Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

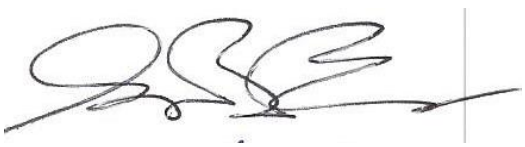
The meeting of the Board of Directors

To be held on Tuesday, 25 September 2018 at 10.00am in the Boardroom, DRI

AGENDA
Part I

		Enclosures	Time
1.	Apologies for absence	(Verbal)	10am
2.	Declarations of Interest	(Verbal)	
3.	Actions from the previous meeting	Enclosure A	
Presentation slot			
4.	Person Centred Care Cindy Storer, Deputy Director of Quality and Governance Dr Vicky Barradell, Consultant Geriatrician and Trust Falls Lead Michelle Thorpe, Matron Also introducing "Darcie", the Therapy Cat	Presentation	10.05am
Reports for decision			
5.	Research and Development (R&D) Strategy Moira Hardy – Director of Nursing, Midwfery and Allied Health Professionals	Enclosure B	10.20am
6.	Annual Statement of Compliance against the NHS Core Standards for Emergency Preparedness, Resilience and Response (2018-19) David Purdue – Deputy Chief Executive & Chief Operating Officer (and Accountable Emergency Officer for the Trust)	Enclosure C	10.30am
7.	Freedom to Speak Up Guardian self-assessment and action plan Karen Barnard – Director of People and Organisational Development	Enclosure D	10.40am
Reports for assurance			
8.	Winter Planning David Purdue – Deputy Chief Executive & Chief Operating Officer	Enclosure E	10.50am
9.	Chairs Assurance Logs for Board Committees held 20 September 2018 Neil Rhodes – Chair of Finance and Performance Committee Kath Smart – Chair of Audit and Non-clinical Risk Committee	Enclosure F	11.05am

	BREAK		11.20am
10.	Finance Report as at 31 August 2018 Jon Sargeant – Director of Finance	Enclosure G	11.30am
11.	Performance Report – August 2018 Led by David Purdue – Deputy Chief Executive & Chief Operating Officer	Enclosure H	11.55am
Reports for information			
12.	Chair and NEDs' Report Suzy Brain England – Chair	Enclosure I	12.20pm
13.	Chief Executive's Report Richard Parker –Chief Executive	Enclosure J	
14.	Minutes of Finance and Performance Committee, 20 August 2018 Neil Rhodes – Chair of Finance and Performance Committee	Enclosure K	
15.	Minutes of Management Board, 13 August 2018 Richard Parker – Chief Executive	Enclosure L	
16.	**To note:** Board of Directors Agenda Calendar Matthew Kane – Trust Board Secretary	Enclosure M	
Minutes			
17.	To approve the minutes of the previous meeting held 21 August 2018	Enclosure N	
18.	**Any other business (to be agreed with the Chair prior to the meeting)**		
19.	**Governor questions regarding the business of the meeting**		12.25pm
20.	**Date and time of next meeting** Date: 23 October 2018 Time: 10.00am Venue: Boardroom, DRI		
21.	**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.		12.30pm



Suzy Brain England
Chair of the Board

19 September 2018

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Action Notes

Meeting: Board of Directors

Date of meeting: 21 August 2018

Location: Boardroom, DRI

Attendees: SBE, RP, KB, PD, MH, DP, SS, AA, LP, JP, NR, JS, PS, KS

Apologies: None.

No.	Minute No	Action	Responsibility	Target Date	Update
1.	**18/4/44**	Presentation to be given to Board on work in theatres and outpatients.	**DP/MK**	**Autumn 2018**	Timetabled for a future Board.
2.	**18/6/47** **18/7/27** **18/7/64**	Workshops to be organised on: • Digitising A&E • LEAN • Values based recruitment	**KB/MK**	**Autumn 2018**	Included in board development schedule.
3.	**18/7/70**	Risk assess the impact of Brexit on the Trust with particular reference to workforce and medicine availability.	**MK/DP**	**August 2018**	Complete. Not a corporate risk at present but will be revisited following formulation of the Trust's Brexit Plan, led by the Chief Operating Officer.

