1	0	3
Jan 2018	1	3	0	0	4
Feb 2018	0	3	0	0	3
Mar 2018	0	0	0	0	0
Total	12	39	6	3	60

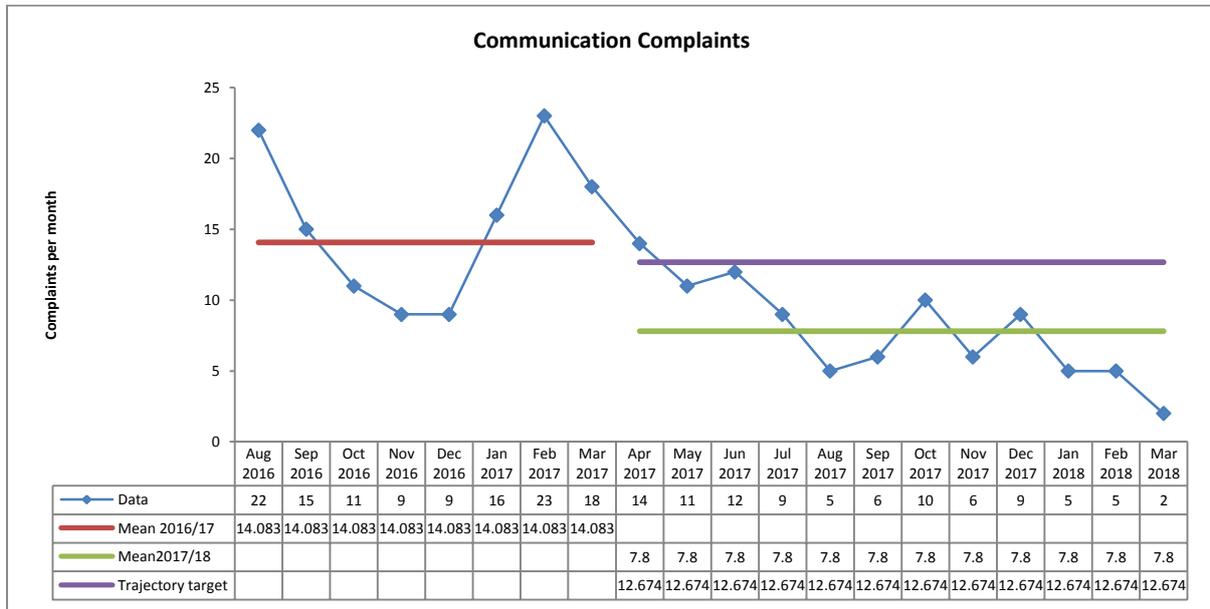
4. TOP 10 REASONS CITED IN A COMPLAINT

The following table lists the top 10 themes identified from complaints for the period from January – March 2018. More than one issue can be identified for each complaint and this data is based on the number of issues, rather than the number of complaints.

	Children and Families Care Group	Diagnostic and Pharmacy Care Group	Emergency Care Group	MSK and Frailty Care Group	Surgical Care Group	Speciality Service Care Group	and Infrastructure (incl Estates)	Total
Diagnosis ↑	3	1	12	6	5	0	0	27
Staff Attitude and Behaviour ↓	4	0	4	4	9	2	0	23
Admissions / transfers / discharge procedure / Sleeper out ↔	2	0	4	9	4	0	1	20
Treatment ↓	1	1	3	4	5	2	0	16
Communication ↓	2	0	2	5	3	0	0	12
Competence ↔	3	1	0	1	3	0	0	8
Medication ↑	2	0	2	0	1	0	0	5
Pain Management ↑	0	0	0	1	3	0	0	4
Nursing – ADL ↓	0	0	1	1	1	1	0	4
Aids / appliances / equipment ↑	0	0	2	0	2	0	0	4

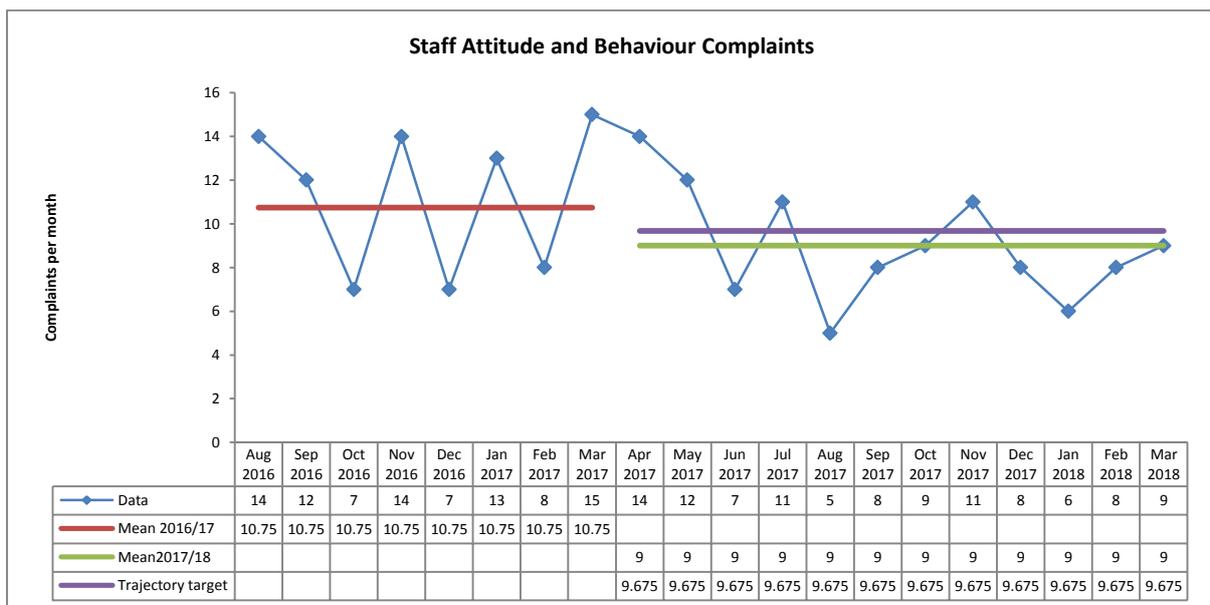
4.1. COMMUNICATION COMPLAINTS (primary complaint)

One of the Quality account objectives set for 2017/18 has been to reduce Communication complaints, as a main theme for the majority of complaints. End of year data illustrates that we have achieved this objective which is well below the trajectory.



4.2. STAFF ATTITUDE AND BEHAVIOUR (primary complaint)

Another objective in the Quality account set for 2017/18 has been to reduce staff attitude and behaviour complaints. End of year data illustrates that we have achieved this objective.



5. RISK CATEGORISATION OF COMPLAINTS

The table illustrates the distribution of risk on complaints over each quarter. The timescale for investigation for Low risk cases has previously been targeted to be 20 days, Moderate risk was 40 days and High risk was 90 days. Since 27th November 2017 all complaints received into the Trust have been allocated a 40 day response timescale in line with national complaints handling guidance. The exception to this is MP complaints which have been allocated 20 days. Timescales can be adjusted based on the complexity of the complaint and this is renegotiated with the complainant to ensure compliance against timescales is monitored accurately.

	Low	Moderate	High	Total
Apr 2017	20	21	2	43
May 2017	22	21		43
Jun 2017	14	25	5	44
Jul 2017	17	23	5	45
Aug 2017	6	20	3	29
Sep 2017	11	27	3	41
Oct 2017	6	29	1	36
Nov 2017	10	28	2	40
Dec 2017	1	24	1	26
Jan 2018	3	29	1	33
Feb 2018	2	23	1	26
Mar 2018	1	21		22
Total	113	291	24	428

6. COMPLAINT REPLY PERFORMANCE

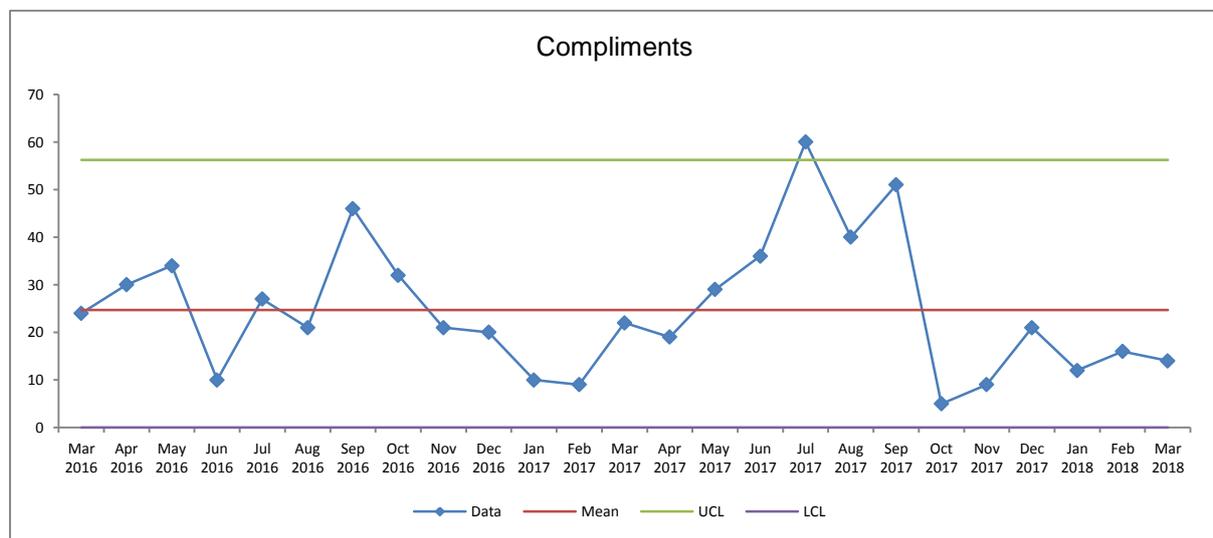
Clearing historical cases at a greater rate than the rate of new complaints is a key aim of improving the handling and management of complaints. Weekly monitoring and performance reporting arrangements are provided to Care Group leads, so that they can ensure that they have effective systems in place. Supportive interventions from the Patient Experience Team, to help improve processes are being taken forward with each Care Group Head of Nursing/Midwifery/Therapies and the Clinical Governance Lead in Diagnostic and Pharmacy Care Group. This method has increased the productivity of Care Groups and there is a gradual reduction of overdue complaints seen in the weekly reports complaint tracking reports. The performance against the reply performance is reported monthly in the BIR Whilst overall performance of complaints which have been responded to within the agreed timescales has decreased in March compared to recent months and is currently at 67%, this is still a significant improvement from 2017. There are significant vacancies and sickness with the PET and Bereavement Team which have resulted in reduced capacity. The recruitment process is in progress for the PET and Bereavement team to increase capacity.

and weekly review meetings with PET Team Leader, Director of Nursing, Midwifery & AHPs and Acting Deputy Director of Quality & Governance continue.

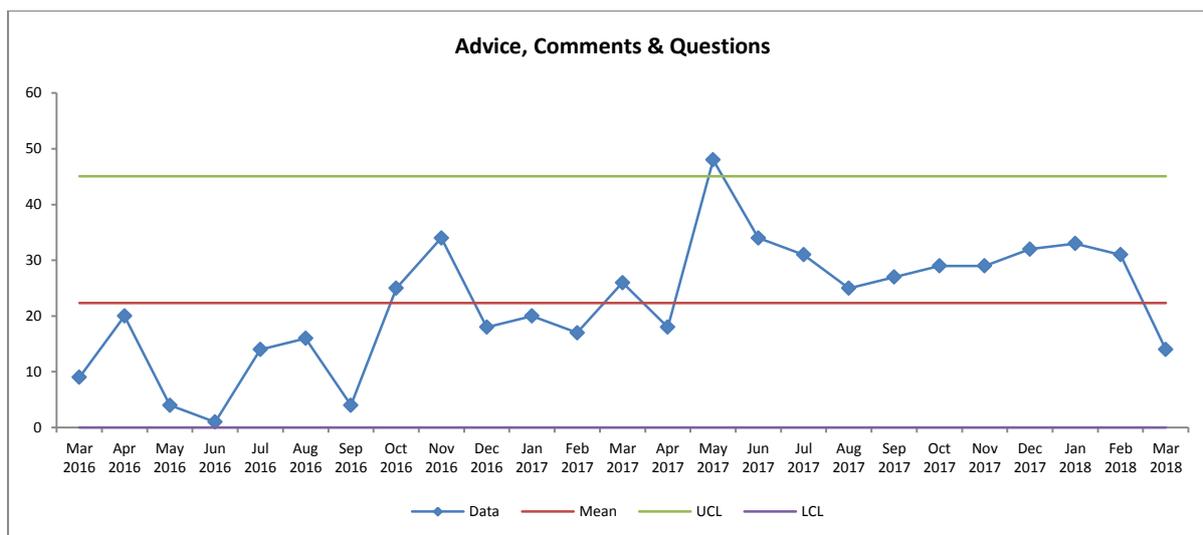
	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
Emergency Care Group												
Complaints	9	7	15	13	9	16	12	15	9	4	9	4
Complaint response - Performance against timescales	9%	33%	40%	70%	29%	33%	42%	73%	87%	83%	93.0%	37.5%
MSK & Frailty Care Group												
Complaints	9	11	6	5	3	5	6	7	3	7	5	8
Complaint response - Performance against timescales	0%	50%	63%	29%	86%	0%	29%	No complaints due for response	73%	100%	80%	75%
Surgical Care Group												
Complaints	9	8	6	9	7	5	8	5	4	10	7	5
Complaint response - Performance against timescales	33%	11%	33%	75%	17%	33%	75%	71%	86%	75%	75%	75%
Childrens & Families Care Group												
Complaints	12	7	6	8	4	4	3	11	4	5	4	5
Complaint response - Performance against timescales	38%	46%	30%	60%	50%	29%	83%	63%	100%	100%	50%	83%
Speciality Care Group												
Complaints	5	4	6	7	5	6	3	3	2	3	1	1
Complaint response - Performance against timescales	0%	33%	50%	33%	0%	59%	40%	100%	66.70%	50%	No complaints due for response	75%
Trustwide												
Complaints	44	42	44	46	29	38	33	41	25	33	26	23
Complaint response - Performance against timescales	18%	35%	44%	58%	35%	35%	26%	50%	73%	80%	82%	67%

7. COMPLIMENTS / ADVICE, COMMENTS & QUESTIONS

The SPC chart below illustrates normal variation of the number of compliments reported on Datix either by the Patient Experience Team or added by wards and departments. Datix is currently being amended to create a simple reporting form for compliments for staff to log various kinds of thank you or compliment to make it easier to record on the system; this should have gone live in September 2017 but due to the issues occurring within Datix, this had to be put on hold until the issues have been resolved. The revised form will be available from the end of May 2018.



The advice, comments and questions raised with the Trust remains mostly above the mean and is an illustration of the enquiries raised that are not complaints or concerns about the quality of care, but obtaining more information or giving feedback.



8. PARLIAMENTARY & HEALTH SERVICE OMBUDSMAN (PHSO)

The latest available national data from the PHSO Q1 and Q2 2016/17 was published in November 2016 and reported in the Q3 report. There is no additional data available from PHSO at the time of reporting.

The tables below, illustrates the number of investigations started in 2017/18, and the outcomes of concluded investigations for the same period (these may have been initially reported in previous financial years).

All complaints referred to PHSO

April 2015 – March 2018

Date referred to Ombudsman	15/16 Q1	15/16 Q2	15/16 Q3	15/16 Q4	16/17 Q1	16/17 Q2	16/17 Q3	16/17 Q4	17/18 Q1	17/18 Q2	17/18 Q3	17/18 Q4	Total
Children and Families Care Group			1						1	1			3
Emergency Care Group	2	1		3	1	1	2	1	3				14
MSK and Frailty Care Group				1	1								2
Surgical Care Group		1											1
Specialty Service Care Group			1				1	1					3
Total	2	2	2	4	2	1	3	2	4	1			23

Outcomes for complaints referred to the PHSO when completed.

This is the total Jan 15 – March 2018

	Upheld	Partly upheld	Not upheld	Total
Children and Families Care Group	1	1		2
Emergency Care Group		4	7	11
MSK and Frailty Care Group		1	1	2
Surgical Care Group		1		1
Specialty Service Care Group			3	3
Total	1	6	11	18

Referrals made to the PHSO in Q4 2017/18

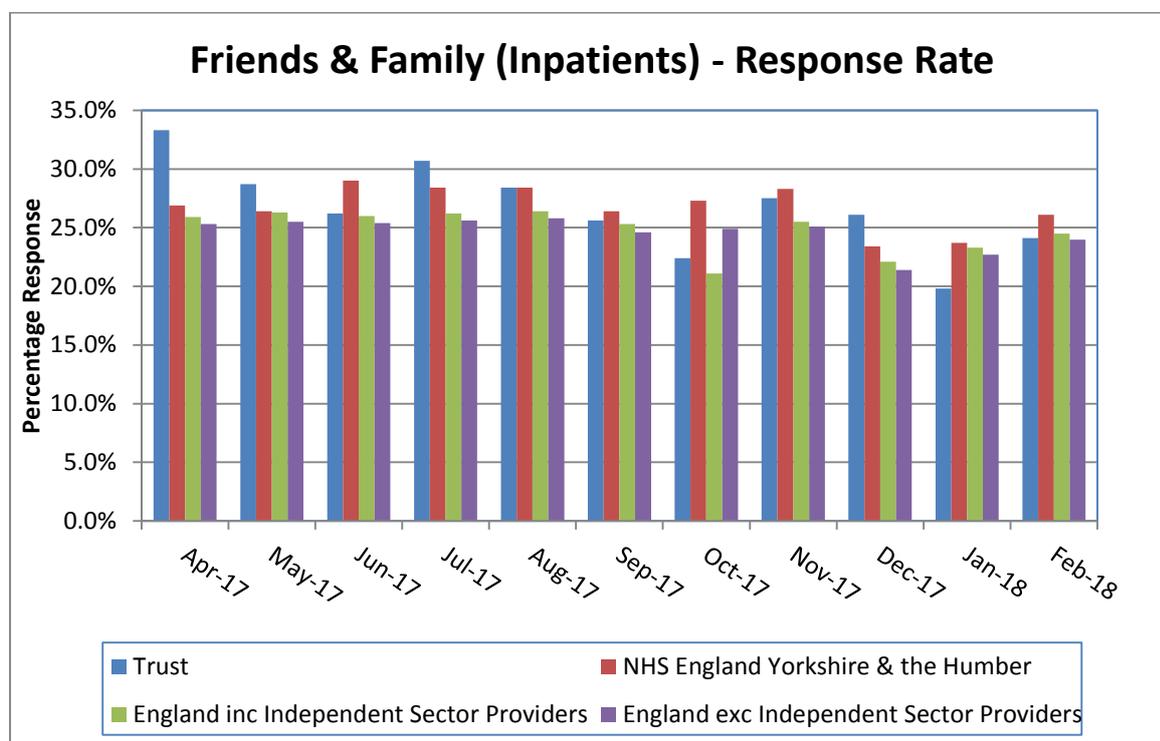
There have been no referrals made to the PHSO in Q4 2017/18

