Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

The meeting of the Board of Directors

To be held on Tuesday 26 September 2017 at 2.30pm in the Lecture Theatre, Doncaster Royal Infirmary

AGENDA
Part I

		Enclosures
1.	Apologies for absence	(Verbal)
2.	Declarations of Interest	(Verbal)
3.	Actions from the previous meeting	Enclosure A
4.	We Care for Our Junior Doctors Alasdair Strachan - Director of Education	Enclosure B & Presentation
5.	The Quality of Junior Doctor and Student Training at DBTH Alasdair Strachan - Director of Education	Enclosure C
6.	Learning from Deaths Quarterly Report Sewa Singh – Medical Director	Enclsoure D (to follow)
7.	Guardian for Safe Working Quarterly Report Jayant Dugar – Guardian for Safe Working	Enclsoure E
Reports for decision		
8.	Annual Statement of Compliance against the NHS Core Standards for Emergency Preparedness, Resilience and Response (2017/18) David Purdue – Chief Operating Officer	Enclsoure F
9.	Working Together Partnership Committees in Common Richard Parker – Chief Executive	Enclosure G
Reports for assurance		
10.	Chairs Assurance Logs for Board Committees held 19 September 2017 Neil Rhodes – Chair of Finance and Performance Committee Philippe Serna – Chair of Audit and Non-clinical Risk Committee	Enclosure H (to follow)
11.	NHS Protect – Withdrawal Of Local Support For Counter Fraud Philippe Serna – Chair of Audit and Non-clinical Risk Committee	Enclsoure I
12.	Strategy and Improvement Report Marie Purdue – Acting Director of Strategy & Improvement	Enclsoure J
13.	Finance Report as at 31 August 2017 Jon Sargeant – Director of Finance	Enclosure K

14. Performance Report – Month 5 2017/18 — Enclosure L
Led by David Purdue – Chief Operating Officer

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

Reports for information

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

17. Chief Executive's Report — Enclosure O
Richard Parker –Chief Executive

18. Minutes of Finance and Performance Committee, 22 August 2017 — Enclosure P
Neil Rhodes – Chair of Finance and Performance Committee

19. Minutes of Audit and Non-clinical Risk Committee, 20 July 2017 — Enclosure Q
Philippe Serna – Chair of Audit and Non-clinical Risk Committee

20. Minutes of Management Board, 7 August 2017 — Enclsoure R
Richard Parker – Chief Executive

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

Minutes

22. To approve the minutes of the previous meeting held 29 August 2017 — Enclosure T

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

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

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

Date: 31 October 2017
Time: 9.00am
Venue: Boardroom, DRI

26. **Withdrawal of Press and Public**

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

Suzy Brain England
Chair of the Board

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Action Notes

Meeting: Board of Directors

Date of meeting: 29 August 2017

Location: Boardroom, BH

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

Apologies: LP, JP

No.	Minute No	Action	Responsibility	Target Date	Update
1.	**17/01/13**	Director of Education to share the Teaching Hospital phase two development plan at a future Board.	**MK**	**Following discussions at QEC**	To be arranged. Target date changed from September.
2.	**17/03/07 & 17/06/3**	A paper be prepared on how the Trust can assure itself that support is in place concerning changes to NHS Protect.	**JS/KEJ**	**September 2017**	Complete. On Board agenda.
3.	**17/04/32**	Timetable six month review of CIPs.	**JS**	**November 2017**	Action not yet due.

No.	Minute No	Action	Responsibility	Target Date	Update
4.	**17/04/54**	Invite NEDs to future quality summit.	**MH**	**October 2017**	A quality summit has not been arranged since the last Board meeting. Target date updated to October 2017.
5.	**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**	**October 2017**	Examination of plans ongoing. Target date updated.
6.	**17/05/51**	Work on complaints and the DNA working group would be brought to Board through the Finance and Performance Committee following quarter two.	**DP**	**October 2017**	Action not yet due.
7.	**17/06/34**	Board to meet with care group directors regarding EEPs.	**MK**	**October 2017**	To be arranged. Target date updated.
8.	**17/06/46**	QEC approach to assurance reporting to be shared with Board.	**LP**	**September 2017**	Complete. To take place before Board in September.

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No.	Minute No	Action	Responsibility	Target Date	Update
9.	**C/17/07/12**	Cyber security action plan to be presented to September's ANCR.	**SM**	**September 2017**	Complete. Went to ANCR on 19 August 2017.
10.	**17/08/24**	Director of People and OD to report back on incidence of MSK issues amongst staff.	**KB**	**September 2017**	Update to be provided at meeting.
11.	**17/08/53**	Medical Director to report back on HSMR performance at Bassetlaw.	**SS**	**October 2017**	Action not yet due.
12.	**C/17/08/25**	COO to monitor RTT volumes from postcodes outside of Trust area.	**DP**	**September 2017**	No change in RTT volumes to date.

Date of next meeting: 26 September 2017
Action notes prepared by: M Kane
Circulation: SBE, AA, NR, KB, DJ, MH, MM, DP, JS, SS, JP, RP, LP, PS

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Title	***We Care* for our Junior Doctors**		
Report to	**Board of Directors**	**Date**	**26th September 2017**
Author	**Dr Alasdair Strachan, Director of Education**		
Purpose			Tick one as appropriate
	Decision		√
	Assurance		
	Information		

Executive summary containing key messages and issues

Nationally it has been highlighted that the morale of junior doctors is historically at a low point which is being reflected in the number of trainees taking breaks from training or leaving training in the UK. Although multifactorial, common themes include not feeling valued, disconnected from the senior management of the organisations they are working in, and not having their views considered. At DBTH the feedback from trainees is that morale is "not bad" but do recognise some of the national issues. This paper sets out to address these issues under the headings of;

- Engagement with Senior Management. This outlines some practical measures already in place and future projects drawn from national best practice
- Quality Improvement and the role of junior doctors. Junior doctors should and want to be a crucial part of our Qii systems
- *We Care* for our trainees. This sets out some practical areas to ensure we support our junior doctors especially around Human Resources, rest and break periods and supporting structures

Key questions posed by the report

- Is the Board assured of appropriate engagement with junior doctors at senior management and Board level?
- How can junior doctors be integral to the Qii projects in the Trust?
- How do "We Care" for our trainees?

How this report contributes to the delivery of the strategic objectives

- **We will work with patients to continue to develop accessible, high quality and responsive services**
  Junior doctors are a key player for bringing about improvements in change alongside patients and other staff

- **As a Teaching Hospital we are committed to continuously develop the skills, innovation and leadership of our staff to provide high quality, efficient and effective care**
  Junior doctors will have improved support and education through the changes outlined. Through engagement with Senior managers and Qii projects innovation and leadership skills will be developed

- **We will develop and enhance elective care facilities at Bassetlaw Hospital and Mexborough, Montagu Hospital and ensure appropriate capacity for increasing specialist and emergency care at Doncaster Royal Infirmary**
  Junior doctors are a crucial part of the current and future workforce so are key to capacity development as well as developing new ways of working through Qii and bringing their experiences from other organisations

- **We will increase clinically led partnership working to benefit people and communities**
  With appropriate support junior doctors can support this objective.

How this report impacts on current risks or highlights new risks

- **Workforce.** This project will ensure we remain an attractive employer to current trainees and to help future recruitment. Improvement of engagement should improve junior doctor sickness absence and productivity.
- **External regulators.** Good trainee experience will ensure good GMC results which are reported to the CQC.

Recommendation(s) and next steps

The Board of Directors is asked to support the initiatives within the paper and to task the Workforce and Education Committee to ensure success.

The Board of Directors is asked to support the work of the Director of P&OD and Director of Education to take forward actions to improve senior managerial engagement with junior doctors.

We Care for our Junior Doctors

Doncaster and Bassetlaw Teaching Hospitals

Background

The NHS is under increasing pressure due to increases in workload and funding constraints. 2016 was an unprecedented year for junior doctors with the first strike for many years and subsequent research revealing deep seated issues around burnout, a lack of support and not feeling valued.

The number of trainees applying directly into core training after the foundation programme is dropping steadily. Junior doctors are taking breaks from training citing burnout (50%) and need for a work-life balance (87%) as the reasons. There are similar trends occurring between core and higher specialty training. National research has revealed relationship between junior doctors and patients is largely unchanged, with 96% feeling valued by them. Relationships with consultants range widely between very good and poor. However, the relationship between trainees and Trust leadership is unequivocal; there is a clear disconnect. A qualitative study in the British Medical Journal described a sense of junior doctors feeling 'dehumanised' by employers, who increased workload demands without regard for their personal lives.

The NHS Constitution's 3rd principle states –

> Respect, dignity, compassion and care should be at the core of how patients and staff are treated- not only because that is the right thing to do, but because patient safety, experience and outcomes are all improved when staff are valued, empowered and supported.

Junior doctors not only provide frontline care to patients 24/7, they are also a dynamic part of the workforce passionate for patient safety and improving their care. The UK Medical Careers Research Group in their extensive junior doctor survey highlighted not only that 79.3% felt either 'not valued at all' or 'sometimes valued' but also highlighted their views were not sought by the hospital. In another survey 91.2% had ideas for improvement in their workplace but only 10.7% had had these implemented. The authors of the Faculty of Medical Leadership and Management review Junior doctor engagement. Investing in the future strongly advised Medical Directors "to consider how they might tap into the latent energy of junior doctors, who move between organisations and are potentially our most powerful agents for change". This paper sets out the current situation in DBTH and asks the Board to support the initiatives outlined below, both as a Board and as individuals.

Junior Doctors at DBTH

Over the recent years the quality of training has been improving across the organisation which has been reflected in the GMC survey results. Junior doctor forums were instated three years ago and have been specialty based to share training and patient safety issues. For the specialties where the forum has been active the benefits can be seen in improved training.

Feedback from the forum and directly to the Director of Education and the College Tutors is that trainees are very busy and value their experience to help them develop. They do not feel their morale is “too bad” but they do not feel part of DBTH and as such do not feel valued by the organisation. They struggle to engage in any significant Quality Improvement projects which many are keen to do.

The Way Forward - Junior Doctors Thriving in DBTH

Health Education England and NHS Employers have produced a number of documents bringing together best practice from other organisations. Having reviewed these documents there a number of key themes. High quality education especially with meaningful supervision and appraisal will be picked up in the response to recent GMC survey. This paper picks up the other main themes below.

1) Engagement with Senior Management

Many organisations have found trainees value the presence of the Chief Executive at the Trust Induction. Richard Parker attended the August induction and was warmly received. He introduced the Board and emphasised that the Chair, Executives and Non Executives are available for trainees to discuss issues they want to raise. He valued the chance to meet trainees and welcome them to DBTH. David Purdue, Chief Operating Officer, has also started to meet the Management trainees who chair the trainee forums to help take forward significant improvements in patient care. The Management trainees also work with Care Group Directors and College Tutors which will ensure Care Group management engagement.

Recommendation

- To further develop this engagement further junior doctor-manager collaborations should be identified to take forward improvement projects.
- Appropriate junior doctor representation should be identified for the Trust committees
- Engagement events with senior management should continue to be developed for junior doctors e.g. this public board.

2) Quality Improvement and the role of junior doctors

Data from top performing Trusts highlights their commitment to Quality Improvement systems which is embedded in their everyday work. Trainees are passionate about patient care and bring a wealth of experience. The national evidence highlights trainee involvement in Quality improvement improves their engagement and helps them identify with organisations. Trainees are required to undertake a project to complete their training so are keen to be involved.

Recommendation

• As DBTH commits to the Qii system it is important junior doctors are core to this and supported by clinicians, managers and the Qii team to undertake projects to bring about lasting changes.

3) We Care for trainees

Many practical issues make the life of the trainee either valued or can cause a great deal of trouble. Ensuring trainee receive contracts, rotas and organisational information in good time. A timely welcome to the organisation by the CEO and Director of Education with key information makes a good impression. Appropriate training and rest facilities make the high pressure work more manageable. Recent papers have highlighted the risks of night shifts to junior doctor's health and especially causing Road Traffic Accidents when driving home. The following initiatives will ensure these important issues are considered and actioned:

Recommendation

- We Care for trainees forum, chaired by a Deputy Director of Education with trainee and POD representation to focus on this area of work in its wider context reporting to Workforce and Education Committee
- More proactive constructive arrangement developed between trainees and the new Medical HR team. Clinics and drop in sessions to be explored.
- Training about sleep hygiene and preparation for overnight on calls included in induction.
- Availability of rest rooms and post on call rooms ensured in the Trust
- Ensuring the culture supports trainees taking appropriate breaks including being able to have naps for those it helps
- Explore the potential of a peer mentoring scheme.
- Encourage and support the re-launch of the junior doctors' mess at DRI and Bassetlaw.

Training of junior doctors at DBTH has improved over recent years. These initiatives should help continue this improvement, help improve care of our patients and help the trainees, some of which are our future employees, feel valued and cared for.

NHS
Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Title	**The Quality of Junior Doctor and Student Training at DBTH**		
Report to	**Board of Directors**	**Date**	**26th September 2017**
Author	**Dr Alasdair Strachan, Director of Education**		
Purpose			Tick one as appropriate
	Decision		
	Assurance		√
	Information		

Executive summary containing key messages and issues
The quality of teaching of our students and junior doctors is central to the delivery of a high quality workforce to care for our patients. The quality of teaching has been recognized by key stakeholders in our attainment of Teaching Hospital status and continues to be a key focus. Student and trainee experience at DBTH is also important for our future workforce recruitment and retention. This paper sets out to demonstrate how DBTH collates feedback from all learners; both medical and non-medical, and how the organisation uses this information to inform improvements within Training and Education and supervisory arenas.
Key questions posed by the report
• Where can we continue to improve our training of junior doctors and students? • How do "We Care" for all of our learners? • How valued feedback is used non-judgmentally for the benefit of all learners?
How this report contributes to the delivery of the strategic objectives
• **We will work with patients to continue to develop accessible, high quality and responsive services** Training and retention of students and junior doctors will ensure current and future high quality accessible services. • **As a Teaching Hospital we remain committed to continuously develop the skills, innovation and leadership of our staff to provide high quality, efficient and effective care** The training, education and clinical supervision given to our learners will be improved and driven by their feedback and engagement. Relationships with College Tutors,

Clinical Supervisors, Learning Environment Managers, Clinical Educators and Mentors will be strengthened

- **We will develop and enhance elective care facilities at Bassetlaw Hospital and Mexborough, Montagu Hospital and ensure appropriate capacity for increasing specialist and emergency care at Doncaster Royal Infirmary**
  All learners are a crucial part of the current and future workforce so are key to capacity development

- **We will increase clinically led partnership working to benefit people and communities**
  With appropriate support all learners can support this objective.

- **Support the development of enhanced community based services, prevention and care**
  Some of our students will move into community based services and will be integral to forging multi professional partnerships in the future

How this report impacts on current risks or highlights new risks

- **Workforce.** The ongoing improvement of training will ensure we remain an attractive employer and placement choice for current and future learners and will help recruitment and retention of staff who feel valued.

- **External regulators.** Good learner experience will ensure good GMC and PPQA results which are reported to the CQC.

Recommendation(s) and next steps

The Board agrees with these programmes and tasks the Workforce and Education Committee to ensure the success of these actions.

The Quality of Junior Doctor and Student Training at DBTH

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

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

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

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

Background

As a barometer of our student placement experiences, the organisation receives quality data from both the General Medical Council (for Doctors in training) and from PPQA (practice placement quality assurance) for student nurses and allied health professionals. We also receive feedback from our Medical Students after their placements. This data enables the Training and Education multi-professional team to address any negative feedback, but to also celebrate and build upon what we are doing well.

GMC survey

In March 2017 the General Medical Council (GMC) surveyed all Doctors who were in a training programme; with Health Education Yorkshire and Humber achieving a response rate of 97.8% (national 98.1%). Where areas are not mentioned there were no, or insufficient responses (under 3)

The headlines from this for DBTH were:

- Overall satisfaction is third highest in Yorkshire and Humber (Harrogate and Sheffield Children's Hospital higher).
- Acute Internal Medicine, General Internal Medicine, General Surgery and Geriatrics were placed as best in the region, with Endocrine, Diabetes and Gastroenterology placed as second best. Geriatrics and Core Medical Training had the 4th best results in the United Kingdom
- Notable improvements were also seen in Emergency Medicine, Obstetrics and Gynaecology and Paediatrics.
- Anaesthesia was the only speciality where the results had declined since 2016.
- No patient safety concerns were identified

Satisfaction within the survey was ascertained against 17 domains:

Overall Satisfaction, Clinical Supervision, Clinical Supervision out of Hours, Reporting Systems, Work Load, Teamwork, Handover, Supportive Environment, Induction, Adequate Experience, Curriculum Coverage, Educational Governance, Educational Supervision, Feedback, Local Teaching, Regional Teaching and Study Leave

These domains were then rated as below Red, White or Green. For the purpose of the paper, all red and green identified domains are included, others were rated as white (Average Score between 25 and 75%)

Red	Below National Average Score (below 25%)
White	Average Score (between 25% and 75%
Green	Above National Average Score (above 75%)

Medicine	**Red**	**Green**
Acute Internal DRI		Handover
Core Medical Training (DRI)		Workload Adequate Experience Reporting Systems Handover Supportive Environment Educational Governance

General Internal (Bassetlaw)	Clinical Supervision Teamwork	Workload
Gastroenterology (DRI)	Regional Teaching	Clinical Supervision
Respiratory Medicine (DRI)	Study Leave	
Renal (DRI)		Workload
Geriatric Medicine		Supportive Environment Educational Governance

Surgery	Red	Green
Otolaryngology	Local Teaching	
Urology		Overall Satisfaction

Anaesthetics DRI	Red	Green
	Teamwork Supportive Environment Educational Governance Educational Supervision	
Intensive Care		Handover

Emergency Medicine	Red	Green
	Feedback	

Paediatrics	Red	Green
Bassetlaw	Adequate Experience	Workload
Doncaster		Regional Teaching

Obstetrics and Gynaecology	Red	Green
Bassetlaw	Reporting Systems	Regional Teaching Study Leave

All College Tutors have constructed a local action plan following the feedback, highlights below:

Medicine

- Using AMU as Hub for trainees improving camaraderie
- Induction streamlined into 2 days and improved presentation material
- Using ACP's to cover the service to facilitate study leave
- Junior Doctors nominated to sit on the Junior Doctor forum to give feedback

Surgery

- ACP's supporting the Junior Doctors to also cover for study leave
- Reconfiguration of some of the surgical services to support educational opportunities
- Specialist teaching rota's developed

Anaesthetics

- Changes made to Induction and supervision
- College Tutor notice board developed to disseminate information
- Improved teaching schedules have been developed
- Monthly meetings with trainee representative to ensure improvements

Emergency

- Changes supported to rota structure to ensure appropriate support and supervision
- Expansion to substantive consultant posts will ensure higher quality supervision

Paediatrics

- Induction programme improved
- Restructure of rota to support wider experience

Obstetrics and Gynaecology

- Increase in Clinical Fellow and Staff Grade Doctors to facilitate more training opportunities
- New obstetric pathways developed
- Training resources improved with more local teaching

DBTH also actively seeks feedback from Junior Doctors after their hospital and specialty induction in order to be able to make any improvements for future trainees and benchmark the current quality. The last feedback received was really great with 85% rating the Induction as Good to Excellent.

Some comments received were:

Great place to be

Focused and easy to follow sessions

There were clear instructions and I felt the whole process was fluid and simple

Truly inspiring talks, I felt that the Trust really cared about our experience and us fitting in

It was really good that the CEO was there and I got the feeling that him and the Medical Director of Education really cared about trainees

Medical Student feedback

Medical Students are also supported as learners within DBTH throughout their years of training and their feedback is also valued – Recent comments would suggest that they consider our organisation to be a great learning and supportive environment:

I found all staff members to be really helpful in the hospital, often going out of their way to accommodate me.

Many scheduled teaching sessions which were very helpful and tailored to my learning especially surrounding exams and starting my F1 job.

Bedside teaching was done wherever possible, and our supervisor was keen to promote this.

My supervisor was very good in ensuring that I met my clinical needs for this placement

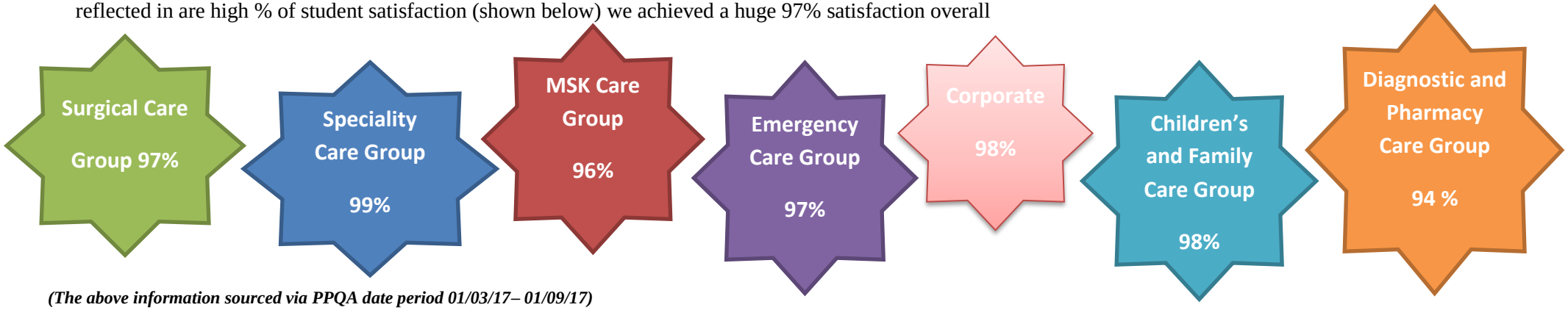
Fantastic teaching, got on really well with all of the surgeons and learnt a lot. All top class, couldnt recommend them enough

Very supportive and felt part of the team and I felt like I was being useful e.g. clerking patients, taking bloods, other clinical skills etc.

Practice Placement Quality Assurance data for Student Nurses

The Practice Placement Quality Assurance (PPQA) website was developed as a regional tool to help all stakeholders meet practice placement quality assurance requirements. Healthcare students spend 50% of their time within clinical settings so it is vital this aspect of their training is of the highest possible standard therefore, all our pre-registration healthcare students are requested to provide feedback as part of our Learning Development Agreement with Health Education England. The source of evaluation feedback comes via this platform. www.healthcareplacements.co.uk.

Historically the PPQA response rate has been low across the region however; in partnership with our local HEI's systems are now in place to increase compliance and we are seeing a significant improvement in the number of returns. DBTH evaluations are extremely positive as we continue to provide high quality student experience, this is reflected in are high % of student satisfaction (shown below) we achieved a huge 97% satisfaction overall



(The above information sourced via PPQA date period 01/03/17– 01/09/17)

They Said	We Did	They Said	We Did
There is a lack of lockers for Students	New lockers purchased – First block arriving September 2017	Difficult to get IT access	IT access issued at Induction Trust Subscribed to Eduroam

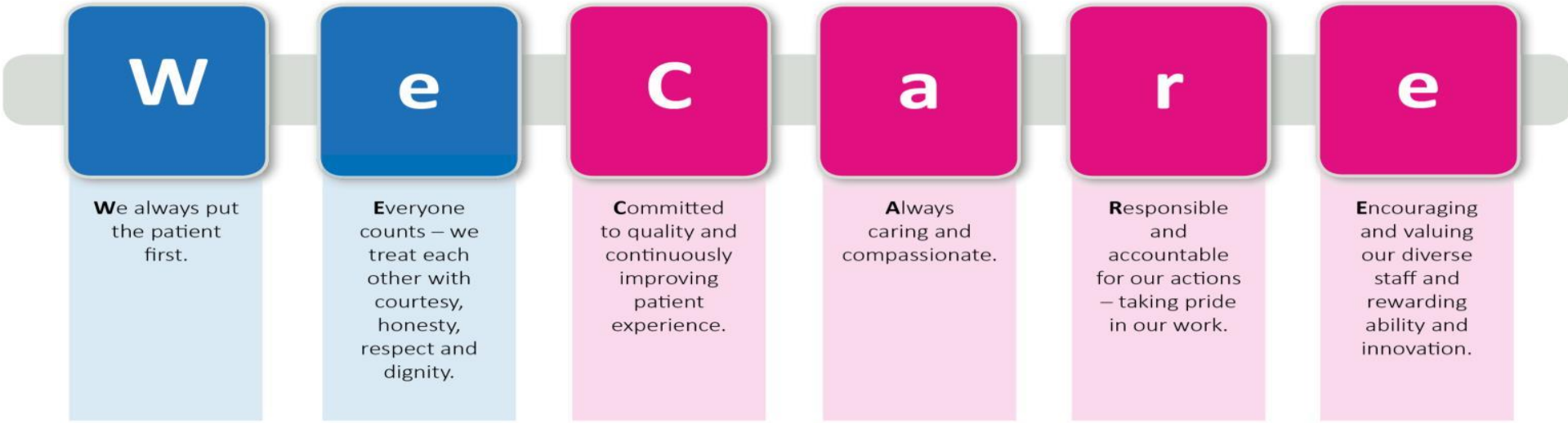
Training of mentors to support different types of learners within the organisation remains high priority with funding directed to clinical areas with the lowest ratio of mentors per student. The Education Leads for each Care Group work with the Learning Environment Mentors (LEM's) for each placement area to ensure a high quality experience for our learners.

Our commitment to all of our learners within DBTH is to listen to them and to value their input and feedback to enable us to offer the highest quality placements.

Summary

External quality assurance reports provide DBTH with valuable information to continue to improve. Although the data is reassuring in many areas we continue to strive to improve.

The Workforce and Education Committee will receive reports and exception reports to ensure the action plans are addressed. These need to be supported by the Care Groups.



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NHS Foundation Trust

Title	**Quarter 1 (17/18) Learning From Deaths Report**		
Report to	**Board of Directors**	**Date**	**26 September 2017**
Author	**Mandy Dalton, Mortality Lead**		
Purpose			Tick one as appropriate
	Decision		
	Assurance		√
	Information		√

Executive summary containing key messages and issues
To inform the Board of the work being undertaken in the Trust and provide assurance of the systems and processes in place to ensure that in-hospital deaths, including those in the Emergency Department, are scrutinised in a structured way in line with National Guidance. In accordance with National Guidance, the Trust's Learning from Deaths Policy was published in August 2017.
Key questions posed by the report
Is the Board assured that the Trust is making progress with "Learning from Deaths"?
How this report contributes to the delivery of the strategic objectives
Patients: *We will work with patients to continue to develop accessible, high quality and responsive services*.
How this report impacts on current risks or highlights new risks
Learning from quality care issues and avoidable deaths to improve the quality of patient care
Recommendation(s) and next steps
▪ The time lapse to mortality review needs to be shortened. ▪ Explore ways of systematically listening to families and carers. ▪ Learning from Deaths Report to be tabled at local clinical governance meetings and for those specialties who have not reached 100% compliance, develop an action plan to achieve 100% by end of Q3.

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Q1 (17/18) LEARNING FROM DEATHS REPORT

1.0 Background and Introduction

In March 2017, the National Quality Board published a framework for NHS Trusts and NHS Foundation Trusts on identifying, reporting, investigating and Learning from Deaths in Care.

This document: **"National Guidance on learning from Deaths"** was specifically to help Trusts initiate a standardised approach to mortality review and clearly stated that the guidance would evolve as we learn.

However, the following minimum requirements were introduced:

- Each Trust should publish a policy; Learning from Deaths, by September 2017.
- Trusts are required to collect and publish "on a quarterly basis" specified information on deaths. This should be through a paper to the public Board. (By Q2 a policy and approach to mortality review and by Q3, publication of data and learning points)

2.0 Current Position

- The Policy, **Learning from Deaths: CORP/RISK 32** , following wide consultation, was agreed at the Clinical Governance Committee on 21st July 2017 and published on the intranet August 2017.
- Data collection and reporting has been ongoing for over 2 years. However, recently more specific data has been collected as described in the national guidance and as agreed locally:

    - 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 issues in care delivery.

3.0 Mortality Review by Care Group

Care Group	Specialty	April			May			June		
		No. of Deaths	No. Reviewed	% complete	No. of deaths	No. Reviewed	% complete	No. of deaths	No. reviewed	% complete
Specialty Services	Cardiology	2	2	100%	5	5	100%	4	3	75%
	Diabetes/endocrinology	0	0	N/A	0	0	N/A	0	0	N/A
	Haematology	0	0	N/A	2	2	100%	3	3	100%
	Renal	2	0	0%	3	1	33%	3	2	66%
	Stroke	9	9	100%	8	8	100%	12	6	50%
	Urology	0	0	N/A	2	1	50%	1	1	100%
	Vascular	3	3	100%	2	2	100%	3	1	33%
	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	0	0	N/A	1	0	0%	0	0	N/A
	General Surgery	10	2	20%	11	11	100%	6	5	83%
MSK & Frailty	T&O	4	4	100%	1	1	100%	5	0	0%
	Care of the Elderly	16	16	100%	12	3	25%	12	10	83%
	Rheumatology	0	0	0	0		0	0	0	N/A
Emergency	Respiratory	3	3	100%	6	6	100%	17	14	82%
	Gastroenterology	2	2	100%	4	4	100%	3	1	33%
	General Medicine	88	20/56	*86%	61	20/16	*60%	65	20/33	*88%
	Emergency Department	15	15	100%	19	19	100%	10	10	100%
	Total :	154	132	86%	147	72	53%	144	101	70%

During quarter 1 there were 445 deaths. 305 (69%) of these have either been screened or reviewed. Of those screened (105), 5% underwent a full Structured Judgement Review (SJR)

3.1 Actions taken throughout quarter 1 to assist specialties with compliance:

- The End of life team "screen" all deaths within general medicine and stroke if the patient was on an EOL care plan. This represents a significant additional workload for the EOL team.
- *General medicine: at least 20 full reviews are undertaken (10 on each site) each month and the remaining deaths are screened by the mortality lead. The first number in the chart denotes those reviewed and the second number those which have been screened. E.g. in June 20 were reviewed and 33 screened (20/33)
- Care of the elderly have now agreed a process to ensure that each of their deaths will be screened and full SJR's undertaken on those identified using a trigger tool.
- The General Surgery Clinical Governance lead is informed of all surgical deaths, the notes are made available to him so that he can allocate a surgical consultant for a SJR.

4.0 Findings and themes

- No death during Q1 was adjudged to have occurred as a result of care issues
- 94% of case notes reviewed contained excellent/good documentation.
- 6% of case notes were difficult to review due to poor documentation and in particular, legibility of handwriting.
- 93% of cases received excellent or good care overall.
- 7% received satisfactory care
- Of those concluded to have received "satisfactory care" the following 3 recurring themes were identified;
    - Inappropriate reasons for DNACPR: e.g. Downs syndrome, learning difficulty, learning disability.
    - Inappropriate end of life place of death.
    - Some lack of knowledge in recognising the dying chronically ill patient resulting in unnecessary interventions and treatment.

5.0 Quality Improvement

Several areas of quality improvement have been identified whilst undertaking this work:

- A quality improvement project is ongoing on wards A5 and 24 to improve the quality of care delivered to a dying patient
- Inappropriate reasons for completing a DNACPR are being raised with individuals at the time by the learning disability liaison nurse.
- Wherever a patient is believed to have been admitted inappropriately from a care or nursing home, the CCG are being notified.

6.0 Conclusion and Recommendations

The Trust has undertaken a significant amount of work and continues to make substantial progress in ensuring that in patient deaths are screened and that those requiring further investigation go on and have a structured judgement review. It is imperative that we continue to build on and develop the process which will ensure that we continue to comply with national guidance. However, in order to ensure that the process of “Learning from Deaths” delivers improvement in care quality and improves the experience of relatives, further resource is required.

To this end, a Business Case is being drawn together for Corporate Investment Group.

The following recommendations are made:

- Screening and /or reviewing of notes should be undertaken within at least 6 weeks of the patient’s death. This is crucial should any issues with care be highlighted and the need for our duty of candour to be applied.
- Explore ways of systematically listening to families and carers.
- This report needs to be considered at local clinical governance meetings in order to ensure that the mortality review process is comprehensive.
- Ensure the continuity and sustainability of the Mortality review work.

Mandy Dalton
August 2017

ACTION PLAN:

	Recommendation	Action	Lead	Completion Target Date	Progress	Monitoring & Evaluation Arrangements	completion date
1	Screening and /or reviewing of notes should be undertaken within at least 6 weeks of the patient's death. This is crucial should any issues with care be highlighted and the need for our duty of candour to be applied.	Inform all Clinical Governance leads of expected timescales. Escalate any non-compliance to care group director	M.Dalton	Sept 2017			
2	Discussions will be held to identify a process for ensuring that any care issues highlighted by family members prior to death will trigger the involvement of the family in a case review.	Mortality review lead, bereavement office team, EOL team and PET team to work together in identifying a process.	M.Dalton	October 2017			
3	Table this report at local clinical governance meetings	Circulate report via CGC for onward distribution. Seek assurance during	M.Dalton	October 2017			

	and for those specialties who have not reached 100% compliance, develop an action plan to achieve 100% by end of Q3.	Q2 of the actions taken in specialties not achieving 100% compliance. Escalate any non-compliance to the Medical Director by end of Q3					
4	Ensure the continuity and sustainability of the Mortality review work.	Develop a business case and submit September /October	M.Dalton	October 2017			

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Title	**Report from the Guardian for Safe Working**		
Report to	**Board of Directors**	**Date**	**26th September 2017**
Author	**Dr Jayant Dugar, Guardian for Safe Working**		
Purpose			Tick one as appropriate
	Decision		
	Assurance		√
	Information		

Executive summary containing key messages and issues
The 2016 national contract for junior doctors encourages stronger safeguards to prevent doctors working excessive hours, during negotiations on the junior doctor contract agreement was reached on the introduction of a 'guardian of safe working hours' in organisations that employ or host NHS trainee doctors to oversee the process of ensuring safe working hours for junior doctors. The Guardian role was introduced with the responsibility of ensuring doctors are properly paid for all their work and by making sure doctors aren't working unsafe hours. The 2016 contract continues to be implemented with 38 junior doctors employed by this Trust on the 2016 contract as at June 2017. This contract changes how safe working is delivered compared to previous contract. This relies on exception reporting by junior doctors and proactive changes by the Trust to avoid unsafe working. This is done through an electronic system called DRS4 provided by Skills for Health. The previous contract relied on a monitoring process. The Guardian is required to provide the Board of Directors with quarterly reports. No gross safety issues have been raised with the Guardian by any trainee. There have been 45 exceptions raised by junior doctors which have been resolved without any fines being levied, 2 of which were education related.

Key questions posed by the report
Is the Board assured that the Trust has safe working in place for doctors in training?
How this report contributes to the delivery of the strategic objectives
• **As a Teaching Hospital we are committed to continuously develop the skills, innovation and leadership of our staff to provide high quality, efficient and effective care** Junior doctors will have improved support and education through the implementation of the new junior doctor's contract which is designed to ensure doctors are working safely and receiving the appropriate training. By having appropriately trained doctors patients will receive a good experience whilst receiving care.
How this report impacts on current risks or highlights new risks
• **Workforce.** By having a safe workforce we remain an attractive employer to current trainees and to help future recruitment.
Recommendation(s) and next steps
The Board of Directors are asked to note this quarterly update.

QUARTERLY REPORT ON SAFE WORKING HOURS April 2017 – June 2017: DOCTORS AND DENTISTS IN TRAINING

Introduction

This report sets outs the information from the Guardian of Safe Working as part of the 2016 Terms and Conditions for Junior Doctors to assure the board of safe working for junior doctors. This report is for the period April to June 2017 (prior to the recent changeover of doctors in training)

The Board will receive a quarterly report from the Guardian as per 2016 contract, which will include:

- Aggregated data on exception reports (including outcomes), broken down by categories such as specialty, department and grade.
- Details of fines levied against departments with safety issues.
- Data on rota gaps / staff vacancies/locum usage
- A qualitative narrative highlighting areas of good practice and / or persistent concern.

High level data

Total number of training posts in DBTH	290
Number of posts contracted by DBTH	161
Number of posts contracted by other Organisations	129
Number of doctors / dentists in training on 2016 TCS	38
Amount of time available in job plan for guardian to do the role:	2 PAs /per week
Admin support provided to the guardian (if any):	None – recent recruitment undertaken
Amount of job-planned time for educational supervisors:	0.25 PAs per trainee

The picture will change over the coming years when all the junior doctors have transitioned onto the new contract. The number of junior doctors on 2016 contract has gone up from 38 to 118 from August.

a) Exception reports (with regard to working hours)

For this quarter, exception reports have only been submitted by individuals across both Emergency and Surgical Care Groups. A total of 45 exception reports have been raised within this quarter of which 2 have been related to Education.

Exception reports by Care Group				
Care Group	No. exceptions carried over from last report	No. exceptions raised	No. exceptions closed	No. exceptions outstanding
General Medicine	0	20	20	0
General Surgery	0	24	24	0
Accident and Emergency	0	1	1	0
Total	0	45	45	0

With regards to doctors still on the 2002 contracts there is no hours monitoring information available at present. The 2002 terms and conditions of service stipulate monitoring must be done twice a year (or once by agreement) so this should be taken in to account. The Trust has approved the establishment of a small medical staffing function – recruitment has taken place and appointments made. Two of the three appointees are currently working their notice period the third junior post is currently undergoing their induction period. Hours monitoring and exception reporting will form part of their role going forward.

b) Work schedule reviews

There are no work schedule reviews required for this quarter.

c) Locum and bank usage

The information provided is complex to analyse as it includes long term locums and data for non-training grade staff to cover rota gaps. This information needs to be refined further as this has an impact on safety and training within the organization. These tables show a significant reliance on locum and bank hours to fill gaps. These numbers should be viewed cumulatively to look for areas with workforce problems. These will be the departments where workforce reviews will be helpful to find solutions. On request, I have received the data for extra hours done by trainee doctors on the 2016 contract; I am able to confirm that none of the junior doctors have breached the hours limit over the reference period.