No.	Minute No	Action	Responsibility	Target Date	Update
4.	**18/8/23**	Board delegated power to the Chief Executive to sign the electrical contract on behalf of the Trust.	**RP**	**September 2018**	Complete. Contract signed and sealed at Executive Team, August 2018.
5.	**18/8/27**	An anonymous DBTH email address be instated through which whistle-blowers could report issues.	**KB**	**September 2018**	In process of completion.

Date of next meeting: 25 September 2018
Action notes prepared by: M Kane
Circulation: SBE, AC, NR, KB, MH, KS, PD, DP, JS, SS, RP, LP, SM

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Title	**Research and Development (R&D) Strategy**			
Report to	**Board of Directors**	**Date**	**20 September 2018**	
Author	**Amy Bell, Clinical Research Development Manager**			
Purpose	To approve the R&D Strategy 2018-2023			Tick one as appropriate
	Decision			√
	Assurance			
	Information			

Executive summary containing key messages and issues

Vision - Consolidate and further develop DBTH as a centre of research excellence by delivering a high-quality research agenda that makes a lasting difference to the quality of clinical care we provide and driving changes in healthcare practice in the NHS.

Mission - To further embed a progressive research culture of critical thinking and enquiry throughout Trust and empower staff with knowledge, confidence and capability in respect to research

Objectives

1. **PATIENTS** - We will engage and involve patients and the wider public in research in a meaningful and constructive way, including but not solely as research participants
2. **PEOPLE** - We will support and invest in our staff to enable them to participate in research, whilst encouraging them to draw upon the best available research findings and develop innovative approaches to clinical practice which improve patients outcomes
3. **PERFORMANCE** - We will capitalise and maximise relevant research opportunities to deliver financial growth, in order to allow appropriate reinvestment in Trust research services
4. **PARTNERS** - We will prove ourselves a proactive and influential partner in the regional and national research landscape, driving change through our research agenda as opposed responding to it
5. **PREVENTION** - We will demonstrate a commitment to extend the number and impact

of quality research programmes, initiating research focussed on improving the health of our local community, burdened by high incidences of common disease

Key questions posed by the report

How will we:
Develop our R&D infrastructure responsibly in line with emerging workforce need
Enhance our research reputation to attract increasing investment from external agencies
Maximise our academic research potential in partnership with Education colleagues

How this report contributes to the delivery of the strategic objectives

Develop the Trust reputation as a centre of research excellence
Attract and retain high calibre staff
Deliver economic benefit to underpin further research growth
Contribute to better quality care, better patient outcomes and improved use of resources

How this report impacts on current risks or highlights new risks

The development and successful implementation of the R&D strategy will greatly contribute to the Trust Strategic Direction.

Strategy identifies clear need for dedicated Clinical Research Facility (CRF) and for continued work with Estates and Facility colleagues to ensure R&D is a continued consideration in respect to relevant site development plans.

Risk - Existing facilities and resource stifling growth, with no dedicated clinical space for research activity. Risk of organisational reputational damage, loss of partner confidence and resultant loss of funding.

Recommendation(s) and next steps

To approve the Strategy.

> Clinical research improves lives. I am extremely proud to work in an organisation that recognises this and supports me to do just that.
>
> DBTH Staff member

Research has been defined as:

> *The attempt to derive generalisable or transferable new knowledge to answer questions with scientifically sound methods including studies that aim to generate hypotheses as well as studies that aim to test them, in addition to simply descriptive studies.*
>
> *Health Research Authority (2017)*

Executive Summary

Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust (DBTH) embraces research at the heart of its business. NHS England acknowledges that by fully integrating research into NHS organisations, they can outperform organisations that do not, leading to better quality care, better patient outcomes and improved use of resources.

Recent years have seen tremendous advances within the Trust, culminating in the attainment of Teaching Hospital status in January 2017. Central to this achievement remains the long-standing commitment of the Trust to deliver a quality, patient centred research programme.

We are extremely proud of the exceptional improvements that were delivered as part of the Research and Development (R&D) Strategy 2013-2018. The foundation ambition of the strategy was to widen the opportunity for research participation for both our patients and staff, thus ensuring equity of access across all services. Realisation of this ambition - and many more besides - have seen the Trust increasingly recognised as a centre of research excellence, as evidenced by increased research placement and effective interagency partnerships, notably with academia and industry.