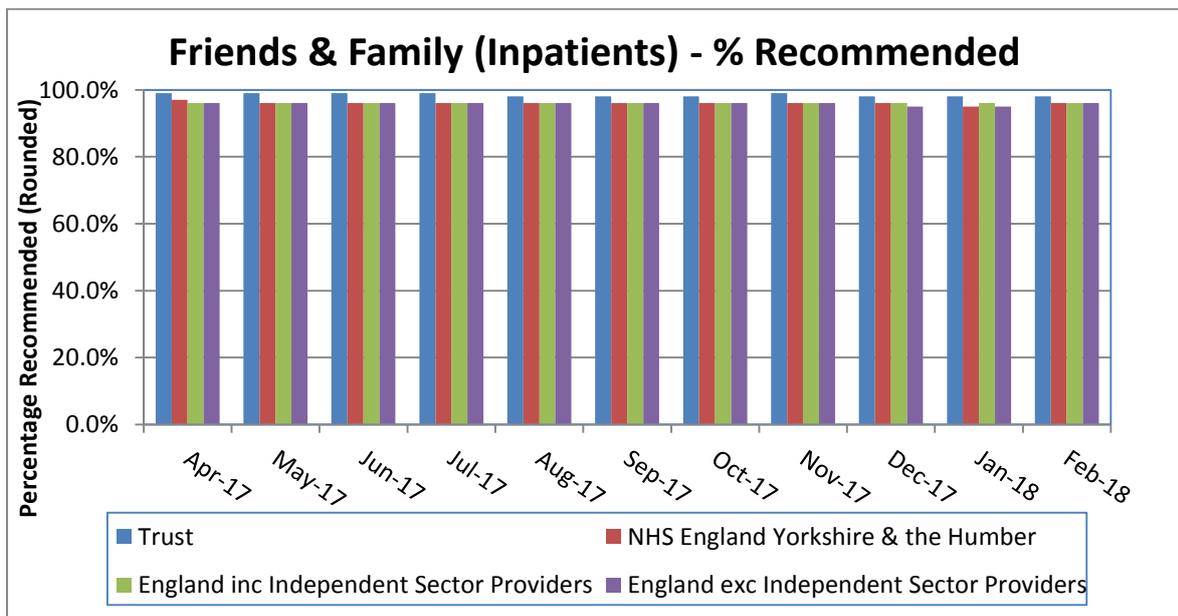
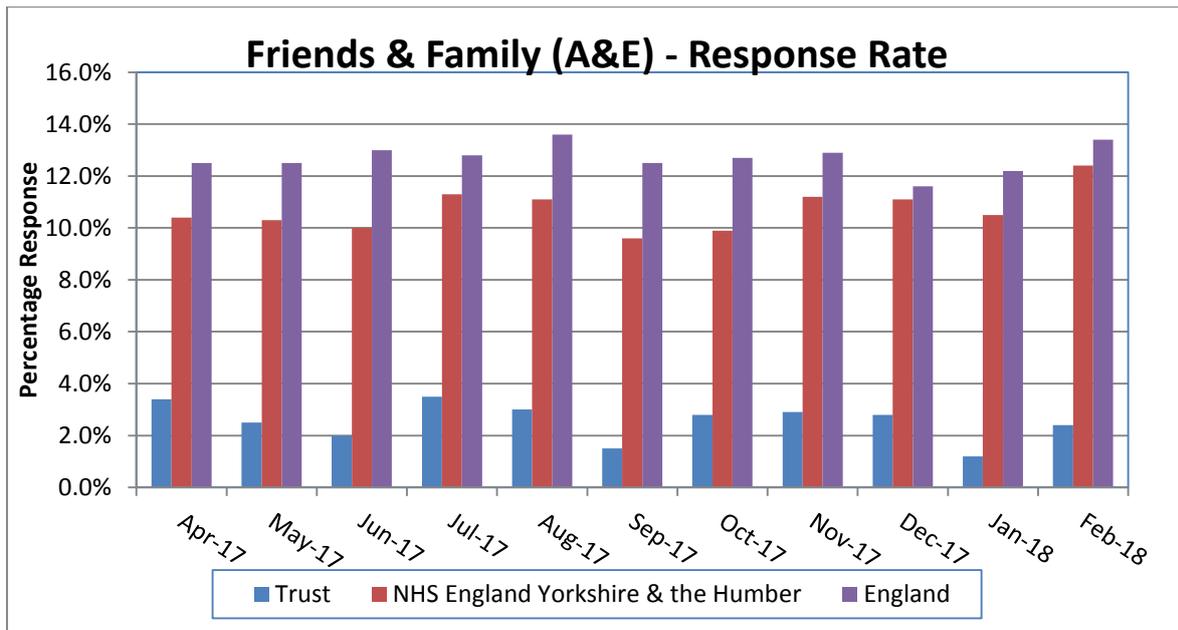
Outcomes from the PHSO in Q4 2017/18

2017/18 Q4	
Nov	
Emergency Care Group	
Partially upheld	1
Grand Total	1

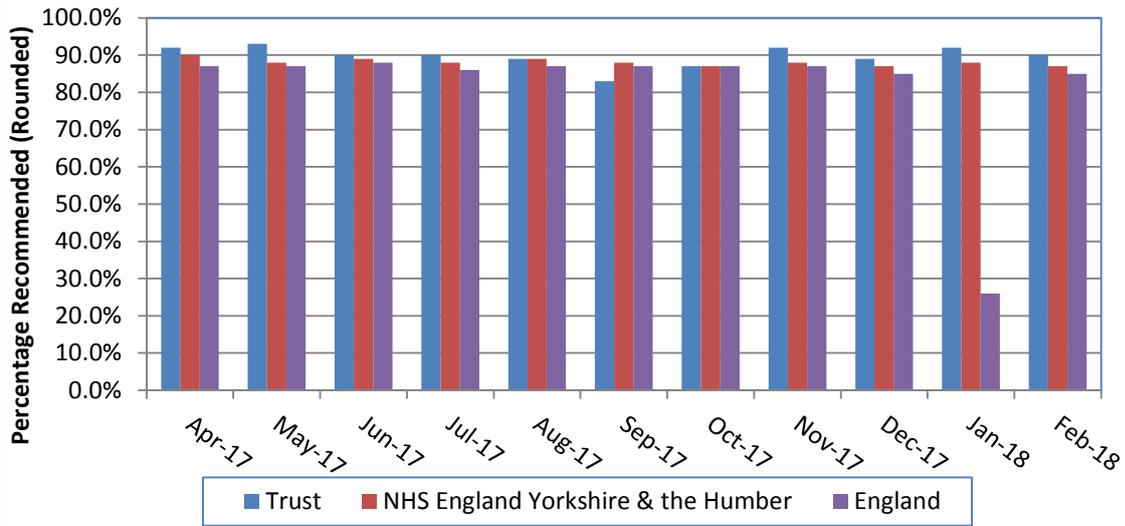
9. FRIENDS & FAMILY TEST (FFT)

The Charts below illustrate the Friends and Family test response rate for inpatients and A&E, with % recommended for the inpatients, A&E and outpatients. This demonstrates variable response rates for Inpatients in Q4 compared to national and regional performance. Of those responses, the percentage recommended remains higher than national and regional performance for Inpatients. A&E response rates remain low, however the percentage recommended remains higher than national and regional performance. This is also reflected in the Outpatient recommended rates.

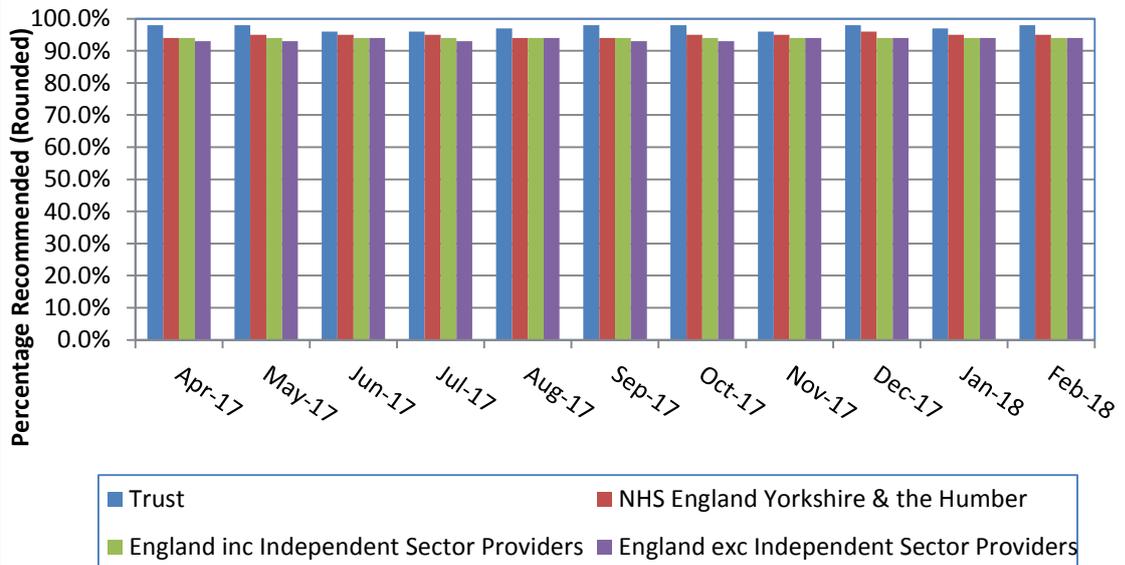




Friends & Family (A&E) - % Recommended



Friends & Family (Outpatients) - % Recommended



WARD PATIENT SURVEYS

There are monthly patient experience surveys completed in the inpatient wards and the cumulative outcomes since April 2017 are shown below. This is mainly positive, with nursing care specific questions being reported to be above 95%. Improvement is required in the amber rated sections. Although the mixed sex accommodation is flagged there have not been any reported breaches this financial year. There are strategies planned to improve on these results and these are listed in the last column.

QAT - Patient Experience Survey - Inpatient wards (3879 patients surveyed - April – March 2018)	Yes %	No %	Strategy to improve
Were you asked how you would like to be addressed e.g. by your first name, Mr, Mrs etc.	94.5	4.5	#Hello my name is....
Do staff introduce themselves to you when they meet you/provide care to you?	97.6	2.4	#Hello my name is....
Do staff ask your permission before they commence any procedure e.g. taking temperature/pulse etc.?	98.4	1.6	Informal consent and customer service skills
Do staff give you conflicting information?	16.4	83.6	Patient information and communication
Are you given the opportunity to wash your hands/use hand wipes as often as you wish?	96.2	3.8	Fundamental nursing care priorities
Do the staff make sure you have everything you need within reach? E.g. drinks/call bell	98.4	1.6	Fundamental nursing care priorities
Do you get enough help from staff to eat your meals?	99.40	0.6	Fundamental nursing care priorities
Do you get enough help with drinks from staff?	99.5	0.5	Fundamental nursing care priorities
If you needed help from staff getting to the bathroom or toilet, did you get it within a timely manner?	98.6	1.4	Fundamental nursing care priorities
If you needed pain relief during your stay, was it provided quickly and without you having to ask twice?	96.1	3.9	Fundamental nursing care priorities
Are you kept informed about how your care/treatment is progressing? (e.g. test results)	94.4	5.6	Involving patients in their care and treatment
Are you given enough information about medicines you are given to take?	95.9	4.1	Patient information and communication
Are you given the opportunity to ask questions about anything you don't understand?	98.5	1.5	Patient information and communication
If your condition becomes worse at any time do you think anyone would notice?	97.7	2.3	Involving patients in their care and treatment
Do you know who you can talk to about your condition/treatment?	96.5	3.5	Involving patients in their care and treatment
Do you share a room or bay with anyone of the opposite sex?	5.8	94.2	Fundamental nursing care priorities
Overall, do you feel you are treated with care and compassion whilst in hospital?	99.0	1.0	Fundamental nursing care priorities

10. PATIENT EXPERIENCE AND ENGAGEMENT COMMITTEE

Patient Experience & Engagement Strategy

The strategy has been produced as an enabling strategy to support the Trust's Strategic Vision. It outlines key priorities in reducing the number of formal complaints the Trust receives, increasing the engagement activities undertaken per Care Group and reducing the number of complaints related to communication and staff attitude and behaviours. This along with the additional objectives will be monitored through the new structure within the Patient Experience & Engagement Committee in the format of a standard template each Care Group will populate when presenting their activity on a biannual basis.

Learning From Patient Experience & Engagement

The Patient Experience & Engagement Committee has met on a monthly basis throughout Quarter 4 monitoring performance and learning from complaints, with contribution from MSK & Frailty, Emergency and Diagnostics & Pharmacy Care Groups using the Care Group template to record and demonstrate activity and compliance against the strategy (see Appendix 1 for completed templates).

MSK & Frailty

The main themes around complaints, concerns, questions and advice relate to person centred care, communication & managing patient expectations. There has been Care Group wide adoption of Qii work in response to patient feedback and a summary of key changes led to the development of the Person Centred Care Tool Kit (below).

Person centred interventions to reduce patient harms and improve patient experience

NHS
Doncaster and Bassetlaw
Teaching Hospitals
NHS Foundation Trust

Use 'This is Me' Say 'Hello My Name is...' Ask 'What Matters to You?'	#EndPIparalysis #EDFIT2SIT Prevent Deconditioning 24 Hour Rehab	#last1000days Value patients time	John's Campaign Welcome and involve carers Open Visiting
Hydration and Nutrition Oral hygiene Social dining China cups	Remove Unnecessary Devices Catheters Cannulas	Good Wound Care Minimise tissue pressure and friction	Advanced Care Planning Me and My Plan
Enhanced Care Plan Supervision and Engagement assessment 5 For Falls	Medication Review Pain Control Identify and Manage Postural Hypotension	Eyes, Ears, Teeth Look after glasses, dentures and hearing aids	Bladder and Bowels Avoid constipation Identify Retention Regular toileting
Healthy Sleep Environment Consider sleep diary	Dementia friendly environment Orientation strategies Engagement activities	Achieving Reliable Care (ARC) #Red2Green	Early Multi-disciplinary team involvement Therapies IDT Pharmacy

#endPJparalysis

10 days in hospital can lead to the equivalent of 10 years ageing in a person over the age of 80, while in hospital. The Care Group have led on this global initiative to prevent deconditioning of patients by encouraging them to get out of bed, dressed and mobilize more when in hospital. Work is ongoing with relatives and carer's to encourage them to bring in day clothes and shoes, with some areas developing comfort rooms, storing clean clothes (single patient use) donated to the ward area.

John's Campaign

John's Campaign is a national initiative to allow the carer's of a patient with Dementia the right (not duty) to have open visiting while their loved ones are in hospital.

All wards in the MSK&F Care Group have visiting times starting from 11.00 – 19.00, or completely open visiting - to ensure that relatives can join ward rounds, participate in care and ensure that communication is transparent, clear and benefits all parties.

The MSK&F Care Group led in implementation of John's Campaign. We held a competition for the best ward John's Campaign awareness board (with the winning ward receiving a prized Tea-Pot as a symbol of our commitment to social drinking with patients). We issue carer's cards to ensure that carer's have unrestricted access to visiting. Carers also have a staff discount in the canteens. This discount has been honoured through the changes to Sodexo catering.

When Carer's feel they are welcome on the ward and part of the team, complaints or concerns are low.

Virtual Fracture Clinic

Traditionally patients suffering suspected fractures attend A&E for an x-ray and initial treatment and then, assuming there is a break, return to the fracture clinic the following day for assessment by a doctor or physiotherapist, who will decide if they need specialist treatment or can be discharged.

There is a lot of demand on the fracture clinic service and patients were often facing lengthy waits before they were seen by a clinician, who may only need to give advice on how the patient can care for the fracture themselves at home.

The new virtual fracture clinic means patients with certain conditions can be sent home from A&E after their x-ray and initial treatment with information leaflets and advice from specially-trained A&E staff. They then receive a telephone call from a member of the orthopaedic team who has reviewed their scans and will discuss with them whether they need to come in for further treatment by a specialist consultant or physiotherapist, or if they can manage the injury at home. Patients who are recommended for treatment at home are still free to come in for an appointment if they choose and can call a dedicated helpline for patients to call if they have any queries or concerns.

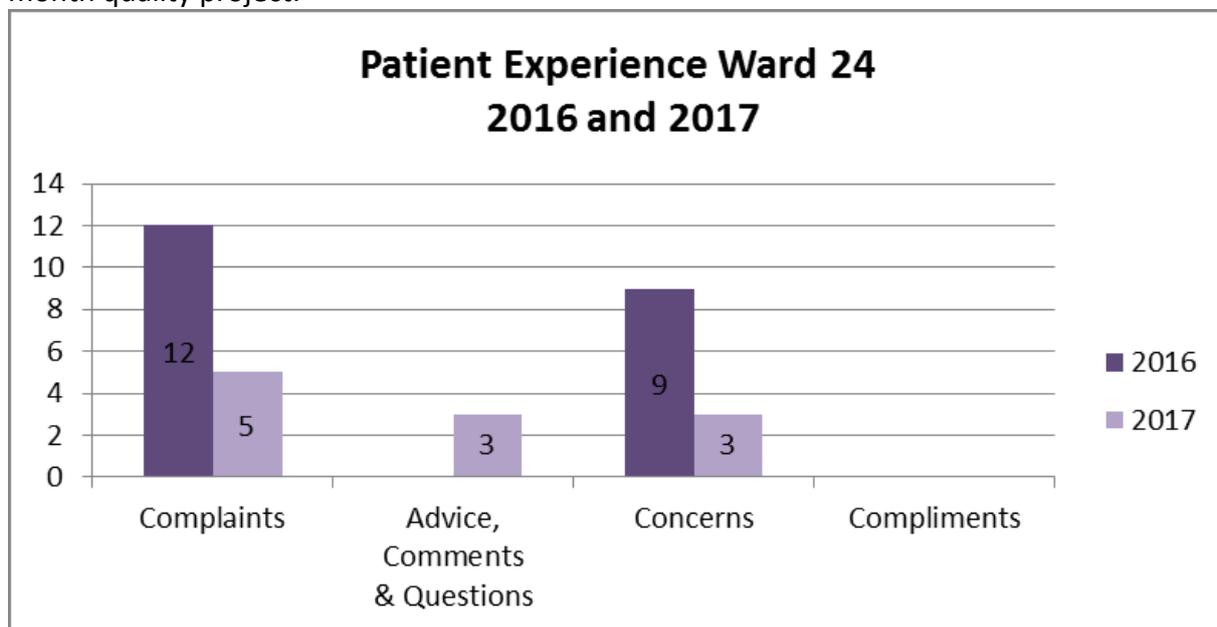
This has been in place at DRI for 2 months with plans to expand at Bassetlaw Hospital, once agreement is in place with our commissioners.

Emergency Care Group

The Care Group agreed a quality initiative to improve the patient experience for all patients on the GI pathway. This was following 2 complex complaints in regard to EOL and other concerns from patients and their relatives on all aspects of the pathway. The areas chosen for improvement were

- Communication in regards to life threatening illness
- Open discussion in regards to life expectancy and advanced care planning
- End of Life care for GI patients
- Staff attitude and behaviour
- Development of specialist liver nurse post

The following graphs show the improvement in the complaints on ward 24 following the 6 month quality project.



Diagnostics & Pharmacy

Learning from a complaint relating to a delayed diagnosis (exclusion of malignancy) led to Radiology amending and reinforcing the process for transferring a request from Inpatient to Out Patient and the Deputy Head of Service has informed clinicians. The Clinicians secretary has reviewed local processes for actioning DNA's.

Further learning from a complex complaint involving Paediatrics and Radiology led to a review of the paediatric radiology reporting service at DBTHFT. This has resulted in paediatric CT and MRI scans being outsourced for reporting by a paediatric specialist radiologist.

Plans are in place to improve the handling of complaints in the Care Group and progress will be reported via the Patient Experience & Engagement Committee.

11. RECOMMENDATION

The Board of Directors is asked to NOTE the Quarter 4 Patient Experience and Engagement report.

Appendix 1



PEEC Care Group
template ECG 23 Mar



PEEC January 2018
MSK.pdf



Radiology PEEC
report - March 2018.c



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

Title	Chair's and NEDs' Report		
Report to	Board of Directors	Date	30 April 2018
Author	Suzy Brain England, Chair		
Purpose			Tick one as appropriate
	Decision		
	Assurance		
	Information		x

Executive summary containing key messages and issues
<p>The report covers the Chair and NEDs' work in April 2018 and includes updates on a number of activities:</p> <ul style="list-style-type: none">• Launching the new Charity• Opening of new catering facility• Governor update• NED reports
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 – April 2018

Launching the new Charity

As an NHS organisation we provide treatment for thousands of patients in Doncaster and Bassetlaw. However there is always more that can be done to support local people at a time when they need it the most.

The aim of our new charity – which Richard and I launched this month - is to raise funds which will be used to enhance the lives of thousands of patients every year by providing excellent care, treatment, experience and research, above and beyond the call of normal funding.

Thanks to the amazing generosity of our supporters, we have been able to go above and beyond routine spending, providing extras which make all of the difference to our three main hospital sites.

Kind and generous donations from patients, local residents and partners have enabled us to purchase things such as adaptive equipment for frail and elderly visitors, toys for youngsters staying on our wards, as well as helping us to purchase specialist diagnosis or treatment tools.



These contributions often make the difference for patients staying with us. By launching DBTH Charity, we are hoping to make it really easy for anyone who is looking to raise funds for Bassetlaw Hospital, Doncaster Royal Infirmary or Montagu Hospital, to help us provide these crucial extras.

Donations made to the Trust make a very real difference to patients' lives each and every year, helping to reduce the everyday stresses and anxieties which may be associated with treatments and illnesses.

In the past, our hospitals have had no specific charitable arm, instead having a number of individual funds for specific projects or departments. While the Trust has undoubtedly benefitted in the past from kind donations from local residents and partners, it has meant some areas have received more attention than others.

By launching the new charity, it will allow the Trust to ensure that we are raising funds which will benefit schemes, projects and services, which cannot be covered by routine income but often with the greatest need.