Bank usage	Agency usage

Row Labels	Sum of Booked Hours
Acute Medicine	970
Anaesthetics	100
Anaesthetics and Critical Care	10
Care of the Elderly	1212
Emergency Medicine	2512
ENT	398
General Medicine	24
Obstetrics and Gynaecology	63
Orthopaedic and Trauma Surgery	4
Paediatrics and Neonates	359
Renal Medicine	3
Grand Total	**5654**

Row Labels	Sum of Booked Hours
Acute Medicine	2260
Anaesthesia Obs	93
Anaesthetics	65
Anaesthetics and Critical Care	991
Anaesthetics and Theatres	143
Breast Surgery	92
Cardiology	1968
Care of the Elderly	372
Diabetes	59
Emergency Medicine	7045
Endocrinology and Diabetes	264
ENT	3971
Gastroenterology	1748
General Medicine	53
General Surgery	1980
Obstetrics and Gynaecology	4053
Orthopaedic and Trauma Surgery	9913
Paediatrics and Neonates	3490
Rehabilitation Medicine	330
Respiratory Medicine	2306
Stroke Medicine	1420
Grand Total	**42616**

Vacancies

Department	No. vacancies
EMERGENCY MEDICINE (DRI)	4
EMERGENCY MEDICINE (BASS)	1
GENERAL & ACUTE MEDICINE	4
RESPIRATORY	4
GENERAL SURGERY	5
HEAD & NECK SURGERY	3
CARE OF OLDER PEOPLE	4
TRAUMA & ORTHOPAEDICS	2
CHILDREN'S	6
WOMEN'S & MATERNITY	7
SURGERY (BREAST)	1
CARDIOLOGY	2

This vacancy information is provided by medical recruitment team, but includes substantive vacancies, some of which to my knowledge are filled by long term locums. This information is useful, if it shows vacant posts by rota and department which need to be filled by other people on the rota or short term locums as this would show if any departments are under significant pressure. I am advised that this data collection is being refined.

d) **Fines**

No fines have been levied in this quarter.

Qualitative information

It is reassuring that no instance of unsafe working has been brought to my notice by junior doctors on 2002 or the 2016 contract.

2 instances of missing educational meeting due to busy ward have been reported and noted by educational supervisors. This level of missed training opportunities seems to be low and may indicate under reporting. No informal contacts from individuals to indicate that there are any problems in this respect.

I have been assured by medical recruitment department that all doctors are rostered on a rota which is compliant with 2002 and 2016 contracts as applicable.

Engagement

I have attended the Regional guardian forum for Yorkshire and Humber. This Trust has low number of exception reports possibly explained by low number of trainees on 2016 contract and compliant rotas and working practices.
The second meeting of junior doctors forum has happened on 24th July with good engagement from the Junior doctors.

Software System

No change from previous report. Trust should consider moving to erostering solution linked to exception reporting to ensure full compliance with new contract

Issues arising & Actions

1. Whilst there has been no recent hours monitoring for doctors on 2002 contract I am advised that this will happen once new medical staffing team is in place later this year.

2. Administrative support for guardian has been agreed with Director of P&OD to reside with the medical staffing team. This post has recently been recruited to.

3. The process for payment of any extra hours has been streamlined after this was highlighted in my last report.

Recommendation

The Board of Directors can be assured that the trainee doctors have a safe working practice as envisaged in the 2016 contract

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Title	Annual Statement of Compliance against the NHS Core Standards for Emergency Preparedness, Resilience and Response (2017/18)		
Report to	Board of Directors	**Date**	26 September 2017
Author	David Purdue, Chief Operating Officer and Accountable Emergency Officer		
Purpose			Tick one as appropriate
	Decision		√
	Assurance		√
	Information		√

Executive summary containing key messages and issues
The Trust is a category one responder under the Civil Contingencies Act 2004 (CCA), which means it has a key role in preparing for and responding to a range of emergency situations and significant service disruptions. Each year Acute Trusts are required to self-assess against 47 National Core Standards for Emergency Preparedness, Resilience and Response (EPRR). The Accountable Emergency Officer is required to declare, on behalf of the Trust, the overall level of compliance against NHS England's Evaluation and Testing Conclusion. **The declaration for 2017/18 is of substantial compliance against the Core Standards.** The self-assessment identified that two of the core standards were 'amber' and an improvement plan is included in the report to address the outstanding issues. A copy of this report, supported by the detail of the core and deep dive standards was received and noted by the Audit and Non-Clinical Risk Committee at its meeting on 19 September 2017.

Key questions posed by the report
The improvement plan also includes actions to address two standards from the 2017/18 'deep dive' on governance which were identified as 'amber'. In its approval of the improvement plan the Board is requested to consider and agree whether the Trust should include information on EPRR in future annual reports.
How this report contributes to the delivery of the strategic objectives
Compliance with EPRR standards supports the Trust in its strategic objectives to: • Provide the safest, most effective care possible; • Develop responsibly, delivering the right services with the right staff.
How this report impacts on current risks or highlights new risks
Compliance with EPRR standards supports the Trust in addressing the risk: • Risk Assessment – the risk lies in lack of compliance with the Core Standards and either not having emergency plans in place, or having a plan that is adequate to enable the Trust to fulfil its duties as a category 1 responder under the Civil Contingencies Act 2004.
Recommendation(s) and next steps
<u>Recommendations</u> The Board is requested to note the self-assessment process undertaken for 2017/18. The Board is requested to approve the statement of compliance at Appendix A for submission to NHS England (Yorkshire and the Humber). The Board is requested to approve the Improvement Plan at Appendix B for submission to NHS England (Yorkshire and the Humber). <u>Next Steps</u> The Statement of Compliance will be submitted to NHS England (Yorkshire and the Humber) on 6 October 2017. Between October and December 2017, LHRP and regional confirm and challenge processes will take place and, by February 2018, regional confirm and challenge processes will be completed. On 1 April 2018 the National Health Services' submission will be submitted to the NHS England Board.

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

BOARD OF DIRECTORS

ANNUAL STATEMENT OF COMPLIANCE

AGAINST

NHS ENGLAND CORE STANDARDS FOR EMERGENCY PREPAREDNESS RESILIENCE AND RESPONSE

2017/18

David Purdue, Chief Operating Officer and Accountable Emergency Officer
September 2017

1. Introduction

National Core Standards for Emergency Preparedness, Resilience and Response (EPRR) were introduced by NHS England in 2013.

Each year Acute Trusts are required to self-assess and declare compliance against 47 core standards:

- 33 generic standards relating to EPRR (from a total of 37 – four are not valid for Acute Trusts);
- 14 relating to the Trust's capability to respond to incidents involving hazardous materials (HazMat), and chemical, biological radiological and nuclear threats (CBRNE).

Extra standards focusing on specific areas are included each year. Prior years have covered:

- HazMat/CBRNE (2014);
- Pandemic influenza (2015);
- Business continuity (2016).

The 'deep dive' area of focus for 2017/18 is on Governance.

2. Statutes and Guidance Underpinning EPRR

The Trust is a category one responder under the Civil Contingencies Act 2004 (CCA), which means it has a key role in preparing for and responding to a range of emergency situations and significant service disruptions.

The CCA (2004) places statutory duties on Category one responders, and the core standards assess the Trust's preparedness and response capabilities to those duties and also to other statutory and regulatory requirements.

The key requirements for compliance are with:

- Civil Contingencies Act 2004;
- NHS Act 2006 (as amended by Health and Social Care Act 2012 - S.46 and 47);
- NHS England Emergency Preparedness Framework 2015;
- National Standard Contract S.30;
- NHS Improvement;
- Care Quality Commission.

3. Process and Timetable

The 2017/18 standards were released in July 2017, with a submission deadline for the Trust's submission of 6 October 2017.

Deadline	Process
By Sept 2017	Self –assessment process and report (Emergency Planning Officer for AEO).
19 Sept 2017	Review of report, supported by the detail of the standards, and statement of compliance by the Audit and Non-Clinical Governance Committee.
26 Sept 2017	Board of Directors approval of report and statement of compliance.
6 Oct 2017	Submission of statement of compliance to LHRP.
Oct 2017 – Dec 2017	LHRP confirm and challenge processes and LHRP documentation submission to regional team and regional confirm and challenge meetings and documentation submission by 31 December 2017.
By Feb 2018	National confirm and challenge meetings with Regions.
1 Apr 2018	NHS England Board submission.

4. Performance Against the Core Standards for 2017/18

The standards applicable to the Trust in 2017/18 are:

Generic Standards

The 33 generic standards remain unchanged from 2016/17 and are based on the duties of category 1 Responders under the Civil Contingencies Act (CCA) 2004.

The areas of coverage are:

- To have suitable governance arrangements in place;
- To assess the risk of emergencies occurring and use this to inform contingency planning;
- To have emergency and business continuity plans in place;
- To have command and control arrangements in place;
- To make information available to the public about civil protection matters and maintain arrangements to warn, inform and advise the public in the event of an emergency;
- To share information with other local responders to enhance co-ordination;
- To co-operate with other local responders to enhance co-ordination and efficiency;
- To provide training and exercises to all involved with EPRR.

Performance Statement on Generic Standards

The Trust is fully compliant with all 33 generic standards except those numbered eight and 36, (the latter of which has been carried forward each year since 2015).

Standards eight and 36 have been assessed as amber (evidence of progress and in work plan for next 12 months). The details relating to non-compliance and actions for improvement are included in the Improvement Plan at appendix B (page 9) for the Board's attention.

HazMat/CBRNE Standards

The 14 HazMat/CBRNE standards examine the Trust's capability and preparedness in responding to incidents.

The standards are used as a basis for annual on-site HazMat/CBRNE audits.

Audits were carried out at Doncaster Hospital on 14 July 2017 (Yorkshire Ambulance Service), and at Bassetlaw Hospital on 11 August 2017 (East Midlands Ambulance Service).

The outcome from both audits was that the Trust was *'prepared in being able to deal with any Chemical Biological Radiological Nuclear Explosive (CBRNE-e)/Hazmat type Incidents'.*

Performance Statement on HazMat/CBRNE Standards

The Trust is fully compliant with all 14 HazMat/CBRNE standards.

5. Performance Against the Deep Dive Standards for 2017/18

Governance Standards

The six 'deep dive' standards for 2017/18 relate to Governance and are:

- The organisation's Accountable Emergency Officer has taken the result of the 2016/17 EPRR assurance process and annual work plan to a pubic Board/Governing Body meeting for sign off within the last 12 months;
- The organisation has published the results of the 2016/17 NHS EPRR assurance process in their annual report;
- The organisation has an identified, active Non-executive Director/Governing Body Representative who formally holds the EPRR portfolio for the organisation;
- The organisation has an internal EPRR oversight/delivery group that oversees and drives the internal work of the EPRR function;
- The organisation's Accountable Emergency Officer regularly attends the organisations internal EPRR oversight/delivery group;
- The organisation's Accountable Emergency Officer regularly attends the Local Health Resilience Partnership meetings.

Performance Statement on Governance Standards

The Trust is fully compliant with four of the six Governance standards.

Board members should note that compliance against these standards is not included in the overall compliance level assessment (paragraph 7 and Appendix A) but that proposed actions against the two standards assessed as amber are included in the Improvement Plan at Appendix B (page 10) for the Board's attention and approval.

6. Overall Performance

Level	Generic Standards	HazMat/CBRNE Standards	'Deep Dive' Governance	Total
Fully compliant	31	14	4	49
Actions <12 mths	2	0	2	4
Actions >12 mths	0	0	0	0

7. Declaration of Compliance

The Accountable Emergency Officer is required to declare, on behalf of the Trust, the overall level of compliance against NHS England's Evaluation and Testing Conclusion (Appendix A).

The Accountable Emergency Officer has declared that two of the core standards are amber.

The declaration is of substantial compliance against the 2017/18 Core Standards.

An Improvement Plan (Appendix B) has been developed to address the outstanding issues.

7. Recommendations

- **The Board is requested to note the self-assessment process undertaken for 2017/18.**
- **The Board is requested to approve the statement of compliance at Appendix A for submission to NHS England (Yorkshire and the Humber).**
- **The Board is requested to approve the Improvement Plan at Appendix B for submission to NHS England (Yorkshire and the Humber).**

David Purdue, Chief Operating Officer and Accountable Emergency officer
September 2017

APPENDIX A

Yorkshire and the Humber Local Health Resilience Partnership (LHRP)
Emergency Preparedness, Resilience and Response (EPRR) Assurance
2017-2018

STATEMENT OF COMPLIANCE

Doncaster and Bassetlaw Teaching Hospitals has undertaken a self-assessment against required areas of the NHS England Core Standards for EPRR v5.0.

Following assessment, the organisation has been self-assessed as demonstrating the Substantial compliance level (from the four options in the table below) against the core standards.

Compliance Level	Evaluation and Testing Conclusion
Full	Arrangements are in place and the organisation is fully compliant with all core standards that the organisation is expected to achieve. The Board has agreed with this position statement.
Substantial	Arrangements are in place however the organisation is not fully compliant with one to five of the core standards that the organisation is expected to achieve. A work plan is in place that the Board or Governing Body has agreed.
Partial	Arrangements are in place however the organisation is not fully compliant with six to ten of the core standards that the organisation is expected to achieve. A work plan is in place that the Board or Governing Body has agreed.
Non-compliant	Arrangements in place do not appropriately address 11 or more core standards that the organisation is expected to achieve. A work plan has been agreed by the Board or Governing Body and will be monitored on a quarterly basis in order to demonstrate future compliance.

Where areas require further action, this is detailed in the attached core standards improvement plan and will be reviewed in line with the organisation's EPRR governance arrangements.

I confirm that the organisation has undertaken the following exercises on the dates shown below:

A live exercise (required at least every three years)	10 June 2017
A desktop exercise (required at least annually)	13 July 2017
A communications exercise (required at least every six months)	May 2017

I confirm that the relevant teams in my organisation have considered the debrief reports and actions required from the cyber incident at North Lincolnshire and Goole NHS FT and The Leeds Teaching Hospitals NHS Trust Pathology Incident. A plan for the identified actions arising is available.

I confirm that the above level of compliance with the core standards has been agreed by the organisation's board / governing body along with the enclosed action plan and governance deep dive responses.

_____

Signed by the organisation's Accountable Emergency Officer

26/09/2017	06/10/2017
Date of board / governing body meeting	Date signed

APPENDIX B

Yorkshire and the Humber EPRR core standards improvement plan 2017-18

Organisation: Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

ACTIONS AND PROGRESS FROM 2016 / 2017

Core standard reference	Core standard description	Improvement required to achieve compliance	Action to deliver improvement	Update on progress since last year
36	Demonstrate organisation wide (including on-call personnel) appropriate participation in multi-agency exercises.	The challenge (shared with acute organisations in South Yorkshire and Bassetlaw) is accessing appropriate multi-agency exercises which can also be used to test on-call managers and executives. (Exercises dates planned for 2016/17 did not take place as they coincided with junior doctors' industrial action). Local partners should work together to develop appropriate multi-agency exercises that meet Health's needs as well those of as multi-agency partners. The Trust should identify, and take part in, relevant exercises.	Continue to discuss at the South Yorkshire and Bassetlaw Health Resilience Sub-Group – to identify relevant multi-agency exercises. Continue to demonstrate capability at a senior level, working closely with local partners to respond to power outages; switchboard failure and junior doctors' industrial action. Identify, and take part in, relevant exercises.	The Emergency Planning Support Officer attended the SY LRF exercise planning day for 2017/18 COMAH exercises on 21 February 2017. The Trust did not attend the exercise at Thorne as there was no part for an Acute organisation to play. The Emergency Planning Officer attended Exercise Vital Sign (Midlands) on 21 March 2017 (attended by NHS England, Public Health England, Ambulance Services, CCGs, Acute Trusts, Critical Care and Trauma Networks, Army, RAF, Naval Regional Command).

ACTIONS ARISING FROM 2017 / 2018 ASSURANCE PROCESS (CORE STANDARDS)

Core standard reference	Core standard description	Improvement required to achieve compliance	Action to deliver improvement	Deadline
8	Effective arrangements are in place to respond to the risks the organisation is exposed to, appropriate to the role, size and scope of the organisation, and there is a process to ensure the likely extent to which particular types of emergencies will place demands on your resources and capacity.	Ensure that all Trust strategies and plans relating to Emergency planning are relevant and up to date.	Review all Trust strategies and plans relating to Emergency planning to ensure that all are relevant and up to date.	31 March 2018
36	Demonstrate organisation wide (including on-call personnel) appropriate participation in multi-agency exercises.	Identify, and take part in, relevant exercises.	Continue to discuss at the South Yorkshire and Bassetlaw Health Resilience Sub-Group – to identify relevant multi-agency exercises. Participate in planned exercises, including: Exercise Seven Hills – 11 October 2017. Exercise Larissa (Outbreak Exercise) – 19 November 2017. Emergo Exercise Mohawk (Mass Casualty – Dispersal Exercise) - 12th December 2017.	31 July 2017

ACTIONS ARISING FROM 2017 / 2018 ASSURANCE PROCESS (DEEP DIVE STANDARDS)

Deep Dive standard reference	Governance standard description	Required to achieve compliance	Action to deliver improvement	Deadline
DD2	The organisation has published the results of the 2016/17 NHS EPRR assurance process in their annual report.	Publish the EPRR compliance statement in the Trust's Annual Report. (This was not a requirement of the 2016/17 Foundation Trust Annual Reporting Manual).	Include the EPRR results in future Annual Reports.	26 September 2017
DD3	The organisation has an identified, active Non-executive Director/Governing Body Representative who formally holds the EPRR portfolio for the organisation.	Identified the Non-executive Director who formally holds the EPRR portfolio in the Trust's Annual Report. (This was not a requirement of the 2016/17 Foundation Trust Annual Reporting Manual).	Identify the Non-Executive Director who formally holds the EPRR portfolio in future Annual Reports.	26 September 2017

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Title	**WTP Committees in Common**		
Report to	**Board of Directors**	**Date**	**27 June 2017**
Author	**Richard Parker, Chief Executive**		

Purpose		Tick one as appropriate
	Decision	x
	Assurance	
	Information	

Executive summary containing key messages and issues

In June, Board agreed to approve the establishment of a Committee in Common which will be a committee of the Board and to appoint to it the Chair and Chief Executive for the Acute Vanguard in order to build a confederated approach that supports the development and implementation of a high level clinical strategy for the WTP.

The Board also approved the draft Joint Working Agreement and a generic set of terms of reference for the Committee. Minor revisions to the JWA have been made to improve clarity of purpose and a specific (DBTH) branded set of terms of reference are attached for approval, enabling the first meetings of the CiC to progress in October.

Key questions posed by the report

- How will the Board and Governors receive information and assurance from the new committee in common?

How this report contributes to the delivery of the strategic objectives

N/A.

How this report impacts on current risks or highlights new risks

A key risk highlighted by the new arrangements is the risk of existing Trust Boards losing sovereignty through the delegation of power to the CiC. This has now been mitigated through the revised 'decision rights' document which requires Trust Boards to be sighted on any proposals for service change and all proposals with strategic impact.

Recommendation(s) and next steps
The Board is asked to approve the documents attached.

DATED: **2017**

(1) BARNSLEY NHS FOUNDATION TRUST

(2) CHESTERFIELD ROYAL HOSPITAL NHS FOUNDATION TRUST

(3) DONCASTER AND BASSETLAW TEACHING HOSPITALS NHS FOUNDATION TRUST

(4) THE MID YORKSHIRE HOSPITALS NHS TRUST

(5) THE ROTHERHAM NHS FOUNDATION TRUST

(6) SHEFFIELD CHILDREN'S NHS FOUNDATION TRUST

(7) SHEFFIELD TEACHING HOSPITALS NHS FOUNDATION TRUST

JOINT WORKING AGREEMENT

1. Introduction

1.1 In this joint working agreement, the following words bear the following meanings:

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 JWA;
Competition Sensitive Information	means Confidential Information which is owned, produced and marked as Competition Sensitive Information including information on costs by one of the Trusts and which that Trust properly considers is of such a nature that it cannot be exchanged with the other Trusts without a breach or potential breach of competition law;
Dispute	any dispute arising between two or more of the Trusts in connection with this Joint Working Agreement or their respective rights and obligations under it;
Meeting Lead	the WTP CiC Member nominated (from time to time) in accordance with paragraph 6.4 of the Terms of Reference, to preside over and run the WTP CiC meetings when they meet in common;
Member	a person nominated as a member of a WTP CiC in accordance with their Trust's Terms of Reference and "**Members**" shall be interpreted accordingly;
"Joint Working Agreement" or "JWA"	this agreement signed by each of the Trusts in relation to their joint working and the operation of the WTP CiCs;
Terms of Reference	the terms of reference adopted by each Trust (in substantially the same form) more particularly set out in the Appendices to this Joint Working Agreement;
Trusts	Barnsley NHS Foundation Trust, Chesterfield Royal Hospital NHS Foundation Trust, Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust, The Mid Yorkshire Hospitals NHS Trust, The Rotherham NHS Foundation Trust, Sheffield Children's NHS Foundation Trust, Sheffield Teaching Hospitals NHS Trust and "**Trust**" shall be interpreted accordingly;

WTP CiCs	the committees established by each of the Trusts to work alongside the committees established by the other Trusts and "**WTP CiC**" shall be interpreted accordingly.

1.2 Each Trust is putting in place a governance structure which will enable it to work together with the other Trusts to implement change.

1.3 Each Trust has agreed to establish a committee which shall work in common with the other WTP CiCs, but which will each take its decisions independently on behalf of its own Trust.

1.4 Each Trust has decided to adopt terms of reference in substantially the same form to the other Trusts, except that the membership of each WTP CiC will be different.

2. Background

2.1 Since 2013, the Trusts have been working together as an innovative partnership (the **Working Together Partnership**) and the Working Together Partnership became an Acute Care Collaboration Vanguard in 2015.

2.2 The Working Together Partnership's stated aims are to strengthen each of the Trusts by sharing collective expertise and knowledge to:

2.2.1 improve quality, safety and the patient experience;

2.2.2 deliver safe and sustainable new models of care;

2.2.3 deliver equity of access and improve activity; and

2.2.4 make collective efficiencies where the potential exists.

2.3 In July 2016 the Boards of the Trusts, as part of the Working Together Partnership, confirmed the creation of the Acute Federation. It was agreed that further phases for changes to the governance structure would develop to enhance the delivery of the new models of care as the service change options became clearer.

2.4 In light of the above, the Trusts have identified that a preferred model for their closer collaboration and joint working is to establish a governance structure that, so far as possible within the existing legislation, enables "group" and common decision making structures; the WTP CiCs.

2.5 More specifically the WTP CiCs will facilitate the Trusts' work in the following four key areas:

2.5.1 **Informatics** - to identify the potential areas where collaboration on informatics systems, services or infrastructure between the Trusts could take place;

2.5.2 **Sharing and adopting good practices** - to enable the adoption of good practice and learning across the Trusts, including the provision of integrated and shared corporate services;

2.5.3 **Sustainable Care Quality** - to improve the provision of sustainable quality care between trusts; and

2.5.4 **Sustainable Service Configuration** - to explore where quality and safety benefits could be achieved from further collaborative working.

2.6 The Trusts will remain as seven separate legal entities with their own accountabilities and responsibilities. For avoidance of doubt there is no intention that the governance structure outlined in this Joint Working Agreement will lead to a statutory merger or acquisition under section 56 or section 56A of the National Health Service Act 2006 (as amended).

3. Principles of working

3.1 The Trusts have agreed to adopt this Joint Working Agreement dated **[INSERT DATE]** and agree to operate the WTP CiCs in line with the terms of this JWA, including the following principles (the "**Principles of Working**"):

3.1.1 through collaboration with each other aspiring, for the benefit of our patients, to be one of the most innovative, safe, caring, responsive, effective, well led and efficient health and care systems by 2020;

3.1.2 making the starting point for everything the Trusts do "can this be done better, safer, more economically for our patients if we work with our partners in a different way?";

3.1.3 move at pace in examining all activities on a "bottom up" basis, across the Trusts, engaging clinical and non-clinical teams to adopt innovative approaches and best practice;

3.1.4 challenge themselves and embrace change where it benefits its patients or the health care system as a whole. Status quo is not an option if we are to do the right thing for patients on a sustainable basis;

3.1.5 establish a governance model which facilitates this approach. Structure will not be a barrier to innovative change while recognising the statutory responsibilities of all seven individual Trust Board of Directors;

3.1.6 models of cost/benefit equalisation will be a key ingredient of the partnership activity to ensure financial loss or gain for any individual Trust is not a barrier to beneficial system change/progress;

3.1.7 seek support from commissioners to ensure changes are achieved at pace in order to gain maximum benefits for patients and system stability;

3.1.8 collaborate and co-operate. Establish and adhere to the governance structure set out in the Terms of Reference to ensure that activities are delivered and actions taken as required;

3.1.9 be accountable. Take on, manage and account to each other for performance of the respective roles and responsibilities set out in the Terms of Reference;

3.1.10 be open. Communicate openly about major concerns, issues or opportunities relating to the joint working subject always to appropriate treatment of commercially sensitive information and competition law compliance;

3.1.11 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;

3.1.12 act in a timely manner. Recognise the time-critical nature of the joint working and respond accordingly to requests for support;

3.1.13 manage stakeholders effectively; and

3.1.14 deploy appropriate resources. Ensure sufficient and appropriately qualified resources are available and authorised to fulfil the requirements and responsibilities set out in this Joint Working Agreement and the Terms of Reference.

4. Process of working together

4.1 The WTP CiCs shall meet together in accordance with and discuss the matters delegated to them in accordance with their Terms of References (attached here as Appendices 1-7).

4.2 The WTP CiCs shall work collaboratively with each other in relation to the committees in common model.

4.3 Each WTP CiC is a separate committee, with functions delegated to it from its respective Trust in accordance with its Terms of References, and is responsible and accountable to its Trust. Acknowledging this and without fettering the decision-making power of any WTP CiC or its duty to act in the best interests of its Trust, each WTP CiCs shall seek to reach agreement with the other WTP CiCs and take decisions in consensus, in light of its aims and Principles of Working set out in clauses 2 and 3 above.

4.4 When the WTP CiCs meet in common, the Meeting Lead shall preside over and run the meeting on a rotational basis for a period of six months.

5. Future Involvement and Addition of Parties

5.1 Subject to complying with all applicable law, and the Trusts' unanimous agreement, third parties may become parties to this Joint Working Agreement on such terms as the Trusts shall unanimously agree.

5.2 Any Trust may propose to the other Trusts that a third party be added as a Party to this Joint Working Agreement.

6. Exit Plan

6.1 Within three (3) months of the date of this JWA the Trusts shall develop and agree an exit plan which shall deal with, for example, the impact on resourcing or financial consequences of:

6.1.1 termination of this JWA;

6.1.2 a Trust exercising its rights under clause 7.1 below; or

6.1.3 the Meeting Lead and the WTP CiC Chairs varying the JWA under clause 10.6.2.

6.2 Once agreed by all of the Trusts, the exit plan shall be inserted into this JWA at Appendix 8 and the Trusts shall review and, as appropriate, update the exit plan on each anniversary of the date of this JWA.

7. Termination

7.1 If any Trust wishes to revoke the delegation of functions to the relevant committee and exit this JWA ("**Exiting Trust**"), then the Exiting Trust shall, prior to such revocation and exit:

7.1.1 send a written notice from the Chair of the Exiting Trust to the other Trusts' Chairs of their intention to do so; and

7.1.2 if required by any of the other Trusts (by sending a written notice within ten (10) business days of receipt of such notice) meet with the other Trusts' Chairs within ten (10) business days of the notice given under clause 7.1.1 to discuss the consequences of such revocation and exit.

7.2 If:

7.2.1 no other Trust sends a notice to the Exiting Trust within the time limit referred to in clause 7.1.2; or

7.2.2 following the meeting held under clause 7.1.2 the Exiting Trust still intends to exiting the JWA,

then the Exiting Trust may (subject to the terms of the exit plan at Appendix 8) exit this JWA.

7.3 If following the steps and meeting (if any) pursuant to clause 7.1.2 above the Exiting Trust revokes its delegation to its WTP CiC and exits this JWA then the remaining Trusts shall meet and consider whether to:

7.3.1 Revoke their delegations and terminate this JWA; or

7.3.2 Amend and replace this JWA with a revised joint working agreement to be executed by the remaining Trusts and to make such revisions as may be appropriate in the circumstance.

8. Information Sharing and Competition Law

8.1 Subject to compliance with all applicable law (including without limitation competition law and obligations of confidentiality (contractual or otherwise)) the Trusts agree to share all information relevant to the provision of the JWA in an honest, open and timely manner.

8.2 The Trusts will ensure they share information, and in particular Competition Sensitive Information, in such a way that is compliant with competition law.

8.3 The Trusts will seek to agree a protocol to manage the sharing of information in accordance with competition law requirements, within three (3) months of the date of this JWA. Once agreed, this protocol shall be inserted into this JWA at Appendix 9 and the Trusts shall review and, as appropriate, update the exit plan on each anniversary of the date of this JWA.

9. Conflicts of Interest

Members of each of the WTP CiCs shall ensure that Members of the other WTP CiCs are aware of any conflict of interest applicable to them, which has any relevance to the work of the WTP CiCs.

10. Dispute Resolution

10.1 The Trusts agree to adopt a systematic approach to problem resolution which recognises the Principles of Working set out in clause 3 above.

10.2 If a problem, issue, concern or complaint comes to the attention of a Trust in relation to any matter in this JWA, that Trust shall notify the other Trusts in writing and the Trusts each acknowledge and confirm that they shall then seek to resolve the issue by a process of discussion.

10.3 If any Trust considers an issue identified in accordance with clause 10.2 to amount to a Dispute requiring resolution and such issue has not been resolved under clause 10.2 within a reasonable period of time, the matter shall be escalated to the Meeting Lead who shall decide in conjunction with the WTP CiC Chairs the appropriate course of action to take.

10.4 If the Meeting Lead and the WTP CiC Chairs reach a decision that resolves, or otherwise concludes a Dispute, the Meeting Lead will advise the Trusts of the

decision by written notice. Any decision of the Meeting Lead and the WTP CiC Chairs will be final and binding on the Trusts once it has been ratified by the Trusts' Boards (if applicable).

10.5 If the matter referred to in clause 10.3 above cannot be resolved by the Meeting Lead and the WTP CiC Chairs, within fifteen (15) Working Days, the Trusts agree that the Meeting Lead and the WTP CiC Chairs, may determine whatever action they believes is necessary including the following:

10.5.1 If the Meeting Lead and the WTP CiC Chairs cannot resolve a Dispute, the Meeting Lead may select an independent facilitator to assist with resolving the Dispute; and

10.5.1.1 the independent facilitator shall:

a) be provided with any information he or she requests about the Dispute;

b) assist the Meeting Lead and WTP CiC Chairs to work towards a consensus decision in respect of the Dispute;

c) regulate his or her own procedure and, subject to the terms of this JWA, the procedure of the Meeting Lead and WTP CiC Chairs at such discussions;

d) determine the number of facilitated discussions, provided that there will be not less than three and not more than seven facilitated discussions, which must take place within 20 Working Days of the independent facilitator being appointed; and

e) have its costs and disbursements met by the Trusts equally.

10.6 If the independent facilitator cannot resolve the Dispute, the Dispute must be considered afresh in accordance with this clause 10 and only after such further consideration again fails to resolve the Dispute, the Meeting Lead and WTP CiC Chairs may decide to recommend their Trust's Board of Directors to:

10.6.1 terminate the JWA;

10.6.2 vary the JWA (which may include a re-drawing the member Trusts); or

10.6.3 agree that the Dispute need not be resolved.

11. Variation

No variation of this JWA shall be effective unless it is in writing and signed by the Trusts (or their authorised representatives).

12. Counterparts

12.1 This JWA may be executed in any number of counterparts, each of which when executed and delivered shall constitute an original of this JWA, but all the counterparts shall together constitute the same agreement.

12.2 The expression “counterpart” shall include any executed copy of this JWA transmitted by fax or scanned into printable PDF, JPEG, or other agreed digital format and transmitted as an e-mail attachment.

12.3 No counterpart shall be effective until each Trust has executed at least one counterpart.

13. Governing law and jurisdiction

This JWA shall be governed by and construed in accordance with English law.

THIS JOINT WORKING AGREEMENT is executed on the date stated above by

……

For and on behalf of Barnsley NHS Foundation Trust

……..

For and on behalf of Chesterfield Royal Hospital NHS Foundation Trust

……

For and on behalf of Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

……

For and on behalf of The Mid Yorkshire Hospitals NHS Trust

……

For and on behalf of The Rotherham NHS Foundation Trust

……

For and on behalf of Sheffield Children's NHS Foundation Trust

……

For and on behalf of Sheffield Teaching Hospitals NHS Foundation Trust

APPENDIX 1

[Insert Terms of Reference for the Barnsley NHS Foundation Trust CiC]

APPENDIX 2

[Insert Terms of Reference for the Chesterfield Royal Hospital NHS Foundation Trust CiC]

APPENDIX 3

[Insert Terms of Reference for the Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust CiC]

APPENDIX 4

[Insert Terms of Reference for The Mid Yorkshire Hospitals NHS Trust CiC]

APPENDIX 5

[Insert Terms of Reference for The Rotherham NHS Foundation Trust CiC]

APPENDIX 6

[Insert Terms of Reference for the Sheffield Children's NHS Foundation Trust CiC]

APPENDIX 7

[Insert Terms of Reference for the Sheffield Teaching Hospitals NHS Foundation Trust CiC]

Appendix 8

Exit Plan

[to be inserted once agreed]

Appendix 9

Information Sharing protocol

[to be inserted once agreed]

DONCASTER AND BASSETLAW TEACHING HOSPITALS NHS FOUNDATION TRUST

TERMS OF REFERENCE FOR A COMMITTEE OF THE BOARD TO MEET IN COMMON WITH COMMITTEES OF OTHER TRUSTS

TERMS OF REFERENCE

1 Introduction

1.1 In this terms of reference, the following words bear the following meanings:

Acute Federation	the federation formed by the Trusts to provide strategic leadership and oversight of the delivery of the Working Together Partnership;
Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust	Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust, Doncaster Royal Infirmary, Armthorpe Road, Doncaster DN2 5LT;
DBH CiC	the committee established by Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust, pursuant to these Terms of Reference, to work alongside the other WTP CiCs in accordance with these Terms of Reference;
DBH CiC Chair	the DBH CiC Member nominated (in accordance with paragraph 7.5 of these terms of reference) to chair the DBH CiC meetings;
"Joint Working Agreement" or "JWA"	the agreement signed by each of the Trusts in relation to their joint working and the operation of the DBH CiC together with the WTP CiCs;
Meeting Lead	the WTP CiC Member nominated (from time to time) in accordance with paragraph 7.6 of these Terms of Reference, to preside over and run the WTP CiC meetings when they meet in common;
Member	a person nominated as a member of a WTP CiC in accordance with their Trust's Terms of Reference, and Members shall be interpreted accordingly;
STP	South Yorkshire & Bassetlaw Sustainability and Transformation Plan;
Trusts	Barnsley NHS Foundation Trust, Chesterfield Royal Hospital NHS Foundation Trust, Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust, The Mid Yorkshire Hospitals NHS Trust, The Rotherham NHS Foundation Trust, Sheffield Children's NHS Foundation Trust, Sheffield Teaching Hospitals NHS Foundation Trust and "**Trust**" shall be interpreted accordingly;
Working Day	a day other than a Saturday, Sunday or public

	holiday in England;
Working Together Partnership	the partnership formed by the Trusts in 2013 to work together to improve quality, safety and the patient experience; deliver safe and sustainable new models of care; and make collective efficiencies;
Working Together Partnership Programme Director	Janette Watkins or any of subsequent person holding such title in relation to the Working Together Partnership;
Working Together Partnership Programme Management Office	Administrative infrastructure supporting the Working Together Partnership;
WTP CiCs	the committees established by each of the Trusts to work alongside the committees established by the other Trusts and "**WTP CiC**" shall be interpreted accordingly;

1.2 Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust is putting in place a governance structure, which will enable it to work together with the other Trusts to implement change.

1.3 Each Trust has agreed to establish a committee which shall work in common with the other WTP CiCs, but which will each take its decisions independently on behalf of its own Trust.

1.4 Each Trust has decided to adopt terms of reference in substantially the same form to the other Trusts, except that the membership of each WTP CiC will be different.

1.5 Each Trust has entered into the Joint Working Agreement on **[DATE TO BE INSERTED]** and agrees to operate its WTP CiC in accordance with the Joint Working Agreement.

2 Aims and Objectives of the DBH CiC

2.1 The aims and objectives of the DBH CiC are to work with the other WTP CiCs to:

2.1.1 provide strategic leadership, oversight and delivery of new models of care through the development of the Acute Federation and its workstreams;

2.1.2 set the strategic goals for the Acute Federation, defining its ongoing role and scope ensuring recommendations are provided to Trusts' Boards for any changes which have a material impact on the Trusts;

2.1.3 consider different employment models for service line specialities including contractual outcomes and governance arrangements;

2.1.4 review the key deliverables and hold the Trusts to account for progress against agreed decisions;

2.1.5 ensure all Managed Clinical Networks or other collaborative forums have clarity of responsibility and accountability and drive progress;

2.1.6 establish monitoring arrangements to identify the impact on services and review associated risks to ensure identification, appropriate management and mitigation;

2.1.7 receive and seek advice from the relevant Reference Groups, including Clinical, Finance, Human Resources;

2.1.8 receive and seek advice from the joint strategic STP Boards in South Yorkshire and Bassetlaw; West Yorkshire and Derbyshire;

2.1.9 review and approve any proposals for additional Trusts to join the founding Trusts;

2.1.10 ensure compliance and due process with regulating authorities regarding service changes;

2.1.11 oversee the creation of joint ventures or new corporate vehicles where appropriate;

2.1.12 review and approve the Terms of Reference for the Acute Federation on an annual basis;

2.1.13 improve the quality of care, safety and the patient experience delivered by the Trusts;

2.1.14 deliver equality of access to the Trusts service users; and

2.1.15 ensure the Trusts deliver services which are clinically and financially sustainable.