This success provides us with an excellent platform to enter into the new phase of our R&D programme. The 2018-2023 Strategy outlines our plans to further increase the quality, volume and breadth of our research output, reaping the reputational rewards of our Teaching Hospital status for the direct benefit of our patients. In line with the Trust Strategic Direction, we must continue to foster a culture of critical thinking and enquiry, whereby staff contribute to the research agenda and actively seek out research evidence in order to apply it during clinical decision making.

The research agenda will continue to be aligned with and influence changes in clinical services delivered within the Trust. We will achieve this through working with colleagues to capitalise on effective internal partnerships between clinical and corporate Trust areas, as well as maximising opportunities for collaborations with regional, national and international partners. Through collaborative working, we will further develop our research portfolio, ultimately contributing to the Trust vision of attracting and retaining high calibre staff and developing our existing staff members whilst driving care quality improvement, innovation and service transformation.

The strategy complements a number of other enabling strategies to deliver the Trust Strategic Direction 2017-2022, notably:

- Clinical Quality and Governance
- Quality Improvement and Innovation
- People and Organisational Development
- Communications and Engagement
- Information and Digital
- Estate and Facilities

Why do we do research?

There is a vital need for all NHS services to be established on a sound research base in order to drive and maintain efficient and high performing clinical services.

A **graphic** to reflect the importance of research to include:

Increased evidence based practice	Patient priority	Generates income
Improved quality, safety and efficiency	Advancing healthcare	Increased trust reputation
Better patient outcomes	Staff recruitment and retention	Promotes clinical excellence

Where we are now

Our patients are at the centre of everything we do; we continue to strive for improvements for them. We deliver our research aspirations whilst keeping our values integral; this embodies our Trust values of 'We Care'.

The landscape for research within DBTH has altered considerably in the last 5 years, largely attributable to the successful delivery of the R&D Strategy 2013-2018. A total of 94% of key performance indicators (KPIs) of this strategy were achieved, across the primary aims of increasing capacity and capability, enhancing the Trust research profile and delivering financial growth whilst developing a robust infrastructure.

	12/13 Before Strategy implementation	**17/18** Post Strategy implementation	***% increase***
Number of approved studies	27	61	*126 %*
Number of participants	446	1000	*124 %*
NIHR Clinical Research Network funding	£355 157 (in year)	£361 351 (in year)	*2 %*
Commercial funding	£ 31 645 (in year)	£250 762 (in year)	*692 %*
Grant funding (including pass through costs)	N/A	£214 468 (in year)	
Active specialties	14	27	*93 %*
Core R&D staff	8.5 WTE	17.63 WTE	*107 %*

Research engagement

Our greatest asset continues to be our capable, vibrant and resilient workforce

Much work has been undertaken to ensure a patient-centred and progressive research culture is embedded across all clinical areas. Increasingly our workforce recognises research as essential to attaining clinical excellence and contributing to the provision of quality, evidence-based services. A total of 97% of staff responders in the recent R&D survey (July 2018) stated it was very important for the NHS to support research, with over 75% expressing an interest in becoming directly involved[1]. This compares with 70% and 63% (respectively) of responders in 2014.

We continue to promote the message that research is everyone's business and empower staff with knowledge, confidence and capability in respect to research. Research has become a routine consideration within Division business planning, affording an opportunity for clinical and research priorities to be aligned for the direct benefit of our patients. Research is now an accepted component of all clinical staff appraisals, with clear criteria agreed for the awarding of additional research Programmed Activities (PAs) for Consultants. This will further increase the scope for commercial collaborations and pave the way for Consultants to act as national Chief Investigators for commercially sponsored clinical trials.

The advancement of the research clinical skill base in our nursing, midwifery and Allied Health professions staff base continues to be a key focus. Specific initiatives have been employed to drive the research agenda at an operational level, including delivering tailored research awareness sessions, as well as the establishment of a multi-disciplinary Research Champion network covering all Trust services. Such initiatives have afforded opportunities for 'talent spotting' across the healthcare professional base, identifying future research leaders and providing bespoke support to enable them to professionally and academically develop in respect to research. Our staff members continue to secure proportionally high numbers of places on the regional academic internship programme; part of a proven, structured progression pathway whereby the skills developed can be implemented to further advance the local research agenda. This pathway has been particularly embraced by our Allied Health Professional (AHP) staff base, who have increasingly demonstrated broad research engagement and a commitment towards the integration of research practices into routine clinical care.