Opening of new catering facility

It was my privilege to open the new Subway and Hot Kitchen facility at DRI on 6 April. The new facilities are courtesy of the Trust's partnership with Sodexo, the world's largest services company.

The kitchens and dining rooms at all three hospitals have undergone a makeover, receiving new kitchen equipment and facilities, a new electronic ordering system and extended opening hours to cater for visitors, patients and staff alike.



The new 'Hot Kitchen' restaurant features a range of delicious menu options from hot food for those on-the-go and tasty snacks, to a live cooking station which offers oriental, Mexican and other exotic tastes. In addition to the Hot Kitchen restaurant, visitors can also find their favourite subs and salads on sale at the Subway outlet which offers all the same meals and deals that are available in its high street restaurants.

The new eateries mean that visitors to the hospital can grab a bite to eat any time between 7.00am and 9.00pm on weekdays, 8.00am and 7.00pm on Saturdays and 9.00am to 6.00pm on Sundays.

Governor update

The Trust has been invited to be one of a handful of trusts to demonstrate its work with governors at the Annual Governor Focus Conference on 24 May.

The invitation is to showcase the work the Trust did around the Governor Effectiveness Review which was completed last summer and reported in October. The review made 12 recommendations which are now being taken forward.

I met Kathryn Dixon, Director of Further Education at Doncaster College and University Centre, earlier in the month who will be joining us as a new partner governor on 25 April.

Governors held a forum and briefing on 6 April at DRI. Rick Dickinson, Acting Deputy Director of Nursing, Midwifery and Quality, gave an overview of the 15 Steps work which was well received and saw high levels of engagement from governors.

Non-executive Director recruitment

Phase two of non-executive director recruitment is underway with our advert now on the DBTH, NHS Improvement, Cabinet Office, Linked In and NED on Board websites.

Application is via CV and covering letter. Closing date is 29 April for interviews on 6/7 June. Appointments will be ratified on 18 June at a special Council of Governors meeting before the rescheduled Timeout.

Non-Executive Director (two roles)
Candidate information



www.dbth.nhs.uk



NED Reports

Linn Phipps attended a meeting of the Care Group Directors, to discuss the work of QEC, and how we can engage more with them in the future.

Linn participated in a QAT for Ward 17, and took away some useful pointers for involving everyone in research and how this can be included even more strongly in our next research strategy.

Linn (and Kath Smart) also attended the recent Governor's briefing around "15 steps" assessments of patient and carer experience of our wards.

New NED, Pat Drake, met with Linn and undertook a tour of DRI.

Kath Smart and Pat Drake have completed Induction visits and SET training and have arranged visits to both DRI & Bassetlaw.

Kath has also met with two members of the Communications team to talk more about the Fundraising Strategy and progress, and attended the Governors session to hear about 15 steps and how Governors are contributing to DBHFT quality assurance processes. Kath also met for handover from John Parker and the Director of Finance on charitable funds matters.



Chief Executive's Report 30 April 2018

Trust selected for NHSI Lean Programme

DBTH is one of seven trusts selected to take part in NHS Improvement's (NHSI) new three year lean programme to support the delivery of a lean management system in the organisation. Lean is an improved method to allow staff and patients to improve their own processes and ways of working.



The programme will build on the success of NHSI's partnership with the Virginia Mason Institute and other independent programmes in the NHS, for example those implemented by Western Sussex Hospitals, Royal Bolton Hospital and trusts in the North East of England.

The seven trusts that have been selected for the programme are:

- Derby Teaching Hospitals NHS Foundation Trust
- Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust
- The Dudley Group NHS Foundation Trust
- East Lancashire Hospitals NHS Trust
- Royal Surrey County Hospital NHS Foundation Trust
- The Hillingdon Hospitals NHS Foundation Trust
- University Hospitals Plymouth NHS Trust

One focus of the programme will be on delivering results patients will see and feel, and bring success to the first cohort by building a network to share best lean practice across the NHS.

NHS Improvement & NHS England announce joint working proposals

NHS England and NHS Improvement have announced a raft of new measures that will see the two bodies working closer together from September 2018. The proposals include:

- Increased integration and alignment of national programmes and activities – one team where possible.
- Integration of NHS England and NHS Improvement regional teams, to be led in each case by one regional director working for both organisations, and a move to seven regional teams to underpin this new approach.



A more joined-up approach across NHS England and NHS Improvement will enable the two bodies to:

- work much more effectively with commissioners and providers in local health systems to break down traditional boundaries between different parts of the NHS and between health and social care
- speak with one voice, setting clear, consistent expectations for providers, commissioners and local health systems
- use NHS England and NHS Improvement’s collective resources more effectively and efficiently to support local health systems and the patients they serve
- remove unnecessary duplication and improve the impact from our work, delivering more for the NHS together than we do by working separately

NHS England and NHS Improvement still have distinct statutory responsibilities and accountabilities and this will continue. The current legislation also means that a formal merger between the organisations is not possible. Instead, they propose to combine forces for those functions where they can better work as one.

Purdah

March 27 marked the start of the pre-election (or Purdah) period which will last until after the local elections on 3 May 2018.

During this time, the Trust will take extra care about undertaking any activity that might be considered politically controversial, including hosting political visits. The normal business and regulation of the Trust must continue although it may mean that some decisions are deferred until after the elections.

The Board will be aware that there is also an election for the South Yorkshire Mayor on 3 May and the Trust will ensure it forms a constructive relationship with whoever wins the seat.

Sharing How We Care

The Trust is hosting a special event in the Education Centre at DRI on 26 April.

The event is our chance to showcase examples and experiences of care, as well as examples of best practice around three themes:

- Patient Centred
- Patient Safety
- Patient Experience.



This is our opportunity to show the importance and value of frontline healthcare staff for patient care, exploring what sets us apart from the rest and discovering why 'We Care'.

All members of the Board are invited.

70 Day #EndPJparalysis Challenge

The Trust is supporting the national #EndPJParalysis Challenge.

The aim is for 1 million patient days of people up, dressed and moving in their own clothes, rather than in hospital gowns or pyjamas (PJs).



As proof of concept in the East of England region, a 100 day challenge before Christmas in nine trusts achieved 91,728 patient days.

The Challenge was formally launched on 7 March by Prof Jane Cummings, Chief Nursing Officer for England who is the Executive Sponsor. It will run from 17 April to 26 June 2018 – to finish in time for the NHS 70th anniversary celebrations on 5 July.

Benefits of #endPJparalysis include:

- Reduced LOS (< 1.5 days in Nottingham University Hospitals' Trauma and Orthopaedic Ward).
- Reduced loss of mobility, deconditioning and risk of falls (37% in same NUH T&O Ward).
- Reduced food wastage due to greater patient mobility and energy need.
- Reduced risk of needing institutional care on discharge.
- Enhanced wellbeing of patients and staff.

#EndPJparalysis 70-day challenge
17th April 2018 - 26th June 2018

"Time is the most important currency in healthcare"
Prof. Brian Dolan

Did you know, 46% of people aged >85 **die within 1 year** of admission to Hospital? (Clark et al 2014)

Deconditioning in hospitalised older patients, can cause serious harm

Aiming for **1 million** patient days dressed in own clothes & moving in **70 days**. Let's help our patients get home back to loved ones

If you had 1000 days left, how many would you want to spend in Hospital? That's why **EVERY DAY** matters

PJ paralysis...

FACT: Reduces mobility
FACT: Loss in strength
FACT: Loss of independence
FACT: Longer stay in Hospital

Aimi Dillion

Aimi Dillion, a Nursing Education Lead at the Trust, has been shortlisted for this year's prestigious Student Nursing Times Awards, under the category of 'Learner of the Year' for work on 'how newly qualified nurses develop resilience'. As part of the project, Aimi looked at how the Trust can help those new to the profession to make the transition from student to Registered Nurse.



Appraisal season starts

From 1 April through to 30 June 2018 it is Appraisal Season. It is our goal to ensure that 90% of all members of Team DBTH have had a good, quality appraisal.

The Trust has created a short, informative video to explain the appraisal process and why it is worthwhile to undertake. You can watch it here: <https://youtu.be/QowyAomc3vY>.

Produce and implement a Quality Improvement & Innovation Strategy that is based on best practice and developed with staff, containing a plan to increase QI capacity and capability within DETH (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 PND and Director of SAH by the SMOs of all programmes	Overight Framework, CGD and other regulatory standards	All project implementation plans are signed off by SMO and QI training implemented as planned in the QI strategy	Work stream sign off by July 2017 QI plan milestones on line with strategy currently being agreed	QI training plan rolled out as planned - not all PND PNs attended yet. Projects identified for supporting workstreams and strategic workplans including pre-operative assessment, stroke reparation and LOS (OR/NHS), transport and enhanced recovery.	Amber	QI action plan being implemented all milestones met to date	Green	DS&I - QI action plan being implemented as planned Successful application to be first phase of new NHS Learning Programme	Green	N/A
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 underway. 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	The IG Group is the GDPR control group, and it is currently working methodically through the GDPR Action plan. Privacy Impact Assessments and Privacy Notices are currently being progressed. A key issue for all Data Controllers is the GDPR defined zero cost and reduced timeframe implications for Subject Access Requests (SARs). Optional: The Data Protection Bill - which is due to receive Royal Assent by Easter 2018 - will define what SAR costs will actually be chargeable in the UK.	Green	PDR progress according to plan. DPH 2018 is going through final Commons process though no date is currently set for Royal Assent. House of Lords will still look to commons with concerns around fines for NHS organisations. DPO to be formally appointed by Board at board meeting on April 30th 2018.	Green	Formal appointment of DPO by board on April 30th. Finalisation of requirements and financial impact once DPA approved by Commons after Easter recess. Royal Assent expected early - mid May
Deliver, with available resource, the prioritised IT work plan and associated projects in support of the care group initiatives, the transformation agenda and the QI activities	Chief Information Officer	Directors Take actions necessary to identify the IT needs within the areas of responsibility	Develop portfolio approach to projects. Establish governance group. Deliver regular updates to care groups. Deliver planned work	Reduce the likelihood of failure 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 mechanisms agreed October 17	Portfolio of projects established and monitored. IT and information governance group TOR to be agreed Oct/Nov, reporting to NHS and GMC. First meeting back to be November 17. Communications regularly with care group GIM community. Capital has been constrained in line with regulation that funds will be available in H2. Focus on current environment	Green	The establishment of the portfolio management approach for IT projects and developments continues apace. Standardised templates and operating procedures have been introduced for all new projects. Projects and developments are being monitored on a weekly basis for issues, risks and progress. Financial planning for 2018/19 is well underway. Regular meetings have been held with the Exec. Team and GIMF on a 1:1 basis to confirm requirements and manage expectations.	Green	Templates and standard project delivery methodology in place. Financial planning completed for capital projects for 2018. IT Governance group established and first two meetings held. Project portfolio delivered as expected given capital not being available until late in 2017/18. Large portfolio of projects with significant business change for 18/19 based on QI capital and CGI approvals	Green	N/A
Deliver the appropriate integration and interoperability technology in support of the Doncaster Place based Intermediate Care Record and if appropriate the DTP		Directors Take actions necessary to support the delivery of the Intermediate Care Record	Develop the internal DETH architecture to deliver first stage data to the IC. Develop technology that supports the internal and external portal. Deliver the clinical view for internal use	Reduce likelihood of failure to deliver Cost Improvement Plans in this financial year	Architecture agreed. Contributions to KCR at Doncaster CGI level. Pilot of clinical viewer complete. Engagement with care groups and consultant community	Architecture draft agreed October 17. Initial pilot presented to clinicians December 27	Significant work in providing data to KCR within project timelines. Clinical viewer is on track to deliver Alpha version by end of financial year. Demo of progress regularly made to exec and clinical community. Building works necessary to ensure technical costs remain very low during pilot	Green	Good progress continues. DETH are currently testing the functionality of the system and completing data verification checks on the data. The overall project is still on target to ahead of the agreed go-live date.	Green	ICR data from DETH clean and migrated to the new system. No outstanding issues. DCP goes live May 23-June 2 2018. IC being supported through regional data exchange activities. Limited other progress due to lack of funding. Portal row live with potential for significant usage profile of DETH into the wider community healthcare	Green	Continued work at IC level to determine future strategic direction of technology across the IC.
Provide appropriate technology support to the Trust for the development of the Single Overight Framework throughout 2017.		Directors Take actions necessary to support the development and delivery of the Single Overight Framework	Define the first stage of the BI framework and 80% of the Single Overight Framework	Reduce likelihood of failure to achieve compliance with performance and delivery targets of the Single Overight Framework, CGD and other regulatory standards	BI Framework designed and implemented. Initial build of BI dashboard in ED and one other identified care group. SOP implemented for systems used today - explore options for getting information from non Trust environments e.g. NHS	BI Framework to pilot by Nov 17. SOP first iteration by Aug 17 including alerts and drill-down	SOP not delivered in full. Some drill-downs and alerts in place. Not to be delivered in accordance with promised timelines as discussed with Director of Strategy. BI pilot framework output is on track to deliver late November 17. ED dashboard in development	Amber	A significant amount of data has been collated from DETH systems we can access routinely (e.g. CAMHS, Spigholby, RSC etc.). Currently pursuing access to other data sources. The information team are currently evaluating the requirements for other BI tool with the aim of providing timely management information. Initial prototype components for the BI dashboard have been developed.	Amber	ED dashboard delivered on plan. However further BI activities halted due to lack of capital and internal delivery capability. No capital assigned for 18/19. BI will use Ad Power BI as a toolset in conjunction with other ICS tools. SOP delivered. Requires resourcing primarily for 18/19	Amber	Liford funds become available, and additional short term resource allocated little progress is expected. Work to progress with Sheffield Hallam University to identify students or post grad students to join the DETH team in September 2018 to progress at a lower cost base. This is based on the success of the SHU students working on the portal
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	Reduce likelihood of failure 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 November	Amber	Strategy agreed at Board of Directors in December. Action plan tracking progress against implementation. EPMG audit of strategy and capital progress Jan 2018	Green	Complete	Green	N/A
Evaluate the potential for Public/Private Partnerships, linked to the Trust strategy direction.	Director of Estates & Facilities	Directors Contribute to the evaluation of all options for developing the Trusts infrastructure and estate	DS&I - The development of capital funding options to support the Trust Strategic direction	Reduce likelihood of failure to ensure that appropriate estates infrastructure is in place	DS&I - Opportunities identified and agreed by Board of Directors DS&I - Support business case development with Finance Team Evaluation of DETH benefits realisation methodology	DS&I - 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/NOV models discussed at commercial board. Letter received 6th Oct from NHS regarding NHS Trust existing tax - which will impact on desirability of progressing NOV schemes. Capital bids will be submitted as calls for funding become available as with successful bid for CPMASU - ED DRG outsourcing. EFM Strategy will contain 5-7 year backing investment programme.	Amber	Gateshead NHS Trust commissioned to undertake a review of opportunities for NOC, report due 21st June to Director of Finance. CPMASU business case costs provided by P21 partner RSP by 12th Jan, full BC due at Board in Jan for submission to NHS in February.	Amber/Green	Ongoing	Amber	Permitted to next year's objectives. Paper due in May

DONCASTER & BASSETLAW TEACHING HOSPITALS NHS FOUNDATION TRUST

**Minutes of the Finance & Performance Committee
held at 8:45am on Friday 26 March 2018
in the Boardroom, DRI**

- PRESENT : Neil Rhodes, Non-executive Director (Chair)
Philippe Serna, Non-executive Director
Jon Sargeant, Director of Finance
Karen Barnard, Director of People & Organisational Development
(leaving 11:50am)
David Purdue, Chief Operating Officer
- ALSO IN ATTENDANCE: Kirsty Edmondson-Jones, Director of Estates and Facilities
David Pratt, Efficiency Director
Ruth Bruce, Head of Performance (from 9:30am)
Alex Crickmar, Deputy Director of Finance
Matthew Kane, Trust Board Secretary (from 9:30am)
Kate Sullivan, Corporate Governance Officer
Marie Purdue, Director of Strategy & Transformation
James Nicholls, BDO
- OBSERVERS : Bev Marshall, Governor Observer
Mahroof Hussain (Observer)
- APOLOGIES : Ruth Allarton, Associate Non-executive Director

Action

Apologies for Absence

- 18/3/1** Apologies were noted from Ruth Allarton and the Chair welcomed Mahroof Hussain and Alex Crickmar to the meeting.

Action Notes from Previous Meeting

- 18/3/2** The action log was reviewed and updated.

AOB

- 18/3/3** No other business was raised.

CIP Work-stream – Catering Services Outsourcing Update

- 18/3/4** The Committee received a presentation from the Director of Estates and Facilities. The presentation had been circulated with the meeting papers. The Committee had requested the update to better understand initial go live issues that had arisen; both on the retail side and patient meals, the solutions put in place to address them and other remedial action and these were the key discussion points of the meeting. The presentation also provided an overview of the contract and assurance process, key project objectives, site plans and financial information.

- 18/3/5** In terms of the retail side of the outsource catering go-live a number of issues had arisen which has resulted in concerns being raised by staff and there was concern in the organisation that the issues had impacted on staff morale. It was noted that at the moment there was an interim retail provision and that the full range of facilities had not yet gone live. It was noted that staff had been informed via Buzz prior to the Go-Live of removal of Staff Discount, it had been agreed with the catering provider that there would be a staff meal option each day for £2.50 and this was in the contract, it had also been agreed that no contract food price would exceed previous prices without staff discount and there were to be additional 'Meal Deal' offers and a loyalty scheme. However, meal deals and loyalty schemes were not in place at Go-Live and there had been inconsistency of pricing across outlets and sites.
- 18/3/6** The Committee reflected on the issues raised, more details were provided and the Committee considered whether there was more the organisation could have done to manage staff expectations and mitigate the issues. The Director of Estates and Facilities reported that the Trust had challenged the outsourcing provider on the issues and had insisted on an immediate price decrease where prices had been outside of the contract agreement but she agreed that, on reflection, more could have been done to manage staff expectations. She gave further details of ongoing discussions with the outsourcing provider. Philippe Serna and Bev Marshall noted that the contract stated there would be no more than one price increase each year. The Trust had strongly challenged additional price increases, details of the contract were provided and it was noted that there were ongoing meetings between the Director of Estates and Facilities and senior managers of the outsourcing provider.
- 18/3/7** The Committee expressed concern about the level of issues raised about patient meals and this was discussed. The Director of Estates and Facilities provided details of the issues raised on Datix; 163 issues had been reported since 12th January. The highest number of these (around a 1/3) related to delivery issues. The top three delivery issues were where food had either been delivered late, wrong or wrong and late. A pie chart and tables illustrated a breakdown, by site, of the issues raised via Datix and other sources.
- 18/3/8** The Director of Estates and Facilities provided a very detailed update on the reasons for the top three issues. A key reason had been that Sodexo had not been able to roll out the electronic 'Saffron' system which, based on orders, determined, amongst many other things, the picking of food to be cooked and food to be ordered. She provided details of further reasons for the issues arising which included; boost times to get the food to the correct temperature had added time into the overall production time and the existing roster times did not provide sufficient time for the food to be plated and boosted before leaving the kitchen to meet the contractual delivery timings.
- 18/3/9** It was clarified that Saffron was in operation at Montagu and Bassetlaw Hospitals but had not yet been rolled out at DRI where the majority of issues had been reported.

- 18/3/10** The Director of Estates and Facilities provided a detailed account of the solutions and remedial measures that had been put in place. It was noted that there had also been a lot of compliments since the roll out.
- 18/3/11** The Chair asked if there were any fundamental issues that had not been addressed. He also asked about the attitude of Sodexo to the issues and he asked whether good progress was now being made. The Director of Estates and Facilities provided a candid update; overall she had been disappointed with the roll out. There had been a collection of operational issues and these should have been anticipated.
- 18/3/12** The Committee reflected on learning that could be taken forward in terms of the contract negotiation; one learning point would be to have negotiated a shorter no service credits period.
- 18/3/13** The Director of Estates and Facilities responded to concerns raised by the Committee about food safety and nutrition; she gave assurance that the Trust had drilled down in to the data and had brought issues to Sodexo's attention; issues had been corrected but she acknowledged that the Trust had relied heavily upon the knowledge and expertise of its own staff to ensure delivery of appropriate food. In response to further concerns about operational issues she gave assurance that the Trust had retained key staff that were highly knowledgeable who were overseeing and policing operational matters and they would be doing this for as long as was deemed necessary by the Trust.
- 18/3/14** The Chief Operating Officer commented that he had been initially disappointed by the roll out but he advised that the number of concerns being brought to his attention had reduced.
- 18/3/15** The Catering Services Outsourcing Update was DISCUSSED and NOTED.