3 Establishment

3.1 Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust's board of directors has agreed to establish and constitute a committee with these terms of reference, to be known as the DBH CiC. These terms of reference set out the membership, remit, responsibilities and reporting arrangements of the DBH CiC.

3.2 The DBH CiC shall work cooperatively with the other WTP CiCs and in accordance with the terms of the Joint Working Agreement.

3.3 The DBH CiC is a committee of Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust's board of directors and therefore can only make decisions binding Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust. None of the Trusts other than Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust can be bound by a decision taken by DBH CiC.

4 Functions of the Committee

4.1 Paragraph 15(2) and (3) of Schedule 7 of the National Health Service Act 2006 allows for any of the functions of a Foundation Trust to be delegated to a committee of directors of the Foundation Trust. This power is enshrined in paragraph 4.3 of Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust's Constitution.

4.2 The DBH CiC shall have the following function: decision making in accordance with Appendix A to these Terms of Reference.

5 Functions reserved to the Board of the Foundation Trust

Any functions not delegated to the DBH CiC in paragraph 4 of these Terms of Reference shall be retained by Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust's Board or Governors, as applicable. For the avoidance of doubt, nothing in this paragraph 5 shall fetter the ability of Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust to delegate functions to another committee or person.

6 Reporting requirements

6.1 On receipt of the papers detailed in paragraph 13.1.2, the DBH CiC Members shall consider if it is necessary (and feasible) to forward any of the agenda items or papers to Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust's Board for inclusion on the private agenda of Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust's next Board meeting in order that Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust's Board may consider any additional delegations necessary in accordance with Appendix A.

6.2 The DBH CiC shall send the minutes of DBH CiC meetings to the Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust's Board, on a monthly basis, for inclusion on the private agenda of Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust's Board meeting.

6.3 DBH CiC shall provide such reports and communications briefings as requested by Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust's Board for inclusion on the private agenda of Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust's Board meeting.

7 Membership

7.1 The DBH CiC shall be constituted of directors of Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust. Namely:

7.1.1 Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust's Chair; and

7.1.2 Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust's Chief Executive,

and each shall be referred to as a “Member”.

7.2 Each DBH CiC Member shall nominate a deputy to attend DBH CiC meetings on their behalf when necessary (“**Nominated Deputy”**).

7.3 The Nominated Deputy for Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust’s Chair shall be a Non-Executive Director of Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust and the Nominated Deputy for Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust’s Chief Executive shall be an Executive Director of Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust.

7.4 In the absence of the DBH CiC Chair Member and/or the DBH CiC Chief Executive Member, his or her Nominated Deputy shall be entitled to:

7.4.1 attend DBH CiC’s meetings;

7.4.2 be counted towards the quorum of a meeting of DBH CiC’s; and

7.4.3 exercise Member voting rights,

and when a Nominated Deputy is attending a DBH CiC meeting, for the purposes of these Terms of Reference, the Nominated Deputy shall be included in the references to “Members”.

7.5 The chair of the DBH CiC shall be nominated by the DBH CiC. In the absence of the DBH CiC Chair the Nominated Deputy of Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust’s Chair shall chair the meeting.

7.6 When the WTP CiCs meet in common, one person nominated from the Members of the WTP CiCs shall be the Meeting Lead and preside over and run the meetings on a rotational basis for a period of six months.

8 Non-voting attendees

8.1 The Members of the other WTP CiCs shall have the right to attend the meetings of DBH CiC.

8.2 The Meeting Lead’s Trust Corporate Secretary shall have the right to attend the meetings of DBH CiC to support the provision of governance advice and ensure that the working arrangements comply with the accountability and reporting arrangements of the WTP CiCs.

8.3 The Working Together Partnership Medical Director, Programme Director and Clinical Reference Group Chair shall have the right to attend the meetings of DBH CiC.

8.4 In the interests of wider collaborative working, the Chair and Chief Executive of the following organisations:

8.4.1 Sheffield Health and Social Care NHS FT;

8.4.2 Rotherham, Doncaster and South Humber NHS FT;

8.4.3 South West Yorkshire Partnership NHS Foundation Trust; and

8.4.4 Nottinghamshire Healthcare NHS Foundation Trust,

shall, in accordance with paragraph 8.5, be invited to attend a DBH CiC meeting on a quarterly basis or on a frequency otherwise agreed.

8.5 Without prejudice to paragraphs 8.1 to 8.4 inclusive, the Meeting Lead may at his or her discretion invite and permit other persons relevant to any agenda item to attend any of the WTP CiCs' meetings, but for the avoidance of doubt, any such persons in attendance at any meeting of the WTP CiCs shall not count towards the quorum or have the right to vote at such meetings.

8.6 The attendees detailed in paragraphs 8.1 to 8.5 (inclusive) above, may make contributions, through the Meeting Lead, but shall not have any voting rights, nor shall they be counted towards the quorum for the meetings of DBH CiC.

9 Meetings

9.1 Subject to paragraph 9.2 below, DBH CiC meetings shall take place monthly.

9.2 Any Trust CiC Chair may request an extraordinary meeting of the WTP CiCs (working in common) on the basis of urgency etc. by informing the Meeting Lead. In the event it is identified that an extraordinary meeting is required the Working Together Partnership Programme Office shall give five (5) Working Days' notice to the Trusts.

9.3 Meetings of the DBH CiC shall be held in private.

9.4 Matters to be dealt with at the meetings of the DBH CiC shall be confidential to the DBH CiC Members and their Nominated Deputies, others in attendance at the meeting and the members of the Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust Board.

10 Quorum and Voting

10.1 Members of the DBH CiC have a responsibility for the operation of the DBH CiC. They will participate in discussion, review evidence and provide objective expert input to the best of their knowledge and ability, and endeavour to reach a collective view.

10.2 Each Member of the DBH CiC shall have one vote. The DBH CiC shall reach decisions by consensus of the Members present.

10.3 The quorum shall be two (2) Members.

10.4 If any Member is disqualified from voting due to a conflict of interest, they shall not count towards the quorum for the purposes of that agenda item.

11 Conflicts of Interest

11.1 Members of the DBH CiC shall comply with the provisions on conflicts of interest contained in the Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust Constitution/Standing Orders. For the avoidance of doubt, reference to conflicts of interest in the Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust Constitution/Standing Orders also apply to conflicts which may arise in their position as a Member of the DBH CiC.

11.2 All Members of the DBH CiC shall declare any new interest at the beginning of any DBH CiC meeting and at any point during a DBH CiC meeting if relevant.

12 Attendance at meetings

12.1 Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust shall ensure that, except for urgent or unavoidable reasons, DBH CiC Members (or their Nominated Deputy) shall attend DBH CiC meetings (in person) and fully participate in all DBH CiC meetings.

12.2 Subject to paragraph 12.1 above, meetings of the DBH CiC may consist of a conference between Members who are not all in one place, but each of whom is able directly or by secure telephonic or video communication (the Members having due regard to considerations of confidentiality) to speak to the other or others, and be heard by the other or others simultaneously.

13 Administrative

13.1 Administrative support for the DBH CiC will be provided by the Working Together Partnership Programme Management Office (or such other person as the Trusts may agree in writing). The Working Together Partnership Programme Management Office will:

13.1.1 draw up an annual schedule of WTP CiC meeting dates and circulate it to the WTP CiCs;

13.1.2 circulate the agenda and papers three (3) Working Days prior to WTP CiC meetings; and

13.1.3 take minutes of each DBH CiC meeting and, following approval by the Meeting Lead, circulate them to the Trusts and action notes to all Members within ten (10) Working Days of the relevant DBH CiC meeting.

13.2 The agenda for the DBH CiC meetings shall be determined by the Working Together Partnership Programme Director and agreed by the Meeting Lead prior to circulation.

13.3 The Meeting Lead shall be responsible for approval of the first draft set of minutes for circulation to Members and shall work with the Working Together Partnership Programme Management Office to agree such within five (5) Working Days of receipt.

APPENDIX A – DECISIONS OF THE DBH CIC

The Board of each Trust within the Working Together Partnership remains a sovereign entity and will be sighted on any proposals for service change and all proposals with strategic impact.

Subject to Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust's Scheme of Delegation, the matters or type of matters that are fully delegated to the DBH CiC to decide are set out in the table below.

If it is intended that the WTP CiCs are to discuss a proposal or matter which is outside the decisions delegated to the DBH CiC, where at all practical, each proposal will be discussed by the Board of each Trust prior to the DBH CiC meeting with a view to DBH CiC requesting individual delegated authority to take action and make decisions (within a set of parameters agreed by Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust's Board). Any proposals discussed at the DBH CiC meeting outside of these parameters would come back before the Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust's Board.

References in the table below to the **"Services"** refer to the services that form part of the joint working between the Trusts and may include both back office and clinical services.

	Decisions delegated to DBH CiC
1.	Providing overall strategic oversight and direction to the development of the Working Together Partnership programme ensuring alignment of all Trusts to the vision and strategy;
2.	Promoting and encouraging commitment to the Key Principles;
3.	Seeking to determine or resolve any matter within the remit of the DBH CiC referred to it by the WTP Programme Office or any individual Trust;
4.	Reviewing the key deliverables and ensuring adherence with the required timescales including; determining responsibilities within workstreams; receiving assurance that workstreams have been subject to robust quality impact assessments; reviewing the risks associated in terms of the impact to the WTP Partnership Programme and recommending remedial and mitigating actions across the system;
5.	Formulating, agreeing and implementing strategies for delivery of the WTP Partnership Programme;

	Decisions delegated to DBH CiC
6.	In relation to the Services preparing business cases;
7.	Provision of staffing and support and sharing of staffing information in relation to the Services;
8.	Decisions to support service reconfiguration (pre consultation, consultation and implementation), including but not limited to: a. provision of financial information; b. communications with staff and the public and other wider engagement with stakeholders; c. support in relation to capital and financial cases to be prepared and submitted to national bodies, including NHS England and/or NHS Improvement; d. provision of clinical data, including in relation to patient outcomes, patient access and patient flows; e. support in relation to any competition assessment; f. provision of staffing support; and g. provision of other support.
9.	Decisions relating to information flows and clinical pathways outside of the reconfiguration, including but not limited to: a. redesign of clinical rotas; b. provision of clinical data, including in relation to patient outcomes, patient access and patient flows; and c. developing and improving information recording and information flows (clinical or otherwise).
10.	Planning, preparing and setting up joint venture arrangements for the Services, including but not limited to: a. preparing joint venture documentation and ancillary agreements for final signature; b. evaluating and taking preparatory steps in relation to shared staffing models between the Trusts; c. carrying out an analysis of the implications of TUPE on the joint arrangements; d. engaging staff and providing such information as is necessary to meet each employer's statutory requirements; e. undertaking soft market testing and managing procurement exercises; f. aligning the terms of and/or terminating relevant third party supply contracts which are material to the delivery of the Services; and

	Decisions delegated to DBH CiC
	g. amendments to joint venture agreements for the Services.
11.	Services investment and disinvestment as agreed within Trust Board parameters and delegated authority;
12.	Reviewing and approving the Terms of Reference and Joint Working Agreement of the CiC on an annual basis.

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Title	**Finance & Performance Committee – Chair's Log**		
Report to	**Board of Directors**	**Date**	**26 September 2017**
Author	**Neil Rhodes, Chair of Finance & Performance Committee**		
Purpose			Tick one as appropriate
	Decision		
	Assurance		X
	Information		

Executive summary containing key messages and issues

Overview

Again, a very full meeting, also attended by colleagues from BDO who are conducting a governance review. New reports, with a sharper focus enabled a crisper progress through the issues and the meeting ran to time.

Assurance area – Performance

A new format of report, which will also be shared with the main Board meeting this time, was well received and commented upon favourably by all.

It focused upon the principal performance issues with analysis and comment, supported by embedded charts from the Single Oversight Framework measures. Since the meeting, David, Ruth and I have agreed to enhance the At-a-glance sheet to better reflect the new approach, and that will be presented at the next meeting.

We were reassured as to the broad performance of the Trust. However, we noted the challenge of hitting 95% of patients having 4 hour access was, as predicted, proving difficult but were reassured by the fact the Trust remains a top quartile performer nationally in this area. No individual items were identified for escalation.

We also received a strong presentation from Jackie Simpkin, Cancer Services Manager, in relation to 62-day Cancer Performance. There was a great deal of interest and lengthy questions.

Assurance area – Workforce Management

A comprehensive workforce management report was considered by the committee. Presented by the deputy director, Anthony Jones, it was thorough and detailed, enabling a good discussion around –

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

All of these are significant contributors to our agenda, in particular the financial aspects. We agreed that this must remain a permanent agenda item and we will work to develop this report and make it more valuable. Feedback from BDO has suggested we might adopt a more pro-active stance and we will be exploring what this looks like.

An item of interest was the profile of completion of appraisals and the relatively poor performance of the executive. We have asked if the Chief Executive will share his perspective with us in relation to that.

Assurance area – Overall Financial Picture

A separate financial highlight report has been prepared for the Board meeting. There are no individual areas escalated for attention. Please see comments under closing the financial gap.

A major area of business, that will now be before the main board, was consideration of a paper from the Director of Estates in relation to the outsourcing of catering. F+P had a detailed presentation and had copies of –

- The main contract
- The KPMG assurance report, with follow up
- Financial precis
- Project plan

We were impressed by the diligence of the work conducted, the assurances given by the Director of Estates and Facilities and the Director of Finance, and we commend the award of the contract to the Board.

Assurance area – Closing the Financial Gap

The headline is that we are showing to NHSi a deficit of £13,261k which is £1,124k behind where our control total should be now even with back end loading of CIPs. Delivering the control total is still achievable but none of us underestimate the challenge. The first CEO-led challenge session re CIPs has taken place now and we are reassured that the Executive are very much on the case. That said, agency spend is still very high, non-pay expenditure has continued to expand and there remains an uncomfortable level of unidentified CIPs.

I agreed with the Director of Finance that we need a little more time to better understand the financial picture of the last few weeks, the drivers for spend and action needed, before we can agree outturn projections that we can all have a higher degree of confidence in. We are looking for that picture at our next meeting on 24 October.

A challenge for F+P is to scrutinise properly activity to balance the books. CIPs are, for the most part, cross cutting and only come together at executive director level. I am exploring with the Director of Finance the value of increased scrutiny of care group budgets at F+P and will be seeking views from non-exec colleagues in relation to that.

Assurance area – Risk Management

The Risk Register was considered, both throughout the meeting and as a separate item at the end. We noted revisions, scoring and the addition of two new risks in relation to community based services.

Key questions posed by the report
• Is the Board assured in respect of the key areas considered in this report?
How this report contributes to the delivery of the strategic objectives
N/A
How this report impacts on current risks or highlights new risks
N/A
Recommendation(s) and next steps
That Board receives the report for assurance.

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Title	**Audit and Non-Clinical Risk Committee – Chair's Log**		
Report to	**Board of Directors**	**Date**	**26 September 2017**
Author	**Philippe Serna, Chair of the ANCR Committee**		
Purpose			Tick one as appropriate
	Decision		
	Assurance		X
	Information		

Executive summary containing key messages and issues

A shorter meeting than usual saw only two audit reports presented. To ensure Committee's time is used to the best effect, and to maximise the time for Q3 audits to get completed, the Committee have agreed to reschedule our November meeting for some time in December.

Assurance area – Internal Audit

The team have delivered 52 of 235 days. It means Quarter 3 is a busy quarter for internal audit with nine audits due but they remain on plan.

In respect of the completed audits presented at this Committee, we were pleased that KPMG were able to provide significant assurance in relation to the catering contract which was recommended by Finance and Performance Committee to Board for sign off, following implementation of the recommendations made.

The other audit was in relation to cyber security. High degrees of awareness were found to be evident but some of the required evidence to support plans, particularly in the area of business continuity, need tightening. An action plan had been drawn up by the CIO and would come back to ANCR in six months' time. The Committee also provided some advice to the CIO in relation to the risk register that was appended to the report. The COO gave us some assurance around the controls in place to address business continuity at the Trust.

A further audit around medical equipment is nearing completion. We have agreed that, for the future audits, views of NEDs would be canvassed in relation to scope and we agreed a process in order to do that.

In respect of past internal audit recommendations, it was pleasing to see that the number of recommendations without evidence had reduced meaning that there was no need to call a lead executive before the Committee to clarify. We anticipate the number of 'blue' (without evidence) recommendations will decrease further once a new electronic system is put in place.

Assurance area - Core Standards for Emergency Preparedness Resilience and Response (EPRR)

We received a positive level of assurance in this area from David and Janette with all but two of the 33 elements rated as green.

Assurance area – Risk Management and Board Assurance Framework

Changes to the BAF and CRR were considered and there was some discussion about the importance of ensuring that our Board and committee agendas mirrored, to a large degree, the key risks in the organisation. Risk will be audited as part of the clutch of audits being undertaken in Q3.

The Committee complimented the summary report that set out the changes in month, we acknowledge the work being undertaken in his area with regard to awareness raising and we hope the audit will enhance processes even further.

Assurance area – Losses and compensation

The usual report was received but a question was raised about whether it would be helpful for NEDs to be taken through them before sign off to ensure independent challenge. We agreed that Matthew, Sewa, Rick and Linn would explore the possibility of strengthening the governance in this area.

Assurance area - Committee Work Plan

The Committee agreed its revised work plan for the year and confirmed its intention to meet four times per year.

There are no items to escalate to Board.

Key questions posed by the report
• Is the Board assured in respect of the key areas considered in this report?
How this report contributes to the delivery of the strategic objectives
N/A
How this report impacts on current risks or highlights new risks
N/A

Recommendation(s) and next steps
That Board receives the report for assurance.

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

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

Executive summary containing key messages and issues

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

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

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

The key changes included:

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

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

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

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

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

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

Key questions posed by the report

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

How this report contributes to the delivery of the strategic objectives

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

How this report impacts on current risks or highlights new risks

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

Recommendation(s) and next steps

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

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

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

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

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

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

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

LOCAL COUNTER FRAUD SPECIALIST REPORT TO THE BOARD

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

Month Issued: **September 2017**

Issued To: **Board**

Author: **Mark Bishop**

NHS PROTECT – CHANGES TO SERVICE DELIVERY

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

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

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

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

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

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

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

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

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

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

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

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

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

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

NHS Protect

Circular

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

Contents

Summary

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

Background

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

Outcomes of the review of NHS Protect

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

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

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

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

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

Contact details

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

Protect

Circular

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

Contents

Summary

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

Background

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

Withdrawal of NHS Protect from ACFS training delivery

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

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

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

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

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

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

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

Contact details

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

Protect

Circular

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

Contents

Summary

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

Background

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

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

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

Action required

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

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

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

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

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

Contact details

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Protect

Circular

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

Contents

Summary

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

Background

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

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

NHS Protect's new operating model

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

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

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

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

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

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

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

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

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

Contact details

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

Annex

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

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

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

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

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

NHS Protect

Circular

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

Contents

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

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

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

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

Contact details

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

NHS Protect

Circular

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

Contents

Summary

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

Background

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

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

Counter fraud guidance

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

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

Information reports and investigation cases on FIRST

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

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

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

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

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

LCFS investigations

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

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

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

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

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

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

Contact details

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

NHS Protect

Circular

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

Contents

Summary

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

Background

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

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

Update on the creation of the NHS Counter Fraud Authority

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

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

Contact details

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

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Title	**Strategy & Improvement Update**		
Report to	**Board of Directors**	**Date**	**26th September 2017**
Author	**Marie Purdue, Acting Director of Strategy & Improvement**		
Purpose			Tick one as appropriate
	Decision		
	Assurance		√
	Information		

Executive summary containing key messages and issues
This paper seeks to provide:- a) Progress on the Strategic Plan Implementation Process – paragraph 2 b) Quality Improvement & Innovation Update – paragraph 3
Key questions posed by the report
Does the approach taken to developing the Strategic Direction and Quality Improvement & Innovation Strategy assure Board that we will comply with best practice and our undertakings to NHSI? Are the Board assured that the implementation and delivery process are sufficiently robust?
How this report contributes to the delivery of the strategic objectives
This report identifies the structures, processes and reporting mechanisms required to support the implementation of the strategy and all of the supporting objectives.
How this report impacts on current risks or highlights new risks
The main risk is that we will not have a credible and supported plan to deliver the transformation required at local or system level, to ensure we can sustain high quality services in line with our revised Strategic Direction. As a subset of this our key stakeholders and partners may lose faith in our ability to manage our own response to this issue and will take more direct ownership and control.
Recommendation(s) and next steps
The committee is asked to **note** the content of this report.

1 Introduction

1.1. This paper seeks to provide:

a) Progress on the Strategic Plan Implementation Process – paragraph 2
b) Quality Improvement & Innovation Update – paragraph 3

2 Strategic Plan Implementation Process

2.1 Following the Board of Governors meeting in July, the Strategic Direction 2017-22 has been forwarded to NHSI. NHSI are still in the process of reviewing local strategies and will feedback following that review.

2.2 The strategy launch is currently underway, supported by the Communications Team and has commenced with a launch at Management Board. An information stand and strategy specific edition of Foundations for Health will be presented at the Annual Members Meeting on 20th September and verbal feedback on this will be available at Board.

2.3 All of the following Steering Groups have now met (Children's & Families Board was already in existence) to drive and oversee the strategy implementation in the following areas:

2.3.1 Urgent & Emergency Care (including Intermediate Care)
2.3.2 Elective Care (including Cancer Services)
2.3.3 Childrens' & Families

The initial meetings have been clinically led and with good attendance and engagement from Care Group senior management teams, corporate departments and Executive membership.

Terms of Reference for Urgent & Emergency Care and Elective Care Steering Groups have now been agreed at the September Management Board, with only a minor amendment. The Terms of Reference of the Childrens' & Families Board will now be revised to align with the other implementation steering groups and this will be also be reviewed and agreed through Management Board.

2.4 Priorities for the Steering Groups have been agreed and work plans are being developed following further input from Care Groups. Work will be undertaken by task & finish groups and progress on these will be overseen by the Steering Groups using a Programme Management approach and reporting into Management Board.

2.5 Strategic changes to services initiated in response to the place based Accountable Care Partnership transformation plan, or South Yorkshire & Bassetlaw Accountable Care System will be managed through these groups.

2.6 Work plans are being developed for discussion and agreement at the first steering group meetings and these will be used within the revised Care Group and Corporate Department business planning process.

2.7 The business planning processes are currently being updated to reflect the new Strategic Direction and the annual planning process for 17/18 will commence at the end of the month.

2.8 **Enabling strategies** – Following Executive Team review the enabling strategies are being reviewed in full by Board Sub-Committees (QEC and F&P) to ensure alignment with the Strategic Direction and summary documents will then be provided to Board. The strategies being submitted to QEC will be reviewed in September and the strategies being reviewed by F&P will be reviewed in October 2017.

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	Review due in 2018
Quality Improvement & Innovation	QEC
People & Organisational Development	F&P and QEC
Finance & Commercial	F&P

3 Quality Improvement & Innovation

3.1 The Quality Improvement & Innovation (Qii) strategy will be submitted to QEC by the end of September, prior to Board in October.

3.2 Work is progressing on two key aspects of the Qii strategy which are developing skills, capability and confidence and the delivery of accessible tools and resources.

3.2.1 A range of Qii training and development has been launched including accredited Silver training now being offered onsite by the Qii team, and champion training to start to build a cohort of individuals to support Qii work within teams and services. Bespoke workshops are also being delivered to a range of teams. Regular articles and tips are being produced weekly in Buzz to ensure all staff have access to the information. An interactive development session on the Qii strategy took place with Governors on 7th September which was well received with positive feedback.

3.2.2 The Qii Toolkit, 'our DBTH Qii Way', has been launched to enable a shared approach and common language on Qii and to support all staff to be confident and skilled using these practical Qii tools and approaches in their everyday work. The toolkit has been designed for flexible use for teams to 'pick it up and use it' with Qii work locally with

support from the Qii team if needed. Care Groups are also able to request a more supported 'Qii Coaching approach' for complex Qii and key priorities.

3.3 In terms of Qii priority workstreams, the newly established strategic committees (Urgent & Emergency Care, Elective, Children's & Families) are utilising a Qii approach and beginning to identify and commission Qii team support. Priorities are also being identified to support delivery of efficiency and effectiveness projects.

4 Summary

4.1 Plans for implementation of the Strategic Direction are progressing well and will require ongoing support and development.

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Title	**Financial Performance – August 2017**			
Report to	**Trust Board**	**Date**	**26.09.2017**	
Author	**Jon Sargeant - Director of Finance**			
Purpose	To update the Board on the financial position for the month of May 2017.			Tick one as appropriate
	Decision			
	Assurance			
	Information			✔

Executive summary containing key messages and issues
• In month position £2.881m deficit, £663k worse than plan • YTD position £13.261m deficit, £1,123k worse than plan • Income was ahead of expected levels in August, but high agency and non pay expenditure has continued. The level of unidentified CIPs also continue to generate a significant overspend.
Key questions posed by the report
• How will the gap in the financial plan be closed • How will the gap in the CIP plan be closed
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 • Aid focus on innovation for improvement • Assist in developing responsibly and delivering the right services with the right staff
How this report impacts on current risks or highlights new risks
• Identifies the size and scale of the gap in the financial and CIP plans for 2017/18
Recommendation(s) and next steps
• Develop action plans for closure of the gaps in the Financial and CIP plans

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

FINANCIAL PERFORMANCE

P5 August 2017

26th September 2017

DONCASTER AND BASSETLAW TEACHING HOSPITALS NHS FOUNDATION TRUST

FINANCE SCORECARD AUGUST 2017

1. Income and Expenditure vs. Forecast

Performance Indicator	Monthly Performance Actual £'000	Monthly Performance Variance £'000		YTD Performance Actual £'000	YTD Performance Variance £'000		Annual Plan £'000	Forecast £'000
I&E Perf Exc Impairments	2,881	663	A	12,842	705	A	16,489	16,070
Income	(30,253)	(588)	F	(152,487)	(3,030)	F	(361,353)	(361,353)
STF Incentive	(770)	0	F	(3,271)	0		(11,547)	(11,547)
STF Adjustment 16/17	0	0		(419)	(419)	F	0	(419)
Operating Expenditure	32,840	1,236	A	163,641	3,962	A	376,553	376,553
Pay	21,980	838	A	108,723	2,913	A	253,957	253,957
Non Pay	10,860	398	A	54,918	1,049	A	122,596	122,596
I&E Perf Exc 16/17 STF	**3,300**	**1,082**	**A**	**13,261**	**1,124**	**A**	**16,489**	**16,489**

F = Favourable A = Adverse

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

2. CIPs

Performance Indicator	Monthly Performance Actual £'000	Monthly Performance Variance £'000		YTD Performance Actual £'000	YTD Performance Variance £'000		Annual Plan £'000	Forecast £'000
Employee Expenses	181	(772)	A	1,023	(1,911)	A	11,675	
Drugs	3	(6)		15	7	F	65	
Clinical Supplies	44	(50)	A	223	(223)	A	1,156	
Non Clinical Supplies	0	(1)		0	(1)	A	10	
Non Pay Operating Expenses	56	(24)	A	144	(157)	A	1,224	
Income	44	14	F	78	(76)	A	369	
Total	**328**	**(839)**	**A**	**1,483**	**(2,360)**	**A**	**14,500**	

3. Statement of Financial Position

All figures £m	Opening Balance 01.04.17	Current Balance 31.08.17	Movement in year
Non Current Assets	***196,907***	***194,066***	***(2,841)***
Current Assets	*33,612*	*63,272*	*29,660*
Current Liabilities	*(31,967)*	*(68,389)*	*(36,422)*
Non Current liabilities	*(79,348)*	*(82,583)*	*(3,235)*
Total Assets Employed	***119,204***	***106,365***	***(12,839)***
Total Tax Payers Equity	***119,204***	***(106,365)***	***(225,569)***

4. Other

Performance Indicator	Monthly Performance Plan £'000	Monthly Performance Actual £'000	YTD Performance Plan £'000	YTD Performance Actual £'000	Annual Plan £'000	Forecast £'000
Cash Balance	1,900	13,297	1,900	13,297	1,900	1,900
Capital Expenditure	635	120	2,038	947	6,481	7,842

5. Workforce

	Funded WTE	Actual WTE		Bank WTE	Agency WTE		Total in Post WTE	Under / (over)
Current Month	*6,031*	*5,618*		*197*	*214*		*6,029*	*2*
Previous Month	*6,031*	*5,583*		*182*	*142*		*5,907*	*124*
Movement	*0*	*(35)*	*0*	*(15)*	*(72)*	*0*	*(122)*	*(122)*

1. Context/Background

The month 5 position for 2017/18 is a deficit of £12,842k, which is £704k behind the planned year to date deficit of £12,137k. However it must be noted that this reported position includes £419k of STF income relating to 2016/17 that cannot be counted towards the Trust's control total. The restated position which will be used by NHS Improvement to monitor the Trust's financial performance, is a deficit of £13,261k which is £1,124k worse than our control total target to date (£12,137k).

Income was ahead of expected levels in August, but high agency and non pay expenditure has continued. The level of unidentified CIPs also continue to generate a significant overspend.

In month 3, £1.5m of balance sheet and reserve flexibilities were released into the position. In month 5, a further release of reserves has been required of £650k.

2. Executive Summary

Subjective Code	In Month Budget	In Month Actual	In Month Variance	YTD Budget	YTD Actual	YTD Variance	Previous YTD Budget	Previous YTD Actual	Previous YTD Variance	Annual Budget	Forecast
1. Income	-30,436	-31,023	-588	-152,729	-156,177	-3,449	-156,963	-156,025	938	-372,900	-373,319
2. Costs	31,604	32,840	1,236	159,678	163,641	3,962	161,445	157,758	-3,686	376,553	376,553
3.Capital Charges	1,051	1,065	14	5,188	5,379	191	5,890	5,824	-66	12,836	12,836
Total Position Before Impairments	**2,219**	**2,881**	**663**	**12,137**	**12,842**	**705**	**10,371**	**7,557**	**-2,814**	**16,489**	**16,070**
4.Impairments	0	0	0	0	0	0	0	0	0	0	0
Total Position After Impairments	**2,219**	**2,881**	**663**	**12,137**	**12,842**	**705**	**10,371**	**7,557**	**-2,814**	**16,489**	**16,070**
Remove STF relating to 16/17	0	419	419	0	419	419	0	0	0	0	419
Position to compare to control total	**2,219**	**3,300**	**1,082**	**12,137**	**13,261**	**1,124**	**10,371**	**7,557**	**-2,814**	**16,489**	**16,489**

I&E position	In Month Plan	In Month Actual	In Month Variance	2017/18 Plan
Position before STF	2,989	3,651	663	28,036
STF funding	-770	-770	0	-11,547
STF funding relating to 16/17	0	0	0	0
Reported position	2,219	2,881	663	16,489

During August, income has been £588k better than expected, this includes £250k relating to Hep C drugs funding for 2016/17, and daycase and elective activity has over-performed in month by £359k. During August, Care Group expenditure was £2.3m higher than budgeted levels. This overspend includes £828k of pay costs where agency premium costs are over and above funded levels, £839k of undelivered CIP savings and £562k of Medinet costs.

The cumulative income position at the end of Month 5 is £3,449k favourable.

Income Group	Annual Budget	In Month Budget	In Month Actual	In Month Variance	YTD Budget	YTD Actual	YTD Variance
Commissioner Income	-302,250	-24,752	-25,237	-485	-125,234	-127,199	-1,965
Drugs	-22,601	-1,862	-2,113	-250	-9,010	-10,004	-994
STF	-11,547	-770	-770	0	-3,271	-3,690	-419
Trading Income	-36,502	-3,051	-2,903	148	-15,214	-15,285	-71
Grand Total	**-372,900**	**-30,436**	**-31,023**	**-588**	**-152,729**	**-156,177**	**-3,449**

The expenditure position in August was £1,236k higher than budgeted levels, after underspend of £1,038k within reserves.

Subjective Code	In Month Budget	In Month Actual	In Month Variance	YTD Budget	YTD Actual	YTD Variance	Previous YTD Budget	Previous YTD Actual	Previous YTD Variance	Annual Budget	Forecast
1. Pay	21,142	21,980	838	105,809	108,723	2,913	106,224	104,290	-1,933	253,957	253,957
2. Non-Pay	9,394	10,830	1,436	48,504	54,454	5,951	52,517	51,374	-1,143	112,382	112,382
3. Reserves	1,068	29	-1,038	5,365	463	-4,902	2,704	2,094	-609	10,214	10,214
Total Expenditure Position	**31,604**	**32,840**	**1,236**	**159,678**	**163,641**	**3,962**	**161,445**	**157,758**	**-3,686**	**376,553**	**376,553**

3. Conclusion

The income position in month 5 is ahead of plan and forecast, but continuing high expenditure in relation to premium cost staffing, corporate non pay expenditure and undelivered CIP savings have led to an in month overspend of £662k. £650k of reserves have been released to support this position.

The Trust continues to spend more money than planned, this is in part driven by the lack of delivery of cost improvement and high agency spend but also significant additional non pay spend in August in a number of areas. The finance team alongside the Care Groups are working on a revised forecast position which will assess whether the financial plan can be realistically delivered. This work will dovetail with the work being completed by BDO to support CIP delivery. Progress will be reported at the next meeting.

4. Recommendations

The Committee is asked to note the month 5 2017/18 financial position of £13.3 million deficit, £1,124k adverse to plan after removal of the 16/17 STF funding.

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Title	**Performance Report – Month 5 2017/18**		
Report to	**Board of Directors**	**Date**	**26 September 2017**
Author	**David Purdue, COO** **Sewa Singh, MD** **Moira Hardy, Acting DNS** **Karen Barnard, DoPOD**		

Purpose		Tick one as appropriate
	Decision	
	Assurance	x
	Information	

Executive summary containing key messages and issues

The Performance Report highlights the key performance and quality targets required by the Trust to maintain NHSI compliance.

The Operations section focuses on the 4 main performance area for NHSI Compliance:

- Cancer, measured on average quarterly performance
- 4hr Access, measured on average quarterly performance
- 18 weeks including Diagnostic waits, measured quarterly but on monthly performance against active waiters, performance measured on the worst performing month in the quarter

The Quality section focuses on the key indicators of mortality and gives specific focus into best practice tariffs, complaints and serious incidents. Infection control against C Diff annual trajectory is also given.

The Workforce section shows staffing levels for the Trust with a focus on sickness/ absence.

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

This month's report is a hybrid version, containing the Operations performance report and commentary presented at F&P Committee on 19 September together with the traditional BIR. This will be honed for future months. The Operations performance report is shown to provide an illustration to Board of how performance information may be presented moving forwards.
Key questions posed by the report
• What are Board's views on the new style Operations performance report?
How this report contributes to the delivery of the strategic objectives
The report contributes to all strategic risks.
How this report impacts on current risks or highlights new risks
The report provides assurance against a number of risks on the Board Assurance Framework and highlights trends which may lead to new risks.
Recommendation(s) and next steps
That the Performance Report be noted.

Executive summary Board of Directors September 2017

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

Provide the safest, most effective care possible

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

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

Referral to Treatment

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

Though performing above the National average, the Trust position remains at 90.1% in August. The key issues relate to 4 significant specialities which have high numbers of patients above 18 weeks caused due to a shortfall in Trust capacity.

The 4 specialities with the largest capacity gaps are

- Ophthalmology 83.4%
- ENT 85.6%
- General Surgery 85.5%
- Orthopaedics 90.0%

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

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

The diagnostic target failed in August at 96.17% which is the worst performance for 6 months, with a combination of audiology and non-obstetric ultrasound delays. The key issue was related to non-obstetric ultrasound which saw its worst performance since February 2015. The issues relate to locum workforce and staff taking leave during the August period. The care group are required to develop a workforce plan for their October accountability meeting.

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

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

The Trust continues to be an outlier in relation to cancelled operations for non-clinical reasons on the day of the operation. The main issues in month were due to theatre overruns and equipment failures. Work to reduce theatre cancellations is being driven by the Theatres transformation project.

In August all cancelled patients were treated within the 28 day standard.

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.

August Performance

Trust 93.57%, Including GP attendances 94.45%

Quarter 2 93.38%, NHSI trajectory for Q2 93.1%

A total of 13807 attendances 888 patients failed to be seen in 4hrs

16.5% of patients were transferred to the urgent care centre at DRI. The streaming pathway for Bassetlaw will be in place by 1st. October 2017

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

The DBTH remains in the top third of Trusts nationally for 4hr access and is currently above trajectory for quarter 2 STF.

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

Cancer Performance

July 62 day performance 84.9%

Performance locally fell just below the required standard of 85%. The key pathway remains urology. Additional monies have been agreed to invest in High Value pathways which includes urology.

A 10 high impact intervention plan has been completed nationally to address the national performance shortfall against 62 day target. This includes the need for inter provider transfer at day 38.

62 day pathways remain a national priority and the key performance target for the Accountable Care System.

Stroke Performance

Stroke performance against direct access in 4hrs improved again in July with an increase of 18% to 74.4%. CT within 1hr improved by 19% to 74.5%.