Active engagement in the regional CArDiNAL (Clinical Doctoral Nurses and Allied Health Professionals) initiative, a doctoral network to further support career development across the healthcare professional base, has led to the Trust supporting two nursing PhD fellowships in partnership with the University of Sheffield. Continued collaboration with our local academic partners will ensure clear career progression opportunities are afforded to our research engaged healthcare professional base.

Integration of research delivery within the nursing staff base remains key for sustainability. Much consideration has been given as to how we can continue to develop our nursing infrastructure in a flexible and responsive way, most notably in respect to our Specialist Nurse Practitioners. Our Research Nurses partner with wider nursing colleagues to deliver successful research outcomes across a range of specialties, adapting their support level dependent on research engagement, service need and clinical demand. This tailored approach has ensured the development of innovative nursing models in relation to research, which have been celebrated both regionally and nationally, including through shortlisting at the Nursing Times Awards in 2016. We have also introduced Clinical Trial Assistants to reduce much of the administrative burden of our nursing workforce, further enhancing our infrastructure a responsive way.

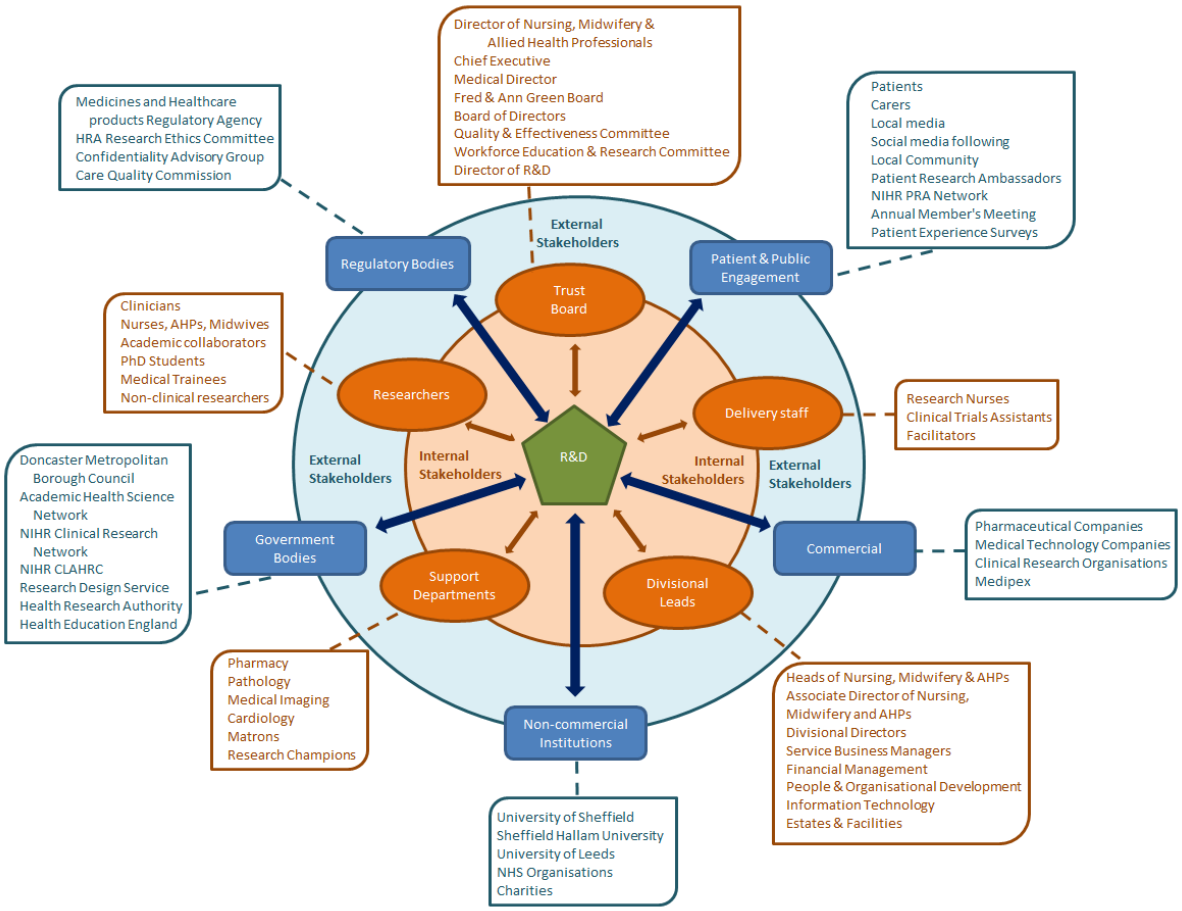
We continue to actively pursue research opportunities for which successful delivery is underpinned by a multi-professional staff base. This approach has afforded a defined model of engagement for our healthcare professionals, such that staff members can develop their research capability through the role of Co-Investigator, with a view to developing in the capacity of Principal Investigator. This clearly defined pathway has supported increasing numbers of Nurses, Midwives and AHPs in successfully undertaking the role of Principal Investigator, delivering quality research across DBTH services.