Carter Model Hospital

- 18/3/16** The Committee received a presentation from David Pratt, the new Efficiency Director, on the Carter Model Hospital. This had come about as a result of a series of recommendations from Lord Carter Coles' 2016 report and these had now been developed and encapsulated in to a Model Hospital Portal that identified what good looked like for NHS provider Boards and identified best practice. A link to the portal was provided in the presentation which had been circulated.
- 18/3/17** There were five areas on the Model Hospital Site:
- Oversight
 - Clinical Service Lines
 - Operational
 - People
 - Patient Experience (Under Construction)

- 18/3/18** Many of the Efficiency and Productivity measures were based on a 'Weighted Activity Unit' or 'WAU'. The base value a WAU was £3,500 – the cost of an

average elective inpatient procedure. Each HRG code or procedure was given a value in WAUs by dividing the national average cost per procedure by £3,500. David Pratt explained how this worked.

18/3/19 The Trust had shared links to the clinical service lines with Care Groups; there had been some good engagement and discussions with Care Groups at meetings.

18/3/20 Some of the largest speciality variances against the national median WAU were illustrated but it was noted that there were some questions around whether organisations applied definitions consistently. In spite of this the portal was an extremely powerful tool and would become more so. The Trust had discussed with Care Groups how best to use the data and the Trust was also looking at those better performing Trusts to see what they were doing differently. An overview of Trust wide and estate variances was provided.

18/3/21 There was significant information on the Portal and the Chair asked which areas provided real areas of opportunity or development and this was discussed. A key area was using the data to inform CIP/Savings, but there was some work to do to distil that information in to how the Trust could actually make savings. There were short term opportunities and an overview of these was provided but there were also some opportunities that would take longer. The real power of the tool was that all the information was in one place and the Trust could see how it was doing in comparison to other organisations. Clinician engagement was really important and one of the Trust's senior clinicians had commented that it was an incredibly powerful tool. The Committee discussed how the information could support making decisions.

18/3/22 There would be continued development of the site and data. The Trust was updated regularly with weekly bulletins on changes and webinars and Q&As. Locally the Trust would focus on continued clinician engagement, refining data inputs.

18/3/23 The Carter Model Hospital Presentation was NOTED.

Performance Report

18/3/24 The Committee received the report which focussed on the three main performance areas for NHSI compliance; Cancer, 4hr Access and 18 weeks Referral to Treatment (RTT). The report also highlighted the ongoing work with Care Groups and external partners to improve patient outcomes. Ruth Bruce presented the report which was taken by exception.

18/3/25 The 'At A Glance' sheet now provided RAG ratings against peers and the national position and the direction of travel compared to the previous month and this was welcomed. Overall performance remained positive and ED continued to show strong performance when compared to the national position. The December and January position for the cancer two week wait (2WW) performance was below the national target of 93% and this was an area of concern. The Chief Operating Officer provided a detailed overview of the 2WW appointment process and an update on mitigations put in place to address the issues.

18/3/26 The Performance Report was NOTED.

Workforce Report

18/3/27 The Director of People and Organisational Development provided an update to the committee in relation to month 11 (February 2018) including vacancy levels, agency spend and usage, sickness rates, appraisals, SET training, turnover and retention rates.

18/3/28 Vacancies - In summary the report detailed a vacancy rate in month 11 of 6.4% against a target of 5%; when taking into account the use of temporary staff the Trust had a 2.6% vacancy rate, although this varied by staff group. Agency spend continued to reduce since the introduction of confirm and challenge meetings such that spend was now at similar levels to 2016/17.

18/3/29 With regard to turnover and stability figures initial comparative data across the ICS had been shared at the Working Together recruitment group. As the Committee had been keen to see this data it was provided within the report but it was noted that further analysis was required.

18/3/30 Sickness - February had seen a reduction in both short term and long term absence. The report provided a comparison between Care Groups and Directorates and included a comparison of short and long term absences.

18/3/31 SET/Appraisals - There had been a continued improvement in the completion of appraisals with a rise up to 66.48%. An implementation plan was being finalised for the transition to a three month appraisal season. SET training continued to see improvements with rates currently at 78.59%.

18/3/32 The key focus was on where the Trust could recruit staff in order to minimise the use of agency staff. There was now closer scrutiny of rostering data and new KPIs and data available. This data was being taken to accountability meetings and was being reviewed to see what high level data would come to the Committee. Philippe Serna welcomed this, he noted the issues relating to rotas often featured in the deep dive reports brought to the Committee and it would be helpful to see this information on a regular basis; it was clarified that initially the data would be for nursing staff only.

18/3/33 The Chair and the Director of People & Organisational Development had been in discussions about the development of an 'At a Glance' sheet to accompany the workforce report to focus on the six key groups of staff. Initial thoughts had been for a dashboard that would look at targets and current levels for each group which would be RAG rated and illustrate the direction of travel and this would sit in front of the detailed report. A draft would be provided for the next meeting for consideration and feedback.

18/3/34 The Committee welcomed the work that had been undertaken by BDO to help to produce KPIs which had now been handed over to the Trust. It was noted that the production of the reports was labour intensive and the Trust would need to continue with the process.

KB

18/3/35 The Committee reflected on the reported reduction in agency spend and this was discussed. The DoF commented that the Trust had much tighter control over this; there were now fortnightly meetings and internally the Trust was currently over accruing. There had been a good intake of junior doctors commencing in post at the Trust in the last rotation of Junior Doctors and this would help in terms of filling rotas and reducing agency costs. The Director of People & Organisational Development commented because of the positive reputation of the Trust for training the Trust had been able to put in additional posts for trainees; although this was a cost pressure it was cheaper than agency staff.

18/3/36 The Workforce Report was DISCUSSED and NOTED.

Finance Report

18/3/37 The Director of Finance (DoF) presented to the Committee a paper summarising performance in month 11. The Committee noted the month 11 2017/18 year to date financial position of £16,336k deficit which was (£437k) adverse to plan.

18/3/38 At Month 11 the Trust had included £1.3m of non-recurrent funding for winter pressures in its position (£671k in month). A further £1.2m of winter funding was assumed to be received in month 12 (yet to be included in the position) however this was linked to the delivery of the trajectory set for A&E performance standards. The Trust continued to forecast it would meet its control total, however this was on the basis of receiving the winter pressure funding outlined and this could be counted towards achieving the Trust's control total. There was just under £200k of overspend allowance for M12 therefore the Trust essentially needed to break even in M12 to meet the target.

18/3/39 There were opportunities to manage the year end position and these were discussed. The Director of Finance was meeting weekly with executives to discuss discretionary spend. In terms of the winter funding assumed to be received in month 12 being linked to the delivery of the trajectory set for A&E performance standards, Philippe Serna asked if that would be a hard cut off, for example was it a case of getting the funding if the Trust met the trajectory and not receiving any of it if we missed the trajectory or was there a phasing element. The Chief Operating Officer provided an update on ongoing discussions with NHSI on this matter, at the moment it was expected that if the Trust maintained current performance the funding would be received.

18/3/40 CIP of £1,353k was delivered in month 11. Key work streams which required focus to support month end were highlighted. BDO continued to monitor and encourage improved list utilisation and patient throughput, and had been working closely with Trauma & Orthopaedics, General Surgery and ENT to realise the potential gains.

18/3/41 Income issues with commissioners in terms of a dispute over maternity coding seemed to have been resolved although commissioners were yet to come in to the Trust to audit the work, as they had been invited to do.

18/3/42 The cash balance at the end of February was significantly higher than planned and the Director of Finance provided an update on the reasons for this. The Trust now

had a Cash Committee which met monthly and the minutes of the meetings would come to the Committee. JS

- 18/3/43** Reflecting on the report as a whole the Committee discussed the likelihood of achieving the year end control total and they considered the key risks to this. The Committee considered whether there was anything further the Trust could be doing to support the position that it was not already and this was discussed; broadly it was felt that the Trust was doing all it could in terms of managing discretionary spend, maintaining Grip and Control (G&C) and driving CIP work streams.
- 18/3/44** The Chair reflected on the relationship with BDO which was now coming to end and he asked whether the Trust was confident it could take the work forward; The Director of Finance acknowledged the contribution of BDO, he expressed that he did not feel anxious about BDO's work ending; most of the work been handed over the in the previous 6-8 weeks and was already being managed by the Trust.
- 18/3/45** In terms of the delivery of CIP, the Chair felt it would be helpful in 2018/19 to have a clearer understanding of how well CIP delivery was being managed by Care Groups, which areas were doing well and which areas were finding delivery challenging. This was discussed and the DoF shared his reflections of Care Group performance over the current year and what could be taken form this. Care Groups were signing up to CIP more formally for 2018/19 and the Trust was being very clear what was expected in terms of delivery of CIP. Cross cutting schemes had been identified and meetings had been held with SROs to agree who was delivering what.
- 18/3/46** The key challenge for 2018/19 was the level of CIP delivery required to achieve the control total; the Trust needed to be very clear about cross cutting schemes, who was managing them and holding people to account and this would be done through G&C. It was agreed to provide an update on the G&C position to the May meeting.
- 18/3/47** The Finance Report was DISCUSSED and the Committee NOTED:
- That the in-month I&E position was slightly behind plan (£48k);
 - The year to date I&E position at month 11 of £16,336k deficit which is (£437k) adverse to plan; and
 - While there is still a significant improvement on run rate (excluding winter pressure costs) it is likely that the Trust will need to earn the winter pressures funding in order to deliver the control total. It is therefore imperative the Trusts cost base is minimised and income maximised in the final weeks of the financial year to support this outcome.
 - The risks set out in this paper.

Financial Plan and Budget Setting 2018-19

- 18/3/48** The Committee received the report of the Director of Finance and Deputy Director of Finance which set out the Trust's draft financial plan for 2018/19 including the income and expenditure plan/budgets, capital plans, cash

requirements and cost improvement programme. The paper set out the key assumptions that underpinned the financial plan and budgets and the next steps required in the process.

18/3/49 The Deputy Director of Finance provided an overview of key headlines:

The draft plan showed delivery of the control total of a £6,615k deficit however there were a number of significant assumptions and risks included in the plan, most notably:

- £20.5m CIPs (5%) was required to deliver the control total. Of this £6.3m was identified as high risk and a further £3.4m as unidentified.
- There was a significant variance on income assumptions between the Trust's draft plan and commissioner offers (i.e. offers lower than plan). The key adverse variances were set out in the paper and mainly related to differences on activity growth assumptions. A requirement for mediation had been escalated to the SY&B ICS and discussions were ongoing with Commissioners.
- The plan assumed the Trust would be able to refinance significant loans, along with requiring borrowings to cover the control total deficit.

18/3/50 Income and Expenditure Plan - The key amendments to the financial plan and budgets since presented to the Committee in February 2018 were highlighted on page 2 of the report. The Deputy Director of Finance summarised the key movements which included:

- Income had increased by £1.02m.
- Pay and non-pay costs had been adjusted reflecting G&C work.
- Non recurrent income had been taken out.
- National Tariff changes had been taken in to account.
- QIPP of £1.39m (relating to an assumed 30% cost reduction associated with Commissioner QIPP plans) had been reclassified as reserves (details of reserves were provided in the report)
- Reduction in centrally held reserves and recharges taking account of budget changes.
- The CIP target has increased by £0.6m to £20.5m.

18/3/51 The report provided an overview of income budgets, income breakdown by Care Group and by source, an update on contract negotiations, expenditure budgets and the process and background to budget setting, pay and non-pay budgets, CIP, the capital programme, the cash position and risks to the financial plan and budgets.

18/3/52 The Deputy Director of Finance drew attention to the alignment of pay budgets and expectations in terms of the national pay award and also provisions for agency staff and additional sessions premiums. In response to a query from Phillippe Serna about whether the Trust had budgeted for agency premiums, the Director of Finance clarified that this was on top of full funding for funded establishment/vacant posts, annual leave and sickness. The budget figure was the top up for covering that with agency.

18/3/53 Cash Position – In response to a query from Phillippe Serna about whether the interest rate on loans was likely to change, the Director of Finance clarified that this was a possibility and had been identified as an issue in terms of refinancing capital loans; this was discussed and further details were provided.

18/3/54 The Committee considered the risks to the financial plan and budgets set out in the report and these were discussed. The Chair noted that some of the risks were significant and these needed to be clearly reflected on risk registers. The Trust Board Secretary clarified that the risk was already on the register and would be reviewed in line with the report.

18/3/55 In the context of recommending the plan to Board, the Committee reflected on the level of risk reported, particularly the reported risk to CIP and the variance on income assumptions between the draft plan and commissioner offers. It was noted that the plan was yet to be completed; amongst other things, commissioner budgets were yet to be agreed and further details were provided on discussions with commissioners and the details of the variances which mainly related to differences on activity growth assumptions. As previously reported, the requirement for mediation had been escalated to the SY&B ICS and it was possible that there would be an intervention with the CCGs and NHSI.

18/3/56 The Chair commented that the key issue was getting the organisation to sign up to and start to deliver their CIPs; the DoF concurred and gave assurance that this was being taken forward.

18/3/57 The Committee:

(1) NOTED the Financial Plan and Budget Setting 2018-19 report.

(2) NOTED the draft plan submitted to NHS improvement, including the key assumptions and risks to delivery

(3) RECOMMENDED the draft income and expenditure plan/budgets, capital plans and cost improvement programme to BOARD and would request that the Board delegate authority to the Committee to APPROVE the plans once completed.

NR

2018/19 Cost Improvements

18/3/58 The Committee received the report of the Director of Finance and Efficiency Director which provided an introduction to the Trust's 2018/19 Cost Improvement Programme. It was noted that some of the schemes, numbers and values in the report were a work in progress and needed further refinement. The report included a summary of a range of schemes and opportunities which were being worked on for inclusion in the 2018/19 CIP Plan. These were summarised at Appendix 1, and had a current total of £17.15m. The list was agreed for work-up at a meeting of the Efficiency and Effectiveness Committee on 19th February 2018. Individual scheme summaries were attached at Appendix 2. The Chair endorsed the paper particularly appendix 2 which provided details of the Senior Responsible Officer (SRO), linked PMO Project Manager and Senior Management

Accountant (SMA) for each scheme.

18/3/59 Completion of Plans - In order to finalise the programme, the Efficiency and Effectiveness Committee had agreed deadlines for completion of project plans. These were split into two groups; the timescales for plans for schemes commencing in April 2018 or elsewhere in Quarter 1 (plans to be complete by the end of March 2018) and for schemes that commenced after Quarter 1 (plans were to be complete by the end of April 2018). The list of schemes in each group was listed in the report. A completed plan meant one with finalised timescales, actions, responsibilities, milestones, deliverables, financials, dependencies and risks included. Each plan would also need to be quality impact and equality assessed.

18/3/60 On Appendix 2 the current position of each scheme was RAG rated Red/Amber/Green and David Pratt provided further explanation of this. The Committee considered each scheme in detail and David Pratt provided further details when requested. The Committee discussed confidence levels in each scheme, challenges, levels of risk, how schemes would be monitored and managed and lines of accountability. David Pratt described the processes and meetings in place to manage and monitor progress. Accountability processes had been changed to a cohort of managers responsible for delivery, this would mean better ownership.

18/3/61 Reflecting on the risk factors discussed the Chair recognised that the current total CIP of £17.15m would be very challenging, at the same time the Trust needed to press ahead with work to deliver the schemes and get them over the line. It was noted that work was still ongoing to identifying new CIP.

18/3/62 One of the biggest challenges for Care Groups and corporate directorates was culture change in terms of the level of change to the processes for driving and managing schemes. There was work to do develop staff and this was being taken forward.

18/3/63 The Committee thanked the Director of Finance and David Pratt for the report which was well presented. The Chair commented that it would be helpful to have a visual tracker in future reports to monitor progress and it was agreed to meet with David Pratt to discuss this.

NR/DP

18/3/64 The 2018/19 Cost Improvements report was DISCUSSED and NOTED.

BDO Update

18/3/65 This was the last meeting James Nicholls, BDO, would be attending as the work BDO had been undertaking at the Trust was coming to an end. He provided an update on progress with the last remaining elements of work.

Grip & Control (G&C) – The final elements of G&C had been reviewed and signed off by the Executive Team (ET) the previous week. Subject to a few changes the BDO G&C work would be complete and handed fully over to the Trust. Recent CIP focus had been on theatres and OPD and there had been good progress with

theatre productivity being at one of highest levels ever which was very positive in terms of the future.

18/3/66 James Nicholls shared his reflections on the work undertaken at the Trust. In terms of continued delivery of G&C, the key area of focus for the Trust should be to focus on ensuring continuous holding to account. BDO had been having daily contact with teams and that level of drive needed to continue. Team working was incredibly important, it was very easy to become adversarial and it was important to maintain the feeling of 'one team', relationships should be open and comfortable with challenge.

18/3/67 Philippe Serna reflected on the level of resource BDO had put in to the organisation and the level of work required to produce reports and management information. He asked whether the Trust had the appropriate level of resource required to take things forward and this was discussed. James Nicholls felt that the Trust had the right people and resources to drive the work forward; the key issues were attitudinal and recognising what was important. The reports themselves were not particularly time consuming to produce, it was about being disciplined and using the data intelligently to encourage and influence people to do things differently. It was key that the Trust continued to check what people were doing and that they were focussed on the right areas.

18/3/68 The Committee thanked James for making himself available to them during the time he had been working with the Trust, this had been very much appreciated. The Chair felt that the Trust had benefited from its association with BDO, a lot of lessons had been learnt about the organisation and what worked and this had been valuable.

18/3/69 The BDO Update was discussed and NOTED.

Minutes of the meeting held on 23 February 2018

18/3/70 The minutes of the meeting held on 25 January 2018 were APPROVED as a correct record.

Items for escalation to the Board of Directors

18/3/71 None

Time and date of next meeting:

Date: 26 March 2018

Time: 9:15am

Venue: Boardroom, DRI

Signed:

Neil Rhodes

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Date

DONCASTER & BASSETLAW TEACHING HOSPITALS NHS FOUNDATION TRUST

**Minutes of the Quality & Effectiveness Committee
held at 2pm on Friday 23 February 2018
in the Boardroom, DRI**

- PRESENT : Linn Phipps, Non-executive Director (Chair)
Alan Armstrong, Non-executive Director
Sewa Singh, Medical Director
Karen Barnard, Director of People & OD
Moira Hardy, Director of Nursing, Midwifery & Allied Health Professionals
- IN ATTENDANCE : Clive Tattley, Governor Observer
Peter Abell, Governor Observer
Marie Purdue, Director of Strategy & Improvement
Rick Dickinson, Acting Deputy Director of Nursing, Midwifery & Allied Health Professionals
Ray Cuschieri, Deputy Medical Director
Matthew Kane, Trust Board Secretary
Kate Sullivan, Corporate Governance Officer
- APOLOGIES: Ruth Allarton, Associate Non-executive Director
Andrew Beardsall, Doncaster and Bassetlaw CCGs
Lisette Caygill, Acting Deputy Director of Quality & Governance

Action

Introduction

- 18/2/1** The members, officers and governor observers were welcomed to the meeting and introductions were made around the table.

Agenda Review & Terms of Reference

- 18/2/2** The Terms of reference were NOTED.

The Chair emphasised that the QEC agenda planning group had worked hard to keep the ways of working of the meeting under review and to respond to member feedback. They had carefully reviewed the agenda to schedule the committee to run within 3 hours, whilst ensuring sufficient time was allowed on the agenda for each item. Some further items would be taken for information only.

With regard to Governor questions the Board of Governors had reviewed ways to optimise the process. The Chair would consider the best process for addressing Governor questions at QEC and the planning group would look at this at their next meeting.

**Planning
Group**

[Post meeting note: The Chair discussed this with the Committee's Governor Members outside the Meeting. Broadly the approach the Committee is adopting is for Governors to be active participants in the strategic discussion item, and

observers for the remaining business items. The Committee has 10 minutes for Governor questions within the agenda, and any further questions relating to the business of the meeting would be taken outside the meeting e.g. by email to ensure no points are lost.]

Apologies

18/2/3 Apologies were received from Ruth Allarton, Andrew Beardsall and Lisette Caygill.