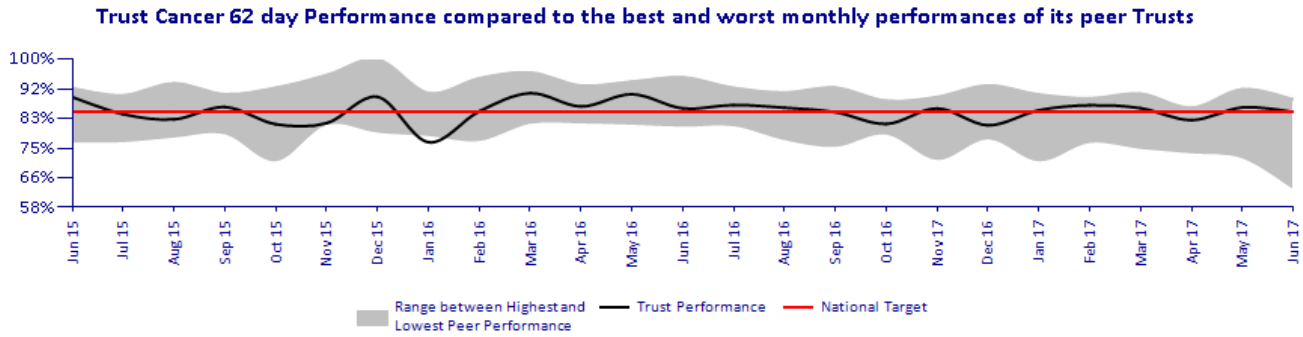
SNAPP performance continues to be the best performance in the region.

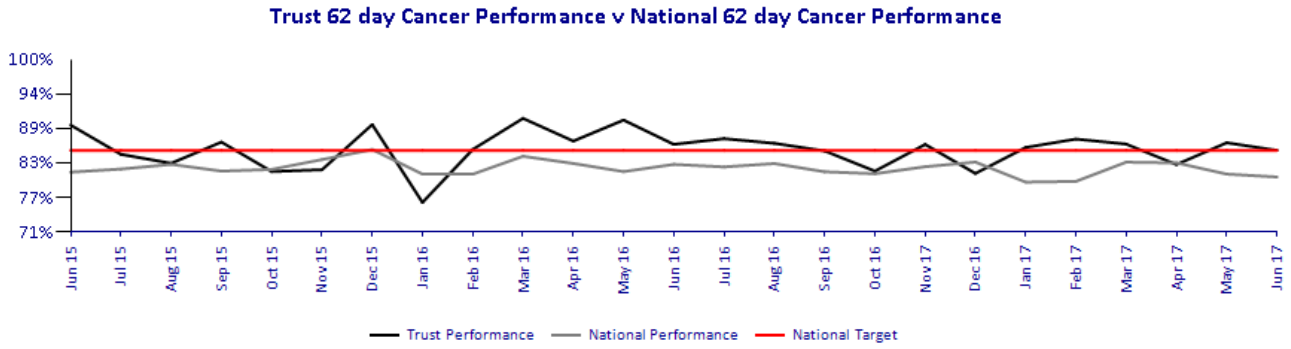
David Purdue Chief Operating Officer September 2017

September Board of Directors Performance Report

Cancer Targets

Cancer targets against performance measures are monitored quarterly and viewed as an annual target. 62 day performance nationally has failed for the past 3 years and is not achieving for the SYB ACS.
A National 8 high impact intervention plan has been shared which DBTH has responded to. Cancer performance is monitored locally through the Cancer alliance.





The table below shows July 2017 performance

The 62 day target has not been achieved in month at 84.9% against the National target of 85%. The key issue remains in urology due to the number of patients requiring treatment. The main cancer is prostrate pathway and the key issues are mainly related to the start of the pathway and the need for diagnostic tests. Urology is a high value pathway and we are waiting the outcome of a National bid through the cancer alliance for additional capacity in both urology clinics and MRI slots. The bid also includes the provision of additional pathway coordinators for diagnostics to support both 2 week wait and 62 day performance.

The performance in lower GI and haematology are as a result of complex pathway management and shared care breaches.

	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
Trust position	91.5%	88%	100%	100%	100%	100%	84.9%	100%	83.3%
Breast	97.5%	88%	100%	100%	100%		100%	100%	
Gynaecology	82.9%		100%				85.7%	100%	
Haematology	100%		100%				75%		100%
Head & Neck	89.4%		100%				100%		
Lower GI	94.3%		100%	100%			60%	100%	80%
Lung	100%		100%			100%	87.5%		61.5%
Other			100%	100%		100%	100%		
Skin	84%		100%	100%			100%		
Upper GI	86.5%		100%				86.7%		100%
Urological	90.2%		97.7%	100%		100%	73.3%		100%

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

CWT Standard	Tumour Group	Performance against CWT standard	High Level View
Two Week Wait	Gynae	82.9%	17 breaches – 8 patient choice, 5 administrative delays, 6 capacity related
	Head & Neck	89.4%	9 breaches – 5 patient choice, 2 capacity, 2 hospital cancellations
	Skin	84%	26 breaches – 14 patient choice, 5 capacity, 2 hospital cancellation, 5 administrative delay
	Upper GI	86.5%	19 breaches – 11 patient choice, 4 capacity, 2 hospital cancellation, 2 administrative delay
	Urology	90.2%	13 breaches – 4 patient choice, 2 capacity, 1 hospital cancellation, 6 administrative delay

62 day	Haematology	75%	1 patient – local pathway - original referral into H&N – 3 tests required to give definite diagnosis
	Lower GI	60%	2 patients – both shared care - 1 patient choice , 1 complex pathway
	Urology	73.3%	9 patients – 6 shared pathway & 3 local pathways . All linked to capacity issues - opd capacity local and inreach, imaging delays
62 day Consultant Upgrade	Lower GI	80%	2 patients – both shared care – 1 patient choice , 1 complex diagnostic pathway
	Lung	61.5%	5 patients – all shared care - 1 treatment capacity (STH) 4 – additional investigations or reporting required

The July positions for 2 week wait and breast symptomatic targets have deteriorated this month and are not compliant with the national target.

The pilot for 2 week wait booking ends at the end of September and an evaluation of the effectiveness of a separate 2 week wait booking team has been undertaken. Gaps in the service provision has led to some administrative issues which have caused breaches. The plan is to move a separate team back in with the central booking office to allow for increased flexibility in capacity planning. This will happen on the 18th of September.

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

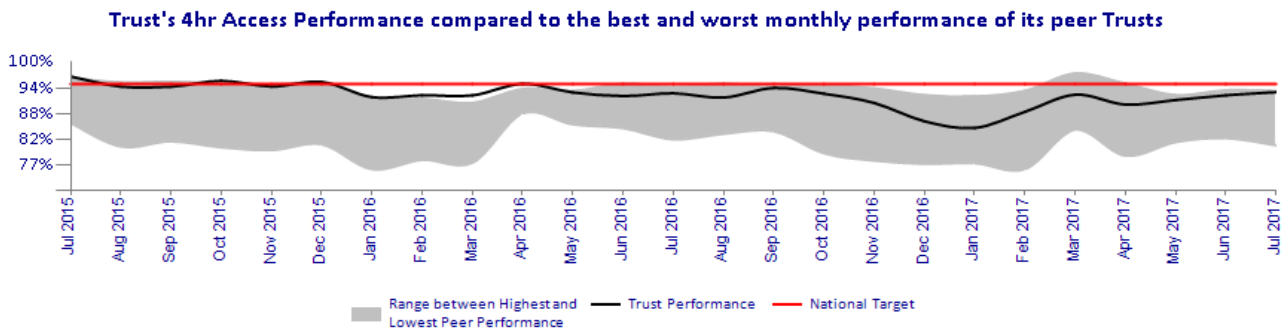
All 2 week wait referrals are now received through the Electronic Referral System (ERS) and the Trust is required to have 80% of all referrals through this pathway by the end of March 2018. Currently the performance is at 48.4% from a starting point of 28%.

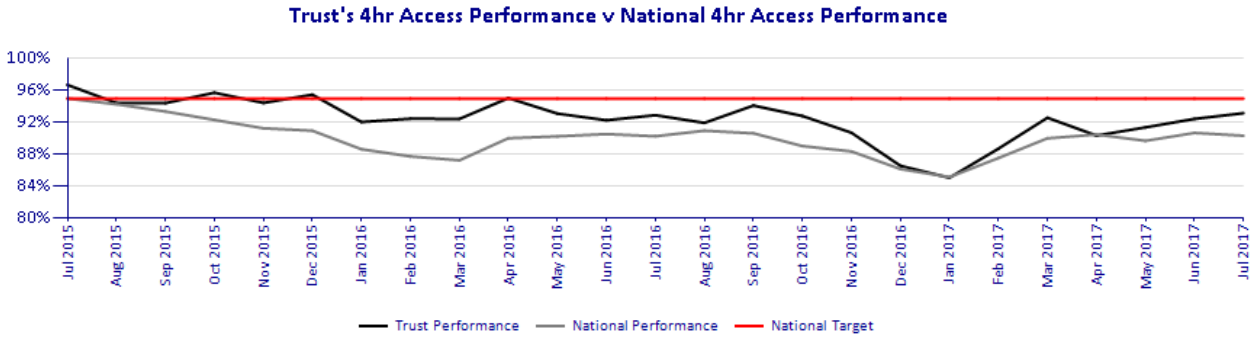
4hr Access Target

The Trust achieved 93.57% in August against the 95% 4hr access target.
The Trust requirement for NHSi is to achieve 93.1% in Quarter 2 at the end of month 2 the position is 93.28%.

Type 1 performance was not achieved on either site - 93.15% DRI, 94.67% BDGH.

August performance maintains the year to date performance at 92.41%.





888 patients failed to be treated in 4hrs, with a total of 13807 patients attending ED. 101 less patients breached in August compared to July, with 728 less attendances.

The main breach reason was wait to see ED doctor/ ED review which accounted for 607 of the 888 breaches. 157 breaches were classed as unavoidable due to the patients clinical condition. The ED waits have predominantly occurred after 18.00hrs following spikes in activity between 17.00-19.00hrs. Medical staffing rotas have been changed to allow for increased staffing out of hours and the consultant in charge is responsible for ensuring that the dept is controlled when they hand over to the on call consultant at 19.00hrs.

The Trust action plan to achieve the 4hr Access Target is monitored weekly through the internal 4hr access meeting and monthly via the A&E Delivery Board.

Performance reviews now concentrate on investigating all breaches to learn from any which are classed as avoidable. A full route cause analysis is undertaken for days when performance drops below 90%.

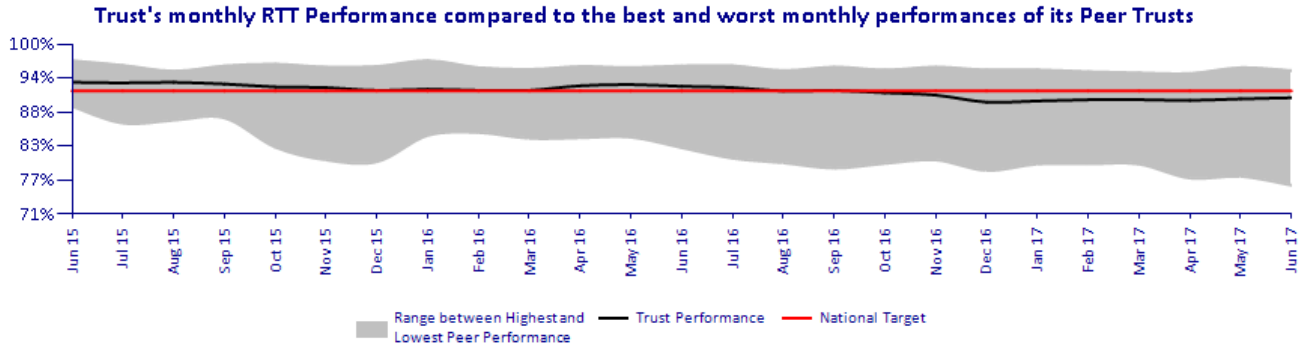
The System Perfect initiative concluded on the 12th of September and key learning is being reviewed to support winter planning. An internal perfect week will run from the 23rd of September and be focused on internal ED and assessment unit performance.

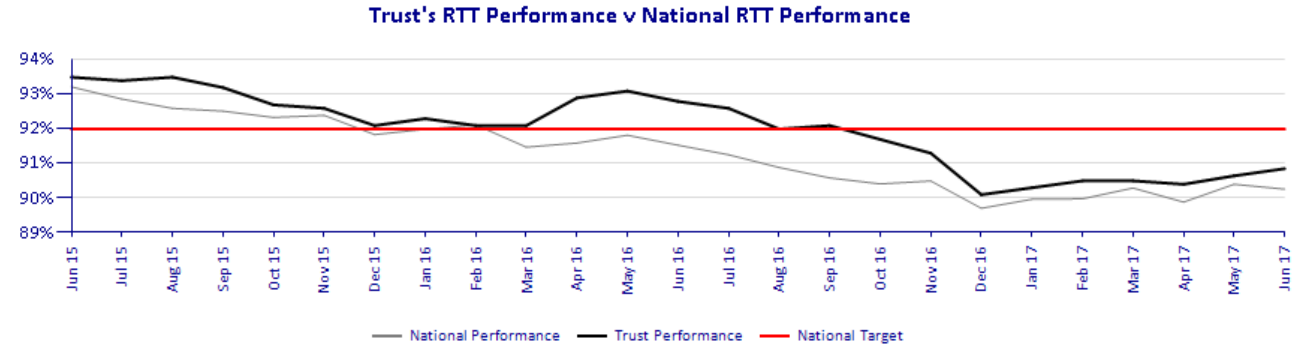
All quality targets have been achieved in August.

In relation to ambulance turnaround times, DBTH continues to have the best outcomes in the South Yorkshire and Bassetlaw STP. The Trust meets monthly with both YAS and EMAS to continue to develop the plans to improve performance.

Referral to Treatment

Incomplete pathways for August ended at 90.1%.





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

Specialties failed to meet 92% in July:

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

Diagnostic performance for August: 96.17%

285 breaches from 7447 tests
Key issues: capacity issues in Audiology, Non Obstetric U/S and nerve conduction studies

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

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

Trajectories are set for each service with timescales to achieve 92% in line with commissioned activity.
Ophthalmology, plan trajectory agreed for 92% at the end of November
- Outsourcing action plan agreed with care group for Ophthalmology due to capacity gap in consultant tier. Advert now out for 4 consultants.

ENT, plan trajectory agreed for 92% by the end of November.
- Additional capacity agreed with care group for ENT resultant in 'super weekends' and planned additional clinics up to December 2017
- New Clinical Lead of ENT to be agreed with COO/CGD
- Change of Business Manager to care group specialties

General Surgery, plan trajectory agreed for April 2018.
Key issue with operating capacity due to theatre availability, 3 additional operating sessions in place from October. Proposed weekend lists for day-case procedures planned.

Specialties Care Group
-Agreed RTT Recovery Plan with Urology Consultant Clinical Lead
- Weekly monitoring meeting in place with Consultant Clinical Lead and Managers
- Additional capacity agreed

Referral Management Plans
-Collaboration with CCG on referral management and support in managing demand: Contract for no growth in referrals, with the exception of urology with a planned increase and dermatology with a planned decrease.
Planned Care Programme Board manages the process of demand management. Overall GP referrals are down but consultant to consultant referrals are up, which means generally there has not been a reduction in activity.

Getting It Right First Time Initiative
Key to improving the performance is ensuring pathways are generated correctly the first time. To assist with this a formal training package has been designed and is being delivered through the data quality team.
- Targeted training in care groups based on data quality issues and increase in 52wk breaches

- New process in place to review and sign off 52wk breaches - COO and Medical Director

Diagnostics
Key issues in Audiology, two locums commenced 10/04 to improve the position.
A Deep Dive into Audiology capacity is being undertaken by the general manager.
Endoscopy capacity secured through external supplier to mitigate patient breaches.
Capacity reviews in non-obstetric ultrasound as a result of increases in obstetric ultrasound.
Nerve conduction studies being undertaken and reported dependent on STH capacity.

Stroke

The achievement of 1 hour scans continues to improve (74.5% at Trust level, compared to 55% for May 17 discharges), as does the percentage for admissions within 4 hours – 74.5% at Trust level, compared to 68.3% for May 17 discharges.

In both pathways, NHS Doncaster was higher than the Trust level (76.7% and 80.0% respectively).

Overall, patient admission times are more tightly spread over the time periods with only 4 showing over 10 hours. Of the 7 patients admitted between 4-6 hours, three were delayed Bassetlaw patients.

In terms of exceptions, there were apparent delays in diagnosis and subsequent transfer to DRI for 4 patients presenting at Bassetlaw Hospital. There appear to have been similar pathway delays in ED for DRI patients and 2 patients had to wait for beds to be available on Ward 16.

Direct admissions within 4hrs, target 90%. There has been a marked increase in performance in June 74.5 % compared with April 56.5% and May 68.3%.

	CCG			
Direct Admission within 4 Hours	Bassetlaw	Doncaster	Other	**Total**
Yes	7	24	4	**35**
No	4	6	2	**12**
Grand Total	**11**	**30**	**6**	**47**
Performance	63.6%	80.0%	66.7%	**74.5%**

Category	Sub Category	Total
Organisational	Beds	2
	Pathway	5
	Staff Availability	
Clinical	Patient Presentation	4
	Patient Needs	1

Scan within 1hr, target 48%

	CCG			
Scan 1 hr	Bassetlaw	Doncaster	Other	**Total**
Yes	7	23	5	**35**
No	4	7	1	**12**
Grand Total	**11**	**30**	**6**	**47**
Performance	63.6%	76.7%	83.3%	**74.5%**

Category	Sub Category	Total
Organisational	Scanner	
	Pathway	8
	Staff Availability	
Clinical	Criteria	
	Patient Needs	
	Patient Presentation	4

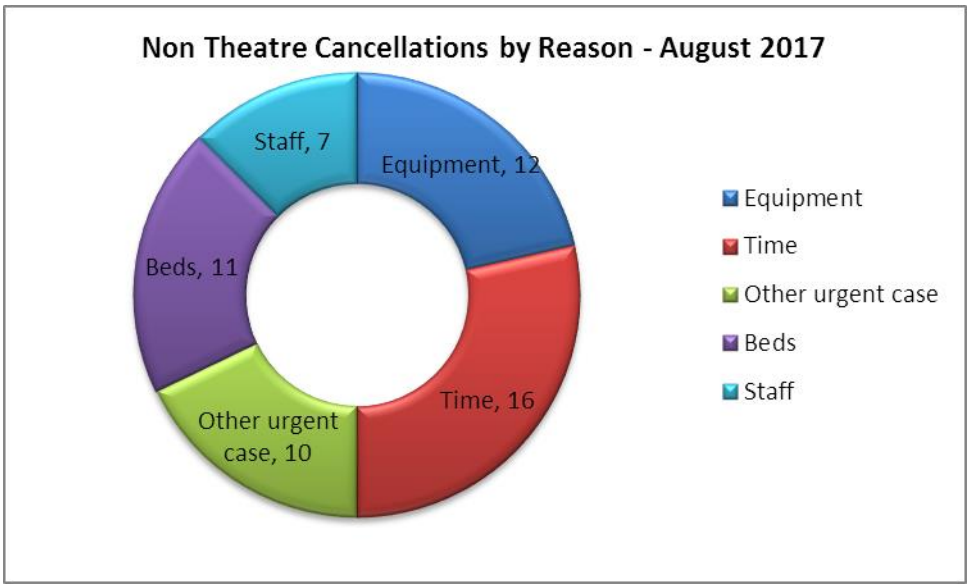
Cancelled Operations

In August, 1.1% of Trust operations were cancelled. This demonstrates a slight improvement on performance from the previous month.

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

Out of these overall cancellations, 56 operations were cancelled for non-theatre reasons: 38 at Doncaster, 12 at Bassetlaw and 6 at Mexborough Montagu.

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



No patients who were cancelled on the day of admission waited over the 28 day standard for their surgery to be rearranged.

DNA and CNA Rates

In August, the overall DNA rate across the Trust fell to 9.23% with a reduction in both the new and follow up non-attendance rates.

Cancelled appointments by the hospital and by patients also reduced in August.

Indicator	Standard	Aug-16		Qtr 1 2017-18	Jun-17	Jul-17	Aug-17
Outpatients: DNA Rate Total (Refreshed Each Month)		9.42%		9.51%	9.69%	9.57%	9.23%
Outpatients: DNA Rate First (Refreshed Each Month)		9.69%		10.12%	10.40%	10.19%	10.11%
Outpatients: DNA Rate Follow Up (Refreshed Each Month)		9.30%		9.22%	9.36%	9.27%	8.84%
Outpatients: Hospital cancellation Rate (Refreshed Each Month)		6.93%		5.80%	6.26%	7.29%	6.04%
Outpatients: Patient cancellation Rate (Refreshed Each Month)		9.80%		10.14%	10.53%	10.71%	10.33%

Outpatients: Patient died cancellation Rate (Refreshed Each Month)		0.24%		0.00%	0.00%	0.00%	0.00%

Work is commencing across the Trust to develop new ways of communicating better with patients regarding their outpatient appointments.

A text reminder service is in place across both sites for outpatients, which clearly informs patients of the cost of wasted appointments.

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

David Purdue September 2017

At a Glance -August 2017 (Month 5)

Page		Indicator	Standard (Local, National Or Monitor)		Current Month	Month Actual	Data Quality RAG Rating
4-5	Monitor Compliance Framework	31 day wait for second or subsequent treatment: surgery	94.0%	M	July	100.0%	
		31 day wait for second or subsequent treatment: anti cancer drug treatments	98.0%	M		100.0%	
		31 day wait for second or subsequent treatment: radiotherapy	94.0%	M		100.0%	
		62 day wait for first treatment from urgent GP referral to treatment	85.0%	M		85.1%	
		62 day wait for first treatment from consultant screening service referral	90.0%	M		96.3%	
		31 day wait for diagnosis to first treatment- all cancers	96.0%	M		98.9%	
		Two week wait from referral to date first seen: all urgent cancer referrals (cancer suspected)	93.0%	M		91.5%	
		Two week wait from referral to date first seen: symptomatic breast patients (cancer not initially suspected)	93.0%	M		88.0%	
6-7		A&E: Maximum waiting time of four hours from arrival / admission / transfer / discharge (Trust)	95.0%	M	August	93.6%	
8-9		Maximum time of 18 weeks from point of referral to treatment- incomplete pathway	92.0%	M	August	90.1%	
		% of Patients waiting less than 6 weeks from referral for a diagnostics test	99.0%	N		3.8%	
6-7	A&E Performance Indicators	Total time in A&E: 4 hours (95th percentile) HH:MM	04:00	N	August	04:46	
		A&E Admitted patients total time in A&E (95th percentile) HH:MM	04:00	N		07:45	
		A&E Non-admitted patients total time in A&E (95th percentile) HH:MM	04:00	N		03:59	
		A&E: Time to treatment decision (median) HH:MM	01:00	N		00:54:00	
		A&E unplanned re-attendance rate %	5.0%	N		0.4%	
		A&E: Left without being seen %	5.0%	N		2.7%	
		Ambulance Handovers Breaches -Number waited over 15 & Under 30 Minutes		N	August	708	
		Ambulance Handovers Breaches-Number waited over 30 & under 60 Minutes				93	
		Ambulance Handovers Breaches -Number waited over 60 Minutes				12	
10-12	Stroke	Proportion of patients scanned within 1 hour of clock start (Trust)	48.0%	N	June	55.0%	
		Proportion of patients directly admitted to a stroke unit within 4 hours of clock start (Trust)	90.0%	N		68.3%	
		Percentage of eligible patients (according to the RCP guideline minimum threshold) given thrombolysis (Trust)	20.0%	N		8.3%	
		Percentage of patients treated by a stroke skilled Early Supported Discharge team (Trust)	40.0%	N		76.9%	
		Percentage of those patients who are discharged alive who are given a named person to contact after discharge (Trust)	95.0%	N		80.8%	
		Implementation of Stroke Strategy - TIA Patients Assessed and Treated within 24 Hours	60.0%	N	August	89.3%	
13	Theatres & Outpatients	Cancelled Operations	0.8%	N	August	1.1%	
		Cancelled Operations-28 Day Standard	0	N		1	
		Out Patients: DNA Rate		L		9.2%	
		Out Patients: Hospital Cancellation Rate		L		6.0%	
				L			
	Effective	Emergency Readmissions within 30 days (PbR Methodology)		L	July	6.2%	

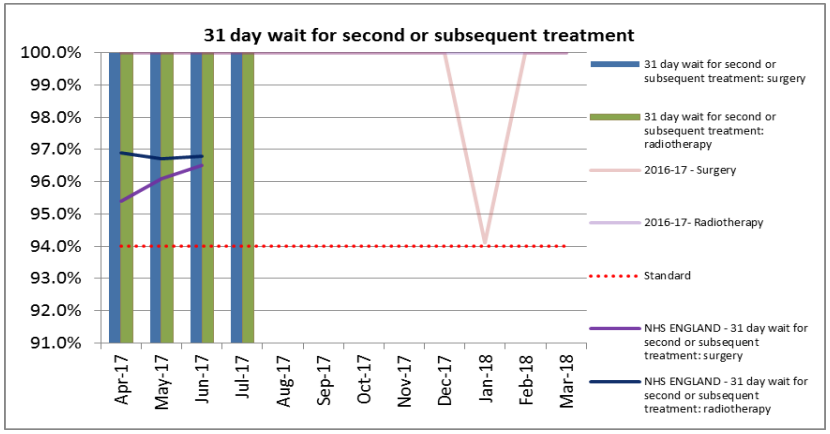
Page		Indicator	Current Month	Month Actual (TRUST)	Month Actual (DRI)	Month Actual (BDGH)	Data Quality RAG Rating
17	Fractured Neck of Femur	% of patients achieving Best Practice Tariff Criteria	August	50.0%	53.3%	43.7%	
		Best Practice Criteria					
		36 hours to surgery Performance		58.6%	60.0%	56.3%	
		72 hours to geriatrician assessment Performance		91.3%	90.0%	93.8%	
		% of patients who underwent a falls assessment	August	100.0%	100.0%	100.0%	
		% of patients receiving a bone protection medication assessment		100.0%	100.0%	100.0%	
		Mortality-Deaths within 30 days of procedure		0.00%	0.00%	0.00%	

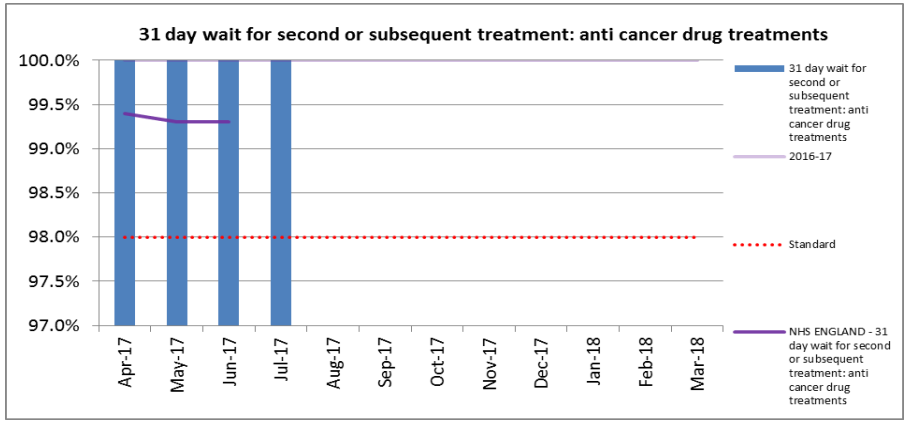
Page		Indicator	Standard (Local, National Or Monitor)		Current Month	Month Actual	Data Quality RAG Rating
19	Safe	Infection Control C.Diff	4 Per Month for Qtr 2 - 45 full year	M	August	2	
		Infection Control MRSA	0	L		0	
16		HSMR (rolling 12 Months)	100	N	Jun-17	89.36	
		Never Events	0	L	August	0	
		VTE	95.0%	N	July	95.0%	
19		Pressure Ulcers	12 Per Month 144 full Year	L	August	7	
		Falls that result in a serious Fracture	2 Per Month 23 full Year	L		1	
		Catheter UTI	Snap shot audit			0.59%	

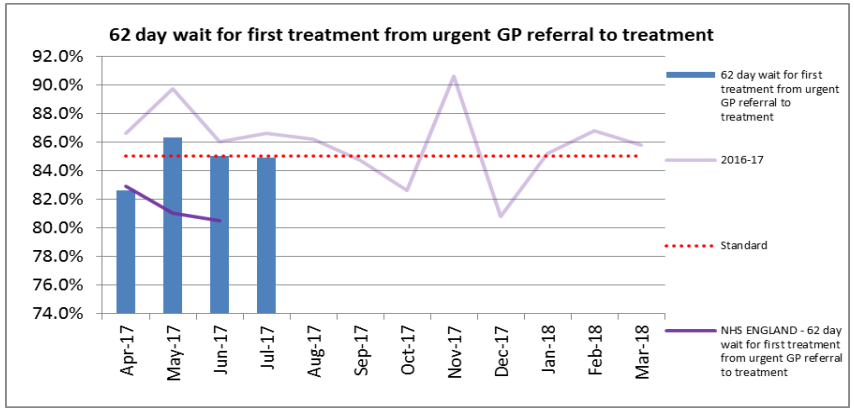
Page		Indicator	Current Month	Month Actual	Data Quality RAG Rating
20	Complaints & Claims	Complaints received (12 Month Rolling)	August	538	
		Concerns Received (12 Month Rolling)		845	
		Complaints Performance		31.0%	
		Clinical Negligence Scheme for Trusts (CNST)		2	
		Liabilities to Third Parties Scheme (LTPS)		1	
		Claims per 1000 occupied bed days		0.13	

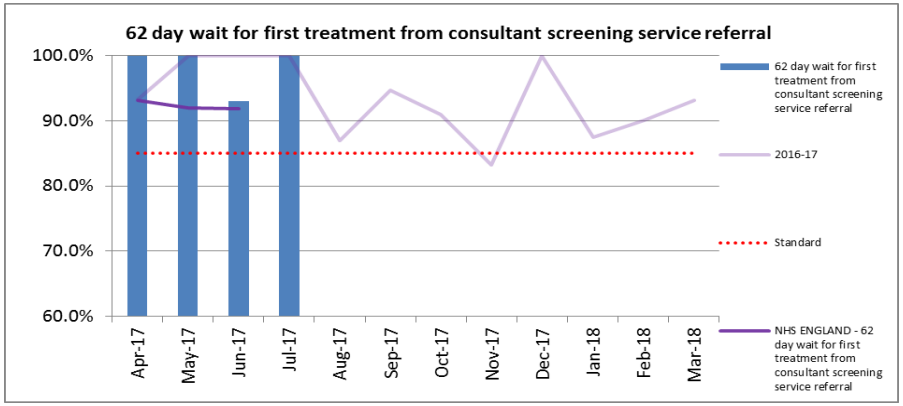
Page		Indicator	Current Month	Month Actual	YTD (Cumulative)	Data Quality RAG Rating
23	Workforce	Sickness	August	4.1%	4.1%	
24		Appraisals			56.6%	
25		SET Training			69.9%	

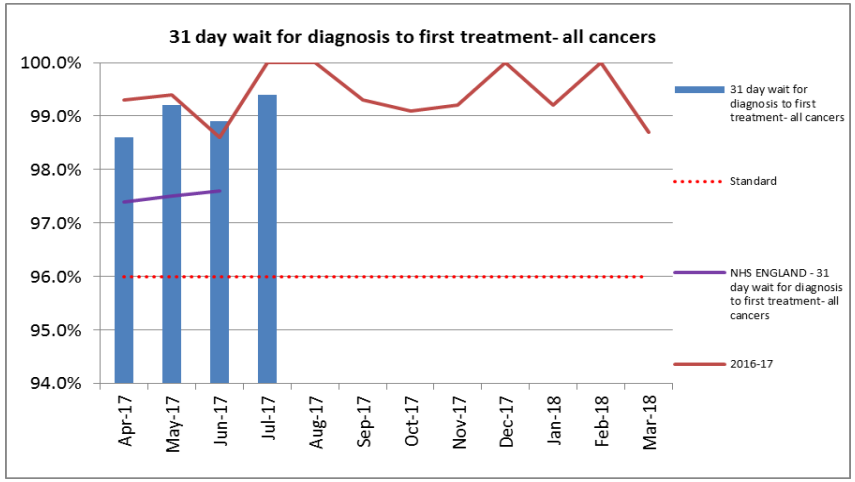
Monitor Compliance Framework: Cancer - Graphs - July 2017 (Month 4)

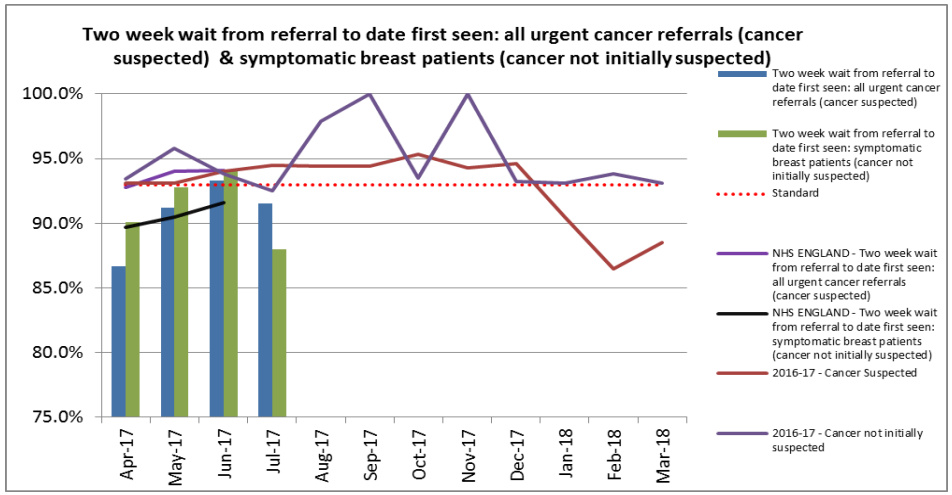




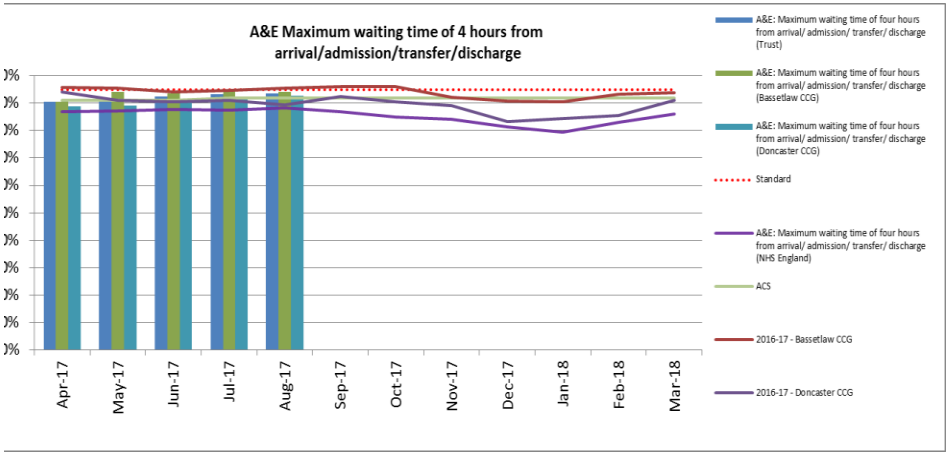


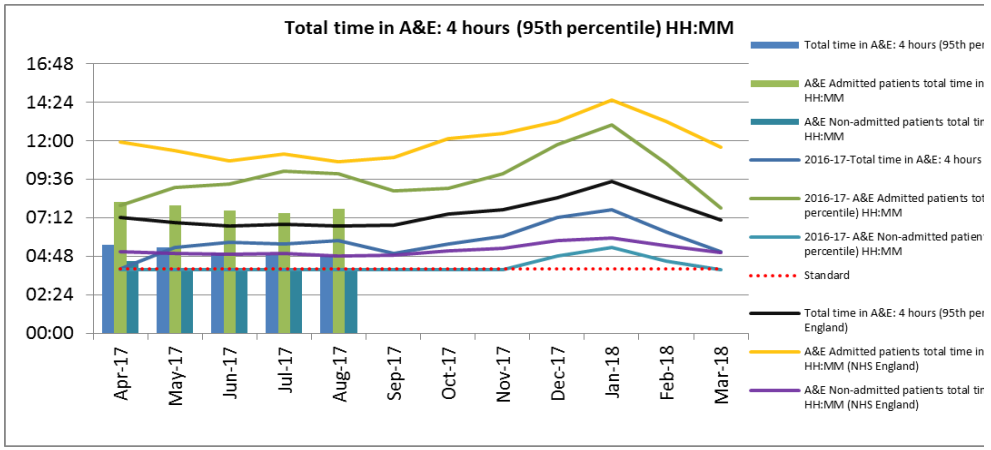


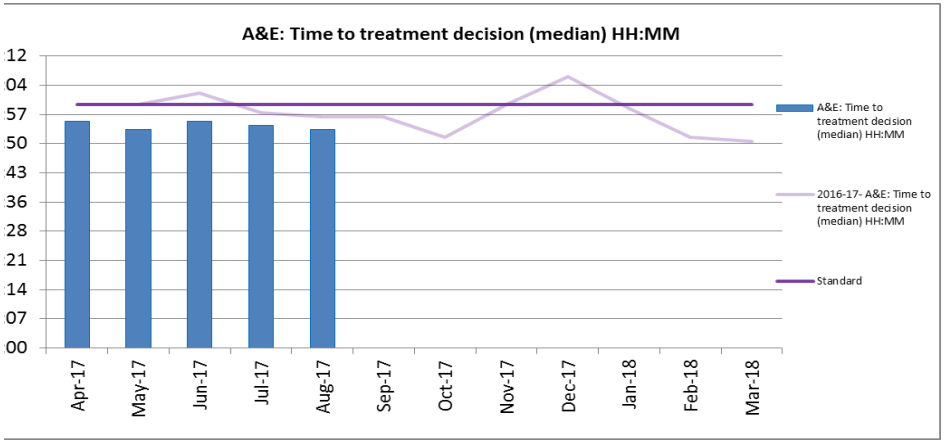


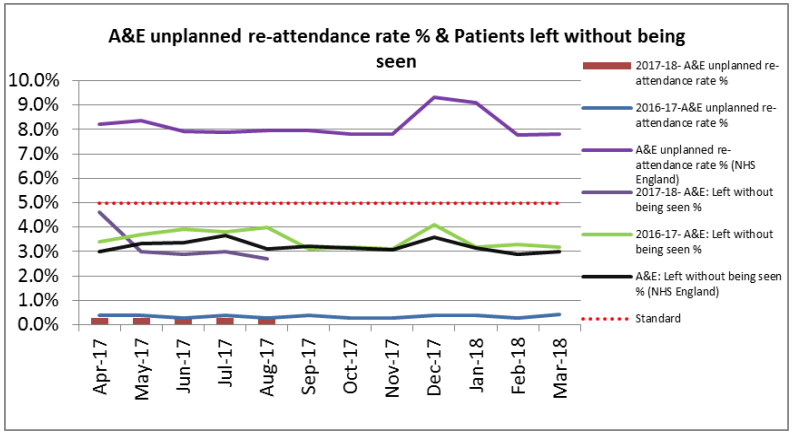


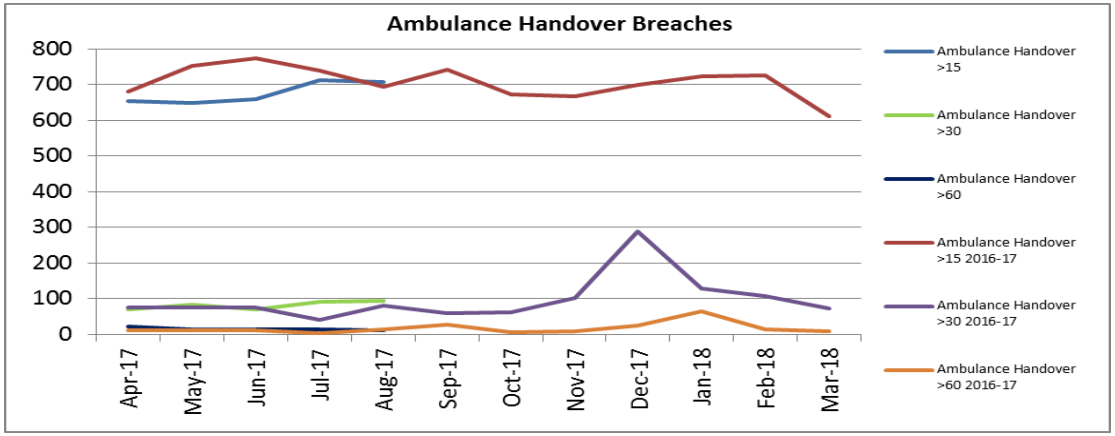
Monitor Compliance Framework: A&E - Graphs - August (Month 5)