[1] *A total of 796 staff members responded to the 2018 survey, of which 65% were clinical staff members.*

Enhancing the Trust research profile

We continue to drive research excellence in collaborative research partnerships, across a range of health and care sectors

Sustained and reliable research delivery has ensured continued partner confidence and repeated placement of studies, further enhancing and contributing to our growing reputation as a research leader. We aim to deliver a tailored approach to our partnership working, to ensure we consistently meet the unique needs of our research partners. The planned development of a Clinical Research Facility (CRF) will further enhance our research capability and reputation in respect to quality research delivery.



A great success has been the establishment and maintenance of a balanced and diverse portfolio, enabling local researchers to address research questions highly relevant to everyday practice. We have both capitalised upon and developed opportunities for collaborative working arrangements with regional research partners, in order to deliver research programmes clinically relevant to our local population.

We continue to be an active and contributing member of the Yorkshire and Humber Collaborations for Leadership in Applied Health Research and Care (CLAHRC), which has enabled us to develop both local and regional research capacity. We will continue to work with CLAHRC under the emerging scheme of ARC (Applied Research Collaboration), particularly with regards to involvement in ACORN, a national network of healthcare partners focused on increasing research capacity across the healthcare professional base. Work to date has led to the appointment of a Research Fellow, to support the increased uptake of research academic opportunities by our healthcare professional base. This appointment has also enabled us to support initiatives to better understand the wider impact of research, including a specific workstream which explores impacts in the context of participant health, service and workforce, knowledge, influence, economy and research capacity. As

an organisation we continue to partner with appropriate agencies to drive the faster translation of research outcomes into tangible benefits for patients, not only through our links with CLAHRC but also through the Yorkshire and Humber Academic Health Science Network (AHSN).

We have capitalised on available and feasible opportunities to deliver quality research for the benefit our local patient population. Now, with our established base and proven track record of successful delivery, we have the opportunity to develop in a more structured and considered way, specifically advancing the Trust's research interests. This requires development of our Chief Investigator capacity and an extension to the Trust Sponsorship capabilities to include Clinical Trials of Investigational Medicine Products (CTIMPs), for which initiatives are ongoing. In view of our Teaching Hospital status, these areas of development have increasingly become key drivers for the Trust.

Much groundwork has been undertaken in these regards, specifically in respect to increased grant capture potential. Recent developments include the securement of statistical support through the University of Sheffield and developing Patient and Public Involvement (PPI) initiatives, including the appointment of Patient Research Ambassador (PRA). This demonstrates our commitment to improve the quality and relevance of our research programme through greater service involvement, key to strengthening future grant applications.

Agreed planning with our Teaching and Education colleagues with respect to the establishment of Clinical Academic Directorates, will ensure we maximise our academic research potential in order to further develop our Chief Investigator base. Through a collaborative approach, we will develop a clear framework against which the award of Clinical Academic Directorate status will be assessed (and continuing status supported) and work with specialties with significant research potential to attain this. We will increase academic and joint appointments with the Universities - an integral part of an institution with a high profile research - to underpin the development of academic research leaders with the potential to secure external research funding through open competition. This will consolidate and further develop the Trust as a research centre of excellence.