Action Log

18/2/4 The action log was reviewed and updated. The Committee focussed on those actions that were not yet complete:

18/2/5 **Action 3 – 17/8/12** – There was an outstanding action to develop an understanding of CQC’s composite indicators and consider appropriate hard and soft metrics required to formulate a balanced scorecard (or similar). This had been a DBTH target adopted in the Quality Accounts in May 2017. Reflecting on the information provided in the Quality Dashboard the committee considered whether a balanced scorecard was still something that needed to be developed separately from the Quality Dashboard. This was discussed in detail and it was resolved that although the quality dashboard provided good quantitative metrics the report needed both hard and soft metrics and it was agreed to work on creating a BSC-style infographic including both qualitative and quantitative information, the latter being sourced particularly from the QD **RD**

18/2/6 **Action 3 – 17/12/29** – Discussions were ongoing between Executives to examine whether the new quality dashboard included sufficient breadth and depth of workforce metrics including nursing. Karen Barnard would provide an update at the next meeting. **KB**

18/2/7 **Action 3 – 17/10/83** - Access to B Drive for NEDs and Governors to view the Quality Dashboard. On-line access was scheduled to be resolved by June/July. In the interim period a PDF would be circulated to Governors and NEDs **MK**

18/2/8 **Action 14 - 17/12/65** - Duty of candour – The committee had requested clarification on who was responsible for following up duty of candour issues with written correspondence and for assurance that staff are receiving support with this. It had since been reported that patient safety leads were providing support. It would be helpful to understand more about how that was working and the matter was discussed. It was agreed to provide an update in June to include an update on governance arrangements and how outcomes were being measured **MH/LC**

STRATEGIC DISCUSSION ITEMS

R&D Assurance Report

18/2/9 The Committee had previously considered the report in detail at a special meeting on 4th January 2018 and actions agreed at that meeting had since been incorporated in to the revised report. The detailed report was presented using

the “deep dive” assurance questions format which had previously been considered; the committee then considered in detail the level of assurance provided for each question:

18/2/10 How do we ensure that research is ethically sound, with appropriate financial governance in place? - Assurance Rating – ASSURED

In response to a question from the Chair, Emma Hannaford provided an explanation of what was meant by ‘Treatment Costs payable by the NHS’; she gave assurance that this had a very small impact and that costs of Studies were always set out and attributed very clearly from the onset.

18/2/11 What assurance do we have that all research opportunities to develop capacity and capability are being explored? - Assurance Rating – ASSURED

It was reported that a strategic approach was taken to developing capability and capacity, particularly concentrating on those areas that were more likely to attract satisfactory levels of recruitment of participants/patients, and/or were answering clinically important questions and/or those that would be income generating. In response to several questions from Alan Armstrong in terms of whether this was implicit the R&D Strategy, Emma Hannaford advised that the Trust was continually making and taking advantage of opportunities, including circulating targeted opportunities and increasing visibility of R&D in general. Funding was a key aspect and this was discussed further; it was clarified that the Trust received income from the CRN based on research activity which the CRN closely monitored. The Trust was expected to set targets each year and these had been achieved year on year.

18/2/12 In response to a query from the Chair about how the Trust decided which studies to conduct, Trevor Rogers clarified that the decision was ultimately taken by the R&D department. He provided an overview of the typical process which included looking at the logistics of being able to deliver the study, for example in terms of the availability of research nurse and consultation with the principal investigator who would decide if they had the patients, whether it was clinically appropriate and whether there were the skills to take the study forward.

18/2/13 A number of successes to date were reported. These included recruiting the first worldwide patient to three separate commercial studies, being shortlisted for HSJ awards 2015 and Nursing Times Awards 2015 and having two clinicians PIs recognised out of 70 nationally by the National Institute for Health Research; this was commended by the Committee.

18/2/14 How will we extend research beyond medical matters to include other professions? - Assurance Rating – ASSURED

The Director of People & Organisational Development provided further assurance that work to extend research beyond medical matters to include other professions had been expanding.

18/2/15 **How do we ensure that research is progressing Teaching Hospital status? - Assurance Rating – ASSURED**

Reflecting on the discussion at the previous meeting, the Director of People & Organisational Development commented it would be helpful for the R&D team to meet members of the Education Team more frequently and she offered her support to facilitate this.

18/2/16 **How assured are we that the Governance Tree for R&D is clear and effective? -**

The report highlighted the thoughts of the R&D department about where the R&D department should sit in terms of the Executive Lead; the rationale for this was set out in the paper and was discussed. The Director of People & Organisational Development advised that this had been discussed by the Executive Team as part of a review of executive portfolios. Once this was completed she would feedback the outcome of the discussions to the committee. The Trust Board secretary highlighted that the Trust also needed to consider where the R&D Committee would sit within the committee structure and he would discuss this with the Medical Director.

KB
MK/SS

18/2/17 **How do we ensure our metrics for success in R&D sufficiently measure patient outcomes as well as activity? - Assurance Rating – ASSURED**

At the previous meeting the details of the R&D KPIs had been provided and the Committee had highlighted the need for KPIs on qualitative outcomes as well as quantitative measures. The updated report provided a link to a snapshot of the outcomes of previously conducted interviews with patients and this was welcomed by the Committee.

18/2/18 The Chair suggested that this should be an area for development in the new R&D strategy. She had previously noted that R&D had a significant number of KPIs and she asked whether they all added value to the work of the department and this was discussed. Emma Hannaford commented that the KPIs were very valuable to the team in terms of breaking down the elements of an issue.

18/2/19 **How do we ensure we are well networked in terms of research? - Assurance Rating – ASSURED**

18/2/20 **How do we ensure that we have identified interdependencies with enabling strategies? - Assurance Rating – ASSURED**

In response to a query from the Chair about how the development of the R&D strategy was progressing, Emma Hannaford provided an overview of progress; the team were working to a timetable and would be pulling the strategy together over the next month. The Chair had discussed with the Director of Strategy & Improvement how the committee could support the process and this was discussed. The offer of support was welcomed and it was agreed that the Director of Strategy & Improvement would provide support to the strategy development and that a high level timetable would be provided.

MP
EH

18/2/21 The R&D Assurance Report was DISCUSSED and the Assurance Rating as set out above were NOTED.

QUALITY & CARE

Quality Assurance Report

18/2/22 The Committee received the report which for the first time comprised three parts that brought together information across a range of areas. The report used the assurance questions and was set out to provide a response to each question for each of the three areas:

- a. Quality dashboard
- b. Hard Truths (nurse staffing and quality metrics)
- c. Clinical Governance

18/2/23 The report was a work in progress; this was the first attempt to bring together a cross cutting report on matters relating to quality of services across a range of areas and it was expected that the report would evolve over time. The Chair welcomed the report and she commended the work undertaken to develop and present it. It was good to recognise achievements and that no red flags had been identified, she recognised the significant improvements highlighted in the report particularly in relation to improvements in NICE guidance compliance.

18/2/24 Focusing on the assurance questions relating to causes for concern (problem issues/red areas) and action plans to address, improve and monitor these, the following were discussed:

a. Quality dashboard

The Friends and Family Test for A&E remained worse than peers and in response to a concern raised by Alan Armstrong the matter was discussed. It was noted that although the response rate was low the responses themselves tended to be positive. The Trust considered individuals' negative feedback alongside other sources for example complaints and compliments and this had not triangulated to any causes for concern.

18/2/25 Learning From Deaths – It was reported that an increasing number of cases (currently over 60%) of deaths were screened or the subject of a Structured Judgement against a target of 100% and Alan Armstrong queried what should be taken from this. The Deputy Medical Director advised that the Trust currently compare favourably with neighbouring Trusts in terms of review rates but in order to achieve comprehensive coverage of deaths, the Trust would require additional resource. With the resources available at the moment the Trust was trying to review as many patients as possible; further resource had been put in place and rates were expected to rise. It was clarified that patients reviewed via other processes were not part of the 60%. The Deputy Medical Director gave assurance that there was a good level of confidence that the Trust was picking up on issues that needed focus through the current level of reviews but it would continue to aim for 100%. The Medical Director highlighted that the Trusts learning from deaths process was considered to be one of best in the country

and he felt that ~~the~~ additional funding for a learning from deaths lead would take the Trust close to 100% standard.

18/2/26 Alan Armstrong asked what the Trust was learning from learning from deaths and this was discussed. There wasn't the wealth of new information available now as there had been when the Trust first started the learning from deaths process because most of the issues had been identified and addressed. The majority of care was reported as good and there were very few instances where the review had identified issues not already identified. What the Trust was learning was that quality of care had improved and this was reflected in the Trusts HSMR. Overall the Trust was assured that quality of care was good but it should continue to maintain vigilance.

18/2/27 One of the biggest areas of learning had been around patient and family experience and around the duty of candour in terms of being more open and transparent and these were areas where there could be more improvement, for example in terms of end of life care. This was discussed and it was agreed that the planning group would consider the 'Quality of patient and family experience in terms of Learning From Deaths' for future deep dive to include: Experience before and after death, what we've learnt, how we measure it, what we've done in context of regional and national work and also provide assurance that we are listening and learning.

**Plannin
g Group**

18/2/28 The Committee had previously raised concern about the use of the term "adequate care" used within the process of the structured judgement reviews for learning from deaths and this had been discussed; The Deputy Medical Director had acknowledged the concerns and provided an explanation of the meaning of the term. It had been agreed to check the language being used by colleagues in the region and to consider an alternative when referring to quality of care and the Chair enquired about this. The Deputy Medical Director advised that the technical term 'adequate' had been accepted nationally and as such the Trust would continue to use the term. Future reports would include an explanation of what adequate care meant.

18/2/29 The Committee considered areas for concern within the Hard Truths (nurse staffing and quality metrics) report and this was discussed. There were no areas that had high risk workforce and high risk quality concerns and the areas with deficits of >10% have no significant quality issues that correlate. There were some correlating workforce deficits of >10% which linked to moderate risks on quality on some wards and this was detailed in the report.

18/2/30 Alan Armstrong asked for assurance that the Trust was working on staff retention and The Director of People & Organisational Development advised that this was a key area of focus for the Trust; she provided an update on work that was ongoing with the Working Together Group of Trusts using the NHS Improvement Toolkit. After further discussion it was agreed to consider staff retention as future discussion topic to include an update on actions.

**Plannin
g Group**

18/2/31 The Committee considered areas for concern in terms of Clinical Governance; There had been litigation within the 3 specialties identified within the Getting it

Right First Time (GIRFT) programme. Subject to a coding validated exercise, the relevant Care Group would take steps to address the position and claims would be triangulated with learning themes from complaints, inquests and serious incidents. Care Groups would provide an update on progress to CGC in six months. Alan Armstrong welcomed the GIRFT data produced in collaboration with NHS Resolution, to show the cost of claims in the context of the volume of activity carried out by each surgical specialty. The Medical Director advised that this was the first time he had seen the claims profile data benchmarked by speciality against national data. He noted that the claims reviewed were based on five financial years from 1st April 2012 to 31st March 2017 of notification to NHS Resolution. He welcomed the data which he felt was one of the best things to come out of the GIRFT initiative.

- 18/2/32** The Chair reflected on discussions earlier in the day at the Finance & Performance Committee about the level of Losses and Compensation claims received, and where review of this should sit. It was suggested that an annual report should be brought to this committee to consider the data and trends at care group level along with an analysis of reasons for claims; this was agreed and after further consideration by the planning group it would be added to the work plan. **Planning Group**
- 18/2/33** The committee considered if there were any further topics on which it wished to receive an update in the future. The Chair felt it would be useful to have a better understanding of the discharge process and this was discussed. The Committee felt it would be useful to receive both qualitative and quantitative elements including the experience of patients. It was agreed that the planning group would consider how the committee could receive assurance of the experience of patients in terms of patient discharge at their next meeting. **Planning Group**
- 18/2/34** The Chair commended the summary report which she felt was excellent and she asked this be fed back to the team who produced it.
- 18/2/35** The Quality Assurance Report was DISCUSSED and NOTED.
- 18/2/36** **Medical Revalidation & Appraisal Process Assurance Report**
- 18/2/37** The Annual Revalidation Assurance Report had been presented to the Committee in August and within the report the ongoing development of the IT system had been identified as a key element to support ongoing Medical Revalidation. The report provided an update on this in the assurance questions format. The Medical Director advised that since the time of reporting he had been assured that the IT department would ensure all the required actions would be completed within the next two months and this was welcomed.
- 18/2/38** The Medical Revalidation & Appraisal Process Assurance Report was NOTED.

Deep Dive on Respiratory Care

18/2/39 In September 2017 the Quality Metrics produced as part of the nurse staffing and quality monitoring triangulation process and report (Hard Truths data) found the Respiratory Unit to be an outlier and this had flagged a need for intervention using a Quality Summit to review improvement and support needs and plans. The October quality and workforce data improved slightly and improved further in November 17. Subsequent to the Quality Summit, a request to undertake a deep dive on the Respiratory Unit and report to the Quality and Effectiveness Committee was made. The report provided triangulated details regarding the measurement of the quality of care, staffing levels and quality of leadership and management. The data provided was from multiple sources and was presented in the assurance questions format accompanied by detailed report.

18/2/40 Significant data from multiple sources had been collated in the report and the Chair thanked colleagues and their teams for the work that had been undertaken to produce the report. Reflecting on the report as a whole the Committee considered whether it had clearly enough identified the assurance question to be addressed and this was discussed in detail. There was further detailed discussion about what was meant by the triangulation of data; although there had been value in the wider deep dive exercise, in terms of triangulating data, it would have been useful to consider the use of other softer metrics and for there to have been greater analysis and comparison of the data. On reflection the committee agreed that it would have been useful to identify the corners of the triangle and ask, for example, *did high staff turnover link to poor patient experience?* and *'was there a relationship between staffing, staff views and patient experience?'* and this was a lesson for the future.

18/2/41 There was further reflection about how the relationships between data might be triangulated, it was important to consider what the data was telling us, whether there were any relationships between the data and reflect on whether there was anything we should be doing to make improvements. It was agreed to consider revisiting Respiratory Care in the future with more clearly set out assurance questions to look at what the data is telling us and to look at relationships between the data, if any.

**Planning
Group**

18/2/42 It was noted that the report had been particularly useful in highlighting work still required on the action plan from the quality summit and that would be taken forward.

18/2/43 The Deep Dive of Respiratory Care Report was DISCUSSED and NOTED.

Risk Interrogation Report - Complaints

18/2/44 The Committee received the report of the Director of Nursing, Midwifery & Allied Health Professionals and Acting Deputy Director of Quality & Governance. This provided the Committee with an interrogation into the risk recorded on the Board Assurance Framework (BAF) relating to the potential failure to improve complaint reply performance as referenced within the Q2 Patient Experience &

Engagement report.

- 18/2/45** Data collected for the CQC Provider Information Return (PIR) highlighted concerns regarding overall complaint reply performance at 20, 40 & 90 days. This had been and continued to be addressed through a robust weekly engagement meeting with Care Groups to review timescales agreed with complainants and improve communication and documentation of progress for monitoring of compliance and escalation purposes. The report used the QEC risk interrogation template as a means to consider whether appropriate actions were being taken and whether the risk score could be adjusted at this point in time.
- 18/2/46** The Committee considered the key milestones and actions to mitigate the risk and the Director of Nursing, Midwifery & Allied Health Professionals advised that the Qii project to improve compliance with the 3 day standard for initial acknowledgement letters was ongoing. In response to a query she clarified that this related to the response rates to complaints and focussed on response times, not the quality of the complaint response letter. The Committee asked whether any information was available in terms of the quality of response letters; Over the course of the year the Chief Executive had been actively engaged in reviewing the quality of the response letters, reviewing all responses and sending the letters back to the Patient Experience Team (PET) if he felt complaints had not been fully responded to, if there were matters of accuracy to be addressed or if he felt the tone of the letter was not as it should be. The Chief Executive had reported that the number of letters being returned to the PET had significantly reduced.
- 18/2/47** In response to several queries it was noted that the Qii project was progressing well. The Committee commended the report, commenting that it was very clear and well presented.
- 18/2/48** The Risk Interrogation Report on Complaints was NOTED.

Patient Experience & Engagement Assurance Report Q3

- 18/2/49** The Committee received the report which provided data relating to Quarter 3 performance using information available from Datix and the learning points from the Patient Experience & Engagement Committee. It aligned key priorities and outcomes that were measured through patient feedback, and outlined the Trust's intentions to implement and monitor performance against the Patient Experience & Engagement Strategy.
- 18/2/50** The report used the assurance questions format and this was welcomed. The Report measured the Trust's performance against the standards identified in the Trust's policy; *complaints, concerns, comments and compliments; resolution and learning* - this included an illustration of trends in overall complaints and concerns received along with complaints and concerns received by management team. The report also included the top 10 reasons cited in a complaint, outcomes from the Friends and Family Test (FFT) and ward patient surveys, and detailed update on learning from patient experience and engagement. 3

examples of Care Group reports to the Patient Experience & Engagement Committee were provided as appendices; the Director of Nursing, Midwifery & Allied Health Professionals commented that there had been significant learning from these reports and this had been very valuable.

18/2/51 Reflecting on the report the Committee noted that overall trend in complaints and concerns showed a statistically significant drop in the overall number of complaints and concerns in October and December 2017. Following further analysis no trends or themes had been identified. The Committee considered the possible reasons for the decrease, for example had this been due to there being fewer causes for complaint or because concerns were being addressed early and therefore not escalating to complaints, the committee also considered whether the decrease could be because people were being discouraged from complaining.

18/2/52 Although there was no clear correlation between the reduction in complaints and a rise in concerns, the Director of Nursing, Midwifery & Allied Health Professionals felt that concerns were being dealt with more quickly. The Chair asked if it might be possible to conduct a survey to look at this and ask, for example, whether someone had raised a concern and if it had been addressed early. It was noted that there had been a rise in the level of advice comments and questions, this related to people calling in. Previously staff had been inclined to advise people to write in and this would have been registered as a complaint but staff were now much more confident resolving issues over the telephone.

18/2/53 In response to a query from the Trust Board Secretary about whether complaints made on social media were reported on the Committee agreed that social media feedback was valuable and that the Trust should be aspiring to report on this in order to get a rounded picture and capture all feedback. It was agreed to clarify whether the communications department were capturing this data and to feed the committees comments back to the Communications Team.

MK/MH

18/2/54 The Patient Experience & Engagement Assurance Report Q3 was NOTED.

LEADERSHIP AND IMPROVEMENT CAPABILITY

18/2/55 Workforce & Education Assurance Report

18/2/56 The Committee received the report which used the assurance questions format and was accompanied by an additional detailed report which included sets of data for each area. Karen Barnard summarised the key areas of focus and areas for concern.

18/2/57 It was reported that the recent CQC visit flagged that Non-Executive Directors did not have a line of sight on the Statutory and Essential Training (SET) compliance rates against each of the core topics. Reflecting on this Bev Marshall asked whether the committee should consider having sight of the more detailed Statutory and Essential Training (SET) data that was taken through the Workforce and Education Committee (WEC) and if so how frequently; it was agreed to report on this bi-annually to commence in August 2018. It was noted

that Alan Armstrong represented the NEDs on the WEC and he gave assurance that he flags up any issues with the Committee should they arise.

18/2/58 It was reported that appraisal rates had seen a further improvement in the last month, however rates may reduce during the remainder of 2017/18 as the Trust aligns due dates with the new appraisal season. The HR Business Partner team has developed an action plan to ensure staff and managers are adequately prepared to undertake appraisals during the season, this is including further training and communication through a variety of methods such as talking heads. In response to a request from the Chair for more information on the new approach to appraisals the Director of People & Organisational Development provided an update: There was general agreement in the organisation that a condensed appraisal period, that avoided holiday periods, would be beneficial. The Trust was trying out a mix of types of appraisals and would get feedback from staff on those in due course and communications were going out to staff to explain expectations. In response to a query from the Chair it was clarified that those areas with lower performance would receive additional help and support.

18/2/59 In terms of recruitment and specifically any future plans for overseas recruitment of nurses Alan Armstrong reflected on the Deep Dive report on the Respiratory Unit which reported that on the previous occasion when Trust had recruited nurses from the Philippines the majority had been unable to pass the International English Language Testing System (IELTS) and therefore the numbers successfully recruited were low and he asked if the English Language Testing requirements had changed since that time. The Acting Deputy of Nursing, Midwifery & Quality provided an update; a new operational standard for English Language Testing had been introduced and accepted by the Nursing & Midwifery Council (NMC). He gave an overview of work undertaken so far including opportunities in terms of a global education programme where nurse would come to the UK for 3 years then return home to share learning, work was also ongoing to encourage Nurses who had emigrated to return to the UK.

18/2/60 In response to a request from Alan Armstrong for assurance that the root causes of variations in staff absence percentages across departments had been investigated, the Director of People & Organisational Development provided an overview of the reasons for sickness absence. There had been long term sickness issues in some smaller departments which had impacted on the staff absence rates and she gave examples of this. 22% of staff absence was due to mental health issues relating to stress, anxiety and depression which were commonly the biggest reason for staff absence in many organisations. There was due to be a deep dive in to this at the next Health & wellbeing Committee Meeting. There was more work to do in this areas; the Trust had been running courses for staff on managing stress and on mental health issues and would be looking at whether the courses being run had added value. The Trust was also interested to learn from the experience of staff that had worked through mental health issues and returned to work.