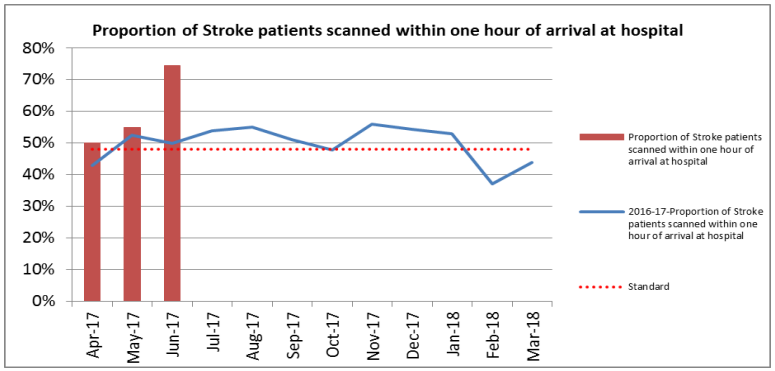


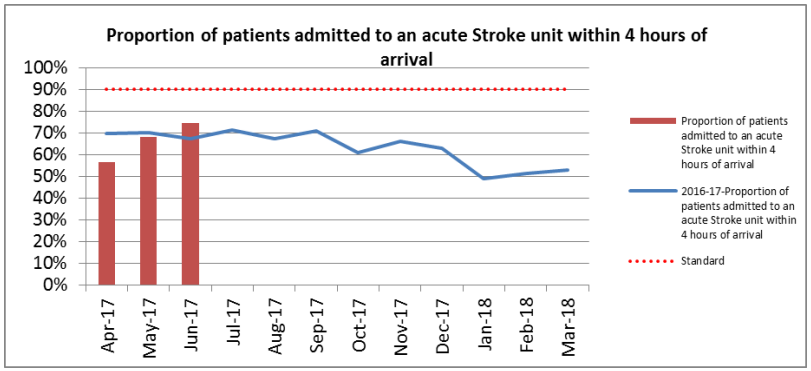


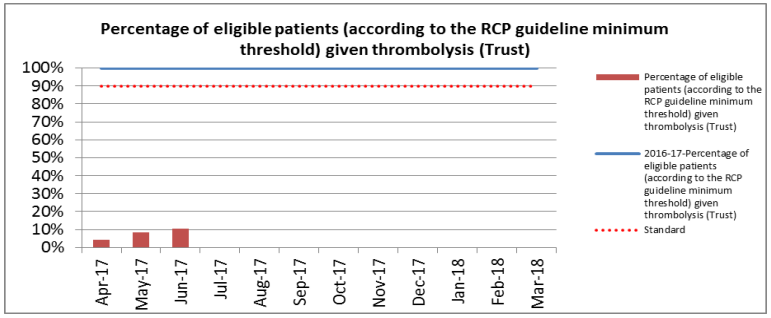


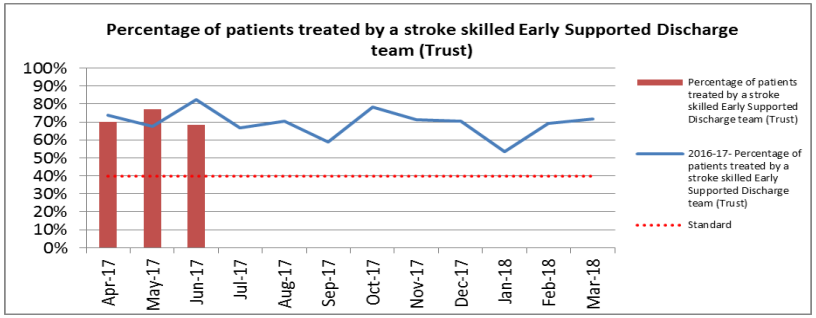


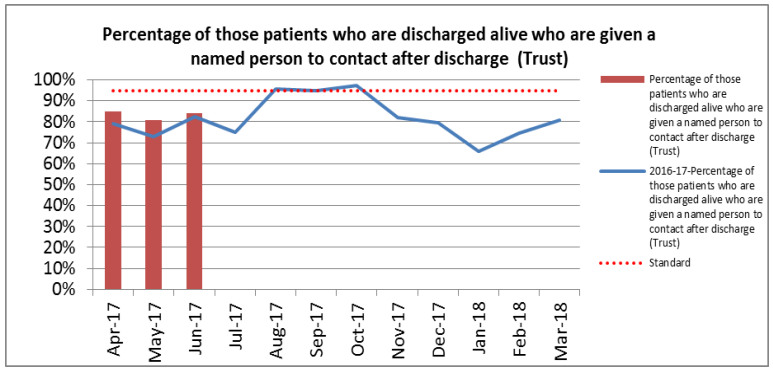
Stroke - Graphs June 2017 (Month 3)

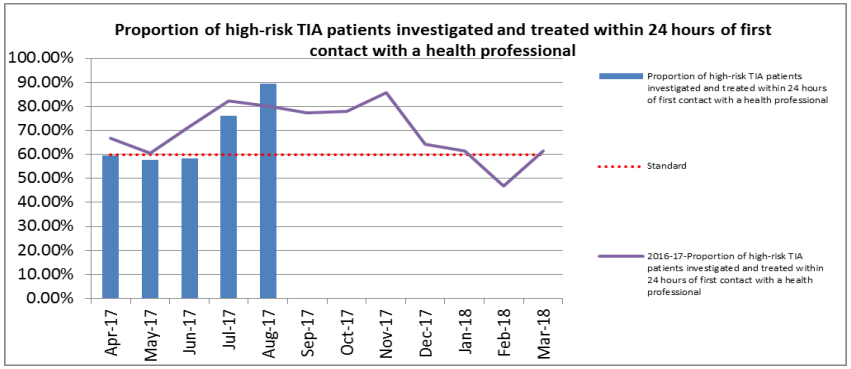




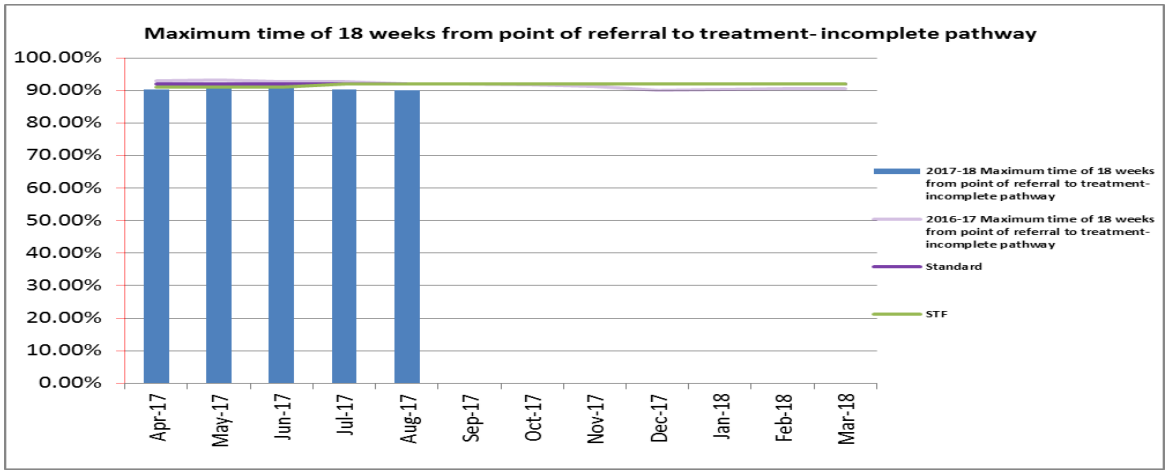


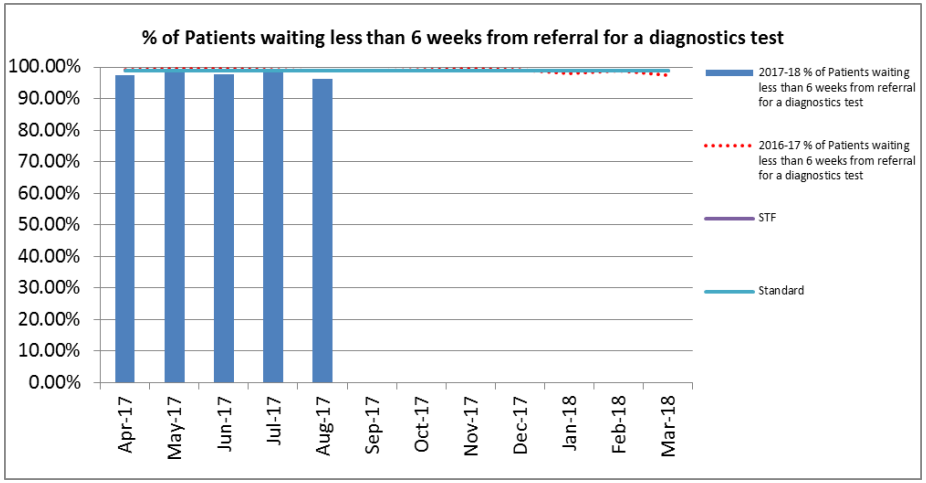


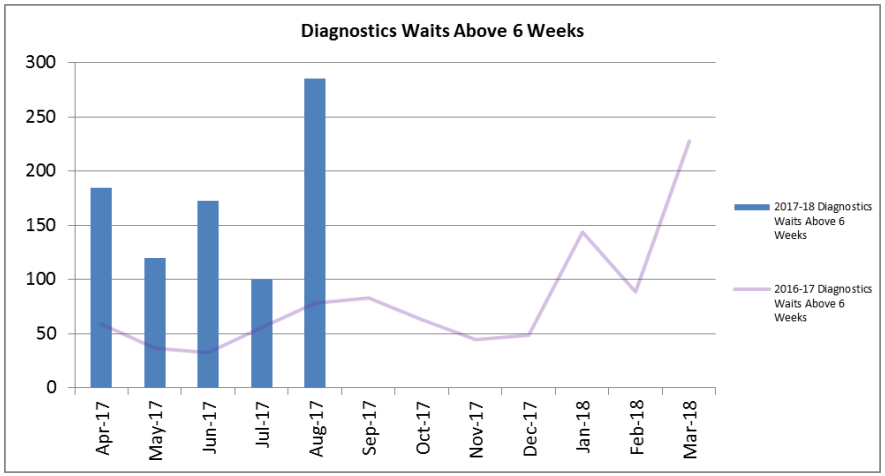




Monitor Compliance Framework: 18 Weeks & Diagnostics - August (Month 5)







Doncaster and Bassetlaw Hospitals NHS
NHS Foundation Trust

Executive summary - Safety & Quality -August 2017 (Month 5)

HSMR: The Trust's rolling 12 month HSMR continues to remain better than expected at 89.4. The mortality monitoring group continue to work in targetted areas to improve mortality.

Fractured Neck of Femur: There has been a deterioration in achievement of BPT for #NOF at BDGH but patient numbers were small. In depth review ofmort alityat BDGH is expected to be complete soon and will be presented to CGC and QEC.

Serious Incidents: SI numbers remain below that reported for the same period last year.

Executive Lead:
Mr S Singh

C.Diff: The number of Clostridium Difficile cases remains above trajectory in August and also for YTD figures.
In light of the continued increase in C Diff cases, infection, prevention & control hove sought to understand why this incr ease is being seen and there is concern that achievement of the internal target to improve on last years performance may not be achieved .
In September 2016, the test for C Diff changed and the new / current test is more sensitive to identification of C DIff. Alth ough not apparent immediately it is believed that the new / current test is showing positive results which would previously have been negative.
A number of measures has been put in place in an attempt to reduce the number of C Diff cases, and as the Post Infection Revi ews (PIRs) have only highlighted two cases where there has been a lapse in care related to antibiotic use, the increased sensitiviity of the new / current test appears to be the reason for the increase in cases.
.

Fall resulting in significant harm: Whilst there has been 1 fall resulting in serious harm in August this is less than the YTD position for 16/17.

Hospital Acquired Pressure Ulcers: The rate of case is slighlty above trajectory this month, but this is expected to reduce when demonstrated unavoidable throug h investigation

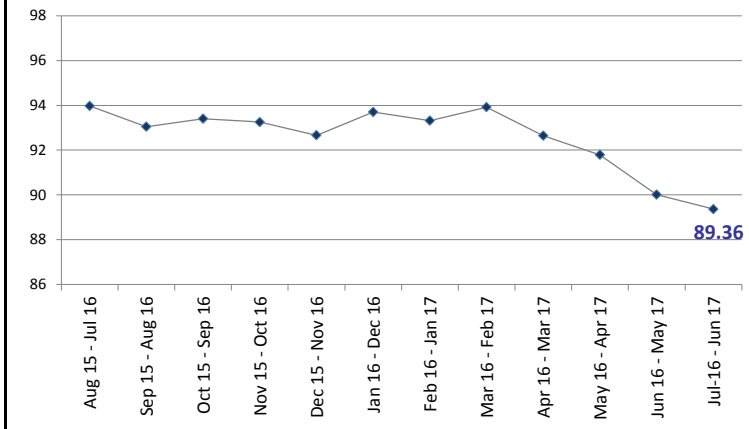
Complaints and concerns: Normal variation is seen in the rate of complaints and concerns. Performance on reply times has deteriorated this month and t he reasons for this will be explored.

Friends & Family Test: Performance remains better than the national average with the exception of ED response rates.

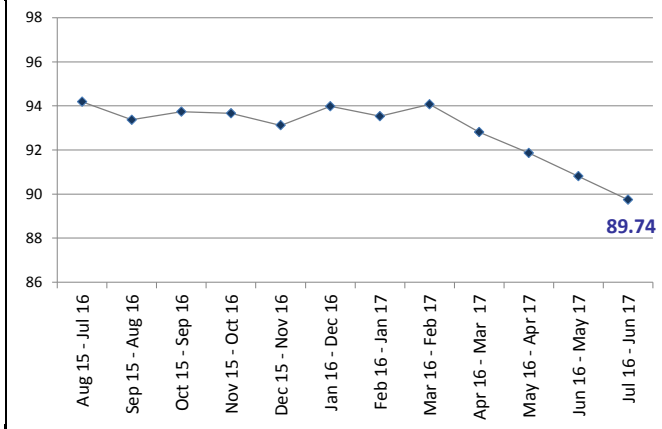
Executive Lead:
Mrs M Hardy

Hospital Standardised Mortality Ratio (HSMR) - June 2017 (Month 3)

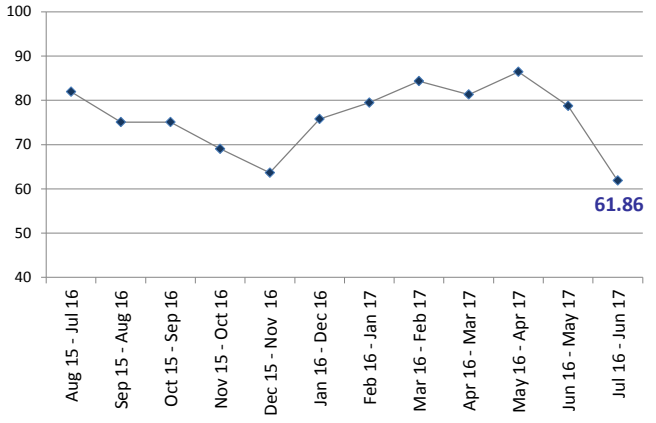
Overall HSMR (Rolling 12 months)



HSMR - Non-elective Admission (Rolling 12 months)



HSMR - Elective Admission (Rolling 12 months)

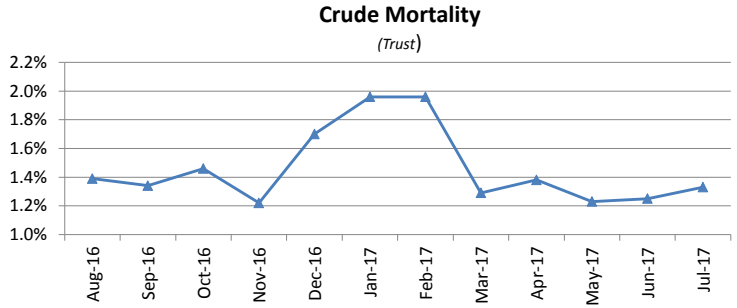


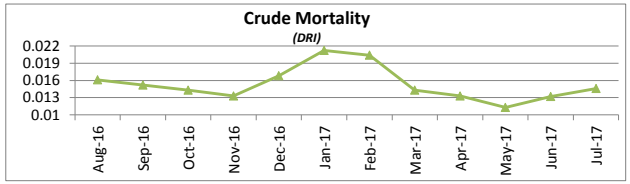
HSMR Trend (monthly)

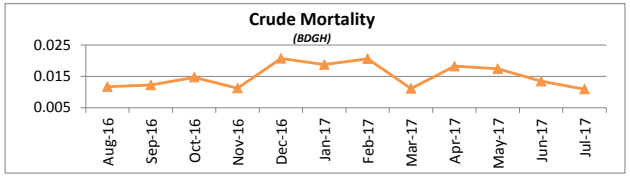
	2014	2015	2016	2017
January	115.45	116.80	99.21	94.91
February	99.11	99.94	97.73	105.54
March	102.91	90.54	97.37	82.71
April	110.49	105.91	88.50	80.9
May	90.93	101.15	96.60	76.68
June	113.74	80.27	93.67	84.75
July	109.94	92.56	97.73	
August	120.18	100.27	87.52	
September	110.10	90.26	95.34	
October	106.58	90.29	88.66	
November	106.84	88.98	82.30	
December	115.87	82.30	93.52	

Crude Mortality (monthly) - August 2017 (Month 5)

(number of deaths/number of patient discharged)



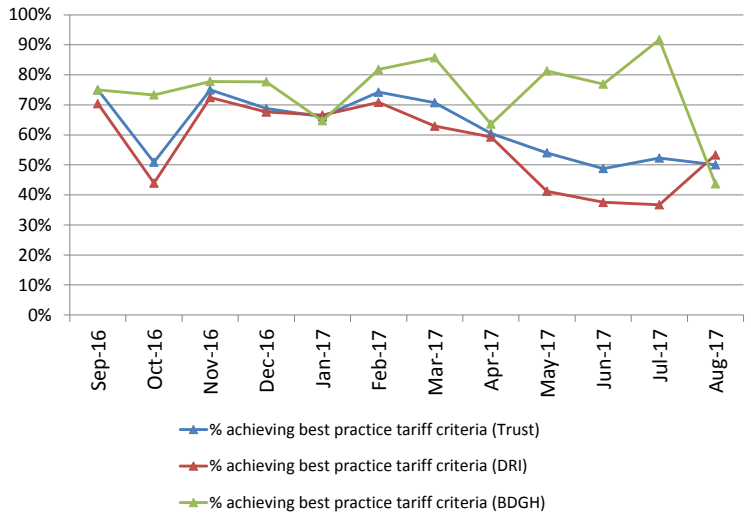




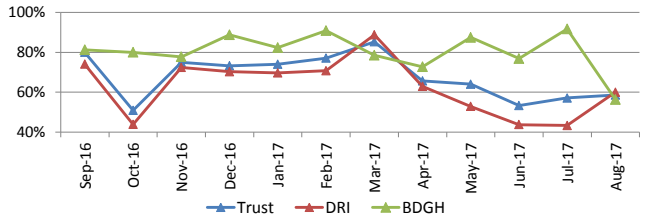
	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17
Trust	1.34%	1.38%	1.22%	1.70%	1.96%	1.96%	1.29%	1.38%	1.22%	1.25%	1.33%	1.01%
Doncaster	1.53%	1.43%	1.33%	1.68%	2.12%	2.04%	1.43%	1.33%	1.13%	1.32%	1.46%	1.01%
Bassetlaw	1.22%	1.47%	1.12%	2.07%	1.87%	2.06%	1.11%	1.82%	1.74%	1.34%	1.09%	1.27%

NHFD Best Practice Pathway Performance - August 2017 (Month 5)

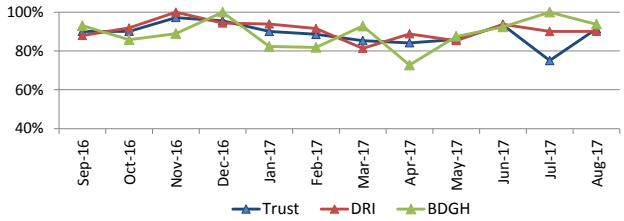
Best Practice Criteria Performance



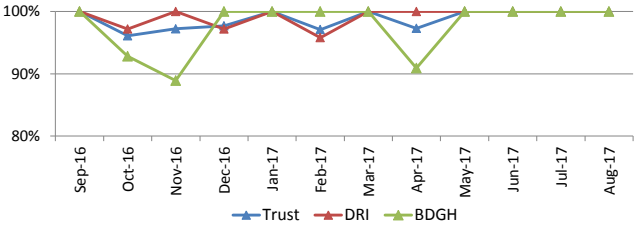
36 Hours to Surgery Performance



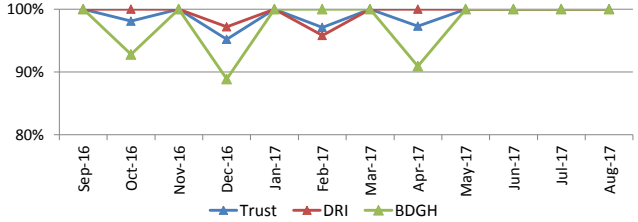
72 hours to Geriatrician Assessment Performance



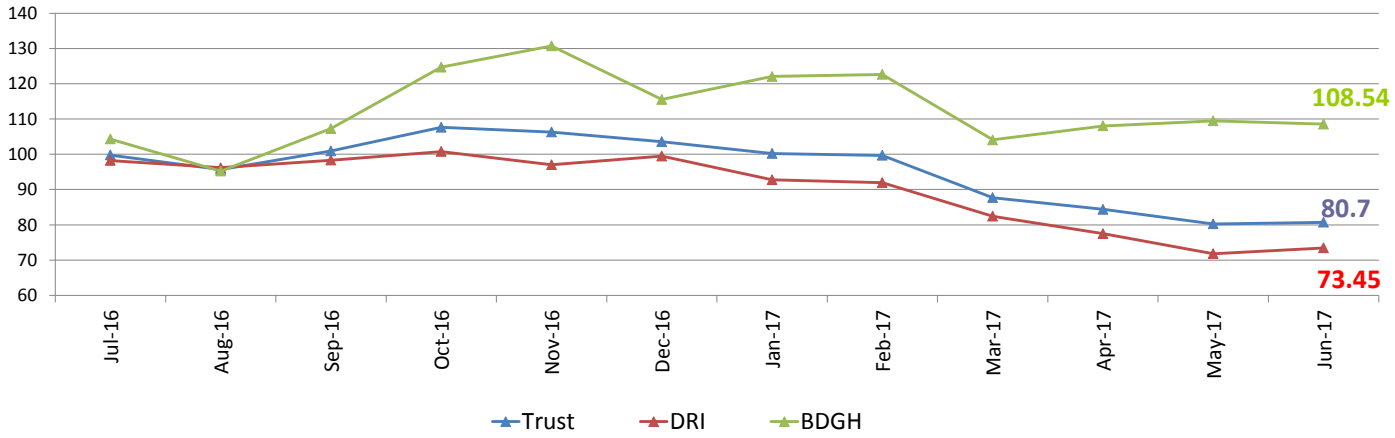
Bone Protection Medication Assessment



Falls Assessment Performance



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



Serious Incidents - August 2017 (Month 5)

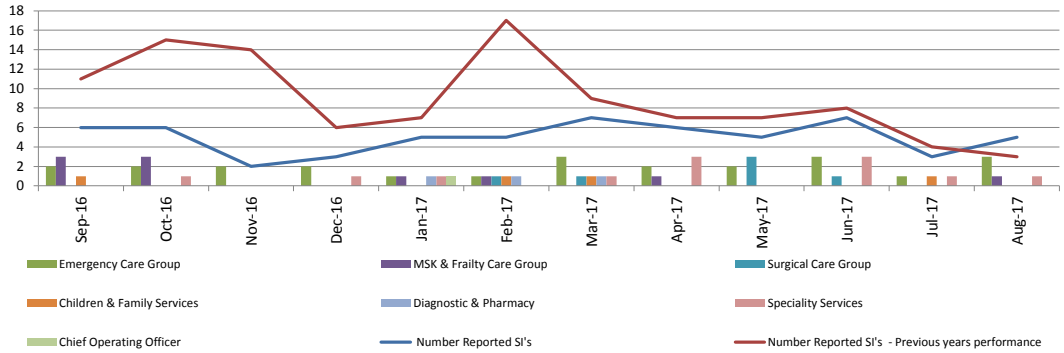
(Data accurate as at 11/09/17)

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

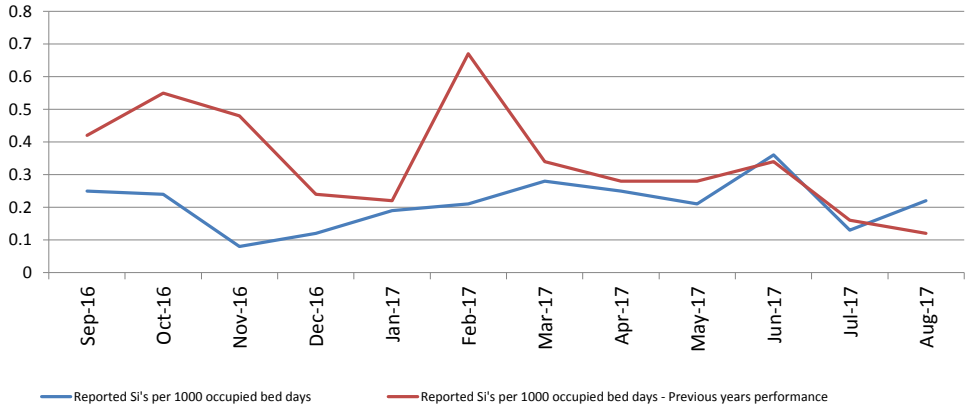
Overall Serious Incidents

Number Serious Incidents Reported

(Trust & Care Group)



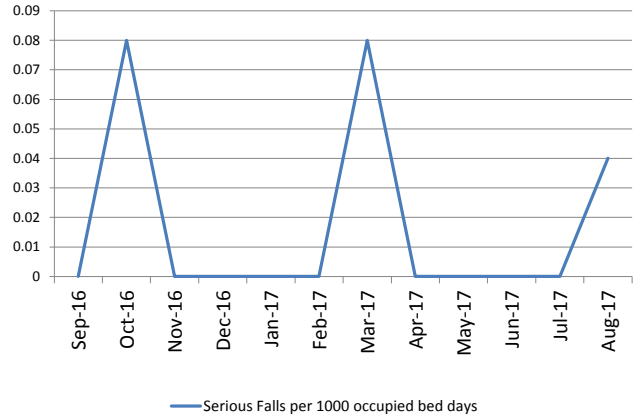
Serious Incidents per 1000 occupied bed days



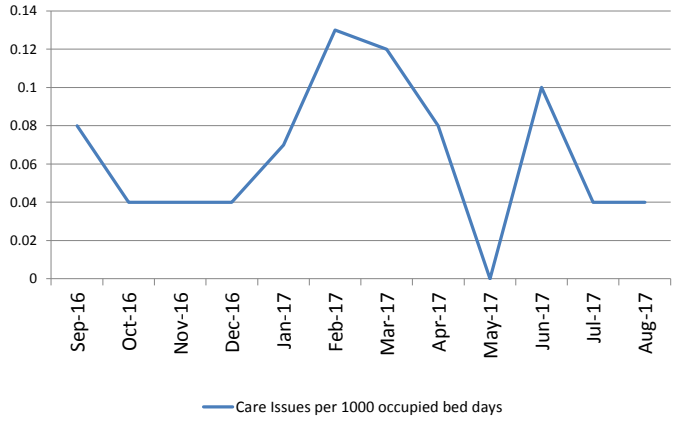
Current YTD reported SI's (Apr 17-Aug 17)	26	Number reported SI's (Apr 16-Aug 16)	29
Current YTD delogged SI's (Apr 17-Aug 17)	11	Number delogged SI's (Apr 16-Aug 16)	6

Themes

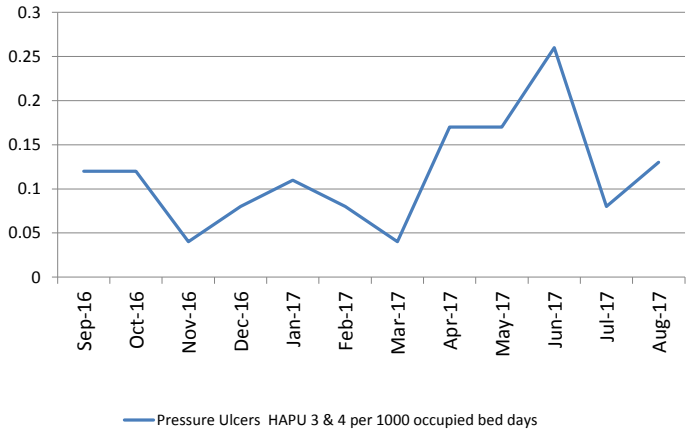
Serious Falls



Care Issues

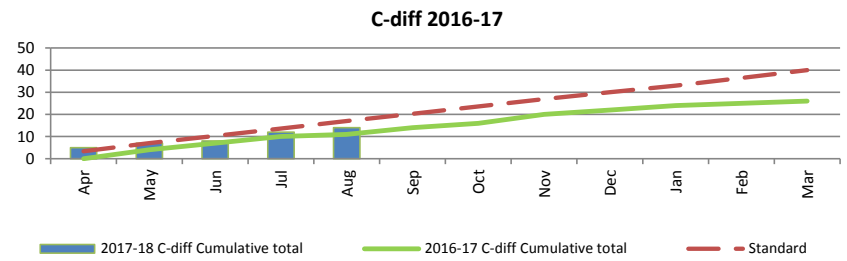


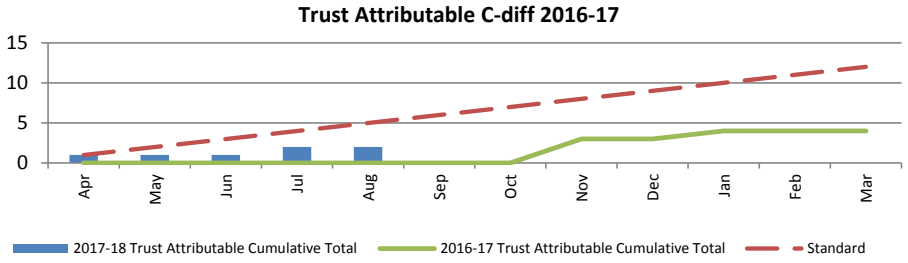
Pressure Ulcers - Category 3 & 4 (HAPU)



Monitor Compliance Framework: Infection Control C.Diff - August 2017 (Month 5)
(Data accurate as at 18/09/2017)

	Standard	Q1	Jul	Aug	YTD
2017-18 Infection Control - C-diff	40 Full Year	8	4	2	14
2016-17 Infection Control - C-diff	40 Full Year	7	3	1	11
2017-18 Trust Attributable	12	1	1	0	2
2016-17 Trust Attributable	12	0	0	0	0

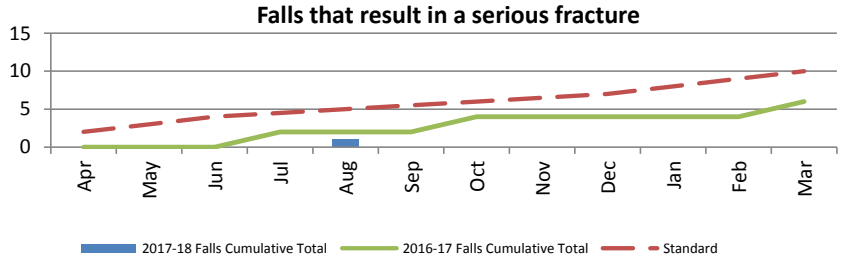




Pressure Ulcers & Falls that result in a serious fracture - August 2017 (Month 5)
(Data accurate as at 11/09/2017)

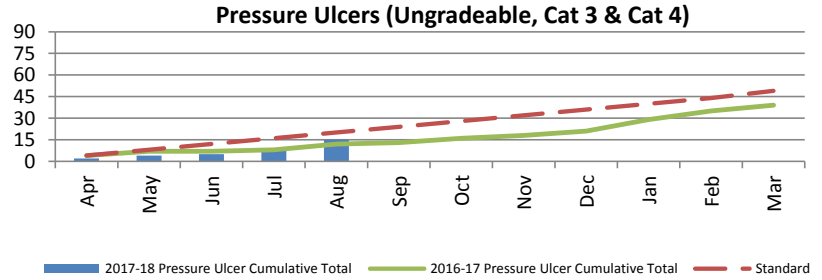
	Standard	Q1	Jul	Aug	YTD
2017-18 Serious Falls	10 Full Year	0	0	1	1
2016-17 Serious Falls	19 Full Year	0	2	0	2

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



	Standard	Q1	Jul	Aug	YTD
2017-18 Pressure Ulcers	34 Full Year	5	3	7	15
2016-17 Pressure Ulcers	60 Full Year	7	1	4	12

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

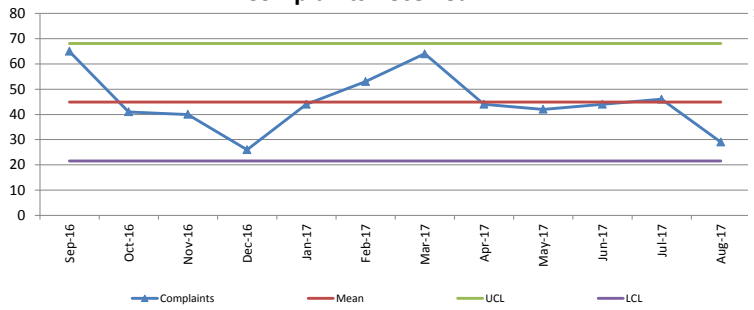


Complaints & Claims - August 2017 (Month 5)

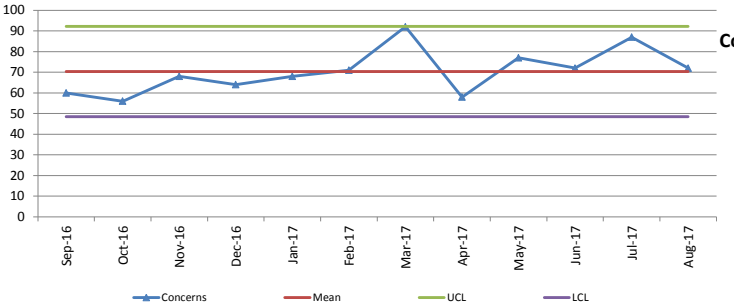
(Data accurate as at 06/09/2017)

Complaints

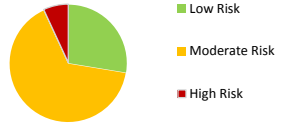
Complaints Received



Concerns Received



August 2017 Complaints Recieved Risk Breakdown

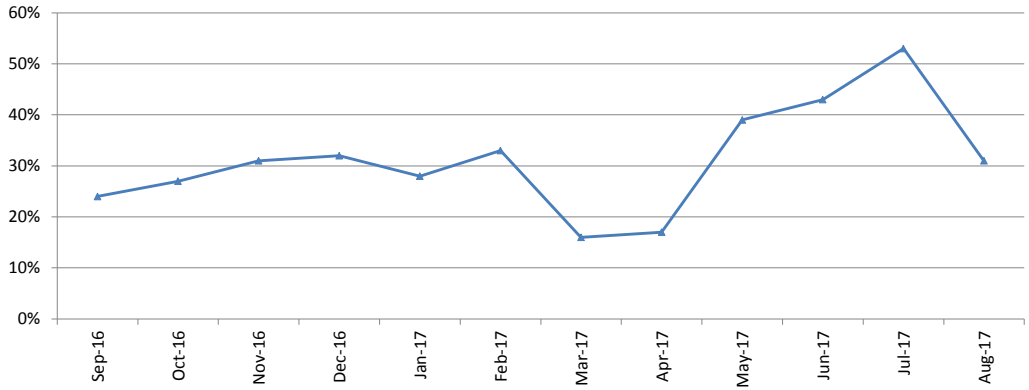


Year to Date Complaints Recieved Risk Breakdown

Complaints - Resolution Perfomance

(% achieved resolution within timescales)

Complaints Resolution Performance



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

Parliamentary Health Service Ombusdman (PSHO)

Month	Number of cases referred for investigation	Number Currently Oustanding
August	Awaiting data	6

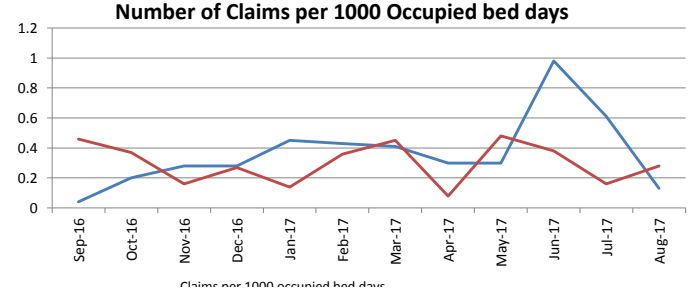
	Number referred for investigation YTD	Outcomes YTD	
2016/17	8	Fully / Partially Upheld	**1**
		Not Upheld	**4**
		No further Investigation	**0**
		Case Withdrawn	**0**
2017/18	4	Fully / Partially Upheld	0
		Not Upheld	1
		No further Investigation	0
		Case Withdrawn	0

Claims

	Current Month	Month Actual	YTD
Clinical Negligence Scheme for Trusts (CNST)	Aug-16	2	**42**
Liabilities to Third Parties Scheme (LTPS)	Aug-16	1	**8**

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

Number of Claims per 1000 Occupied bed days

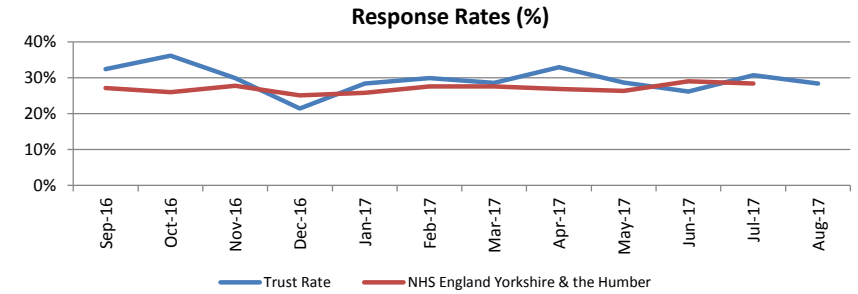


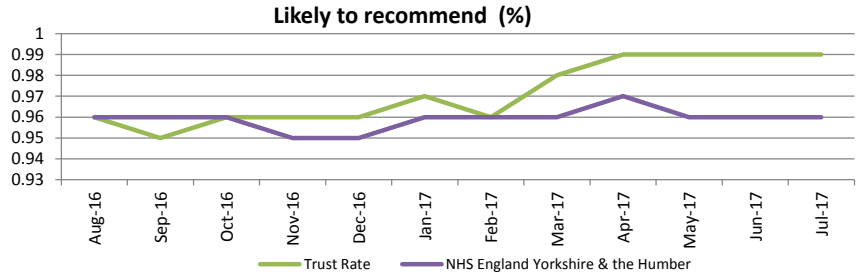
Friends & Family - August 2017 (Month 5)

(Data accurate as at 11/09/2017)

Inpatients

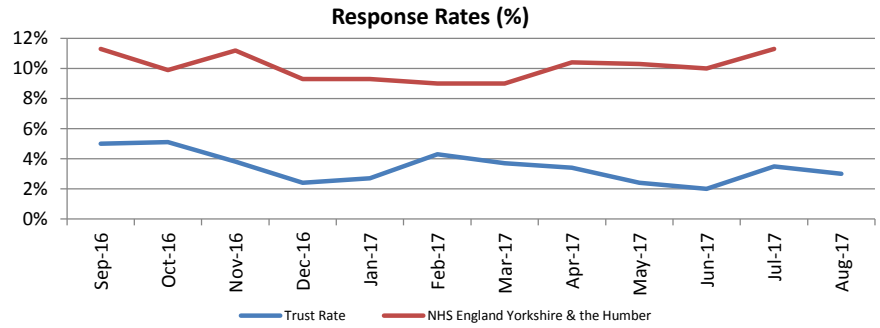
Please note: At the time of producing this report no further benchmarking data is available from NHS England.