Financial growth

Sustained financial growth continues to be delivered and increased income generated through various funding streams

Increased transparency in financial costings, management and resource allocation continue to be a key focus and have ensured a growing understanding of the income and reinvestment potential inherent within research delivery across all Divisions.

The Trust research programme is funded via a combination of an annual National Institute for Health Research (NIHR) allocation, commercial research income, charitable funding through the Greens Legacy and external grant applications. The Trust maintains active involvement in all relevant Department of Health and NIHR initiatives and in doing so has maximised available funding through NIHR and opportunity for partnership.

Commercial delivery remains a key driver for the Trust. The commercial portfolio continues to be diversified with further scope to extend into the Medical Technology arena. A proven track record for meeting key performance targets and consistent delivery of contractual obligations has strengthened our existing commercial partnerships, with our exceptional achievements attracting new partners. Our unique commercial set up and delivery model give us a competitive edge with respect to patient recruitment, and affords the clinical delivery team every opportunity to maximise the recruitment window. Successes include the recruitment of the first worldwide and the first European patient to a number of studies across several specialties. These achievements were acknowledged by the NIHR, with two of our Consultants celebrated at a national event of only 70 Principal Investigators.

> It typically costs £1.15 billion before a new medicine can be licenced for use. Without this investment from the commercial sector, NHS patients would not have access to important and effective new treatments. Our commercial collaborations enable our patients to have greater treatment options, and access novel treatments at the earliest available opportunity.

Our research delivery is underpinned by robust governance structures in respect to research initiation, delivery and management.

The regulatory landscape for research can be complicated, riddled with acronyms and multi-agency involvement. Within R&D, we wish to capitalise on all clinical enthusiasm for research and ensure our staff members are fully supported in navigating the regulatory framework, in an efficient and proactive way. We continue to provide skilled support in the development of innovative research ideas into well-designed and competitive research proposals, supporting partner identification, funding detection and regulatory applications as required.

We also offer a study identification process whereby a staff member with a research interest but without a research idea, is afforded the opportunity to collaborate nationally with other centres to jointly deliver a project adopted on the NIHR Portfolio. Operational oversight of research activity is maintained throughout the lifecycle of all research projects, to ensure study-specific key performance indicators are met whilst maintaining wider regulatory and Good Clinical Practice compliance, across all service areas.

SWOT

Strengths	**Weaknesses**
• Unique capabilities in respect to commercial set up affording a competitive advantage • Geographical/demographical - high burden of common disease • Broad engagement across range of specialities and professional groups • Reputation in respect to research delivery and continued achievement of quality indicators • Established collaborations with regional partners • Teaching Hospital Status • Dynamic R&D team with strong clinical experience • Dedicated support services • Research included in job planning process • Developing a progressive research culture of critical thinking	• Facilities/resources stifling growth • No dedicated clinical space for research activity - unable to take forward clinically relevant projects • Split site operations • Not enough staff members acting in Chief Investigator role • Not all staff aware of R&D opportunities • Poor visibility of R&D team across Trust • Disjointed communication for funding and career development opportunities • Not having sponsorship capacity for Clinical Investigational Medicinal Products (CTIMPs) trials • Long-term financial planning - lack of financial reserves • Not enough critical mass in respect to academic staffing
Opportunities	**Threat**
• Further spread a progressive research culture of critical thinking • Unexploited clinical areas • Diversify commercial portfolio and pursue collaborations new technology • Business/product development • Trust Strategic Direction and enabling strategies • Align service an research needs in new services • Develop research programmes to specifically address needs of local population • Increased grant capture • Grow Bassetlaw and Montagu operations • Capitalise on reputation and magnetism • Provide clinical staff base better engagement opportunities in respect to career development • More structured ways to engage patients and the public	• Changing national and international landscape • Sustainable financial backing - capital investment required • Reputation damage risked through inadequate facilities/resource - operationally ceilinged • Staff moving if not supported to deliver own account CTIMP

Where do we want to be? Incorporates Objectives

Our service is:

Responsive

Enabling

Searching

Engaged

Accessible

Reliable

Collaborative

High-quality

Our **vision** is to consolidate and further develop DBTH as a centre of research excellence by delivering a high-quality research agenda that makes a lasting difference to the quality of clinical care we provide and driving changes in healthcare practice in the NHS. In order to realise this vision, our **mission** is to further embed a progressive research culture of critical thinking and enquiry throughout Trust and empower staff with knowledge, confidence and capability in respect to research.