18/2/61 The Workforce and Education Assurance Report was NOTED.

18/2/62 GOVERNANCE AND RISK

18/2/63 RCOG Action Plan

18/2/64 The Committee received an update from the Medical Director on progress against actions resulting from the Royal College of Obstetricians & Gynaecologists (RCOG) recommendations. The majority of actions were completed and good progress was being made on the remaining actions. Progress had been monitored by the RCOG, in January the RCOG had advised that they were satisfied with progress and no longer wished to monitor action plan.

18/2/65 It had been agreed to present the results of a staff survey undertaken to establish a baseline for morale within the team. The Medical Director explained that the responses had only recently been collated and he apologised for not presenting the report at this time as agreed; unfortunately initial results suggested that morale remained low and this required further consideration by the Executive Team (ET). Although it had been expected that work from the action plan to improve team working and culture would take time these results were still disappointing. The Medical Director advised that he would present the results to the committee at the next meeting after consideration by the ET who would agree next steps. It was expected that a refreshed plan would be developed after the survey feedback had been reviewed. In response to a query from the Chair, the Medical Director confirmed that it was still intended to carry out the staff survey every 6 months. **SS**

18/2/66 The RCOG Action Plan was DISCUSSED and NOTED.

18/2/67 Board Assurance Framework and Corporate Risk Register

18/2/68 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.

18/2/69 There had been two changes to the risk register since the last meeting: The first related to failure to adequately treat patients due to unavailability and lack of supply of medicines. The Medical Director advised that this was a national issue outside the Trusts control, the matter had been discussed at Board and controls had been put in place. He gave assurance that the Trust was proactive in developing contingency plans to deal with shortages and non-supply of medicines and this was reported to the Clinical Governance Committee (CGC) on a regular basis. In response to a suggestion from the Chair and further discussion it was agreed to provide a risk interrogation at the next meeting on how the Trust is mitigating the risk in dealing with shortages and non-supply of medicines and to consider reputational risk. **SS**

18/2/70 The second change related to a refinement to the scoring of the existing risk of failure to achieve complaint reply performance standards; this was detailed in the covering report.

- 18/2/71** The Board Assurance and Corporate Risk Register were NOTED.
- 18/2/72** **Minutes of sub-committees**
- 18/2/73** The minutes of the following committees were NOTED:
- Clinical Governance & Quality Committee held on 17 November 2017 and 15 December 2017.
 - Workforce & Education Committee held on 20 November 2017.
- 18/2/74** **Minutes of the meetings held on 14 December 2017 & 4 January 2018**
- 18/2/75** The minutes were APPROVED as a true record.
- 18/2/76** **Any other business**
- 18/2/77** No other business was declared.
- 18/2/78** **Governor questions regarding the business of the meeting**
- 18/2/79** Care Per Patient Day – Peter Abell noted that there had been a decrease of 12% for care hours per patient day (CHPPD) for midwives and registered nurses and he commented that this seemed significant. He asked if this reflected an actual decrease in care hours provided or if it was as a result of more patients and greater pressure in the system. Further to this he asked if there was a way to triangulate this information with quality metrics and were there patterns across other months that could be identified; there had been staff sickness but the key issue had been an increased numbers of patients in January. When compared over several months the overall CHPPD rate showed a fluctuating rate similar to that of peers but it had been lower than national rates. It was noted that the quality data for January was not available for all metrics at this stage but would be available for the next meeting, it would then be possible to look at the data on the quality dashboard at the next meeting when it was due to be presented
- Meeting Round-up**
- 18/2/80** It had been a good meeting and reflecting on the papers the committee endorsed the combined Quality Assurance Report. Although timekeeping to the agenda timings had been good it was felt that some papers should have been allocated more time and the planning group would reflect on this at their next meeting.
- 18/2/81** **Future Discussion Topics**
- 18/2/82**
- Research Activity & Governance Arrangements
 - QEC's Quality Metrics Requirements
 - Risk Interrogation
 - Progress against RCOG Action Plan – cultural issues
 - Governance Arrangements for Assurance to the Board
 - Junior Doctors Assurance
 - Quality of Patient Experience in terms of Learning from Deaths
 - Staff retention including an update on actions being taken

- 18/2/83 Identification of New Risks**
- 18/2/84** No new risks were identified.
- 18/2/85 Items for Escalation to the Board**
- 18/2/86** None.
- 18/2/87 Time and date of next meeting:**
- 18/2/88 Regular Bi-Monthly Meeting**
 - Date: 24th April 2018
 - Time: 2pm
 - Venue: Boardroom, DRI

Signed:.....
Linn Phipps

.....
Date

UNAPPROVED DRAFT

DONCASTER & BASSETLAW TEACHING HOSPITALS NHS FOUNDATION TRUST

**Minutes of the Audit & Non-Clinical Risk Committee Meeting
held at 2pm on Thursday 4 January 2018
in the Boardroom, DRI**

PRESENT : Philippe Serna, Non-executive Director (Chair)
Linn Phipps, Non-executive Director

IN ATTENDANCE : Mark Brookes, People & OD for Karen Barnard
Mark Bishop, Local Counter Fraud Specialist
Robert Fenton, Internal Audit (KPMG)
Michael Green, External Audit (EY LLP)
Matthew Kane, Trust Board Secretary
Andrew Leverton, Head Medical Technical services
Claire Partridge, Internal Audit (KPMG)
Julie Robinson, Overseas Visitors Manager
Jon Sargeant, Director of Finance
Kate Sullivan, Corporate Governance Officer

GOVERNOR OBSERVERS: Bev Marshall, Public Governor
George Webb, Public Governor

Action

Apologies for absence

18/1 Apologies were received from John Parker, Kirsty Edmondson-Jones and Karen Barnard.

Terms of Reference

18/2 The Terms of Reference (TOR) had been added to the agenda for information as a standing item as was now the practice for other committees. It was noted that the ToRs had been slightly amended in June 2017 to reflect changes to the Board committee structure. The Committee reviewed and discussed the ToRs and the following was agreed to be recommended as part of the next review:

4.2 - Other Assurance Areas – It was noted that the committee would review the work of the other committees within the organisation whose work could provide relevant assurance to the committee’s own scope of work. In response to a query from George Webb it was clarified that this included the Finance & Performance Committee (F&P) and Quality & Effectiveness Committee (QEC). The ToRs would be amended to reflect this.

6.1 – Financial Reporting – The ToRs set out that the Committee would review the Annual Report and Financial Statements before submission to the Board. The ToRs would be amended to reflect that the Committee would also, if appropriate, ‘recommend’ those documents to the Board for approval.

7.2 – Other Areas of Work Health and safety, fire and security - It was noted that the committee would receive reports from relevant directors and officers, including the Local Security Management Specialist, on the arrangements for compliance with relevant health and safety, fire and security standards. Reflecting on a presentation received by the Board and previous reports received by the Committee, the Committee considered in detail the scope, frequency and level of assurance it would like to receive in the future. The Committee currently received the minutes of the Health & Safety Committee for information and a bi-annual report but it was felt that this provided insufficient assurance or understanding of key issues. The Committee agreed that a more focussed report was needed, and they reflected on the assurance questions reporting framework used by QEC. After further discussion it was agreed to arrange a meeting to discuss the matter in more detail, to consider the use of the QEC assurance reporting and to agree on the style and frequency of the reports.

- 18/3** The ToRs were REVIEWED and RECOMMENDED as part of the next review of the Terms of Reference.

MK

Minutes of the meeting held on 19 September 2017

- 18/4** The minutes of the meeting held on 19 September 2017 were APPROVED as an accurate record.

Matters arising and action notes

- 18/5** The action notes of the meeting held on 19 September 2017 were reviewed and updated.

Internal Audit Progress Report

- 18/6** The Committee received an update on progress against the internal audit plan; four internal audit reports had been finalised since the last meeting.

- 18/7** **Cyber Maturity Assessment** - The report had been covered in depth at the previous meeting.

- 18/8** Action Plan (Pages 24/25) – Linn Phipps asked whether the management responses to red rated recommendations had been carried out as these had target deadlines which had now passed, this was discussed. Claire Partridge, Internal Audit, commented that it would have been very challenging to deliver the required actions within the timeframe; the Director of Finance (DoF) concurred and advised that a lot of work was underway and updates were being provided regularly by the Chief Information Officer to the Executive Team (ET). He undertook to pick the matter up with the ET at their next meeting and feedback to the Committee.

JS

- 18/9** **Medical Equipment** – Assurance Rating: partial with improvements required

Overall, Medical Equipment processes and controls were found to be well designed and in line with practice elsewhere. However, sample testing identified that whilst these are well designed they were often not operating as they should in practice. Eight recommendations were raised in total, one of which was high priority, six were medium priority and one was low priority. Andrew Leverton, Head of Medical

and Technical Services at the Trust gave overview of key issues and work being undertaken. In response to several queries he confirmed that work to address the recommendations was on track and clarified what equipment was included when describing 'medical equipment'. With regard to 'medical equipment' and 'loaned equipment' it would be clarified whether Occupational Therapy (OT) equipment, for example crutches, & Physio Equipment was included.

AL/JS

18/10 Workforce Planning Phase 1 - Assurance Rating: significant with minor improvement opportunities.

Overall the Trust's new People and Organisational Development (P&OD) Strategy was found to be in line with good practice within the sector, to be appropriately aligned with the Trust's new Strategic Direction, to appropriately address the Trust's workforce risks (as detailed within the Trust's Board Assurance Framework and Corporate Risk Register) and that there were established governance arrangements to support its effective implementation. Four medium priority recommendations were raised in total.

18/11 Phase 2 was due to commence over the following few months and would be reported on at a future meeting.

18/12 Linn Phipps reflected on the review of the Trust's enabling strategies undertaken by Quality and Effectiveness Committee and F&P; it had been noted that there had been a general issue of a lack of milestones within the strategies and Quality and Effectiveness Committee would be picking up on this as well as monitoring processes at future meetings.

18/13 Recommendation 3 - Implementation Plan – In response to a question from the Chair it was clarified that work to expedite the development of a clearly articulated Implementation Plan to support the delivery of the P&OD strategy was in progress.

18/14 Risk Management - Assurance Rating: significant with minor improvement opportunities.

The new BAF had been reviewed and had been found to be similar to those in use at other NHS Trusts and contained the key elements indicated in good practice guidance. The strategic aims of the Trust had been made central to the structure and the key drivers to achieving the strategic aims had associated assurance ratings. There was a clear link to corresponding risks from the Corporate Risk Register (CRR), with controls, assurance sources and identified gaps in assurance detailed. There was accountability with named risk owners in line with best practice. Two medium priority and two low priority recommendations were raised in total.

In response to a query the Trust Board Secretary undertook to circulate the risk appetite statement once it had been drafted.

MK

18/15 Care Group Risk Register Testing (Page 15) – Linn Phipps raised concern about the finding that there was a large variation across the Care Groups in both the volume and level of risks included within Datix. It was noted that some Care Groups had a narrow focus whereas others document all risks identified. A balanced approach

between completeness and maintaining clarity was needed. Linn Phipps suggested that perhaps people were not finding the process useful or perhaps it was a cultural issue in terms of reporting culture and this was discussed. It was noted that these issues had been raised within 'Recommendation 1' and the Trust Board Secretary gave some context to the issues; there was evidence that the work was being done however there were some housekeeping issues and these were being tracked and prompted and were also being reviewed by relevant executives.

18/16 **Audit Plan** - The audit plan remained on track to be delivered within the planned number of days, some changes had been made to the plan and these were noted in the paper. In response to a query from the Chair an overview of the rationale for the changes was provided and it was clarified that the audit plan remained within budget as changes had either been reallocated days or facilitated through use of contingency days.

18/17 The Chair raised concern that there appeared to be some slippage with some of the fieldwork and this was discussed. Claire Partridge gave an update on progress, there had been some slippage as Internal Audit had wanted to ensure that the right teams were assigned to each audit. Some of that work had now been undertaken.

18/18 **Key performance indicators (KPIs)** - Linn Phipps noted that all of the KPIs were input measures and she asked whether it would be possible to include impact and outcome measures and this was discussed. Claire Partridge agreed and she undertook to include some anecdotal KPIs in future.

The Committee NOTED the Progress Report.

Internal Audit Recommendation Tracker

18/19 The Committee received an update on the progress the Trust had made against outstanding internal audit recommendations.

18/20 Claire Partridge apologised for the delay in providing evidence against progress with recommendations. The Chair emphasised the importance of the document, it was key that evidence was provided that recommendations had been met, Linn Phipps echoed this and the matter was discussed further; Claire Partridge would meet with the Trust Board Secretary and DoF outside of the meeting to discuss how assurance would be provided, an updated report would be circulated to Committee prior to next meeting, to include IT risks and the report would be re-issued for the next meeting. Any queries were to be forwarded to the Trust Board Secretary.

**RF/MK
/JS**

18/21 The Internal Audit Recommendation Tracker was DISCUSSED and NOTED.

Internal Audit Technical Update

18/22 The Committee received the report and Internal Audit drew attention to the suggested actions in relation the main technical issues which were currently having an impact on the health sector.

18/23 The Internal Audit Technical Update was provided for information and NOTED

Overseas Visitors Policy

- 18/24** Julie Robinson, Overseas Visitors Manager presented the Policy which had been taken through the Patient Experience Committee (PEE). The policy had been updated in line with feedback from the PEE and from Governors and was presented for approval prior to submission to the Policy Group.
- 18/25** People who did not normally live in the UK were not automatically entitled to use the NHS free of charge, regardless of their nationality or whether they held a British passport or had paid National Insurance contributions and taxes in this country in the past. Entitlement to free NHS treatment was based on residence status alone. This included British Citizens who were no longer resident in the UK. There were exemptions to charges, which were outlined in the document. Guidance on Implementing the Overseas Charging Regulations was provided by the Department of Health and the Trust's Policy was based on this and defined the administrative process which related to overseas patients receiving and paying for treatment from the Trust.
- 18/26** The committee reflected on the policy in the context of recent media coverage relating to the matter of overseas visitors accessing NHS services for free when they were not eligible for free treatment. The Director of Finance provided details of those services subject to the greatest abuse, this included maternity services, and this was a national issue and the committee reflected further on the impact on individuals in terms of patient experience.
- 18/27** Bev Marshall raised concern about the capacity of the Overseas Visitors Team to deliver Trust wide training on the policy and procedures; It was clarified that the Training was not mandatory at the moment, sessions were advertised in DBTH Buzz it was hoped that the training would be part of staff inductions in the future. Bev raised further concern about the capacity of staff to complete the required forms which were essential to being able to charge for treatment as they appeared to be quite onerous and this was discussed; it was noted that only part 1 of the forms needed to be completed by staff in departments, the rest was completed by the Overseas Visitors Team.
- 18/28** The Chair thanked Julie for the report. The Committee noted it was very clear and well presented.

The Overseas Visitors Policy was APPROVED.

Effectiveness of Internal Audit

- 18/29** The Committee received the report of the Director of Finance which provided details of a review of Internal Audit performance for 2017/18.
- 18/30** The Trust and Internal Audit had worked well together and relationships between key staff in both organisations were strong. There had been some difficult discussions but these had been done professionally. Linn Phipps welcomed the anecdotal content of the report; she suggested a KPI for KPMG could be to develop good relationships with the Trust. This was discussed; Internal Audit would be conducting mini surveys and this was welcomed.

18/31 The Effectiveness of Internal Audit report was DISCUSSED and NOTED.

External Audit Progress Update Report & Management Letter

18/32 The Committee received the report of External Audit presented by Michael Green. The Management Letter, dated June 2017, had been compiled following the finalisation of the 2016/17 financial statement audit and focussed on process and control issues identified during the audit. The letter identified recommendations which were set out in an action plan appended to the letter. In the months subsequent to the letter management had responded to the recommendations and the responses were detailed in the report.

18/33 It was clarified that many of the issues had been known to the organisation. The recommendations would be tested again as part of the next audit.

18/34 The External Audit Progress Update Report & Management Letter were NOTED and would be recirculated.

MK

Suspensions and Exclusions Report

18/35 Mark Brooks provided a summary on the cases that were currently listed.

18/36 The Suspensions and Exclusion Report was NOTED.

Standing Orders, SFIs and Scheme of Delegation

18/37 The Trust Board Secretary presented the Standing Orders (SOs), Standing Financial Instructions (SFIs) and Scheme of Delegation (SoD). These formed the core suite of governance documents which, along with the Constitution, governed how the Trust operated and did business. They were required to be reviewed annually and any changes considered by ANCR for recommendation to the Board of Directors. The documents had been reviewed by the Director of Finance and the Trust Board Secretary and a schedule of the proposed changes were attached as Appendices. The tracked documents were also attached as appendices.

18/38 The documents were reviewed in detail; concern was raised that in two instances the wording had been changed to say that under certain circumstances where it had previously stated that power should be delegated to the Chief Executive and Chair this had been changed to the Chief Executive following consultation with the Chair. The Trust Board Secretary explained that this reflected legislation and was in no way to disempower the Chair, the previous wording had been incorrect and the update reflected what would actually happen. After further discussion the following changes were agreed:

Throughout All

- *NHS Protect* to be replaced with *NHS Counter Fraud Authority*.

MK

Standing Orders

- Ensure review dates were aligned (now + 1 year)
- Define Emergency Powers and include legislation to reflect legal reasons for the change from CE & Chair to CE in consultation with Chair.

Scheme of Delegation

- Page 4 – Include legislation to reflect legal reasons for removal of Chair.
- Page 15 – Add Deputy CEO

18/39 The Chair thanked the Trust Board Secretary for the summary report of changes which had been helpful in light of the level of tracked changes.

18/40 The Standing Orders, SFIs and Scheme of Delegation were RECOMMENDED for approval by the Board subject to the agreed changes.

Board Assurance Framework and Corporate Risk Register

18/41 Matthew Kane presented the Board Assurance Framework and Corporate Risk Register which were evaluated by executive leads prior to the meeting. Hard copies were provided.

18/42 The Board Assurance Framework (BAF) contained all of the risks to the Trust's five strategic objectives. One risk had been added to the BAF since the last meeting relating to failure to respond to patient complaints in required timescales and, in addition, a further two risks which had been escalated as extreme; the soundness of these two ratings were currently being assessed by executives. Additionally there had been one change to an existing risk on the BAF. Changes were noted in the summary and were highlighted in italics.

18/43 As part of the review of governance processes it had been proposed to combine all risks on to one register rather than three registers, one for each sub-committee of the Board. It would still be possible to identify which risks were held by which committee.

18/44 There had been no changes to the Corporate Risk Register in the quarter, other the cyber risk highlighted in the covering report.

18/45 The Committee reflected on the report and considered the matter of trends; currently the report showed the current and target rating and did not reflect movement from the prior position or prior changes and the committee considered this would be useful. It was agreed to consider using arrows to show the direction of travel in future reports.

The BAF and Corporate Risk Register were REVIEWED and NOTED.

Review of Constitution

18/46 The Committee considered a report of the Trust Board Secretary which set out the proposals for changes to the Trust constitution as part of the three-yearly review.

18/47 It was noted that a number of the changes had already been discussed in other fora, such as the Appointments and Remuneration Committee of the Board of Governors, in addition to which two additional proposals were made for change:

- That 'registered pharmacists' be added to the eligibility criteria for the clinical non-executive role cited in section 22.8.
- That the number of partner governors be expanded to include relevant partner organisations such as Doncaster College and Doncaster Deaf Trust. This would of course be dependent on the relevant organisations wanting to join the Board of Governors.

Both suggestions were endorsed by the Committee. George Webb advised that the Board of Governors had previously been larger and had been reduced down to 35 members.

18/48 The following issues and additional changes were noted:

18/49 Delete Doncaster CVS (paragraph 2.4.1 and 3, pages 26 and 27) which closed in October 2016 due to lack of funding. This change would be incorporated.

18/50 Bev Marshall queried whether the partner governor appointments could be left generalised or whether additional public governors could be co-opted. The Trust Board Secretary clarified that Schedule 7 of the NHS Act 2006 required all public and staff governors to be elected and that only organisations specified in the constitution as a partnership organisation may appoint a member of the board.

18/51 George Webb queried the continued existence of the panel referred to in section 18. The Trust Board Secretary undertook to ascertain the Panel's status. [Subsequent to the meeting, it was clarified that the Panel had been quietly disbanded by NHS Improvement in January 2017 as no substantive questions had been put to it in over three years of its operation]. This section would be deleted.