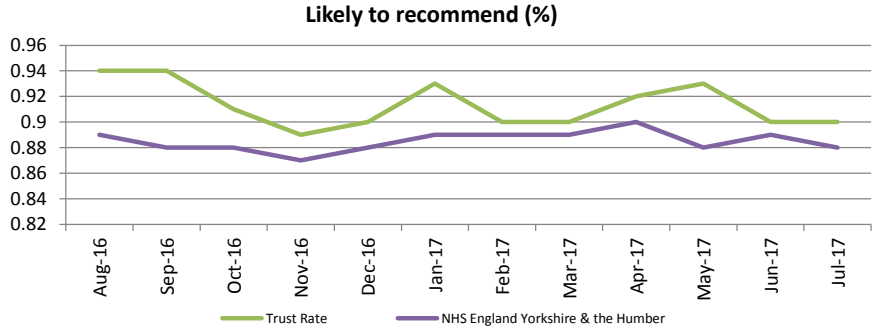




Accident & Emergency

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





Doncaster and Bassetlaw Hospitals NHS
NHS Foundation Trust

Executive summary - Workforce - August 2017 (Month 5)

Sickness absence
Whilst the Trust saw a reduction in April to 4.01% and a further reduction again in May to 3.25% which is below the Trust target of 3.50%. we have continued to see a rise since then up to August being 4.12% resulting in a cumulative figure of 4.08%. In August we have seen a rise in the number of staff off sick across all timescales. Whilst we continue to benchmark favourably across Yorkshire and Humber we will scutinise this rise in August.

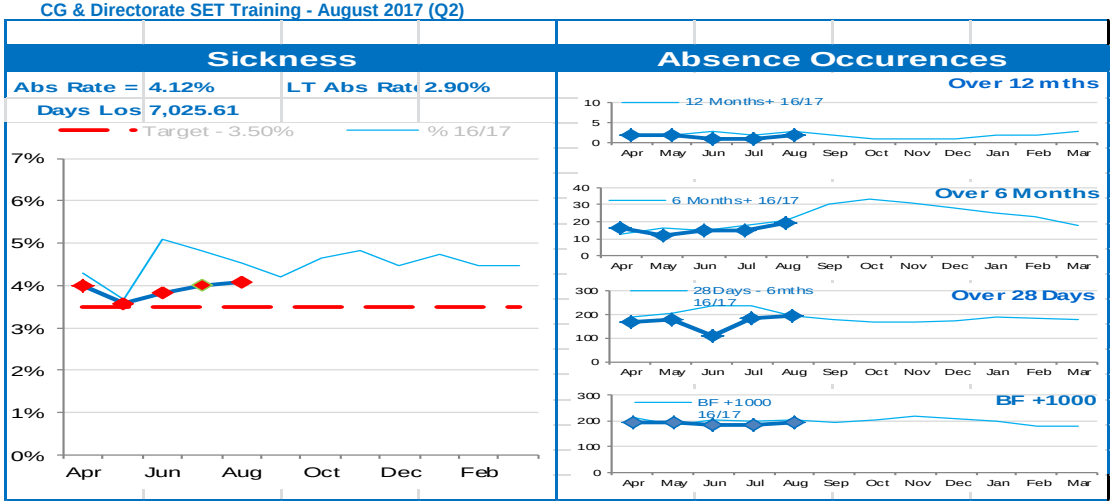
Appraisals
The Trusts appraisal completion rate continues to hover around 57% with August compliance rate being 56.55%. We continue to have a focus in discussions at accountability meetings. In order to enhance the quality of appraisals a review of the current paperwork has been undertaken and the paperwork updated .

SET
We have seen a small reduction in compliance with Statutory and Essential Training in August to 69.90% but generally across most areas the upwards trajectory continues.

Staff in post
Please see attached tab covering staff in post by staff group

Workforce: Sickness Absence - August (Month 5)

CG & Directorate SET Training - August 2017 (Q2)



	Aug-17		Cumulative	
	Days Lost	% Rate	Days Lost	% Rate
Doncaster & Bassetlaw Teaching Hospitals NHS FT	**7025.61**	**4.12%**	**34,347.17**	**4.08%**
Chief Executive Directorate	0.00	0.00%	21.00	0.50%
Children & Family Care Group	746.01	4.21%	3,764.23	4.27%
Diagnostic & Pharmacy Care Group	652.67	3.49%	3,541.81	3.85%
Directorate Of Strategy & Improvement	5.00	0.99%	9.80	0.42%
Emergency Care Group	745.49	3.38%	4,389.94	4.00%
Estates & Facilities Directorate	1277.73	7.33%	5,319.59	6.17%
Recharge Medics	0.00	0.00%	8.00	0.10%
Finance & Healthcare Contracting Directorate	113.84	5.05%	517.08	4.66%
IT Information & Telecoms Directorate	92.27	2.84%	469.03	2.85%
MSK & Frailty Care Group	795.62	3.11%	4,240.05	3.39%
Medical Director Directorate	0.00	0.00%	7.24	0.63%
Nursing Services Directorate	49.60	2.87%	257.13	3.07%
People & Organisational Development Directorate	102.00	3.73%	465.05	3.34%
Performance Management Directorate	163.09	2.56%	988.66	3.13%
Speciality Services Care Group	766.62	4.19%	3,681.45	4.08%
Surgical Care Group	1515.67	4.91%	6,663.11	4.36%

Top 10 Absence Reasons

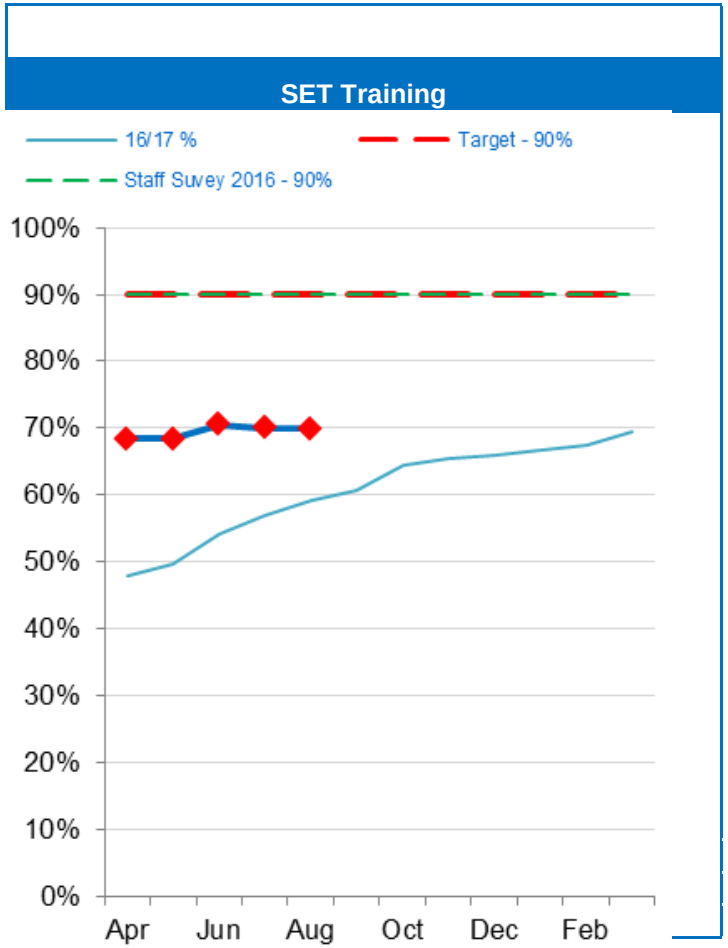
Absence Reason	Days Lost	%
S10 Anxiety/stress/depression/other psychiatric illnesses	1,973.00	21.20
S12 Other musculoskeletal problems	1,120.00	12.00
S98 Other known causes - not elsewhere classified	1,044.00	11.20
S25 Gastrointestinal problems	828.00	8.90
S11 Back Problems	736.00	7.90
S28 Injury, fracture	527.00	5.70
S26 Genitourinary & gynaecological disorders	516.00	5.50
S99 Unknown causes / Not specified	394.00	4.20
S13 Cold, Cough, Flu - Influenza	309.00	3.30
S30 Pregnancy related disorders	237.00	2.50

Workforce: SET Training - August (Month 5)

Appraisal Reviews

CG & Directorate SET Training - August 2017 (Q2)

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



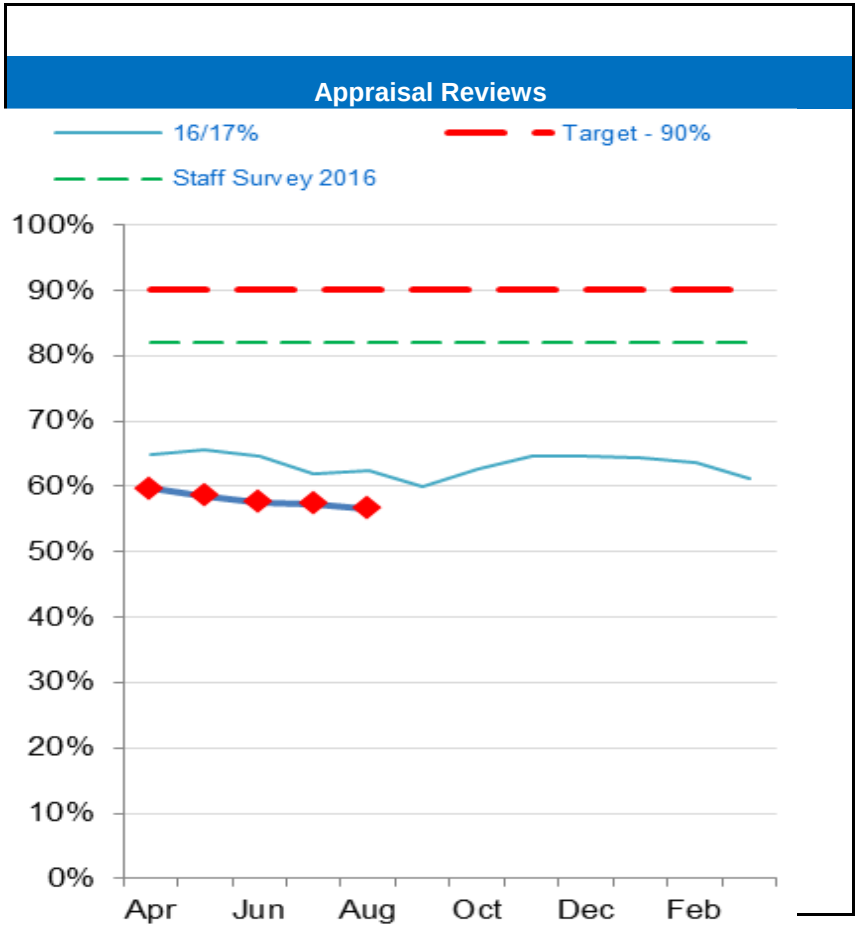
	% Compliance
Doncaster & Bassetlaw Teaching Hospitals NHS FT	**69.90%**
Chief Executive Directorate	**63.17%**
Children & Family Care Group	**74.40%**
Diagnostic & Pharmacy Care Group	**77.68%**
Directorate Of Strategy & Improvement	**98.31%**
Emergency Care Group	**62.13%**
Estates & Facilities	**44.06%**
Finance & Healthcare Contracting Directorate	**94.55%**
IT Information & Telecoms Directorate	**93.55%**
MSK & Frailty Care Group	**79.53%**
Medical Director Directorate	**85.15%**
Nursing Services Directorate	**76.54%**
People & Organisational Directorate	**89.27%**
Performance Directorate	**76.62%**
Speciality Services Care Group	**68.12%**
Surgical Care Group	**70.06%**

Workforce: Appraisals - August (Month 5)

Appraisal Reviews

CG & Directorate Appraisals - August 2017 (Q2)

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



	% Completed
Doncaster & Bassetlaw Teaching Hospitals NHS FT	**56.55%**
Chief Executive Directorate	25.93%
Children & Family Care Group	60.45%
Diagnostic & Pharmacy Care Group	60.64%
Directorate Of Strategy & Improvement	86.67%
Emergency Care Group	54.39%
Estates & Facilities	11.46%
Finance & Healthcare Contracting Directorate	51.39%
IT Information & Telecoms Directorate	63.03%
MSK & Frailty Care Group	78.19%
Medical Director Directorate	75.00%
Nursing Services Directorate	63.08%
People & Organisational Directorate	94.62%
Performance Directorate	81.40%
Speciality Services Care Group	55.74%
Surgical Care Group	57.52%

Workforce: Staff in post - August (Month 5)

Staff in Post

	FTE	Headcount	FTE	Headcount	FTE	Headcount	FTE	Headcount	FTE	Headcount
Staff Group	**Apr-17**		**May-17**		**Jun-17**		**Jul-17**		**Aug-17**	
Add Prof Scientific and Technic	173.34	189.00	173.68	189.00	174.74	191.00	172.45	188.00	176.46	192.00
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
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
Allied Health Professionals	317.79	369.00	316.78	367.00	320.54	372.00	325.55	378.00	331.05	384.00
Estates and Ancillary	572.83	825.00	571.80	827.00	571.28	826.00	572.38	828.00	569.27	828.00
Healthcare Scientists	129.53	143.00	129.10	142.00	127.60	141.00	127.07	140.00	124.47	137.00
Medical and Dental	498.11	523.00	497.26	522.00	501.41	616.00	500.76	617.00	497.55	636.00
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
Students	3.00	3.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
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**

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Title	**Nursing Workforce Information**		
Report to	**Board of Directors**	**Date**	**26 September 2017**
Author	**Moira Hardy, Acting Director of Nursing, Midwifery & Quality** **Rick Dickinson, Acting Deputy Director of Nursing, Midwifery & Quality**		
Purpose			Tick one as appropriate
	Decision		
	Assurance		
	Information		✔

Executive summary containing key messages and issues

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

- The workforce data submitted to UNIFY demonstrates the overall planned versus actual hours worked to be 100% for August 2017.
- Care Hours Per Patient Day (CHPPD) for August 2017 is similar to recent months at 7.8.
- Workforce information and Quality and Safety profile meeting requirements of NHS England (NHSE), relating to Hard Truths demonstrates that one ward was Red for Quality. A quality summit is being arranged.

Key questions posed by the report

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

How this report contributes to the delivery of the strategic objectives

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

How this report impacts on current risks or highlights new risks

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

Risk associated with not meeting regulatory and commissioner requirement.

The risks identified have been mitigated by the use of temporary staffing to provide planned versus actual hours worked at 100% in August. Despite the use of temporary staff to maintain

safe staffing levels the Trust has remained within the 3% agency cap. The main risk in relation to staffing continues to be the recruitment to Registered nurse and midwifery vacancies and opportunities to recruit are actively being explored.

Recommendation(s) and next steps

The Board of Directors is asked to NOTE the content of this paper and SUPPORT the actions identified to ensure that the risks associated with inappropriate nurse staffing levels are appropriately managed.

Key issues and actions include:
- the continuing work of the Non-Medical workforce utilisation programme as part of DBTH Strategy and Improvement programme
- Exploring recruitment opportunities for nursing and midwifery
- Analyse the AUKUH data collection from July, ward nurse staffing requirements will be available to the Quality Effectiveness Committee in October 2017.
- Consider the NQB consultation on Midwifery Staffing levels.

1. INTRODUCTION

This paper provides the Board of Directors with detailed information relating to the Nursing Workforce; highlighting issues which may impact upon the Trusts ability to provide appropriate staffing levels and skill mixes. It also updates on the implementation on Care Hours per Patient Day (CHPPD), which has been a required national return since 01 May 2016 and the data submitted to UNIFY.

2. WORKFORCE INFORMATION

The workforce data submitted to UNIFY provides the actual hours worked in August 2017 by registered nurses and health care support workers compared to the planned hours. The Trusts overall planned versus actual hours worked was 100% in August 2017, slightly increased from 99% in July.

2a. Actual versus planned staffing levels (based on daily data capture)

The data for August 2017 (Appendix 1) demonstrates that the actual available hours compared to planned hours were:

- within 5% for 21 Wards (51%), the same as July
- between 5% – 10% for 13 Wards (32%) one more than July
- surpluses over 10% for 5 Wards (12%) on less than July
- deficits over 10% for 2 Wards (5%) remains the same as July

The wards where there were surpluses in excess of 10% of the planned hours are Gresley Unit, Rehab 2, Wards 16, CCU/C2 and C1; each ward requiring additional staff to support patients requiring enhanced care.

The wards where there were deficits in excess of 10% of the planned hours are M1 and Labour Ward at Bassetlaw Hospital. The lower than planned staffing levels were due to:

- Labour Ward and M1 are due to staff sickness absence and vacancies. The service was optimised through the maternity service on call management and use of community staff to ensure safe services.

2b. Care Hours Per Patient Day (CHPPD)

Utilising actual versus planned staffing data submitted to UNIFY and applying the CHPPD calculation the care hours for August 2017 are shown below, with a slight increase in the overall and registered midwives and nurses:

Care Hours Per Patient Day (CHPPD) – August 2017			
Site Name	**Registered midwives/ nurses**	**Care Staff**	**Overall**
BASSETLAW HOSPITAL	5.1	3.5	8.7
DONCASTER ROYAL INFIRMARY	4.5	3.3	7.8
MONTAGU HOSPITAL	2.2	2.8	4.9
TRUST	**4.5**	**3.3**	**7.8**

The CHPPD care hours data from May 2016 –August 2017 remain consistent, with a slight increase overall from March 2017.

2c. Quality and Safety Profile

The Quality Metrics (appendix 1) for adult wards include 19 indicators that cover each of the five CQC Key Assessment Criteria (safe, effective, caring and responsive, with the overall score illustrating well led). Ward A5 has flagged as high risk for August 2017. The issues from the quality metrics are the lack of data for clinical observations and fluid balance audit, handwashing compliance rate, FFT positive and

negative recommendations and low appraisal rates. A Quality Summit is being arranged with the nursing leadership team and a Non-Executive Director will be invited.

3. PLANNED ACTIONS AND KEY RISKS

The major issue facing most acute hospitals nationally, and locally, continues to be the challenge of filling qualified vacancies. The actions to mitigate the risks which have been detailed in previous papers are continuing, along with systems and processes to meet the expectations outlined in the safe staffing and efficiency correspondence. These are:

- The continuing work of the Non-Medical workforce utilisation programme as part of DBTH Strategy and Improvement programme.
- Analyse the Safer staffing, AUKUH data collection from July, ward nurse staffing requirements will be available to the Quality Effectiveness Committee in October 2017.
- Consider the NQB consultation on Midwifery Staffing levels.
- Provide further detailed comparison CHPPD data as this becomes available nationally
- Continue to explore recruitment opportunities for nursing and midwifery

4. RECOMMENDATION

The Board of Directors is asked to NOTE the content of this paper and SUPPORT the identified actions.

APPENDIX 1: HARD TRUTHS August 2017 Paper

ce /Quality/Safety Profiles July 2017 Data

				Workforce Information - Days				Workforce Information - Nights				Planned v Actual			Safe	Effective	Caring	Responsive	Well Led	Profile		WQAT annual assessment 2015/6	WQAT annual assessment 2016/17
Care Group	Matron	Ward	No of Funded Beds	Hours Total Planned Days reg nurse/mwfe	Hours Total Actual reg nurse/mwf	Hours total planned support staff	Hours Actual Support Staff	Hours Total Planned Days reg nurse/mwfe	Hours Total Actual reg nurse/mwf	Hours total planned support staff	Hours Actual Support Staff	Total Planned Hours	Total Actual Hours	Variance	Total score	Total score	Total score	Total score	QM total score	Work-force	Quality	Rating	Rating
Surgical	NS	B6	16	745	651	290	402	528	432	264	264	1827	1749	96%	0.5	3.0	1.0	1.5	6.0				
	NS	20	27	1674	1467.5	976	930	713	713	713	874	4076	3984.5	98%	1.0	1.0	2.0	0.5	4.5				
	NS	21	27	1643	1370	945.5	1073.5	713	682	713	770.5	4014.5	3896	97%	1.0	1.0	0.0	1.5	3.5				
	LM	S12	20	1038.5	964	744	735	660	660	330	330	2772.5	2689	97%	1.5	0.0	1.0	3.0	5.5				
	RF	SAW	21	1419.75	1358.75	744.75	750.75	1092.75	893	740.35	752	3997.6	3754.5	94%	1.0	2.0	1.5	1.5	6.0				
	LC	ITU DRI	20	5782	5663	160	160	4587	4441	0	0	10529	10264	97%	1.5	1.0	0.0	1.5	4.0				
	LC	ITU BDGH	6	1565	1551.5	159	135	1392	1390	0	0	3116	3076.5	99%	0.0	0.0	1.0	1.5	2.5				
												30333	29414	97%									
MSK and Frailty	SS	A4	24	1275	1200	1080	1196	720	720	720	892	3795	4008	106%	0.0	0.0	0.0	1.5	1.5				
	SS	B5	30.7	1680	1571	1680	1529	1080	984	720	732	5160	4816	93%	0.5	1.0	3.0	1.0	5.5				
	AH	St Leger	35	1800	1737	1470	1550.5	1080	1068	1080	1428	5430	5783.5	107%	1.0	1.0	2.0	1.5	5.5				
	AH	1&3	23	1560	1437.5	1335	1513	720	720	1440	1800	5055	5470.5	108%	1.0	0.5	0.0	1.5	3.0				
	SS	Mallard	16	1080	1002.5	1080	1170	720	720	900	1128	3780	4020.5	106%	1.0	2.0	0.0	2.0	5.0				
	SS	Gresley	32	1440	1080	1440	2016	1080	1080	1080	1500	5040	5676	113%	1.5	0.0	1.5	1.5	4.5				
	SS	Stirling	16	1080	1072	1080	1112.5	720	720	816	816	3696	3720.5	101%	0.5	1.0	1.0	1.5	4.0				
	KM	Rehab 2	19	1110	937.5	945	1158.5	720	720	720	1476	3495	4292	123%	0.0	0.5	0.0	1.5	2.0				
	KM	Rehab 1	29	1500	1209.5	945	1014	720	720	720	956	3885	3899.5	100%	3.0	0.5	0.0	2.0	5.5				
												39336	41687	106%									
Specialty Service	JP	18	12	1392	1144	96	286	744	744	372	372	2604	2546	98%	1.5	0.5	0.0	2.0	4.0				
	JP	18 CCU	12	1116	948	372	425	744	744	372	372	2604	2489	96%	0.0	0.0	1.0	2.0	3.0				
	AW	32	18	1752	1392.5	744	704.5	744	744	372	421.25	3612	3262.25	90%	1.0	1.0	0.5	2.0	4.5				
	AW	16	24	1720.5	1461.5	1116	1538	1488	1440	1116	1548	5440.5	5987.5	110%	1.5	1.0	0.0	1.5	4.0				
	RM	17	24	1488	1088	1147	1346	1116	1060	1116	1188	4867	4682	96%	2.5	1.5	1.0	2.0	7.0				
	JP	CCU/C2	18	1116	1096	744	922	744	744	744	972	3348	3734	112%	1.0	2.0	0.0	3.5	6.5				
	RM	S10	20	1178	1155	976	889	744	744	372	365	3270	3153	96%	0.0	0.0	1.0	1.5	2.5				
	RM	S11	19	1145	1139	1003	948	744	744	408	432	3300	3263	99%	1.5	0.0	0.0	2.0	3.5				
												29046	29117	100%									
Emergency	MH	ATC	21	1488	1226	1116	1087	1116	943	744	1032	4464	4288	96%	0.5	0.0	2.0	2.0	4.5				
	SS	AMU	40	2604	2253	2232	2486	2604	2347.5	2232	2750.5	9672	9837	102%	2.5	0.5	1.0	3.5	7.5				
	MH	A5	16	744	744	744	883.5	744	744	744	792	2976	3163.5	106%	1.5	3.0	2.0	3.0	9.5				
	MH	C1	16	976.5	981.5	744	1008	744	744	744	1038	3208.5	3771.5	118%	0.5	1.0	2.0	2.0	5.5				
	SC	24	24	1116	1074	1488	1536	1116	1068	1488	1524	5208	5202	100%	2.0	0.0	3.0	1.5	6.5				
	SC	25	16	744	744	1116	1236	744	744	1116	1272	3720	3996	107%	2.0	0.0	0.0	1.0	3.0				
	SC	Respiratory unit	56	2867.7	2472	2604	2380.5	2604	2448	2604	2508	10679.7	9808.5	92%	1.0	1.0	2.0	2.5	6.5				
												39928	40067	100%									
Children and Families	AB	SCBU	8	738	738	0	33	682	682	0	0	1420	1453	102%	0.0	0.0	0.0	1.0	1.0				
	AB	NNU	18	2385	2181	48	48	1979	1803	121	121	4533	4153	92%	1.0	0.0	0.0	1.0	2.0				
	AB	CHW	18	1084	1072	471	471	946	946	319	319	2820	2808	100%	1.0	0.0	0.0	1.0	2.0				
	AB	COU/CSU	21	1097	1097	762	762	682	671	605	605	3146	3135	100%	1.0	0.0	0.0	1.0	2.0				
	SS	G5	24	1461	1272	744	752	1020	996	372	359.5	3597	3379.5	94%	1.0	1.0	2.0	2.5	6.5				
	SS	M1	26	1495.5	1175.75	860	800.5	682	647	341	341	3378.5	2964.25	88%	0.0	2.0	0.0	1.5	3.5				
	SS	M2	18	883.25	820.9	414.25	374.75	682	660	341	362	2320.5	2217.65	96%	1.0	0.0	0.0	1.5	2.5				
	SS	CDS	14	2305.7	2066.35	802	792.5	2376	2072	682	737	6165.7	5667.85	92%	0.0	0.0	1.0	1.0	2.0				
	SS	A2	18	883.25	820.5	414.25	374.75	682	660	341	362	2320.5	2217.25	96%	0.0	3.0	0.0	1.5	4.5				
	SS	A2L	6	1395	1145.5	404	328.25	1023	938	341	333	3163	2744.75	87%	0.0	1.0	1.5	1.0	3.5				
												32864.20	30740.25	94%									
		Trust Position										**171507**	**171024**	**100%**									

Footnote: Paediatrics undertake a patient experience survey but will move to utilising FFT

Appendix 1. Quality Indicator Metrics

Measure	Detail
SI's (excluding pressure ulcers)	number (avoidable)
Falls resulting in harm	number per 1000 bed days per month against trajectory
Repeated falls	number per 1000 bed days per month against trajectory
Clostridium Difficile	number against trajectory plan
Safety thermometer - pt harms	% new harms (new P ulcers, new VTE's and new UTI's)
Pressure ulcers	avoidable severe Pressure Ulcers
Physiological observation audit	Productive ward data until Safety Facilitators review
FFT INPATIENT	
FFT	net adopter - % positive scores
FFT	Unlikely to recommend
FFT	response rate
FFT MATERNITY TOUCH POINT 1	
FFT	net adopter - % positive scores
FFT	Unlikely to recommend
FFT MATERNITY TOUCH POINT 2	
FFT	net adopter - % positive scores
FFT	Unlikely to recommend
FFT	response rate
FFT MATERNITY TOUCH POINT 3	
FFT	net adopter - % positive scores
FFT	Unlikely to recommend
FFT MATERNITY TOUCH POINT 4	
FFT	net adopter - % positive scores
FFT	Unlikely to recommend

OVERALL RATING

Patient discharges	35% discharges before 12 noon
Length of Stay	reduce LOS by 10% based on 2014/5 out-turn
Appraisal	rolling 12 month appraisal rate
Statutory and Essential to Role training	rolling SET training rate
E roster	effective time should be 76%
Complaints attributed to Care Group	Care Group rather than ward level

No avoidable
Results in top 10% consistently - 75% of time including 2 months prior to assessment

Results above 2014/15 and through assessment period with 50% being in top 20%
Results above 2014/15 and through assessment period but not in top 20%
results below 2014/5

Red
any
more falls than 2014/5
more multiple falls than 2014/15
exceeds trajectory
<92% harm free
exceeds trajectory
<85%
Less than 94%
Greater than 1%
Less than 23%
Less than 91%
Greater than 2%
Less than 93%
Greater than 1%
Less than 38.5%
Less than 86%
4% and above
Less than 80%
2.0% and above

2 or more Red

< 2014
> LOS from 2014/5
<65%
<65%
>80% or less than 70%
> complaints than 2014/5

Amber
Same number of falls as last year
same number of repeated falls as last year
92-93% harms free
85-94.9%
94% - 95.49%
0.5% - 1%
23% - 29.49%
91% - 94.49%
1.5% - 2%
93.01 - 95.49%
0.5% - 1%
38.5% - 64.99%
86% - 91.49%
2.6% - 3.99%
80.01% - 89.99%
1.5% - 1.99%

1 Red indicator OR 2 Amber indicators

between Trust 2014 result and 35%
A longer LOS than Dr foster case mix adjusted LOS but improved by 10% from 2014/5
65%-89%
65%-89%
77-80% or 75-70%
Same number as 2014/5

Parameters
Green
none
less falls than last year (by 0.1-9.9%) less than trajectory
within trajectory
within trajectory
93-95% harm free
within trajectory
>=95%
95.5% - 96.99%
0.1% - 0.5%
29.5% - 35.99%
94.5% - 97.99%
1% - 1.49%
95.5% - 97.99%
0.1% - 0.5%
65% - 76.99%
91.5% - 96.99%
1.0% - 2.59%
90% - 98.99%
1.0% - 1.49%
No red indicators OR 2 Blue Indicators OR 1 amber, 1 green 1 Blue
meet target of 35%
At the Dr Foster case mix adjusted LOS or less
>90%
>90%
75-77
less complaints than 2014/5

Blue
none
exceeds 10% improvement and no avoidable
exceeds 10% improvement
better than trajectory and no avoidable
>95% harm free
better than trajectory and no avoidable
>=98%
97% and above
0%
36% and above
98% and above
Less than 1%
98% and above
0%
77% and above
97% and above
Below 1%
99% and above
Below 1%

2 or more blue indicators with 1 green indicator

Meet 35% target and a 10% improvement on 2014 ward result
Lower than Dr Foster case mix adjusted LOS by 10%exceeds 10% improvement and no avoidable
>92%
>92%
green for 6 months
less complaints than 2014 and exceeds 10% improvement

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Title	**Chair's and NEDs' Report**		
Report to	**Board of Directors**	**Date**	**26 September 2017**
Author	**Suzy Brain England, Chair**		
Purpose			Tick one as appropriate
	Decision		
	Assurance		
	Information		x

Executive summary containing key messages and issues
The report covers the Chair and NEDs' work in September 2017 and includes updates on a number of activities: • Opening of The Hub • Fundraising • Governors' Update • NED Recruitment • Annual Members' Meeting • Other meetings
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 – September 2017

Opening of The Hub

It was my pleasure to open The Hub at Bassetlaw Hospital earlier this month.

The new purposely designed facility encompassing training, education and library services under one roof offers a seamless service for students, doctors in training and staff.

The Hub combines the facilities previously housed in the old Kilton Hospital with the Management Suite and meeting rooms. The new location is now more central and accessible for all staff and students and benefits from a manned reception desk during office hours.

As part of the design the space was modernised to accommodate a library and resource centre. This shows our commitment towards Bassetlaw Hospital and being a leading teaching hospital in the region.

Charitable Fundraising

I was pleased to meet with fundraisers Bassetlaw League of Friends who are keen to re-ignite their efforts; they have supported the hospital for 60 years and are liaising with us to buy equipment which makes the patient stay more comfortable. We will seek to promote their efforts on our behalf.

I have also had a further meeting with Doncaster Cancer Detection Trust. Supporters have gone a long way towards raising funds for a new CT scanner and we are beginning to put plans in place. We will also seek to promote their efforts on our behalf.

I should also mention with great thanks a former nurse at DRI, Miss Baker, who got in touch with the Trust last month and then donated £10,000 to our charitable funds. We are grateful for her generosity.

It is clear that there are many individuals and local businesses in Doncaster, Bassetlaw and beyond who have a strong connection to our hospitals and want to support our patients through their fundraising. We would be pleased to hear about any fundraising efforts in order to promote them to our staff and members and so we can maximise the impact of donations for our patients.

Governors' update

September has been a busy month for the Board of Governors. In the space of week they have attended no fewer than six events including:

- The Timeout on 7 September in which they had presentations from Linn Phipps on herself and the work of the committee she chairs, the Quality and Effectiveness Committee. Rebecca McGeehan and Marie Purdue gave a presentation on Qii, "Quality, Improvement and Innovation". Richard Parker and David Purdue spoke extensively about our services in paediatrics and ophthalmology. Mr Abdul Hussain talked about the pioneering work and research of the bariatrics team on 'diabesity', utilising surgery to cure diabetes in overweight sufferers.

- DBTH Star Awards on the evening of 7 September. This was our showcase of innovation and commitment where we thanked teams and individuals and awarded prizes for those judged best in their category.

- Opening of The Hub at Bassetlaw Hospital on 11 September. Governors recognised the significance of this investment in Bassetlaw.

- Governor Effectiveness Review at Montagu Hospital on 12 September which was externally facilitated by Sandi Carman, Assistant Chief Executive of STH. Governors debated the issues raised in the report and refined the recommendations in the review.

- Governor Briefing session on 13 September in which Karen Barnard and David Purdue gave presentations on staff engagement and winter planning respectively. Afterwards, Vice Chair of Governors Mike Addenbrooke sent a note to Governors recommending attendance as they were an excellent way to extend knowledge about current Trust activity.

- Meeting with NHS Improvement on 15 September where the governors got to probe the regulator's view of the Board and its capability in managing the finance, performance and quality of the Trust.

A number of governors also attended food tasting with Sodexo. I realise it is a heavy workload but thank governors for their continued commitment to the Trust and for championing hospital services within the area.

My thanks to Lisa Bromley who has stepped down as Partner Governor for Bassetlaw CCG having secured a role in the ACS. Lisa will be replaced by Dr Victoria McGregor-Riley (pictured).

Doncaster Council has also advised of a replacement Partner Governor for Pat Knight who retired in May. He is Griff Jones, currently Assistant Director for Adult Care and Safeguarding at the Council. We welcome Griff and Victoria.

NED Recruitment

Governors agreed on 31 August to open recruitment for all NED roles whose terms end in 2018. This will be done in two parts following several information sessions at which people can find out more about the role of the non-executive director.

This has become more urgent following the resignation of our NED with clinical experience following his successful appointment to a new senior full-time role which was likely to conflict with his role with us. We wish Martin all the best in his role as Director of Medical Education and as Director (Honorary Treasurer) at the Association for the Study of Medical Education (ASME).

We have written to 101 businesses, education establishments and community organisations to raise awareness about the roles and to invite them to nominate senior colleagues for the four capacity building sessions we are holding in late October to tell people more about the Trust and the positions. Recruitment will commence shortly afterwards.

The sessions are taking place:

- On 23 October, 10-11.30am at Bassetlaw Hospital and 2-3.30pm at DRI
- On 24 October, 10-11.30am at Bassetlaw Hospital and 5.30-7pm at DRI

My thanks to Kathryn Singh (RDaSH), Ian Black (SW Yorkshire Partnership), Linda Challis (Chesterfield) and Sarah Jones (SCH) as well as our own Marie Purdue for agreeing to participate and promote the work of NEDs.

Governors' ACS conference

I am pleased to say that plans are unfolding well for the Governor Briefing about the South Yorkshire ACS which I am leading. The date has been set for the morning of October 27th at Rotherham's New York Stadium. Speakers include former Health Minister, Alan Johnson, and Sir Bruce Keogh. Once this is completed we will start on plans for a conference for NEDs across the sub-region and after that for councillors and MPs.

Annual Members' Meeting

We hosted our Annual Members' Meeting on 20 September. Thanks to Richard and Jon for their presentations of the 2016/17 year and to our many contributors who held stalls for the public which profiled the Trust's work.

Other meetings

During September I attended the latest Working Together Partnership Meeting, met with Jo Miller (CEO of DMBC), attended a northern workshop on Delivering Transformation and Change in Local Health Systems and a Chair's networking meeting organised by NHS Providers. This month saw a further NHS Providers Board meeting and a good discussion as held about how the organisation can help burgeoning ASCs.

NED Feedback

Linn was delighted to attend part of one of the Trust's Person centred care days. These are aimed at front line staff. They aim to cover what is person centred care and how this applies to areas such as Dementia, falls, and End of life. This made great use of patient stories, with the End of life session (by Stacey Nutt and Karen Lanaghan) focussing on Harry's story and involving his son Arthur, who was discharged to a care home for his end of life, according to his wishes. Our plans for improvement in End of life care centre round the 5 Patient Priorities:

- Recognising – that the patient is dying
- Supporting – individual needs
- Communicating – with all parties
- Involving – all parties in decisions
- Planning – and then doing it!

There was also a lively question & discussion session, for example asking why we don't (yet) include person-centredness in medical training, and some memorable thoughts:

- "You can't get it right unless you have those conversations"
- "Every time I imagine the patient is my family member".
- "How people die lives on in the memories of those left behind".
- "It's about the right care, the right people, the right place, the right time – every time".

Martin attended the North of England Chair's event on behalf of the Chair. The performance of North of England NHS sub-regions was presented. The evolution of Sustainability and Transformation Plans (STP); Accountable Care Partnerships (ACP); Accountable Care Systems (ACS); and Accountable Care Organisations (ACO) across the North of England was described and discussed. Attendees had the opportunity to explore areas discussed in more detail. The South Yorkshire and Bassetlaw Accountable Care System was presented as a case study at the meeting'

Chief Executive's Report
26 September 2017

Enabling Strategies

Board will remember that it approved the five-year vision for the Trust at the end of July and, since then, work has been taking place on the 10 supporting strategies that will ensure delivery in each of the key work elements of the Trust.

The Executive Team undertook a very productive half-day session on 13 September examining each of the documents and detailed versions of six of the ten strategies are being considered by Quality and Effectiveness Committee on the morning of September's Board Day. The rest will be considered by Finance and Performance Committee in October.

Summaries of all the enabling strategies with the exception of the Finance Strategy and Estates and Facilities Strategy will be put before Board for approval in October. By their nature, the Finance and Estates and Facilities Strategies must take account of the plans within the other eight strategies so they will come to Board in November.

CIP Governance Review

Executive colleagues have commissioned BDO to undertake a review of the governance processes relating to the Trust's Cost Improvement Plans. BDO have worked with the Trust previously in examining the underlying deficit.

As Board will be aware, the Trust is aiming for an ambitious target of £14.5m in 2017/18 and the Director of Finance is reporting on progress on a monthly basis to Finance and Performance Committee.

The review will assess the Trust's capability to deliver schemes and also help to generate new ideas for delivery in future years. The Trust has just instituted new processes for holding work-steam leads to account for delivery of CIPs and the review will also look at the robustness of those arrangements.

ACS Away Day

I attended an ACS away day earlier in the month which established five key priority work-streams moving forward to tie in with the work being undertaken around the hospital services review.

Further details are given in a Part 2 briefing paper.

The flagship status of the SY & Bassetlaw ACS means that its performance, especially during winter, must be positive. The three year plan for the ACS was also described. Year one is very much about establishing the ACS. By year three, it hopes to be operating with devolved responsibilities.

Public engagement activities are in the pipeline with a new website and events for governors, NEDs and politicians planned.

Bassetlaw CCG

Suzanne Bolam, our Head of Therapies in MSK and Frailty, attended Bassetlaw CCG's public session on 12 September and her digest is appended to my report.

Catering contract

The meeting later today will seek final sign off of contracts for the Trust's new catering contract with Sodexo. I have been pleased to see patients, public and governors availing themselves of the opportunity to 'taste' some of the new selection of patient food on offer during sessions over the past couple of weeks.

In the meantime, the Trust was subject to an inspection by Doncaster Council's environmental health inspector on 7 September 2017 for patient and retail services and we are pleased to confirm that the Trust will retain the coveted Food Hygiene Rating of 5. Well done to the catering team for this excellent result.

Installation of new Gum Bins

As part of the Trust's commitment to Keep DBTH Tidy, we are encouraging patients, visitors and staff to dispose of their used chewing gum in new bright pink, dedicated bins installed around the three hospital sites.

The new gum receptors, called Gumdrops, are made out of recycled chewing gum and have been installed at Doncaster Royal Infirmary, Bassetlaw Hospital and Montagu Hospital in the hope to improve unsightly chewing gum across the organisation's sites which is very costly to remove.

Dropping used gum into a normal litter bin helps to keep our sites clean but it is not recycled and eventually ends up in landfill. Using the eco-friendly containers, gum is removed from the bins and recycled into plastic, which is used to create more Gumdrops, as well as wellington boots, coffee cups and mobile phone covers.

Celebrating our Stars

It was an honour and a privilege to open the DBTH Stars event at the Keepmoat Stadium on 7 September.

The event, which was presented by BBC Look North's Harry Gration, recognises members of DBTH for their contributions in patient care, behind the scenes running, leadership, compassion and new ideas.

The ceremony was a fantastic showcase of all the great work our staff have dedicated themselves to over the last year. It really showed how much our staff care about their patients and colleagues and, in turn, how much our local communities appreciate them. There was a real sense of pride and team spirit at the awards and we see the enthusiasm and energy returned to practice throughout the organisation.

My thanks to everyone who took part, the people who nominated and were nominated, our sponsors, to the Communications and Engagement Team for pulling it altogether and, finally, to the winners:

- Leader of the Year: Dr Juan Ballesteros, Consultant in Emergency Medicine
- Unsung Hero of the Year: John Malee, Service Assistant
- Educator of the Year: Julie Shaw, Midwifery Clinical Educaton
- Learner of the Year: Rebecca Fox, Assistant Practitioner
- Improvement Award: Ward 25 Team
- Most Caring Person: Jo Mann, Cancer Nurse Specialist
- Volunteer of the Year: Library Volunteers
- Researcher of the Year: Jennie Harris, Specialist Physiotherapist
- Innovator of the Year: Cindy Storer, Head of Nursing MSK and Rod Kersh , Consultant in Elderly Medicine
- Team of the Year: Respiratory unit team
- Star of the Year: Ward 18 Staff
- Star of the Stars: Jennie Harris, Specialist Physiotherapist

Secretary of State Visit

We understand that Secretary of State for Health, Jeremy Hunt will be visiting Doncaster on 7 December. We understand that he will pay a visit to either ourselves or RDaSH. We look forward to welcoming them.

New uniforms for service assistants

Earlier this month we began the phased roll out of service assistant uniforms, starting with the DRI site.

The change in uniform will help to give our service assistants, who provide essential patient care services, the professional appearance and identity to match the professional performance they provide day in and day out to our patients. They will move from a light blue outfit to a red and pink combination.

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Clinical Commissioning Group Feedback Template

Governing Body of	Bassetlaw / Doncaster CCG
Date of meeting	12 September 2017 Suzanne Bolam –Head of Therapies

Key messages from the meeting:

- Changes to Chair of Group from October – will be Dr Kelly. I think he would welcome more awareness of DBTH clinical services review as frequently mentioning potential changes and needing reassurance re future services and impact for Bassetlaw.
- Plans to engage more frequently with DBTH CEO as occurred previously. Has been discussed with Richard Parker and meetings now rescheduled.
- Several appointments to senior posts at CCG - positive for stability and feel they will have more capacity to work on key areas.
- Chief Officer Idris Griffiths made frequent reference to ACS and working together and generally very supportive of DBTH but also need to ensure specific guardianship of Bassetlaw
- Concern re financial position which is more challenged than ever before. Using reserves and need to take action now for improved longer term position. Question from committee regarding costs of some DBTH services - Chief Officer and Director of Finance explained and supportive of DBTH
- All friendly and welcoming
- I found it useful and relevant to my role - happy to go again

Item	Key issues raised	Action
Health Checks – statutory requirement but variable uptake and not identifying patients at risk of LTC's. Good use for LD patients	CCG to review and may link to innovation funding to improve value and target key conditions	This presents an opportunity to link to some of DBTH pathway work and improve primary care input/response

Please return completed forms to Matthew Kane, Trust Board Secretary, matthew.kane@dbh.nhs.uk

Paediatrics Update: Positive re no complaints Reported that DBTH is trying hard with recruitment and some success. Generally aware of issues and supportive. Committee requested ongoing update as remains an area of concern	Reviewed activity –will ask for graphs next time. Noted Ambulatory care appointments not all utilised each day Recent email regarding referral of children after 6.30pm to ensure improved 'transfer of care ' welcomed	Will be asking if GP's can refer direct to Ambulatory Care /Impact on cost To share with all GP's
ACS Home Work Stream	Red Bags containing all pts key items - DNACPR not being sent back by DBTH or sometimes not completed correctly	Will discuss with DBTH
Diabetes development £ discussed. Challenge to identify funding for 2 years	This has impact on response possible. Some elements of initiative not going ahead due to risk of funding.	CCG awaiting further feedback.
QUIPP programme	Keen to progress business cases. Governing body want more detail of schemes/progress	All committee asked to review. Audit taking a lead to review process. Clinical engagement will be investigated and firmed up re process.
Performance	Ambulance services to be discussed in private section of meeting. Biggest concern is cancer waits 18 Wk RTT – discussion re promoting more use of private sector at GP referral stage. Feedback that private sector have shorter waits and may be complying with agreed pathways re NP:FU more than DBTH	 Action plans underway CCG to follow up/request a deep dive in MSK. Might be useful for DBTH to follow up with CCG?

	A&E-reported as challenging but holding up. 3% activity reduction	

DONCASTER & BASSETLAW TEACHING HOSPITALS NHS FOUNDATION TRUST

Minutes of the Finance & Performance Committee
held at 9:15am on Tuesday 22 August 2017
in the Boardroom, DRI

PRESENT	:	Neil Rhodes, Non-executive Director (Chair) Martin McAreavey, Non-executive Director Jon Sargeant, Director of Finance Karen Barnard, Director of People & OD David Purdue, Chief Operating Officer Marie Purdue, Director of Strategy & Improvement
ALSO IN ATTENDANCE:		Anna Moulding, Acting Deputy Director of Finance Lesley Hammond, General Manager Matthew Kane, Trust Board Secretary Angela O'Mara, Exec Team PA
OBSERVER	:	Bev Marshall, Governor Observer
APOLOGIES	:	Philippe Serna, Non-executive Director

Action

Apologies for Absence

17/8/1 Apologies were noted from Philippe Serna.

Action Notes from Previous Meeting

17/8/2 The action log was reviewed and updated.

Any other business

17/8/3 No additional business was declared.

PERFORMANCE

Business Intelligence Report

17/8/4 In addition to the standard format Business Intelligence Report, David Purdue presented to the Committee example performance charts to consider for future use. The charts included highest and lowest peer performance, a national benchmark and where appropriate performance across the Accountable Care System. The Chief Operating Officer agreed to share the performance charts with the committee members for further consideration.

17/8/5 Cancer targets were discussed in detail; guidance for 62 day pathways had now been published which clarified the need for inter hospital transfers to be completed by day 38. An action plan to improve performance in this area was to be submitted to the CCG by early September 2017.

17/8/6 Achievement of the referral to treatment target was recognised as a national issue with the measure not having been achieved for sixteen consecutive months. Five specialities were identified to be adversely affecting the Trust's performance and appropriate action plans were in place to address this. A number of hard to recruit to posts were noted to impact on performance and a need to review service provision was recognised. Whilst robust plans were in place to address performance issues, these were balanced against discussions with the CCG regarding activity levels in line with contract requirements.

17/8/7 The Chair requested that a standardised performance report should be agreed with the Head of Performance for presentation at future meetings. The Chair sought views on this and welcomed feedback from the governor observer. Where data was not available due to the timing of the meeting it was suggested that the previous month's data be included for completeness. **DP/NR**

17/8/9 In order to devote a specific focus on workforce performance data it was agreed that a people subcategory would be included on future agendas. Data would include workforce management, agency spend and staff welling being/sickness absence. **AO**

17/8/10 Martin McAreavey requested additional information relating to the following data:

- the number of eligible patients who received stroke thrombolysis
- benchmarked position for direct access to stroke unit within four hours and patients discharged with a named contact

With regards to thrombolysis David Purdue explained that the treatment was only available to a limited numbers of patients and agreed to share the detail with the Non-Executive Director. In addition he would ensure that the appropriate benchmark was added to the performance charts for direct access to stroke unit and discharged with a named contact. A recent improvement in direct access had been seen due to remapping of the stroke pathway and work in the emergency department to improve education and capacity. **DP**

The Business Intelligence Report was NOTED.

4 Hour Access Deep Dive

17/8/11 Lesley Hammond, Emergency Care General Manager was welcomed to the meeting to co-present the deep dive topic with David Purdue, Chief Operating Officer.

17/8/12 The presentation provided an insight into the importance of the performance measure, which required Trust wide accountability and was linked to receipt of Sustainability and Transformation funding. Both Doncaster and Bassetlaw emergency departments were operating above the original agreed operating levels and options to improve the environment were being considered subject to appropriate funding being received. A proactive approach to manage attendance levels was in place, supported by a front door assessment and streaming service at DRI. A requirement for streaming to be in place at

Bassetlaw was noted by October 2017. Alternative workforce models had been implemented in order to provide additional support to the department from the various specialties.

17/8/13 Extended stays within the emergency department were known to negatively impact on capacity, safety levels and patient outcomes. A range of local issues were discussed around workforce and activity levels with 70% of the target breaches related to internal delays within the department. Staffing levels have been challenging, particularly at middle grade which was a national problem; the impact of IR35 and the agency cap have compounded this. However, a recent recruitment campaign had proved successful and the number of permanent ED consultants was now much improved and the benefits of substantive staff welcomed.

17/8/14 Quarter 1 performance across South Yorkshire stood at 91.4%, as compared to a national performance of 90.3%; both achieved in excess of the Q1 target of 90%. Targets for Q2 would increase to 93.1%, 90.1% in Q3 and 95% to be achieved in March 2018. A range of initiatives have already been introduced to improve performance but further service and cultural changes would be required to support this trajectory and a national high impact intervention plan had been agreed.

17/8/15 Looking ahead winter plans have been prepared by a strategic working group and would be launched in September as part of System Perfect. This would take place between 5 and 12 September to ensure that patient flow was as efficient and safe as possible across the range of health and social care settings.

17/8/16 Bev Marshall acknowledged the importance of A&E within the hospital and expressed gratitude on behalf of the governors to all colleagues working in this area. Lesley Hammond agreed to share this feedback with all relevant staff.

17/8/17 Consideration was given to future deep dive topics, including the opportunity to include Information Management & Technology and Estates & Facilities. The Trust Board Secretary would consult with the relevant executives outside of the meeting and feedback possibilities for discussion.

FINANCE

Catering Services Outsource Update

17/8/18 Kirsty Edmondson-Jones provided an update to the Committee on progress to date. Following a request by the Trust, KPMG had undertaken a review of the draft contract documentation to ensure it was fit for purpose and in line with industry best practice. A number of recommendations arising from this were considered and consulted on with Capsticks solicitors and a management response prepared. In order that the finalised contract could be reviewed by members of this Committee ahead of Board it was agreed to circulate this prior to the next meeting and a suggested date of 14 September was proposed. **KEJ**

17/8/19 The Committee were reminded that only one bidder tendered for the joint patient and visitor catering offer which facilitated a significant level of

investment in equipment and facilities to provide an appropriate offer going forward. However, once the bidder had been agreed contract negotiations were no longer possible and with this in mind a significant amount of work had been completed to ensure its suitability for the Trust, its patients, staff and visitors.

17/8/20 Whilst the usual timescale for implementation was noted to be 12 weeks from the date the contract was signed this would be dependent upon the response from the initial union discussions relating to the TUPE transfer process and the timing of the proposed change over the Christmas/New Year period.

The Catering Services Outsource Update was NOTED.

Reference Costs

17/8/21 The Committee received the second of a series of reports which provided an overview of the reference costs submission for 2016/17.

17/8/22 In 2015/16 internal audit undertook an audit of processes and adherence to guidance, the identified outcome was "significant assurance with minor improvement opportunities". An action plan was developed and actions completed. The opportunity to audit this area was taken again in 2016/17 however, due to a change in timetable to incorporate the Costing Transformation Programme this audit was carried out against an incomplete output and took into consideration anticipated planned activity. The same outcome was achieved as in 2015/16. A gap in activity identified by KPMG for resolution was being investigated at the time of the audit and the Director of Finance advised the variance had now been verified and was not a cause for concern.

17/8/23 Due to the deadline for submission sign off will take place before the next meeting of the Committee and will be agreed between the care groups and management accounts. The final paper in the series will be presented at September's meeting.

The Reference Costs report was NOTED.

Impact of the Overseas Visitors Team

17/8/24 Julie Robinson, Overseas Team Manager, presented to the Committee an overview of the regulations and associated practice adopted by the Trust to ensure appropriate charging of overseas visitors.

17/8/25 A significant change in regulations had been seen over the last three years. Interpreting the national guidance had proved to be challenging in order that the complexities were understood and translated into operational guidance. Following approval of a business case a small team of colleagues were established in March 2016 to ensure adherence to guidance. The team have improved practice, facilitated improved data collection and raised awareness within the Trust and across the GP network.

17/8/26 A summary of invoices raised in respect of overseas visitor charges for the

financial year 2015/16 and 2016 /17 demonstrated the increased awareness and potential income opportunities, although the actual income received was relatively low by comparison. Further work to recover outstanding debts was being progressed via NHS Shared Business Services.

17/8/27 Opportunities to continue to improve awareness, educate, and share best practice would be progressed alongside work with the CCGs to establish risk share arrangements, which would positively impact on income. The support of the executives to share the importance of overseas visitor's identification was requested, especially with those colleagues that were patient facing.

17/8/28 Julie Robinson was thanked for her informative presentation which provided an insight into the challenges faced by the Trust and the wider issues arising from referrals included exploitation and modern slavery concerns.

The Impact of the Overseas Visitors Team presentation was NOTED.

Financial Performance Report – Month 4 2017/17

17/8/29 The Director of Finance presented to the Committee a paper summarising performance in month 4. A deficit position of 9.96m was noted, 42k behind plan. However, as this position included 419k 2016/17 STF income which cannot be counted towards the control total the restated position was a deficit of 10.38m, 461k worse than the control total.

17/8/30 Income had over performed in July but high agency expenditure had continued. The level of unidentified CIPs also continued to generate a significant overspend. Weekly challenge meetings around agency spend were ongoing, although there was an expectation that agency spend would decrease at the next junior doctor rotation in view of increased staffing. In answer to last month's query Jon Sargeant advised the impact of IR35 had resulted in an increase in costs of 1m within the first four months of the financial year. This increase was attributable to a 13% increase in payment rates, coupled with the need to pay employers NI contributions.

17/8/31 An improved position was noted for July, in terms of both income and pay costs, moving forward the areas of focus would be reduction of agency costs and delivery of three to four major efficiency and effectiveness programmes.

17/8/32 Month 4 delivery of efficiency and effectiveness programmes was reported at 1,157k against a plan to date of 2,676k, 1,519k behind target. The year-end forecast was currently 8.3m against a 14.5m target, an additional 4.5m of pipelines schemes were currently being worked up.

17/8/33 Governance arrangements for the monitoring of the EEPs have been updated since the last meeting and weekly reports have been trialled to establish worksteams for escalation. A number of priorities for the month ahead were highlighted to ensure effective robust practices were in place. A qualitative review of the plans would be undertaken, with consideration given to reviewing actions and anticipating potential pinch points much earlier. Development of new schemes and progressing of those pipeline opportunities would continue.

17/8/34 The Chair enquired of the timetabled workstreams for presentation to the Committee and it was agreed that the Director of Finance would give further thought to the order of attendance, taking into consideration the time between reviews to ensure progress can be made. **JS**

The Financial Performance Report was NOTED.

RISK

Corporate Risk Register, BAF and Identification of New Risk

17/8/35 The Trust Board Secretary updated the Committee on changes to the Corporate Risk Register (CRR) and Board Assurance Framework (BAF) since the last meeting. A list of current risks and their alignment to the respective committees was provided for information. In order to ensure appropriate staff knowledge a series of risk refresher sessions have been planned and Non-Executive Directors were welcomed to attend these.

17/8/36 A template of risk interrogations questions provided by the Chair of the Quality & Effectiveness Committee was provided as an appendix to the report to consider for future use.

17/8/37 In view of the volume of items on the agenda a suggestion was made that the Committee consider the level of assurance and any associated new risks at the time the paper was reviewed. Appropriate text could also be included in the recommendation section of the cover sheet.

Items for escalation to the Board of Directors

17/8/38 No items were noted for escalation

Minutes of the meeting held on 20 July 2017

17/8/39 The minutes of the meeting were agreed as a true record subject to the addition of Anna Moulding, Acting Deputy Director of Finance as in attendance.

Time and date of next meeting:

Date: 19 September 2017
Time: 9:15am
Venue: Boardroom, DRI

Signed:…….. **…….**
Neil Rhodes **Date**

UNAPPROVED DRAFT

DONCASTER & BASSETLAW TEACHING HOSPITALS NHS FOUNDATION TRUST

Minutes of the Audit & Non-Clinical Risk Committee Meeting held at 2pm on Friday 20 July 2017 in the Boardroom, DRI

PRESENT	:	Philippe Serna, Non-executive Director (Chair) John Parker, Non-Executive Director
IN ATTENDANCE	:	Ken Anderson, Head of IT Developments & Programmes Karen Barnard, Director of People & OD Mark Bishop, Local Counter Fraud Specialist Steve Clark, External Audit (EY LLP) Mark Dalton, Internal Audit (KPMG) Richard Dickinson, Acting Deputy Director of Nursing, Quality & Midwifery Michael Green, External Audit (EY LLP) Matthew Kane, Trust Board Secretary Jon Sargeant, Director of Finance Leanne Shaw, Executive PA (Minutes) Sean Tyler, Head of Compliance Roy Underwood, Head of Information Governance Suzy Brain England, Chair of the Board (observing)
GOVERNOR OBSERVERS:		Bev Marshall, Public Governor George Webb, Public Governor

Action

Apologies for absence

17/140 Apologies were received from Linn Phipps and Simon Marsh.

Minutes of the meeting held on 24 March, 26 May and 30 May 2017

17/141 John Parker was welcomed to the meeting.

17/142 The minutes of the meeting held on 24 March 2017 were APPROVED as an accurate record, subject to the following amendments;

17/143 17/45 - "Q3" should read "Q4".

17/144 The minutes of the meetings held on 26 and 30 May 2017 were APPROVED as an accurate record of the meetings.

Matters arising and action notes

17/145 The action notes of the meeting held on 16 December 2016 were reviewed and updated, and matters arising were discussed as follows;

17/146 16/129 - Karen Barnard agreed to provide an update outside of the meeting in relation to reviewing the quality of appraisals. **KB**

17/147 16/216, 16/285, 16/361 - Matthew Kane agreed to chase progress with the Director of Estates and Facilities. **MK**

17/148 17/72 - Matthew Kane to circulate an email response from Richard Dickinson in relation to legal expenses for sharps injury claims. **MK**

Internal Audit Progress Report

17/149 Mark Dalton provided the Committee with an update on progress against the internal audit plan, reporting that eight 2016/17 reports and one 2017/18 report had been finalised, with a further five reviews due to commence in the second quarter of 2017/18. The audit plan remained on track to be delivered within the planned number of days, with 14 out of 235 days delivered so far.

17/150 The Committee was asked to approve the following changes to the plan;

a) Delay of Teaching Hospital Status review
b) Review the new Catering Contract (to seek to provide assurance that the contract was robust and appropriately structured)
c) Undertake a review of the management of medical equipment

17/151 In response to a query from John Parker, Karen Barnard clarified that the Teaching Hospital Status review had only been delayed and would be carried out following a period of transition.

17/152 In response to a query from Philippe Serna in relation to the value of the continuous monitoring and assurance of Core Financial Systems, Jon Sargeant commented that the bulk of work was to check reconciliations were being done and the proposal was to use some days to ensure challenge and assurance around the financial and SBS processes.

17/153 The audit reports for the nine completed reviews were provided for information and Mark Dalton drew attention to the executive summaries and overall assurance rating for each review as follows;

Payroll System and Data Analysis - *significant assurance with minor improvement opportunities.*

17/154 Philippe Serna raised a query in relation to the level of overpayments and Karen Barnard commented that the Trust had been high in comparison to other Trusts, which had been namely due to the late submission of termination forms. Managers would be reminded of future deadline dates and Philippe Serna reinforced the importance of communicating this expectation. Mark Dalton explained that the assurance rating had been given based on the strong recovery rate.

17/155 In response to a query from George Webb in relation to the high proportion of return to work after sickness interviews not being carried out, Mark Dalton explained that the data analysis had taken place on the ESR system, which had not captured return to work information.

17/156 IG Toolkit (phase 2) - *significant assurance.*

17/157 Independent Programme Assurance over the Outsourcing of Finance Systems - phase 3 - *significant assurance with minor improvement opportunities.*

17/158 Duty of Candour - *partial assurance with improvements required.* Instances of non-compliance had been found in relation to;

- delays in initial discussions taking place and providing written confirmation
- sharing the findings of serious incident investigations with patients and their families
- completing templates on DatixWeb
- reporting of near misses
- how to manage Duty of Candour / additional training needs

17/159 Six recommendations had been made and agreed by management.

17/160 In response to a query from Philippe Serna in relation to an incident graded as low harm, Richard Dickinson provided a comprehensive explanation.

17/161 Incident Reporting, Investigation and Learning - *partial assurance with improvements required.* It was identified that the Trust's policies did not reflect current Trust practice or the national guidance. Instances of non-compliance had been around the timely completeness of reviews and the submission of reports to Commissioners. Nine recommendations had been made and agreed by management.

17/162 Patient Safety and Infection Control - *significant assurance with minor improvement opportunities.*

17/163 Deprivation of Liberty and Mental Capacity Act 2005 - *partial assurance with improvements required.* Instances of non-compliance had been in relation to the documentation of mental capacity assessments in both medical and nursing records, and the clarity of DoLS. Five recommendations had been made including to carry out the monitoring of compliance more frequently.

17/164 In response to a query from John Parker, Richard Dickinson commented that improvements had been seen in the awareness of the team, systems had been put in place to chase local authorities in a timely manner, additional staff training had been provided and the DoLS application process had been simplified.

17/165 Financial Reporting Month End Checklist (Month 11) - *significant assurance with minor improvement opportunities.*

17/166 The Committee:

(1) NOTED the Progress Report.

(2) APPROVED the changes to the Internal Audit Plan identified in minute 17/9.

Internal Audit Technical Update

17/167 Mark Dalton presented the report and drew attention to the suggested actions in relation to cyber security, off-payroll workers, race equality standards and staff survey results.

The Internal Audit Technical Update was provided for information and NOTED.

Recommendation Tracker

17/168 Mark Dalton provided a summary on the progress the Trust had made against outstanding internal audit recommendations.

17/169 In response to a concern raised by John Parker in relation to the 21 out of 30 recommendations reported as actioned but not fully validated, Matthew Kane commented that a system had been put in place whereby a review of outstanding internal audit recommendations would take place at the Executive Team meeting and executive leads would be required to provide an explanation of any non-compliance.

17/170 Philippe Serna echoed John Parker's concern about progress and requested that the executive lead with the highest proportion of recommendations identified as being completed but not evidenced be invited to provide an explanation at the next ANCR meeting. **MK**

The Recommendation Tracker was NOTED.

Health Sector Audit Committee Briefing

17/171 Steve Clark presented the report. Matthew Kane was asked to circulate the 'Key questions for the Audit Committee' to all the Non-Executive Directors. **MK**

The Health Sector Briefing was NOTED.

Annual Audit Letter

17/172 Steve Clark presented the report which summarised all of the audit work that had been undertaken in accordance with the audit plan.

The Annual Audit Letter was NOTED.

Suspensions and Exclusions Report

17/173 Karen Barnard provided a summary on the cases that were currently listed. Two cases had been concluded and one further case had been resolved.

17/174 John Parker spoke on behalf of the Committee and thanked Karen Barnard and her team for the positive progress that had been made in relation to suspensions and exclusions.

The Suspensions and Exclusion Report was NOTED.

Effectiveness of Whistleblowing Arrangements

17/175 Karen Barnard reported that as part of the Well-led review undertaken by Deloitte, the policy for whistleblowing arrangements had been reviewed and had been found to be fully aligned with national policy and guidance, and staff had been aware and comfortable with escalating concerns. No recommendations were proposed and the Committee was assured of the effectiveness of the Trust's whistleblowing arrangements.

17/176 Karen Barnard provided an update on the concerns raised since the commencement of the FTSUG (Freedom to Speak Up Guardian) work, reporting that out of the eight concerns raised, two remained open with ongoing actions in place.

17/177 In response to a query from Bev Marshall, Karen Barnard confirmed that a review would take place and be presented to the Committee on an annual basis.

The Effectiveness of Whistleblowing Arrangements Report was NOTED.

Update on IT Capability Report

17/178 Ken Anderson reported that significant progress had been made to address the outstanding actions on the IT capability report raised by the internal audit report.

17/179 A copy of the Information Management and Digital Technology 5-year Strategy was presented which set out the business requirements for a digitally integrated healthcare environment that would provide new technology to;

- Improve patient care
- Support agile working
- Work towards a paper-light organisation
- Reduce administration costs
- Increase operational intelligence
- Maintain a secure, cost effective, resilient and fully supported technical environment

17/180 Ken Anderson drew attention to the Information Governance and Cyber Security section within the strategy and explained that elements of the data security standards set out in the response to the Caldicott report would be incorporated within the Trust's Information Management and Security Strategy.

17/181 John Parker reminded the Committee that draft reports had to be approved by the Executive Team prior to being submitted to ANCR. Philippe Serna expressed his concern in relation to the absence of the cyber security action plan that had been requested previously and asked that this was escalated to the Board.

17/182 In response to a query from Jon Sargeant, Mark Dalton confirmed that the cyber security audit had been delayed from July and was scheduled to take place in August, the results of which would be presented to the next ANCR meeting in September and would expect to provide some level of assurance.

17/183 Ken Anderson was asked to circulate the results from the previous penetration testing that had been carried out in March to the Executive Directors. **KA**

The IT Capability Report update was NOTED.

Draft Risk Management Policy

17/184 Matthew Kane presented the report, noting the update to the policy in view of the changes to the board committee structures and ongoing revisions to the Board Assurance Framework and Corporate Risk Register.

The Draft Risk Management Policy was recommended to Board for approval.

[George Webb left the meeting].

Board Assurance Framework and Corporate Risk Register

17/185 Matthew Kane presented the first versions of the Board Assurance Framework and Corporate Risk Register that had been revised in line with guidance and aligned to each committee accordingly. The documents were still in the development stage and Matthew explained the intended purpose of each document as follows;

- BAF - reflect the key risks to the Trust's four strategic objectives
- CRR - details the Trust's extreme risks (15 and above)

17/186 A number of risks had been mapped over, removed or amalgamated. Management Board would be responsible for approving changes to the Corporate Risk Register and the Board of Directors would be responsible for approving changes to the Board Assurance Framework.

17/187 Philippe Serna queried the accuracy of the current ratings and the controls in place and Matthew Kane provided an explanation, reporting that risks had been reviewed with Executive Directors. Suzy Brain England commented that she was confident that any actions would be addressed at the appropriate Committee meeting and any risks escalated to the Board of Directors if necessary.

17/188 A discussion took place and Matthew Kane was tasked with defining original risk scores / current risk scores in future reports. Mark Dalton reminded the Committee that the BAF and CRR would form part of internal audit's core reviews and would be presented at a future ANCR meeting.

The BAF and Corporate Risk Register was REVIEWED and NOTED.

LCFS Progress Report Q1 2017/18

17/189 Mark Bishop summarised the key points of the report as follows;

- The implementation of the new NHS Counter Fraud Authority had been delayed until Autumn 2017
- Estates and Facilities had yet to see significant improvements in SET training compliance for fraud awareness. Performance Management results had increased due to the incorrect inclusion of locum doctors

- Annual Fraud Survey results
- Three new trace requests issued in relation to 'hospital hoppers' - process improved to include a flagging system
- The National Fraud Initiative (NFI) exercise had completed
- Investigation referrals - 10 new referrals, 17 had closed, three were pending sanction actions and four remained open for further development

17/190 Mark Bishop was commended for the positive Annual Fraud Survey results.

The LCFS Progress Report for Q1 was NOTED.

[Ken Anderson left the meeting].

LCFS Annual Report 2016/17

17/191 Mark Bishop provided a summary of the counter fraud activity throughout the financial year of 2016-17 and reported that 34 new referrals had been received which was in line with neighbouring trusts, and the appropriate sanction actions had been undertaken.

17/192 In response to a query from Philippe Serna in relation to the results of the Self Review Tool, Mark Bishop commented that there was no cause for concern with the amber rated areas of activity, and these were as a result of a lack of evidence.

17/193 It was reported that a response had finally been received from NHS Protect in relation to the review of their functions and services, and this would be reviewed by Philippe Serna and Mark Bishop and reported at the next meeting.

The LCFS Annual Report was NOTED.

Counter Fraud Annual Survey Report 2016/17

17/194 Mark Bishop presented the report, detailing the results of the 2016/17 annual staff fraud awareness survey. The total number of responses exceeded the expectations by 53% from the previous year.

17/195 In response to a query from Suzy Brain England in relation to tracking where fraud had occurred, Mark Bishop reported that length of service was not a contributory factor, but it was more a case of personal circumstance and opportunity.

The Annual Staff Fraud Awareness Survey Report 2016/17 was NOTED.

[Steve Clark left the meeting].

Security Management Annual Report 2015/16

17/196 Sean Tyler presented the report and drew attention to the progress achieved throughout 2015/16 to maintain a safe and secure environment, and to comply with standards set by NHS Protect. Further key points of security related matters and activity were as follows;

- Access Control - following an enforcement notice for Fire Safety Works, it had

been agreed that access control would be installed on the new phase of works within the Women & Children's Hospital. Work would be undertaken to standardise access control across all sites

- Sanctions - a total number of 11 criminal sanctions had been reported within the year. Although this had been the highest in the Yorkshire and Humber region, the reporting of sanctions had been recognised as a positive step

17/197 John Parker raised a concern over the lack of security presence compared to neighbouring trusts. Sean Tyler explained that there had been a delay with the Security and Car Parking tender and that the Trust would be exploring the potential of a framework agreement with DMBC.

17/198 In response to a query from Philippe Serna, Sean Tyler clarified that the Trust's security provider had continued to run on a rolling monthly contract due to financial pressures.

17/199 In response to a query in relation to an alleged assault, Sean Tyler was tasked with investigating and providing an explanation on the reasons behind non-prosecution. **ST**

The Security Management Annual Report was NOTED.