18/52 The proposal to delete the provision that disqualifies a person who is an existing executive or non-executive director at another foundation trust or a governor, executive or non-executive director of a body whose business includes provision or commissioning of goods and services for the health service in Doncaster and Bassetlaw from being a director at this Trust (annex 6, paragraph 5.1.7, page 75) was questioned by George Webb. The Trust Board Secretary advised that the proposal had arisen from discussions at a recent Board of Directors meeting and the ongoing recruitment process for non-executive directors. The Trust Board Secretary advised that such a provision was not contained within the core constitution and was now felt to be outdated, given the large scale partnership working operating throughout the region and the potential benefits of experience that such an arrangement might bring.

18/53 Furthermore, George Webb felt that the change highlighted in the previous bullet point should have been discussed with governors prior to being proposed for deletion. The Trust Board Secretary advised that proposed constitutional changes came from a variety of sources, including governors' meetings, and that the process was that any such changes needed to be agreed by both Board of Governors and Board of Directors. However, there was no indication that one body must agree the changes before another. The process this time would involve going to Board of Directors on 30 January and Board of Governors on 31 January. This was simply due to scheduling of the respective meetings. The Chair of the Committee reminded the Trust Board Secretary to make sure the matter went before governors.

18/54 George Webb also challenged strongly that the nine-year maximum term could be applied in such a way as to include time already served by existing governors thereby debarring governors from re-election who had already served nine or more years. He did not see how such a rule could be applied since most laws were not applied retrospectively. The Trust Board Secretary advised that it had been made clear during the debate on 26 October that governors who had already served nine or more years on the expiry of their current term would not be permitted to stand for re-election and this was recorded in the minutes. Governors had then voted on the motion, in full knowledge of the consequences on those who had served nine or more years, and the motion had been approved. The changes proposed in the report purely served to implement the agreed resolutions made by the Board of Governors. Bev Marshall felt that the issue was one upon which governors may require clarity.

18/55 Following on, Bev Marshall noted that during the debate at Board of Governors on 26 October 2017 the Chief Executive had also clarified that governors already in post, and having exceeded nine years' service, would be allowed to complete the balance of their current term. He proposed that some wording be added to section 13. The Trust Board Secretary agreed that some suitable wording may clarify the matter.

18/56 The changes proposed in the report, together with those others noted in the discussion, were RECOMMENDED to Board of Directors on 30 January 2018.

MK

Losses and Compensation Payments

18/57 A summary of the information from the Loss & Compensation file, held within Financial Accounts, was presented.

18/58 The Losses and Compensation Payments report for the period October to December 2017 was NOTED.

Waiving of Standing Orders

- 18/59** It was noted that the level of single tender orders had increased as tighter ordering process controls had been introduced. The Director of Finance gave an update on the single tender waiver relating to alterations to the emergency department at Bassetlaw Hospital.
- 18/60** The Waiving of Standing Orders quarterly report was NOTED.

LSMS Reports Q2 & Q3 2017/18 – Including Work plan And Update on Health & Safety Committee & ToR

- 18/61** The Director of Facilities and Estates was sick and her Deputy was on leave, therefore both reports were deferred to the next meeting.
- 18/62** The LSMS Reports Q2 & Q3 2017/18 – Including Work plan and Update on Health & Safety Committee & ToR were DEFERRED to the March 2018 meeting. **KEJ**

LCFS Progress Report Q3 2017/18

- 18/63** Mark Bishop summarised the key points of the report which included outline details of new referrals and the status of on-going investigations (*anonymised for reasons of confidentiality*). A total of six new referrals were included plus updates to eight ongoing referrals. Details were provided in response to a query about awaited sanctions.
- 18/64** Updates were provided on:
- The NHS Counter Fraud Authority was now fully online
 - Fraud, Bribery and Corruption policy had been updated
 - There was a new test for dishonesty
 - The Counter fraud element of Statutory and Essential to Role training stood at 92% across the Trust.

The LCFS Progress Report for Q3 was NOTED.

Issues escalated from sub-committees

- 18/65** None.

Issues for escalation to Board of Directors

- 18/66** None

Sub-committees

Any Other Business

- 18/67** New EU general data protection legislation had been introduced and the Chair asked where this was being considered by the Trust. The Trust Board Secretary advised that this had been discussed by the ET and would be taken to Board. It was also a recommendation of the Cyber security report.

Evaluation of the meeting

18/68 It had been a good and open meeting however there was general feeling that the agenda was overloaded and this had led to the meeting running over time. There had been a good level of challenge and it had been helpful to have good attendance from management to respond to question arising from the audit reports. There had been active participation from all attendees and this was welcomed. It was agreed to reflect on the agenda times in more detail for future meetings.

Time and date of next meeting:

18/69 **Date:** 23 March 2018
Time: 2pm
Venue: Boardroom, DRI

Signed:

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Philippe Serna
Chair

.....
Date



Minutes of the Meeting of the Management Board
of
Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust
on
Monday 12 March 2018 at 2pm
in the Boardroom, DRI

Present:

Andrew Barker	Care Group Director - Diagnostics & Pharmacy
Karen Barnard	Director of People & Organisational Development
Antonia Durham Hall	Care Group Director - Surgical
Kirsty Edmondson-Jones	Director of Estates & Facilities
Eki Emovon	Care Group Director - Children and Families
Moira Hardy	Director of Nursing, Midwifery and Allied Health Professionals
Thrinath Kumar	Care Group Director - MSK & Frailty
Nick Mallaband	Care Group Director – Emergency Care Group
Tim Noble	Associate Medical Director
Richard Parker	Chief Executive (Chair)
Willy Pillay	Deputy Medical Director
David Purdue	Deputy Chief Executive & Chief Operating Officer
Marie Purdue	Director of Strategy & Transformation
Gillian Payne	Care Group Director - Speciality Services
Jon Sargeant	Director of Finance
Sewa Singh	Medical Director
Jochen Seidel	Acting Care Group Director – Surgical
Ken Anderson	Head of IT Programmes and Development (<i>for Simon Marsh</i>)

In attendance:

Matthew Kane	Trust Board Secretary
Kate Sullivan	Corporate Governance Officer

Apologies:

Simon Marsh	Chief Information Officer
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Action

Minutes of the previous meeting

MB/3/18/1	The minutes of Management Board on 12 February 2018 were approved as an accurate record.
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**MB/3/18/2 Matters arising and action notes**

The action notes were reviewed and updated and the following was noted:

After the circulation of the meeting papers the Chief Executive had met with the Chair of the Board to discuss the Care Group structure, there had been further discussions with Executives and an update on the outcome of those discussions would be taken under any other business (AOB).

- MB/3/18/3** MB/17/8/39 – Following concerns raised by Tim Noble there had been an ongoing investigation to clarify the process for alerting the clinical team to book CT scans for 2 week wait cancer (2ww) patients. Further work was required to clarify the referral process and booking rules. The matter had been ongoing for some time and it was resolved that the Deputy Chief Operating Officer and Head of IT Programmes and Development would undertake to resolve the matter and provide an update at the next meeting. **KA/EC/DP**
- MB/3/18/4** MB/17/12/40 – Nick Mallaband provided an update on discussions between the Deputy Medical Director and Care Group Directors (CGDs) to discuss extra sessions rates of pay and overnight on call rates of pay. The Deputy Medical Director would summarise the discussion in a briefing note to be circulated for further consideration. An update would be provided at the next meeting. **SS**
- MB/3/18/5** MB/18/02/43 – The updated Standard Operating Procedures (SOPs) for Emergency Care Standards of the Emergency Department (ED) had been due to come back to the meeting however Nick Mallaband reported that the actions previously agreed had been more difficult to progress than originally expected. This was discussed and it was agreed to defer the item until such time as the document was completed. **CGDs/JS**

CORPORATE ISSUES**ICS/ACP Update**

- MB/2/18/1** Richard Parker provided an update on the Hospital Services Review and key issues relating to 2018/19 planning in terms of the Integrated Care Systems (ICS, previously the Accountable Care System ACS):

As had previously been reported, the recently issued planning guidance for 2018/19 included specific guidance for ICSs to be monitored on aggregate (system) control totals, this would give access to full System Transformation Funding (STF) and other support measures. However, if an ICS were to miss the overall control total, the whole system (both commissioner and provider) would have their STF withheld. The alternative



was for organisations to proceed on the basis of individual control totals however this would mean that they would not be eligible for the full suite of support measures, including significant funding. There were risks associated with both options. The Trust had indicated that it would accept the system control total in principle but other organisations had not reached an agreement to sign up to the system control total and the Chief Executive shared some of the concerns of other organisations on the matter.

- MB/2/18/2** A key risk for organisations in SY&B in terms of the system control total was that control totals for some organisations within the system were significantly short of the true financial position, details were provided and this was discussed. Sir Andrew Cash was due to meet with Ian Dalton, Chief Executive, NHS Improvement (NHSI) and Simon Stevens, Chief Executive, NHS England (NHSE) to consider incentives to allow all organisations in the ICS to sign up to the system control total agreement. There would be a further meeting of the ICS after this.
- MB/2/18/3** The guidance also set minimum standards for service delivery and advised CCGs of levels of activity to be commissioned to ensure delivery of services to patients, all of which need to be reflected in contracts between providers and commissioners for 2018/19. There was still significant work to be carried out in agreeing plans for 2018/19 with local CCGs, the CCG's affordability gap was unclear and the Trust needed to agree with the CCGs their expectation for RTT delivery. It was noted that mediation may be required to reach an agreement; this would be covered in more detail in the Budget Update.
- MB/2/18/4** It was noted that Sir Andrew Cash was leaving Sheffield Teaching Hospitals as Chief Executive and would be taking the role of ICS lead on a part time basis.
- MB/2/18/5** Hospital Services Review (HSR) – The Chief Executive provided an overview of discussions at the recent HSR meeting of Chief Executives and Accountable Officers. The group had discussed the proposals for CT and Hyper Acute Stroke Unit (HASU); a judicial review was underway and the proposals could not be progressed further until the outcome of the review was known, an update on this was provided and it was noted that significant work was underway to ensure everything possible had been done in terms of consultation. In terms of timeframes it had been proposed to produce a draft report in respect of the reviews to be considered in April. It was noted that there was a growing understanding that some solutions would require significant capital that was not available in the system.



MB/2/18/6 The ICS/ACP update was DISCUSSED and NOTED.

Medical Staffing

MB/2/18/7 The Director of People & Organisations Development delivered a presentation on the Trust's new Medical Workforce function. The presentation slides, which had been circulated prior to the meeting, provided an overview of the following:

- Structure – An illustration of the structure and an overview of the roles within the structure was provided.
- Short Term Objectives – key objectives included providing a robust advisory service to all medical staff and managers and more efficient recruitment processes especially consultant recruitment.
- Medium/Long Term Objectives – These included support for Care Groups with the management of doctors (both performance and behavioural issues) and work with rota co-ordinators to ensure consistency across Care Groups with rota management, bank usage, additional shifts, annual leave etc.

MB/2/18/8 There were some significant challenges and areas for improvement and some of those challenges were harder than had originally been anticipated.

Local challenges included:

- No historical knowledge within the team and shortfalls in data.
- The new team needed upskilling.
- Changing negative perceptions.

National challenges included:

- The junior doctor contract was still creating challenges (exception reporting processes, different pay protection arrangements and rota rules).
- It was possible that there would be a new consultant contract.
- National shortage of doctors in some specialties.
- National streamlining work for doctors in training.

MB/2/18/9 Nick Mallaband commented that from an operational perspective there had been a noticeable significant improvement in the service; the Director of People & Organisational Development welcomed the feedback and would share the comments with the team.

MB/2/18/10 The Medical Staffing Update and Presentation were DISCUSSED and NOTED.

**Finance Report**

- MB/2/18/11** Management Board received the Finance Report for January 2018.
- MB/2/18/12** The Director of Finance (DoF) presented to the Committee a paper summarising performance in month 10. The Committee noted the month 10 2017/18 year to date financial position of £15,198k deficit. After removal of the 16/17 STF adjustment and the variance relating to donated assets, this is restated to a deficit of £15,534k.
- MB/2/18/13** Whilst elective income was over £1 million less than plan, income from Emergency had improved this position, with total income in January being the highest recorded all year at around £30 million.
- MB/2/18/14** The DoF reminded Management Board that he had previously provided an update on discussions with NHSI relating to Tranche 1 funding received by the Trust in December. NHSI had advised that in order to receive the funding it required the Trust to adjust the 2017/18 forecast by an amount equal to that of the funding and the Trust had agreed to this at that stage and there were to be further discussions with NHSI on the matter. Since that time NHS Improvement had been advised that the Trust was not able to meet its revised control total however, subsequent discussions with NHSI indicated that there was a possibility the Trust would be able to keep the funding.
- MB/2/18/15** There were still two months to go to the year end and although the Trust continued to forecast that it would hit the year end control total there were still some risks around this forecast and these were outlined in the paper. It was key that the Trust continued with the progress being made and remained focused on discretionary spend.
- MB/2/18/16** A key concern was ensuring the Trust met capital expenditure spend for the year and this was discussed. The recent poor weather conditions had slowed progress and the DoF gave an overview of ongoing capital work. In response to a query from Thrinath Kumar he explained the limits for the tender process and non-tender procurement.
- MB/2/18/17** The Finance Report was NOTED.

2018/19 Budget Update

- MB/2/18/18** Following on from the Planning Guidance presentation received by Management Board in February, the DoF provided an update on progress with business planning focusing on the following key points:



- Budget offers would be sent out the following day for sign off shortly followed by CIP plans.
- The Trust had worked through all the planning guidance and been through a series of meetings with Care Groups.
- From those meetings the best estimates of costs and expenditure had been established and, assuming all STF funding, the Trust had extrapolated and a planned deficit of £20m and this was what the budgets were based upon.

MB/2/18/19 As reported earlier in the meeting by the Chief Executive there was still significant work to be carried out in agreeing plans for 2018/19 with local CCGs. The DoF explained that when offers had come in from the CCGs it had brought to light a fundamental difference between the Trust and CCGs interpretations of guidance in terms of expected levels of growth; both CCGs determined little or no growth resulting in a significant gap between the expected offer and the offer made. The DoF provided an overview of the variances in the plan for elective growth, outpatients and emergency activity and he provided details of the specific areas of the guidance in dispute which related to the expected growth of waiting lists. The Trust had challenged the CCG's assertions and shown them information to illustrate that overall waiting lists had increased and that the Trust required significant further income. This was a significant challenge and the Trust had asked for mediation to resolve the issues.

MB/2/18/20 The 2018/19 Budget Update was DISCUSSED and NOTED.

Staff Survey Results

MB/2/18/21 Management Board received a presentation on the staff survey results from the Director of People and Organisational Development along with a detailed report included in the papers. The presentation provided a detailed update and highlighted key points:

The response rate had increased to 50% of staff. Broadly there had been an improvement against the 2016 results in key areas however at the same time in several of those areas the Trust was rated in the bottom 20% of organisations nationally. In some areas the Trust was placed in the bottom five when compared to neighbouring organisations. Both the national and regional comparisons were disappointing.

MB/2/18/22 A summary of the Trust's results against the average scores for acute trusts, including the trusts top five and bottom five ranking scores, was illustrated in the presentation.

MB/2/18/23 An overview of other areas for development was provided, these included



appraisal rates and value of appraisal, recognition and value and support from line managers.

MB/2/18/24 Next Steps – The Chief Executive had published a message to all staff on 6 March about the results and action required. Local results had been shared with senior management teams. Further analysis was needed to identify key areas of focus locally and SMART action plans would be developed, supported by HR Business Partners. Action Plans would be shared with staff and managed through accountability meetings. There would be a review of the Trust level action plan and a focus on key concern areas on disability and BME staff by the new Diversity and Inclusion Group (reporting to the Workforce and Education Committee, WEC).

MB/2/18/25 The Chief Executive recognised that some Care Groups had achieved fantastic results and had shown significant improvement; it was important to take learning from those areas and ensure this was shared and taken forward in action plans.

MB/2/18/26 Management Board considered the results. Eki Emovon commented that although the results were disappointing they were not all unexpected and he highlighted some of the issues faced by staff and these were discussed; some departments had undergone significant change and reorganisation, some staff felt that their feedback and suggestions had not been taken on board or had been ignored when in fact work had been taken forward in response to the feedback and this needed to be addressed; The Chief Executive agreed that it was these kind of issues that really needed to be addressed, it was crucial that key messages from Executives and Management Board were effectively communicated to middle and first line managers to share with staff.

MB/2/18/27 The Staff Survey Results were NOTED.

Replacement Consultants

MB/2/18/28 The following proposals for replacement consultants were presented by Care Coup Directors for consideration:

Replacement Rheumatology Consultant – MB had previously approved the case, two years prior, however the Trust had been unsuccessful recruiting to the post. The case had been based on some Kingsgate work which had identified a shortfall in capacity and MB had approved the case on the basis of the CCG underwriting the activity but this was yet to be resolved.



Concern was raised about the basis for the case and the contracting issues in terms of the CCG and this was discussed in detail. Although Management Board supported the case in principle, it was NOT APPROVED. It was agreed to bring the case back to the meeting after a review of the Job Plan and once contract/funding issues had been resolved.

TK

Replacement Consultant Gastroenterology and Physician – The case was APPROVED subject to the amendment the Job Description (JD) references to medical on call on page 2 of 14.

Replacement of 4 x Consultant Orthopaedic Surgeons – The case was APPROVED subject to a review of the JD and Job Plans by the Medical Director.

Replacement Consultant Cardiology – The case was APPROVED.

Replacement Consultant Urology – The case was APPROVED.

MB/2/18/29 The Medical Director reflected on the cases submitted and he noted that the Job Plans had been presented in various formats and that there was a lack of consistency in terms of key information regarding on-call rotas amongst other things. It was agreed that all future job plans were to be taken through the Medical Director's office for final review.

ALL CGDs

Corporate Risk Register

MB/2/18/30 Management Board considered a report of the Trust Board Secretary which set out for consideration the Board Assurance Framework and Corporate Risk Register.

MB/2/18/31 No new risks had been escalated via Datix in the month although the risk relating to CPAP machines which was previously discussed at Management Board was reviewed on 9 March 2018 and given a rating of 20 (L4 x I5 - extreme). One new risk has been escalated by the Director of Finance to the BAF and this was detailed in the covering report.

MB/2/18/32 Details of two changes proposed to risk ratings were provided. These included a proposed change to the risk 1244 relating to 'Failure to deliver Cost Improvement Plans in this financial Year' which had been changed from a risk rating of 16 (L4 x I4) to a risk rating of 8 (L2 x I4) and this was considered. Management Board agreed to de-escalated the risk from the Corporate Risk Register.

MB/2/18/33 The report on the Corporate Risk Register and BAF was NOTED.

**Forthcoming Assessments, Inspections and Reviews**

- MB/2/18/34** Management Board considered a report of the Trust Board Secretary which set out forthcoming assessments, inspections and reviews. It was noted that the Assessments, Inspections and Reviews Policy would be brought to a future meeting for review. The Chief Executive reported that the Trust was anticipating that it would receive the Draft CQC Inspection report in late March early April.
- MB/2/18/35** The report was NOTED.
- MB/2/18/36** **KEY ISSUES FOR CARE GROUPS**
- MB/2/18/37** **Standard Operating Procedures for Emergency Care Standards of the Emergency Department (ED)** – An update had been provided earlier in the meeting (MB/2/18/5).
- MB/2/18/38** **Update on Extra sessions rates of pay and overnight on call rates of pay (WP/KB)** - An update had been provided earlier in the meeting (MB/2/18/4).
- MB/2/18/39** **Capture of lost consultant sessions (update from discussions with Medical Director and CGDs)** - The Medical Director summarised discussions on the matter with Care Group Directors. The key points were covered in the next item (MB/2/18/39-40).
- MB/2/18/40** **Carry-over of annual leave and date of leave year (NM)**
- MB/2/18/41** The Trust had communicated to the organisation over the course of the previous year that annual leave could only be carried over in exceptional circumstances and only with the approval of an executive director. Confirmation had been received by Executives from senior managers across the Trust of the levels of annual leave to be carried over and on that basis the Trust expected to release an accrual which had previously been carried over to mitigate the cost of covering annual leave taken within the year from a previous period.
- MB/2/18/42** Nick Mallaband delivered a presentation which proposed that releasing accruals would only work if cover for leave in the current year could be covered within current contracts and without using agency/bank staff. This was challenging for some departments, particularly in specialties that were under recruited. He gave a detailed illustration, including financial information, using the emergency department as an example.



MB/2/18/43 In terms of operational performance he also raised concerns in terms of needing as many staff working this year as possible and potential spikes in annual leave at the end of the leave year. He also raised concern about staff morale and goodwill of staff. The presentation included some suggestions which included a reconsideration of the accrual release based on calculations of the cost of covering annual leave within the current year and allowing up to five days carry over for all staff groups in under recruited specialties at the discretion of the CG Directors.

MB/2/18/44 Management Board considered the presentation, the matter was discussed at length and there was a candid debate. The matter of annual leave periods for consultants was discussed; it acknowledged that some staff had carried over the previously allowed five days for several years consecutively and that there may have been an impact on staff morale as a result of no longer being able to carry it over. At the same time it was noted that the accrual the Trust anticipated being able to release was significant, this had been discussed previously on a number of occasions and the rules introduced to allow carry over of annual leave only in exceptional circumstances for the leave year 2017/18, which would allow that accrual release, had been first communicated to the Management Board in early 2017.

MB/2/18/45 It was noted that it had been proposed at that time that annual leave should be phased over the year so as to avoid spikes in annual leave at year end. After further debate it was resolved that the rules introduced would stand and that there would be no carry over of annual leave in to the 2018/19 leave year unless approved by an executive director, as had previously been agreed.

MB/2/18/46 The presentation on Carry-over of annual leave and date of leave year was DISCUSSED and NOTED.

MB/2/18/47 The following information items were NOTED:

- Business Intelligence Report as at 31 January 2018
- Chief Executive's Report
- Minutes of the Corporate Investment Group meeting held on 29 January 2018
- Minutes of the Planned Care Programme Board meeting held on 21 December 2017
- Minutes of the Elective Care Steering Group meetings held on 15 January 2018
- Minutes of the Urgent & Emergency Care Steering Group meetings held on 10 January 2018

**MB/2/18/48 Any other business**

Care Group Structure - The Chief Executive advised that in recent weeks the executive team had considered, in the context of commencing with the Trust's five year strategy, how the organisational structure would help the Trust to achieve its goals, as well as meet any challenges in the context of the ICS, over the next few years. As such they had reflected on what was working well, what could improve and what would best support the Trust strategically. As part of this they had reflected on the care group structure, they had considered whether the current structure was working as it had been originally intended in terms of accountability, working across services, and where services sat within the structure. Following several weeks of consideration executives had reached some conclusions and following a meeting between the Chief Executive and the Chair of the Board the previous week they had agreed on a proposal to streamline the number of Care Groups.

MB/2/18/49 The proposed grouping of current Care Groups was (names were yet to be agreed):

- Specialised Support Services
- Medicine and Emergency services
- Surgery and Cancer Services
- Families Services

The approximate number of staff and the total budget for each grouping was provided.

MB/2/18/50 The Chief Executive provided a detailed account of the matters considered by executives and the background and rationale for the proposals, these had included how the Trust best managed junior medical staff, complete pathways would be across one or two rather than up to four Care Groups, improved utilisation of bed stock, support for care groups in terms of accountability and delivery and wider support issues.

MB/2/18/51 The Care Group Directors considered the proposals and the following key points were raised and discussed:

- Administrative/Secretariat support for Care Groups.
- Which specialities / functions would sit within each new Care Group and whether the new structure would strengthen working together.
- How individual services would be supported and strengthened through the new structure.
- Lines of responsibility and accountability.



- Care Group engagement and involvement with the Board.
- Concern was raised about the scale of some of the proposed groups in terms of head count of staff and how much support each Care Group would need; It was essential that the support was underpinned by a strong staff development programme.

MB/2/18/52 In response to a question from Willy Pillay about the Executive Team's conclusions in terms of areas they felt were not working in the current structure the Chief Executive provided some examples and these were discussed. He emphasised that there had been significant consideration around the emerging future outlook for the Trust in the context of the ICS.

MB/2/18/53 Management Board asked whether there were any examples of other trusts taking similar steps nationally and this was discussed; it was noted that in general trusts were moving back to smaller structures.

MB/2/18/54 There was further clarification about the services and specialities within each proposed group. Concern was raised about the scale of some of the proposed groupings, particularly in terms of the number of staff and whether there would be sufficient support staff, in terms of the number of general managers, business managers and accountants, allocated to each group to provide the required support and this was discussed. Tim Noble emphasised that there needed to be consistent support.

MB/2/18/55 In response to a query about timeframe for the change it was clarified that the Trust intended to make the changes in quarter 1.

MB/2/18/56 There was further detailed discussion and Care Group Directors shared their views about where specialities and services should sit within the structure.

MB/2/18/57 Management Board considered lessons from the previous restructure of the Care Groups particularly in terms of the pace of change. In general it was felt that there needed to be a clearly set out timeframe for the change and that it needed to happen sooner rather than later. In terms of the reduction in the number of Care Group Directors, concern was raised about clinical representation at Management Board and the impact on the balance of future meetings. This was discussed. It was suggested that more than one Care Group representative attend Management Board, the Chief Operating Officer welcomed this suggestion and gave assurance that this would be considered further although there needed to be regard given to an optimum size of attendance to avoid meetings becoming too unwieldy. In response to a query from Tim Noble about corporate directorates the Chief Executive clarified that some Executive Director portfolios would be changing and he described the structure.



MB/2/18/58 A briefing would be prepared for the Board, there would be further meetings with Care Group directors over coming weeks and the matter would be discussed again at the next meeting. **ALL**

Items for escalation from sub-committees

MB/2/18/59 None.

Date and time of next meeting

MB/2/18/60 The next meeting of Management Board would take place 16 April 2018 at 2pm in the Boardroom.

Board of Directors Agenda Calendar

STANDING ITEMS			OTHER / AD HOC ITEMS
MONTHLY	QUARTERLY	BIANNUAL / ANNUAL	
MAY 2018			
CE Report	QEC Minutes	Annual Report	
Business Intelligence Report		Quality Account	
MB Minutes		Annual accounts	
HWB Decision Summary		ISA260 and quality account assurance	
Finance & Performance Minutes		Charitable Funds minutes	
Finance Report		Mixed Sex Accommodation	
Chairs' Assurance Logs			
JUNE 2018			
CE Report	Report from the Chair of the ANCR committee (Verbal)	MB Annual Report	
Business Intelligence Report		SOs, SFI, Scheme of Delegation	
Bed Plan		ANCR Annual Report	
MB Minutes			
Finance & Performance Minutes			
Finance Report			
Chairs' Assurance Logs			
JULY 2018			
CE Report	Chief Executive's Objectives		Reference Costs
Business Intelligence Report	ANCR Minutes		Diversity and Inclusion
MB Minutes	Estates Quarterly Performance		
Finance & Performance Minutes	Board Assurance Framework		
Finance 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	
MB Minutes			
Finance & Performance Minutes			
Finance Report			
Chairs' Assurance Logs			
NOVEMBER 2018			
CE Report	QEC minutes	Annual Compliance against the National Core Standards for Emergency Preparedness, Resilience and Response (EPRR)	
Business Intelligence Report	Board Assurance Framework & corporate risk register Q2		
Nursing Workforce	Estates Quarterly Performance		

MB Minutes			
Finance & Performance Minutes			
Finance Report			
Chairs' Assurance Logs			
DECEMBER 2018			
CE Report	Report from the Chair of the ANCR committee (Verbal)		
Business Intelligence Report			
MB Minutes			
Finance & Performance Minutes			
Finance Report			
Chairs' Assurance Logs			
JANUARY 2019			
CE Report	ANCR minutes (16.12.16)	Budget Setting / Business Planning / Annual Plan	Constitution
Business Intelligence Report	Chief Executive's Objectives	SOs, SFI, Scheme of Delegation	CT/HASU (part 2)
MB Minutes	Complaints, Compliments, Concerns and Comments Report		Joint working
Finance & Performance Minutes			External reviews policy
Finance Report			
Chairs' Assurance Logs			
FEBRUARY 2019			
CE Report	QEC Minutes	Budget Setting / Business Planning / Annual Plan	Finance Strategy
Business Intelligence Report	Board Assurance Framework & corporate risk register Q3		
MB Minutes			
HWB Decision Summary			
Finance & Performance Minutes			
Finance Report			

Chairs' Assurance Logs			
MARCH 2018			
CE Report		Budget Setting / Business Planning / Draft Annual Plan	
Business Intelligence Report			
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	
MB Minutes	Estates Annual Report	Staff Survey	
HWB Decision Summary	Board Assurance Framework & corporate risk register Q4 (inc. annual assurance summary)		
Finance & Performance Minutes			
Finance Report			
Chairs' Assurance Logs			

**Minutes of the meeting of the Board of Directors
Held on Tuesday 27 March 2018
In the Boardroom, Montagu Hospital**

Present:	Suzy Brain England OBE	Chair of the Board
	Alan Armstrong	Non-executive Director
	Karen Barnard	Director of People and Organisational Development
	Moira Hardy	Director of Nursing, Midwifery and Allied Health Professionals
	John Parker	Non-executive Director
	Richard Parker	Chief Executive
	Linn Phipps	Non-executive Director
	David Purdue	Chief Operating Officer
	Neil Rhodes	Non-executive Director
	Jon Sargeant	Director of Finance
	Philippe Serna	Non-executive Director
	Sewa Singh	Medical Director
In attendance:	Kirsty Edmondson-Jones	Director of Estates and Facilities
	Matthew Kane	Trust Board Secretary
	Simon Marsh	Chief Information Officer
	Marie Purdue	Director of Strategy and Transformation
	Adam Tingle	Acting Head of Communications and Engagement
	David Cuckson	Governor (observing)
	Yvonne Butcher	Staffside (observing)
	Gina Holmes	Staffside (observing)
	Mr Ahmed Eid	Orthopaedic Consultant (observing)
	Mahroof Hussain	Observer
	Cindy Storer	Head of Nursing – MSK and Frailty (part)
	Becky McCombe	Senior Sister, Gresley Ward (part)

ACTION

Welcome and apologies for absence

18/3/1 Apologies for absence were submitted on behalf of Ruth Allarton. Adam Tingle was welcomed to his first meeting as Acting Head of Communications and Engagement.

Declarations of Interest

18/3/2 Board was reminded of the need to keep their register of interests up-to-date.

Actions from the previous minutes

18/3/3 The list of actions from previous meetings was noted and updated.

Achieving Reliable Care

18/3/4 The Board considered a presentation from the Head of Nursing for MSK and Frailty on the work the Trust was doing on the Achieving Reliable Care (ARC) project.

18/3/5 The Board was advised that ARC involved a number of facets:

- A consistent approach to the delivery of all patient care (reducing variability).
- A clear, visual, plan for each patient that was communicated to the multidisciplinary team.
- An ability to demonstrate that the patient gets what they need when they need it.
- A mechanism for collecting information about each delay at individual and ward level allowing targeted interventions to be tested to reduce causes of delays across the system.

18/3/6 Examples of interventions were:

- Supporting the planning of a patient's care, ensuring each action was allocated a timescale for completion.
- Considering all the actions that were required to take the patient through to their planned discharge date.
- Providing a consistent approach to the delivery of all patient care, reducing variability and demonstrating that patients get what they need when they need it. When they do not, delays were highlighted earlier, contributing to a culture where delays were no longer accepted as the 'norm'.
- Making the invisible, visible as each and every delay was captured.

18/3/7 The outcomes to date had seen significant reductions in the length of stay for patients on a number of wards, some by as much as 30%, and almost 3,000 bed days had been saved. ARC had been utilised on over 2,127 patients and 5,232 delays had been recorded.

18/3/8 Further planned work and next steps were shared. These included:

- Developing systems and processes for all participating wards to receive length of stay data each month.
- Developing systems and processes for the Qii team to lead task and finish groups for frequently experienced delays (e.g echo, 24 hour tapes).

- Continued monthly steering groups to monitor length of stay and delay data and improvements.
- Recognising and celebrating achievement with wards who were reducing length of stay.
- Scaling up ARC to other wards within DBTH with support from the Improvement Academy.

18/3/9 Following the presentation, the Board asked questions on a number of issues where the following points were noted:

- It was confirmed that data from ARC had yet to be fed into the quality dashboard.
- Reasons were given for the variability between performance on the eight wards who were using ARC.
- There was an ambition to translate ARC to Bassetlaw wards.
- The work had not resulted in any evidence of increased readmissions.
- Staff had been involved in the process, through 1-2-1s and opportunities to ask questions.

18/3/10 The presentation on ARC was NOTED.

Fundraising Strategy

18/3/11 The Board considered a report of the Acting Head of Communications and Engagement that was presented for approval the Trust's fundraising strategy.

18/3/12 The strategy had the following aims:

- to set appropriate fundraising priorities and infrastructure to support fundraisers;
- to establish a process to engage with staff in both applying for and raising charitable funds for the care group/ward/department;
- to explore new revenue streams and opportunities.

18/3/13 In response to a question from Alan Armstrong, the Board was advised that resource would be contained within the existing envelope. The Chief Executive felt the Trust could build upon its work with local businesses

through the STAR awards and be more proactive in its relations with the Chamber of Commerce around fundraising.

18/3/14 In response to a question from Linn Phipps, it was clarified that this Strategy was not an enabling strategy and so did not align with the five Ps. The strategy had been to Charitable Funds Committee but the Committee did not have authority to approve it therefore it was coming to Board for sign off.

18/3/15 The Board APPROVED the Fundraising Strategy.

Amendments to Committee Membership

18/3/16 The Board APPROVED the following changes to board committee membership:

- On Audit and Non-clinical Risk, Kath Smart to replace John Parker
- On Finance and Performance, Pat Drake to fill vacancy
- On Quality and Effectiveness, Pat Drake to fill vacancy
- On Charitable Funds, Kath Smart to replace John Parker as Chair
- On Charitable Funds, Pat Drake to fill vacancy
- On Nominations and Remuneration, Pat Drake and Kath Smart to replace John Parker and fill vacancy

Chair's Assurance Log for Board Committees

18/3/17 The Board considered assurance reports of the chairs of Audit and Non-clinical Risk and Finance and Performance Committees following their meetings held 23 and 26 March.

18/3/18 The Audit and Non-clinical Risk Committee had considered a range of audits that offered varying degrees of assurance to the Board. They had also received reports into cyber maturity, the audit recommendation tracker, the audit plan and local counter fraud. A new approach regarding assurance over health and safety was to be discussed following this meeting of Board.

18/3/19 The Chair of Finance and Performance Committee gave a brief overview of the areas where the Committee had taken assurance. With four days of the year left to go, the Trust was on track to hit its control total in 2017/18. However, efficiency savings of circa. £20m were sought as part of next year's plan. An update on the work BDO had done to support the Trust through the current year had been considered and Board reiterated its support to the Director of Finance for the decision to employ them.

18/3/20 The Committee had considered an update on the Trust's new catering arrangements which had presented a testing transitional period but they were assured that issues were being gripped and there would be ramifications if performance did not drastically improve. The Board

stressed the need for patients to receive a high quality catering service.

18/3/21 The Director of Finance then went on to present the budget for 2018/19. The draft plan showed delivery of the control total of a £6,615k deficit however there were a number of significant assumptions and risks included in the plan, most notably:

- Circa. £20.5m CIPs (5%) was required to deliver the control total. Of this, £6.3m was identified as high risk and a further £3.4m as unidentified.
- There was a significant variance on income assumptions between the Trust's draft plan and commissioner offers (i.e. offers lower than plan). The key adverse variances were set out in the paper and mainly related to differences on activity growth assumptions. A requirement for mediation had been escalated to the SY&B ICS and discussions were ongoing with Commissioners.
- The plan assumed the Trust would be able to refinance significant loans, along with requiring borrowings to cover the control total deficit.

18/3/22 It was noted that the plan was yet to be completed. Amongst other things, commissioner budgets were yet to be agreed and the details of the variances that mainly related to differences on activity growth assumptions were outstanding. As previously reported, the requirement for mediation had been escalated to the South Yorkshire and Bassetlaw Integrated Care System and it was possible that there could be an intervention from NHSi and NHSE to ensure alignment of plans.

18/3/23 Given the current fluidity of discussions on the budgets, Board stopped short of approving the current position and authorised the Director of Finance to begin issuing budgets as necessary.

18/3/24 Board AGREED that:

- (1) Power be delegated to Finance and Performance Committee in April 2018 to approve final versions of the budgets including capital plans and effectiveness and efficiency plans together with the annual plan and commissioner contracts.
- (2) All members of the Board be invited to attend the April Finance and Performance Committee for the purpose of asking questions and giving views on the finance items.

Finance Report – February 2018

18/3/25 The Board considered a report of the Director of Finance that set out the Trust's financial position at month 11. The deficit in month 11 was £832k,

behind the monthly plan by £48k. The year-to-date position was a £16.336m deficit.

18/3/26 The Trust's elective and day case income was £606k less than plan; however, emergency income had continued to mitigate this position achieving £976k above plan, while clinical income achieved £1.322m. The Trust's forecast showed that it was on course to meet its control total, however this was on the basis of receiving winter pressure funding of £1.2m, which was linked to the delivery of the targets set for Emergency performance standards.

18/3/27 Further to a question from the Chair, Board was assured that everything possible was being done to ensure the Trust hit its control total in 2017/18. In terms of next year, the matter of whether trusts within the South Yorkshire and Bassetlaw Integrated Care System would be subject to a single or system control total or plan was still to be resolved.

18/3/28 The Board NOTED:

- That the in-month I&E position was behind plan (£48k);
- The year to date I&E position at month 11 of £16,336k deficit was (£437k) adverse to plan;
- While there was still a significant improvement on run rate (excluding winter pressure costs) it is likely that the Trust would need to earn the winter pressures funding in order to deliver the control total. It was therefore imperative that the Trusts cost base was minimised and income maximised in the final weeks of the financial year to support this outcome.

Performance Report as at 28 February 2018

18/3/29 The Board considered a report of the Chief Operating Officer, Medical Director, Director of Nursing, Midwifery and Allied Health Professionals and Director of People and Organisational Development that set out clinical and workforce performance in month 11, 2017/18.

18/3/30 Performance against key metrics included:

- 4 hour access - In February the Trust achieved 90.2% against the 95% standard (including GP access). In total, over 12,579 patients were seen.
- Referral to Treatment – In February, the Trust performed below the standard of 92% achieving 90%.

- Cancer targets – In January the 62-day performance achieved the 85% standard, coming in at 85.6%.
- HSMR – The Trust's rolling 12 month HSMR remained better than expected at 87.42.
- C.Diff – Remained below trajectory for the month, however still above last year's performance, although on trajectory to achieve the nationally set target.
- Nursing Workforce - The Trust's overall planned versus actual hours worked in February was 98%. No wards had been rated red for quality in the past three months.
- Appraisal rate – The Trust's appraisal completion rate had seen a further rise to 66.48%. The Trust's goal was to get to 90% with the introduction of Appraisal Season in April 2018.
- SET training – Compliance with Statutory and Essential Training (SET) remained static and at the end of February the rate was 78.59%.
- Sickness absence – February had seen a decrease in monthly sickness levels to 4.54%.

18/3/31 In response to a question from Alan Armstrong, the Board was advised that an action plan for 'did not attends' had been developed and would be reviewed in three months.

18/3/32 The Board NOTED the Performance Report.

The Board adjourned at 10.35am and reconvened at 10.45am.

Reports for Information

18/3/33 The following items were NOTED:

- Chair and NEDS' report
- Chief Executive's report
- Minutes of Management Board, 12 February 2018
- Working Together Partnership briefing
- Board of Directors' Calendar

18/3/34 In response to a question from Alan Armstrong about the role of the VCF Panel mentioned within the Management Board minutes, Board was

advised that the role of the Panel was to bring consistency, rigour and discipline to requests for recruitment and additional staff.

Items escalated from Sub-Committees

18/3/35 None.

Minutes

18/3/36 The minutes of the meeting of the Board of Directors on 27 February 2018 were APPROVED as a correct record.

Any other business

18/3/37 The Board placed on record its thanks to John Parker who was attending his last Board meeting before stepping down as a non-executive director at the Trust.

Governors questions regarding business of the meeting

18/3/38 David Cuckson commended the work undertaken through the Patient Experience and Engagement Committee to improve performance times in respect of complaints. In response to a further question about the fundraising policy, the Board assured that measures would be taken to ensure staff could draw from the charity.

Date and time of next meeting

18/3/39 9.00am on Monday 30 April 2018 in the Boardroom, Doncaster Royal Infirmary.

Exclusion of Press and Public

18/3/40 It was AGREED that representatives of the press and other members of the public be excluded from the remainder of the meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest.

Suzy Brain England
Chair of the Board

Date