Security Update

17/200 Sean Tyler provided an update on the Trust's security arrangements and drew attention to key points within the report as follows;

- Change to reporting structure
- Risk assessment had been carried out in view of the recent terror attacks
- Changes to the local policing service provision
- Ten Clinical Educators attended and completed the Train the Trainer Course for the delivery of Conflict Resolution
- Increase in Conflict Resolution training compliance
- Action plan for security access
- Security incident reporting

17/201 Sean Tyler was asked to confirm whether the Trust wished to continue striving to achieve an overall green rating on provision of providing a safe and secure environment. **ST**

The Security Update was NOTED.

[Karen Barnard and Richard Dickinson left the meeting].

Losses and Compensation Payments

17/202 The Losses and Compensation Payments report for the period March to June 2017 was NOTED.

Waiving of Standing Orders

17/203 Jon Sargeant presented the quarterly report, explaining that much firmer processes

had been put in place for the requesting of single tender waivers.

17/204 In response to a query from Philippe Serna, Jon Sargeant agreed to liaise with Procurement to identify if the number of single tender waiver requests had reduced. **JS**

The Waiving of Standing Orders quarterly report was NOTED.

Hospitality Register

17/205 The Hospitality Register for the period April 2016 to March 2017 was NOTED.

Committee Annual Report

17/206 The purpose of the report was to provide the Board of Directors with a summary of the Committee's activity for the year 2016/17. A request was made to update section 7.2 to reflect the recent response received from NHS Protect in relation to the review of their functions and services.

17/207 The Committee Annual Report was RECOMMENDED to the Board of Directors, subject to the minor amendments as discussed and agreed.

Committee Effectiveness Self-assessment Action Plan

17/208 Matthew Kane presented the action plan that set out current progress against each of the recommendations, noting that the majority of the actions had been completed and implemented. Matthew also commented that a review of the current work plan remained outstanding.

17/209 In response to a query from Philippe Serna, Matthew Kane was tasked with arranging risk mapping exercises to ensure all outstanding actions had been progressed and completed by the next ANCR meeting. **MK**

The Committee Effectiveness Self-assessment Action Plan was NOTED.

Use of Trust Seal

17/210 The report provided assurance that the use of the seal during the period 17 June 2016 to 30 June 2017 was carried out in compliance with the standing order. It was agreed that this report would not be required to be presented to future ANCR meetings.

The Use of Trust Seal report was NOTED.

Standards of Business Conduct and Employee Declarations of Interest Policy

17/211 Mark Bishop explained that the policy had been reviewed and amended in accordance with the new guidance from NHS England for the management of conflicts of interest. The main changes were highlighted as follows;

- Electronic probity register that would be maintained in the Trust Board Office
- Adoption of NHS England declaration form
- Gift value increased to £50 from £25
- Decision making staff groups

- Categories of interests

17/212 In response to a query from George Webb in relation to Non-Executive Directors' terms of employment, Matthew Kane explained that the terminology within the policy for 'decision making staff' had been adopted from national guidance.

The Standards of Business Conduct and Employee Declarations of Interest Policy was APPROVED.

Issues escalated from sub-committees

17/213 None.

Issues for escalation to Board of Directors

17/214 It was agreed to escalate the Cyber Security action plan / penetration testing and security issues to part 2 of the meeting.

Sub-committees

17/215 The minutes of the Information Governance Committee meeting held on 7 February and 4 April 2017 were NOTED.

17/216 The minutes of the Health and Safety Committee meeting held on 14 March 2017 were NOTED.

Evaluation of the meeting

17/217 It was felt that a number of reports had been lengthy but some had lacked focus. Moving forward reports would be streamlined and would provide more detail on the covering sheet.

Any Other Business

17/218 Nothing to report.

Time and date of next meeting:

17/219 **Date:** 19 September 2017
Time: 2pm
Venue: Boardroom, DRI

Signed:

…….. ……..
Philippe Serna **Date**
Chair

UNAPPROVED

Minutes of the Meeting of the Management Board
of
Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust
on
Monday 7 August 2017 at 2pm
in the Boardroom, DRI

Present:

Richard Parker	Chief Executive (in the Chair)
Andrew Barker	Care Group Director - Diagnostics & Pharmacy
Karen Barnard	Director of People & Organisational Development
Kirsty Edmondson-Jones	Director of Estates & Facilities
Moira Hardy	Acting Director of Nursing, Midwifery and Quality
Nick Mallaband	Acting Care Group Director - Emergency
Simon Marsh	Chief Information Officer
Gillian Payne	Care Group Director - Speciality Services
Willy Pillay	Assistant Medical Director
David Purdue	Chief Operating Officer
Marie Purdue	Acting Director of Strategy & Improvement

In attendance:

Leanne Shaw	Executive PA (minutes)
Matthew Kane	Trust Board Secretary
Anna Moulding	Acting Deputy Director of Finance
Mandy Espey	Care Group General Manager - MSK & Frailty
Fiona Littlewood	Care Group General Manager - Children & Families

Apologies:

Eki Emovon	Care Group Director - Children and Families
Jon Sargeant	Director of Finance
Thrinath Kumar	Care Group Director - MSK & Frailty
Jochen Seidel	Acting Care Group Director - Surgical
Sewa Singh	Medical Director

Action

Minutes of the previous meeting

MB/17/7/1 The minutes of Management Board on 10 July 2017 were approved as an accurate record of the meeting.

Matters arising and action notes

MB/17/7/2 The action notes were reviewed and updated.

MB/17/7/3 MB/16/6/28 - David Purdue agreed to contact Khalid Habib for an update in relation to the review of the Nurse Endoscopists, in order to close off the action. **DP**

MB/17/7/4 MB/17/6/19 - Corporate Investment Group (CIG) had approved the case to recruit 1.2wte Band 3 admin posts to support clinical governance within Children's & Families Care Group, as a pilot for a period of 12 months fixed term, and a review would return to CIG.

MB/17/7/5 MB/17/6/22 - Kirsty Edmondson-Jones reported that fire safety work had restarted on level 7 and would be completed in eight weeks. The issue with the circuit board and nurse call had been rectified.

MB/17/7/6 MB/17/6/42 - Simon Marsh confirmed that emails would remain in the Enterprise Vault following migration to the new NHSMail 2 system. Simon agreed to investigate if emails could be auto-deleted after a period of two years. **SM**

MB/17/7/7 MB/17/6/45 - Richard Parker reported that no further comments had been received in relation to the tenure of the Trust's Care Group Directors and he would feedback to the Trust Medical Committee as requested. **RP**

Finance Report as at 30 June 2017

MB/17/7/8 Anna Moulding presented the finance report that set out the Trust's financial position at month 3. Key points from the report included;

- The deficit for month 3 was £7.993m, £15k ahead of plan
- Pressure in relation to the release of £600k non-recurrent and £875k recurrent reserves due to;
  - high medical staffing spend
  - unidentified CIPs
  - elective income lower than planned
- NHSi had been made aware of the release
- CQUIN risk reserve query with NHSe / NHSi

MB/17/7/9 Richard Parker explained that high risk Care Groups would attend the Finance & Performance Committee meeting when required to discuss the recovery plan to bring the financial performance into line with the agreed plan.

MB/17/7/10 Fiona Littlewood had concerns in relation to budget queries and the limited access of data since the introduction of the new financial / payroll systems.

The Finance Report was NOTED.

Feedback from Care Groups / Corporate Directorates

MB/17/7/11 Specialty Services - Gill Payne provided the following update;

- New Vascular Consultant recruited / one pending

- Resignation in Stroke
- Two Diabetes posts advertised
- Urology job planning ongoing

MB/17/7/12 Willy Pillay provided a verbal update in relation to a recent Vascular meeting that had been facilitated by NHSE in order to support STH and DBTH clinicians to agree a common vision for Vascular Services moving forward. A summary would be circulated to attendees of that meeting and further discussions would be required to decide how collaboration would take place.

MB/17/7/13 Richard Parker commented that the next steps would be to identify and appoint a single clinical lead in order to develop the model and drive the service forward.

MB/17/7/14 Andrew Barker raised concerns in relation to the difficulty in recruiting Interventional Radiologists.

MB/17/7/15 Emergency - Nicholas Mallaband provided the following update;

- Acute Physician recruited
- Two substantive ED Consultants recruited
- Further interviews to take place on 30 August
- Whistleblowing letter sent to Bassetlaw CCG from anonymous DBTH ED nurses in relation to unfit streaming - listening meeting took place to address concerns and the outcome had been communicated back to the CCG
- Improvement in performance / 4th in the country for medicine

MB/17/7/16 Richard Parker reminded Management Board of the Freedom to Speak Up group that had been established and suggested 'surgeries' to be held within Care Groups, to re-publicise the Freedom to Speak Up Guardian's role which had been to ultimately address staff concerns and maintain confidentiality and anonymity.

MB/17/7/17 Diagnostics & Pharmacy - Andrew Barker provided the following update;

- CQC visit on Thursday 10 August 2017
- Imaging / diagnostics wait target back on track
- Consultation within Pharmacy in relation to extended hours and weekend working had been completed successfully and would be implemented in October / November

MB/17/7/18 MSK & Frailty - Mandy Espey provided the following update;

- CoE specialty - 4th in country in terms of positive feedback from medical trainees

- Most improved care Group in terms of quality metrics
- Nominated for a Nursing Times award for Patient Centred Care
- Theatre staffing / anaesthetics cover - daily operational challenges affecting activity
- Medical staffing issues orthopaedics (consultant, SAS and FY2) causing some operational challenges now and over next few months
- Awaiting development and implementation of Hospital@ model to support more sustainable workforce model, reduced reliance in FY2 and increased use of ACPs
- New rota to be implemented on 4 September, likely to be teething problems in the first few weeks until bedded in
- Care of the Elderly consultant now in post
- Unable to recruit to Rheumatology consultant, out to advert again - however alternative plan being developed with team

MB/17/7/19 Children's & Families - Fiona Littlewood provided the following update;

- Two Paediatric Consultants recruited / locum Obstetrician post shortly
- Agency / non pay overspend - investigating
- Quality improvement work around CIPs
- Performance good overall / concerns re. management of 2ww cancer patients
- Job planning / theatre efficiency - reviews ongoing
- Estates review re. antenatal clinic flow
- Fire notification works
- Bereavement garden progressing / funding for parent bereavement room
- Review of A3 process to commence
- Nurse workforce issues

MB/17/7/20 People & Organisational Development - Karen Barnard reported that medical staffing recruitment had commenced.

MB/17/7/21 Finance - Anna Moulding reported that the recruitment process had been completed and the new structure would be circulated for information. **AM**

The feedback from Care Groups / Corporate Directorates was NOTED.

Work in ED

MB/17/7/22 Nick Mallaband presented the paper to seek approval to trial a new payment model in ED at DRI whereby locums would be paid per patient rather than per hour, in order to improve productivity, improve attainment of the 4-hour target and reduce middle grade spend.

MB/17/7/23 David Purdue asked that admissions were included as part of the collation of productivity data.

MB/17/7/24 A discussion took place and Nick Mallaband was unsure of the effect the new payment model for locums would have on substantive members of staff, but commented that it would provide the opportunity to performance manage both locums and substantive members of staff and allow the collation of accurate productivity data for analysis.

MB/17/7/25 Management Board was broadly supportive of the proposal and Richard Parker asked that the following four components were considered as part of the test of change;

- Contractual or other obligations would not be broken
- Delivery of a system that would improve productivity and outcome
- Dependable and justifiable in relation to governance
- Consider financial impact

The Work in ED paper was NOTED, and Management Board SUPPORTED the pilot.

ED Staff Reward Scheme

MB/17/7/26 Nick Mallaband presented the paper to seek approval to trial a reward scheme for members of staff within ED who achieve process measures towards the 4-hour target. The scheme would assign a monetary value against specific measures being met and members of staff would be given autonomy and control to spend money for improvements within their own department.

MB/17/7/27 Concerns were raised in relation to the isolation of the reward scheme within ED only. Richard Parker explained that ED interfaced with a number of departments who also had an impact on patient flow and achieving the 4-hour target, and fairness across the Trust should be considered in relation to incentivisation.

MB/17/7/28 A lengthy discussion took place and whilst Management Board acknowledged the proposal, requested that further work was carried out in order for a decision to be made in relation to moving the concept forward. **NM**

The ED Staff Reward Scheme paper was NOTED.

Update on Financial & Performance Committee activity

MB/17/7/29 Anna Moulding gave a verbal update from the previous Finance & Performance Committee and reported that the key areas of discussion had been;

- Progress on the unidentified CIP gap
- Current financial position
- Admin workstream
- Catering
- New process in relation to medical agency spend

The verbal update was NOTED.

Corporate Risk Register

MB/17/7/30 Matthew Kane presented the new style Corporate Risk Register and Board Assurance Framework and explained that the original risk scores had been updated following the Audit and Non-Clinical Risk Committee meeting, and changes to the policy had been agreed.

The Board Assurance Framework and Corporate Risk Register was NOTED.

Fire Safety at Montagu Hospital - update

MB/17/7/31 The Fire Service had recently visited Montagu Hospital to inspect the cladding following the Grenfell Tower disaster and after visiting the wards, concerns were raised in relation to the compartmentalisation of Rehab 2.

MB/17/7/32 In response to the issue compartmentalisation raises around the evacuation of patients at night, the bed capacity had been reduced by ten and staffing levels had been increased to ensure the safe evacuation of patients from upper floors and a revised plan would be developed.

MB/17/7/33 The Fire Service advised that work to improve compartmentalisation would be necessary to be undertaken to remedy the fire safety issues, but completing the refurbishment of Rehab 2 would allow the Fred and Ann Green Rehabilitation Unit to achieve 'Centre of Excellence' status for rehabilitation medicine. The Fred and Ann Green Legacy may be approached to consider the Centre of Excellence. The research capacity and capability would be increased to support the development of the Centre of Excellence model and submitted to the Corporate Investment Group in August.

The verbal update was NOTED.

Chief Executive's Report

MB/17/7/34 The Chief Executive's report was provided for information NOTED.

Business Intelligence Report as at 30 June 2017

MB/17/7/35 The Business Intelligence Report was provided for information and NOTED.

Forthcoming Assessments, Inspections and Reviews

MB/17/7/36 David Purdue reported that the process for managing external reviews, visits, inspections and accreditations would be re-instated and a summary report would be presented to the Management Board on a monthly basis.

MB/17/7/37 Members were reminded to notify the Trust Board Office of any upcoming external reviews, visits, inspections and accreditations so that they could be added to the register and report. **All/MK**

Minutes of the Corporate Investment Group meeting

MB/17/7/38 The minutes of the Corporate Investment Group meeting held on 26 June 2017 were provided for information and NOTED.

Minutes of the Planned Care Board meeting

MB/17/7/39 The minutes of the Planned Care Board meeting held on 15 June 2017 were provided for information and NOTED.

MB/17/7/40 David Purdue commented that once the DBTH Planned Care Steering Group had been set up, the terms of reference would be clarified to prevent an overlap of responsibilities with the Planned Care Board.

MB/17/7/41 A discussion took place in relation to PLCV checklists and David Purdue agreed to chase up the query in Orthopaedics at the DBH Strategic Contracting meeting at Doncaster CCG. **DP**

Minutes of the Children's & Family Board meeting

MB/17/7/42 The minutes of the Children's & Family Board meeting held on 2 May 2017 were provided for information and NOTED.

MB/17/7/43 David Purdue reported that the operating age for general surgery on children had been reduced from 10 years to 7 years with a plan to reduce to 5 years.

MB/17/7/44 The meeting had been well represented and was progressing positively.

Any Other Business

MB/17/7/45 Marie Purdue agreed to circulate the new Strategic Direction outside of the meeting. **MP**

MB/17/7/46 Fiona Littlewood raised concerns in relation to the availability of 'backing' information in order to approve invoices. Anna Moulding reported it was a national agreement that finance staff did not see patient identifiable information, however recognised the issues this was presenting and agreed to contact with the Head of Information Governance to try and resolve. **AM**

MB/17/7/47 Fiona Littlewood highlighted concerns in relation to the safety of DBTH members of staff at East Laith Gate House and agreed to forward any further details to the Chief Executive, Chief Operating Officer and Director of Estates & Facilities for support and resolution. **FL**

MB/17/7/48 Willy Pillay commented that a letter had been distributed to consultants from the Local Medical Committee in relation to new hospital standard contract requirements and David Purdue agreed to raise it at the next DBH Strategic Contract meeting at Doncaster CCG. **DP**

Items for escalation to the Board of Directors

MB/17/7/49 None.

Items for escalation from Sub-Committees

MB/17/7/50 None.

Date and Time of Next Meeting:

MB/17/7/51

Date: 11 September 2017
Time: 2pm
Venue: Boardroom, DRI

Board of Directors Agenda Calendar

STANDING ITEMS			OTHER / AD HOC ITEMS
MONTHLY	**QUARTERLY**	**BIANNUAL / ANNUAL**	
OCTOBER 2017			
CE Report	ANCR minutes	Charitable Funds minutes	
Business Intelligence Report	Chief Executive's Objectives	Fred & Ann Green Legacy minutes	
Nursing Workforce	Complaints, Compliments, Concerns and Comments Report		
MB Minutes	R&D Strategy metrics (in BIR)		
Finance & Performance Minutes	Safeguarding & maternity metrics (in BIR)		
Finance Report	P&OD Quarterly report		
Chairs' Assurance Logs			
NOVEMBER 2017			
CE Report	QEC minutes	Annual Compliance against the National Core Standards for Emergency Preparedness, Resilience and Response (EPRR)	
Business Intelligence Report	Board Assurance Framework & corporate risk register Q2		
Nursing Workforce			
MB Minutes			
Finance & Performance Minutes			
Finance Report			
Chairs' Assurance Logs			
DECEMBER 2017			
CE Report	Report from the Chair of the ANCR committee (Verbal)		
Business Intelligence Report			
Nursing Workforce			
MB Minutes			
Finance & Performance Minutes			
Finance Report			

As at 19 July 2017

Chairs' Assurance Logs			
JANUARY 2018			
CE Report	ANCR minutes (16.12.16)	Budget Setting / Business Planning / Annual Plan	
Business Intelligence Report	Chief Executive's Objectives	SOs, SFI, Scheme of Delegation	
Nursing Workforce	Complaints, Compliments, Concerns and Comments Report		
MB Minutes	R&D Strategy metrics (in BIR)		
Finance & Performance Minutes	Safeguarding & maternity metrics (in BIR)		
Finance Report	P&OD Quarterly report		
Chairs' Assurance Logs			
FEBRUARY 2018			
CE Report	QEC Minutes	Budget Setting / Business Planning / Annual Plan	
Business Intelligence Report	Monitor Quarterly Declaration Q3		
Nursing Workforce	Board Assurance Framework & corporate risk register Q3		
MB Minutes			
HWB Decision Summary			
Finance & Performance Minutes			
Finance Report			
Chairs' Assurance Logs			
MARCH 2018			
CE Report	Report from the Chair of the ANCR committee (Verbal)	Budget Setting / Business Planning / Draft Annual Plan	
Business Intelligence Report	Monitor Q3 Results Notification	Staff Survey	
Nursing Workforce		Fred & Ann Green Legacy minutes	
MB Minutes			
HWB Decision Summary			
Finance & Performance Minutes			

Finance Report			
Chairs' Assurance Logs			
APRIL 2018			
CE Report	ANCR minutes	Draft Annual Report	Mandatory training update
Business Intelligence Report	Chief Executive's Objectives	Draft Quality Account	
Nursing Workforce	Complaints, Compliments, Concerns and Comments Report	Budget Setting / Business Planning / Final Annual Plan	
MB Minutes	R&D Strategy metrics (in BIR)		
HWB Decision Summary	Safeguarding & maternity metrics (in BIR)		
Finance & Performance Minutes	P&OD Quarterly report		
Finance Report			
Chairs' Assurance Logs			
MAY 2018			
CE Report	Monitor Quarterly Declaration Q4	Annual Report	
Business Intelligence Report	QEC Minutes	Quality Account	
Nursing Workforce	Report from the Chair of the ANCR committee (Verbal)	Annual accounts	
MB Minutes	Board Assurance Framework & corporate risk register Q4 (inc. annual assurance summary)	ISA260 and quality account assurance	
HWB Decision Summary		Charitable Funds minutes	
Finance & Performance Minutes		Mixed Sex Accommodation	
Finance Report			
Chairs' Assurance Logs			
JUNE 2018			
CE Report	Board Assurance Framework	MB Annual Report	
Business Intelligence Report	Report from the Chair of the ANCR committee (Verbal)	SOs, SFI, Scheme of Delegation	
Nursing Workforce	Monitor Q4 Results Notification	ANCR Annual Report	
Bed Plan			
MB Minutes			
Finance & Performance Minutes			

Finance Report			
Chairs' Assurance Logs			
JULY 2018			
CE Report	Chief Executive's Objectives		Reference Costs
Business Intelligence Report	Complaints, Compliments, Concerns and Comments Report		Diversity and Inclusion
Nursing Workforce	R&D Strategy metrics (in BIR, to include R&D annual summary)		
MB Minutes	Safeguarding & maternity metrics (in BIR)		
Finance & Performance Minutes	ANCR Minutes		
Finance Report	P&OD Quarterly report		
Chairs' Assurance Logs			
AUGUST 2018			
CE Report	QEC minutes	Proposed AMM arrangements	Health and Wellbeing
Business Intelligence Report	ANCR Minutes	Annual Security Report	
Nursing Workforce		Infection Control Annual Report	
MB Minutes		Risk Policy	
Finance & Performance Minutes			
Finance Report			
Chairs' Assurance Logs			
SEPTEMBER 2018			
CE Report			Catering Report
Business Intelligence Report			Teaching Hospital
Nursing Workforce			
MB Minutes			
Finance & Performance Minutes			
Finance Report			
Chairs' Assurance Logs			

OTHER ITEMS	
Review the appointment of Peter Brindley (Executor of Fred and Ann Green Will)	3 yearly (May 2018)
Constitution review	3 yearly (Jan 2018)

Minutes of the meeting of the Board of Directors
Held on Tuesday 29 August 2017
In the Boardroom, Bassetlaw 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	Acting Director of Nursing, Midwifery and Quality
	Martin McAreavey	Non-Executive Director
	Richard Parker	Chief Executive
	Linn Phipps	Non-executive Director (via Skype, part)
	David Purdue	Chief Operating Officer
	Neil Rhodes	Non-executive Director
	Jon Sargeant	Director of Finance
	Philippe Serna	Non-executive Director
	Sewa Singh	Medical Director
In attendance:	Marie Purdue	Acting Director of Strategy and Improvement
	Simon Marsh	Chief Information Officer
	Matthew Kane	Trust Board Secretary
	Emma Shaheen	Head of Communications and Engagement
	Mike Addenbrooke	Public Governor
	George Webb	Public Governor
	Clive Tattley	Partner Governor
	Emma Challans	Deputy Chief Operating Officer
		Staff-side

ACTION

Welcome and apologies for absence

17/08/1 Apologies for absence were received on behalf of John Parker.

Declarations of Interest

17/08/2 Board was reminded of the need to keep their registers of interests up-to-date.

17/08/3 It was noted that Martin McAreavey had recently become the Director of Medical Education for the University of Bradford and that this had been added to his register of interest.

Actions from the previous minutes

17/08/4 The list of actions from previous meetings was noted and updated.

Learning from Deaths – Learning, Candour & Accountability

17/08/5 The Board received a report of the Medical Director that set out a new approach for learning from deaths.

17/08/6 The events at Mid Staffordshire and Morecambe Bay and the subsequent review of hospitals with regard to investigating and learning from deaths had led the CQC to propose a new approach to learning from deaths.

17/08/7 New guidance from the National Quality Board placed a number of requirements on hospital trusts, including that a non-executive director be identified with lead responsibility and that quarterly reports be made to the Board on the numbers of deaths, numbers reviewed, numbers of potentially avoidable deaths and qualitative information.

17/08/8 The Trust had already completed a significant amount of work and continued to make substantial progress in ensuring that all patient deaths were screened and that those requiring further investigation have a structured judgement review. It would continue to build on and develop the process to ensure it was comprehensive and robust.

17/08/9 Linn Phipps, as lead non-executive for learning from deaths, commented that she was very assured by the work taking place and that the Trust would act on feedback from families. Further work was being undertaken to identify a range of soft metrics that would also measure learning.

17/08/10 A business case was in development to ensure that specialist resource was in place. Further to a question from the Chair, the Medical Director confirmed that escalation would be via the Mortality Monitoring Group and the serious incident process. Monthly reports would come to Clinical Governance Committee and quarterly reports would come to Board.

17/08/11 With a correction to page 15 of the Policy replacing the words "Clinical Governance and Oversight Committee" with "Quality and Effectiveness Committee" the Learning from Deaths Policy was endorsed.

ENT Masterclass

17/08/12 The Board considered a presentation from Mr Muhammad Shahed Quraishi, ENT Consultant on the ENT Masterclass.

17/08/13 The Masterclass had started as an idea in 2005 and was now one of the most well attended clinical courses in the world. It had begun as a masterclass for doctors in training but then developed into a number of different areas of clinical practice and was held across the world, becoming part of the official curriculum in some areas.

17/08/14 The ENT Masterclass website contained many invaluable resources and saw as many as 65,000 hits per year from around 85 different countries together with social media sites. The Masterclass continued to break new ground and was an example of excellence within Doncaster.

17/08/15 Board NOTED the report and thanked Mr Quraishi for his presentation.

Emeritus Status

17/08/16 The Board considered a report of the Medical Director that sought to grant Dr David Northwood Emeritus status at the Trust.

17/08/17 The Trust had taken the view that it would wish retiring consultants to maintain their contact with the Trust and their colleagues locally and, where requested, would consider offering Honorary Emeritus status, with its associated rights of access to the library and postgraduate meetings. The title was awarded to consultants who had provided meritorious service to the Trust.

17/08/18 The Board APPROVED the grant of Emeritus Consultant Status to Dr David Northwood, formerly Consultant Anaesthetist at Doncaster & Bassetlaw Teaching Hospitals NHS Foundation Trust.

Health and Well-being Update

17/08/19 The Board considered a report of the Director of People and Organisational Development that sought reaffirmation from the Board to its commitment to improving staff health and wellbeing and supporting the related agenda and actions moving forward.

17/08/20 The report demonstrated the achievements made in the last two years and the positive impact this was having on the health and wellbeing of staff. It also highlighted the challenges going forward.

17/08/21 The Trust's performance had been acknowledged through a range of national and local awards and there had been a positive impact on sickness absence rates. Board noted the importance of health and well-being, the CQUIN attached to good performance and the high numbers of staff (87%) who felt health and well-being was important.

17/08/22 Philippe Serna noted that performance in respect of specific health and well-being indicators was a 'mixed bag'. The Chief Executive commented that work was taking place to help staff and patients to live a healthy lifestyle. The potential new catering contract and website would both contribute towards this aim.

17/08/23 Health and well-being reports regularly fed into the Workforce and Education Committee and the staff survey. The Board's thanks were passed on to the Health and Well Being Lead and her team.

17/08/24 Martin McAreavey asked the Director of People and Organisational Development about the incidence of MSK problems amongst staff and she would report back separately on this. **KB**

17/08/25 The Board:

(1) ACKNOWLEDGED the progress made with regards to health and wellbeing activity and the challenges that lay ahead.

(2) REAFFIRMED its commitment to improving staff health and well-being and supporting the agenda and actions moving forward.

Risk Identification, Assessment and Management Policy

17/08/26 The Board considered a report of the Trust Board Secretary that sought approval of a revised Risk Identification, Assessment and Management Policy.

17/08/27 The Policy had been revised following changes to the committee structure and board assurance framework. Two further amendments to the Policy were proposed adding "corporate directors" into paragraph 3.3 and substituting the words "Trust Board Secretary" for "Head of Corporate Affairs" in 3.5.

17/08/28 Board APPROVED the Risk Identification, Assessment and Management Policy.

Trust Seal

17/08/29 Board APPROVED use of the seal in respect of the lease relating to Sunshine Day Nursery, Bassetlaw Hospital, Worksop, S81 0BD.

Chairs Assurance Logs for Board Committees held 22 August 2017

17/08/30 The Board considered the assurance reports of the Chairs of Finance and Performance and Quality and Effectiveness Committees, following their meetings on 22 August.

17/08/31 Following a question by Alan Armstrong in relation to Finance and Performance Committee, the Chief Executive provided assurance over the new catering arrangements following the closure of Silks Restaurant. The importance of effective communications was emphasised. Board were also advised about the work to create an integrated Board to Ward performance report.

17/08/32 In the absence of the Chair of Quality and Effectiveness Committee, the Medical Director presented the report, mentioning the escalated items in relation to the Royal College report, issues around the response of switchboard and medical records. All three issues were under monitoring by Clinical Governance and Quality and Effectiveness Committees. The Committee had also received an excellent 'deep dive' presentation from the Acting Director of Nursing, Midwifery and Quality in relation to patient experience and engagement.

17/08/33 Board RECEIVED the reports for assurance.

CQC Insights Report

17/08/34 The Board considered a report of the Acting Director of Nursing, Midwifery and Quality that set out details in relation to the CQC's monitoring tool known as CQC Insights.

17/08/35 The tool would be made available to the Trust on a monthly basis and used as a risk monitoring tool and information pack for any inspector to refer to when considering inspecting the Trust, through the Quality Surveillance Groups held regionally and also during the planning of an inspection to focus on particular core services.

17/08/36 It was the latest iteration of tools following the historical CQC Quality Risk Profile (QRP) and Intelligent Monitoring Report (IMR). This report complemented the NHSI Single Oversight Framework, DBTH Clinical Governance Objectives, DBTH Quality Assessment Tool and Quality Metrics and DBTH Accountability Framework as well as external accreditation schemes.

17/08/37 The Board NOTED the report and SUPPORTED the monitoring of quality using the CQC Insights report with other quality monitoring tools and processes described in the report.

Mixed Sex Accommodation

17/08/38 The Board considered a report of the Acting Director of Nursing, Midwifery and Quality that provided a Declaration of Compliance with the requirement to eliminate mixed sex accommodation. This continued to be managed in line with national requirements, as it had been in previous years.

17/08/39 The Board NOTED the contents of the report.

Strategy and Improvement Report

17/08/40 The Board considered a report that provided assurance on progress on the strategic plan implementation process and quality improvement and innovation agenda.

17/08/41 Following Board's approval in June, the Strategic Direction 2017-22 had been forwarded to NHS Improvement. A formal launch was planned for September. Final drafts of the enabling strategies would be reviewed at Executive Team on 13 September to ensure alignment before agreement at board committees and ratification at the subsequent Trust Board.

17/08/42 Steering Groups had been developed to drive and oversee the strategy implementation in the areas of urgent and emergency care, elective care and children and families.

17/08/43 The Quality Improvement & Innovation (Qii) strategy and its associated action plan had been completed and been shared at Clinical Governance Committee. A Lead Consultant for Qii had been appointed and would work with the Qii Team on a number of areas including supporting the strategic change overseen by the steering groups. A Qii session had been run for Board and one was planned for governors.

17/08/44 Board NOTED the report.

Finance Report as at 31 July 2017

17/08/45 The Board considered a report of the Director of Finance that set out the Trust's financial position at month 4, 2017/18.

17/08/46 The month four position was £2.384m deficit, £475k worse than plan. The Year to Date (YTD) position was £10.380m deficit, £461k worse than plan. The underlying position for the end of the month was much better than in the previous month as total pay expenditure had dropped in July, however the non-pay spend and non-delivery of CIP continued to cause a pressure on the bottom line position.

17/08/47 Agency spend had improved in month, partly due to seasonal impact and in part due to weekly meetings with each care group to review agency spend. The cash position at the end of July was £11m and work continued to support the payment of suppliers through the SBS invoicing system.

17/08/48 Neil Rhodes expressed confidence in the systems and processes being employed to bring spending back under control but required further assurance around the delivery of CIP schemes. The Board was advised that the Trust had commissioned work to assist with identifying confidence in delivery and the future pipeline.

17/08/49 Further to a question from Philippe Serna about level of capital expenditure, the Director of Finance advised that work was taking place to reshape the capital plan on the basis of a successful bid to the ACS for a CT scanner.

17/08/50 The Board NOTED the Trust's financial position.

Business Intelligence Report as at 31 July 2017

17/08/51 The Board considered a report of the Chief Operating Officer, Medical Director, Acting Director of Nursing, Midwifery and Quality and Director of People and Organisational Development that set out clinical and

workforce performance in month 4, 2017/18.

17/08/52 Performance against key metrics included:

4 hour access - In July the Trust achieved 93.18% (93.9% including GP attendances) against the 95% standard.

RTT – In July, the Trust performed below the standard of 92% achieving 90.3%, with three specialities continuing to not achieve the standard for the month. These were general surgery, ENT and Ophthalmology. In September, general surgery would access an additional three operating sessions and in ophthalmology an external company was performing catch up work at weekends, specifically on cataract work.

Cancer targets – In June, the 62-day performance achieved the 85% standard and quarter one overall achieved 85.1%. Two-week waits achieved 93.3% against 93% standard, however the standard was not achieved for the quarter.

HSMR – The Trust's rolling 12 month HSMR remained better than expected at 90.23 for May 2017. HSMR for April 17 was 91.89.

C.Diff – The rate of cases was slightly above trajectory compared to last year. Interventions on deep cleaning, antibiotic stewardship and monitoring hand-washing compliance continued.

Appraisal rate - The Trust's appraisal completion rate continued to hover around 57% with a small reduction from 58.51% to 57.59%. The Trust would continue to focus on this standard as part of the revised accountability meetings, with particular attention given to all senior managers having their appraisal as close to the start of the financial year as possible and other staff appraisals being aligned to meet the peaks and troughs of operational demand.

SET training - There had been a further increase in compliance with Statutory and Essential Training (SET) and at the end of July the rate was 71%. Across most areas the positive upwards trajectory continued.

Sickness absence – In July the Trust saw a slight rise in staff with absences between one and six months. The HR business partners were working with their care groups and corporate directorates to drill down into the reasons why that increase had occurred. Overall sickness/ absence rate remained favourable to other NHS organisations regionally and nationally.

17/08/53 Further to a question from Martin McAreavey, it was agreed to bring back details on the HSMR performance at Bassetlaw Hospital following a review through the Mortality Monitoring Group. **SS**

17/08/54 The Business Intelligence report was NOTED.

Nursing Workforce Report

17/08/55 The Board considered a report of the Acting Director of Nursing, Midwifery and Quality which provided detailed information relating to the nursing workforce, highlighting issues that could impact on the Trust's ability to sustain appropriate staffing levels and skill mixes.

17/08/56 The overall planned versus actual hours worked in July 2017 was 99%, a one per cent drop since June. Care Hours Per Patient Day (CHPPD) stood at 7.8 across the Trust, up 0.2 since June. No wards were assessed red for quality in the month.

17/08/57 The Board of Directors NOTED the content of the paper and SUPPORTED the actions identified to ensure that the risks associated with inappropriate nurse staffing levels were appropriately managed.

Key issues and actions included:

- The continuing work of the Non-Medical workforce utilisation programme as part of DBTH Strategy and Improvement programme.
- Exploring recruitment opportunities for nursing and midwifery.
- Analysis of the AUKUH data collection from July. Ward nurse staffing requirements would be available to the Quality Effectiveness Committee in October 2017.
- Considering the NQB consultation on Midwifery Staffing levels.

Reports for Information

17/08/58 The following items were NOTED:

- Chair and NEDS' report
- Chief Executive's report
- Proposed Arrangements for Annual Members' Meeting
- Finance and Performance Committee minutes, 20 July 2017
- Quality and Effectiveness Committee minutes, 22 June 2017
- Board of Directors' Calendar

17/08/59 The Chief Executive briefly advised of a meeting he attended earlier in the day relating to devolution across Yorkshire. It appeared that there was now a divergence of views between Sheffield and Rotherham on the one hand who wished to remain part of Sheffield City Region and Doncaster and Barnsley who wished to join a new Yorkshire-wide bid. The Chief Executive acknowledged that neither bid was likely to move forward without a consensus amongst the local authorities in South Yorkshire. Council meetings were taking place imminently to look at this.

17/08/60 In response to a question from Philippe Serna, the Chief Executive confirmed that issues identified in the recent IRMER inspection were not as significant as first thought.

Items escalated from Sub-Committees

17/08/61 None.

Minutes

17/08/62 The minutes of the meeting of the Board of Directors on 25 July 2017 were APPROVED as a correct record.

Any other business

17/08/63 There was no other business considered.

Governors questions regarding business of the meeting

17/08/64 Mike Addenbrooke asked whether there was optimism that vacancies within audiology, ophthalmology and children's would be filled. The Chief Executive gave an update on the staffing situation. Staffing in paediatrics continued to be a challenge.

17/08/65 Furthermore, Mike Addenbrooke asked what assurance could be given that staff attitudes and communication – which historically had been the largest cause of complaint – were improving. The Chief Executive advised that all staff received ongoing training and regular refresher sessions around breaking bad news and customer service were provided. Accordingly, the Trust was seeing a reduction in the number of complaints.

17/08/66 In response to comment from George Webb about the difficulty in recruiting nurses, the Board were advised that the challenges existed within specific areas within the Trust, such as paediatrics and midwifery. The Trust had workforce plans in place and was working with Sheffield Hallam University to drive up the number of places. The Trust had seen an increase in the number of roles it was filling since last year but it needed to be recognised that there was no easy solution to a national problem and no prospect of vacancy rates improving rapidly. The national difficulty

in recruiting specialist paediatric nurses was illustrated by the fact that Great Ormond Street ran at a vacancy rate of 12-15%.

Date and time of next meeting

17/08/67 2.30pm on Tuesday 26 September 2017 in the Lecture Theatre, DRI.

Exclusion of Press and Public

17/08/68 It was AGREED that representatives of the press and other members of the public be excluded from the remainder of the meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest.

Suzy Brain England **Date**
Chair of the Board