In line with the Trust Strategic Direction, and drawing upon interdependencies of other Trust enabling strategies, we will achieve this through the following objectives:

PATIENTS - We will engage and involve patients and the wider public in research in a meaningful and constructive way, including but not solely as research participants

We will more readily engage in relevant Patient and Public Involvement initiatives, linking with appropriate NIHR and regional networks to ensure we improve the quality and quantity of member engagement across our research portfolio, utilising co-design methodology as appropriate.

This will require:

- Increasingly capturing and acting upon patient experience and engagement feedback, in order to inform and refine our service delivery
- Ensuring our patients feel confident in asking clinical colleagues about research opportunities relevant to their condition, by promoting the NIHR 'OK To Ask' campaign across our services
- Implementing a 'consent to contact' initiative whereby we develop a research database enabling the ready identification of potential research participants
- Adopting a cohesive approach to function as a single team across all sites to ensure patients are afforded the same opportunity to participate in research irrespective of care locality

PEOPLE - We will support and invest in our staff to enable them to participate in research, whilst encouraging them to draw upon the best available research findings and develop innovative approaches to clinical practice which improve patients outcomes

We will continue to increase our research capacity and capability at all levels from novel researcher through to research leader. We will ensure research activity by our multi-disciplinary staff is encouraged and actively supported throughout the organisation, with research contributions duly acknowledged through Trust award schemes and in job planning processes.

This will require:

- Establishing clear communication channels to enable the rapid dissemination of relevant and varied research opportunities

- Supporting professional development pathways for Trust staff members, including securing appropriate clinical mentorship and training, in order to develop their role of high quality independent investigators
- Strongly encouraging these staff members to initiate high quality research, which may qualify for support from the NIHR Clinical Research Network, including Trust-sponsored, investigator-led clinical trials
- The creation of Academic Directorates, academic posts and joint appointments with the Universities including Professorial Chairs, a key driver in increasing the quality and originality of our research output

PERFORMANCE - We will capitalise and maximise relevant research opportunities to deliver financial growth, in order to allow appropriate reinvestment in Trust research services

To deliver the growth outlined in this Strategy, we must continue to explore innovative partnerships with both the public and private sectors in order to attract investment as appropriate. We will further stabilise existing funding structures through NIHR by being a model partner organisation, whilst also mobilising the workforce to increase grant capture.

This will require:

- Developing a dedicated clinical research facility (CRF) for research, in order to ensure an environment highly conducive to quality research and increased commercial placement
- Strategically focusing available income on priority areas with research potential, according to maximum patient benefit
- Being an exemplar research partner, delivering to time and target and meeting contractual obligations to maximise associated income and repeated collaborations
- Encouraging and identifying innovative ideas that can be exploited and progressed to commercialization

NHS Trusts in England were estimated to receive £6,658 in revenue from life science companies for each patient recruited into commercial clinical research studies.

This is in addition to an average of £5,250 pharmaceutical cost saving for each patient recruited into pharmaceutical-based commercial clinical research studies, where a trial drug replaced the standard of care.

PARTNERS - We will prove ourselves a proactive and influential partner in the regional and national research landscape, driving change through our research agenda as opposed responding to it

We are aware of our role in a wider system of healthcare, academia and industry and recognise the collaboration required in order to deliver research for direct patient benefit. We will build on our existing strengths whilst exploiting new opportunities for partnership.

This will require:

- Undertaking the focussed pursuit of appropriate interagency and multi-disciplinary research collaborations, both internal and external to the Trust
- Capitalising on established strong relationships with neighbouring trusts and clinical commissioning groups, building on the foundations of our proven history of working together in order to improve health and care for our population by delivering collaborative research proposals
- Further developing effective partnerships between clinical and corporate Trust areas, to better understand service needs and how research interest can be aligned for mutual benefit
- Horizon scanning to identify future and emerging technologies and initiating new collaboration with regional Medical Technology companies

PREVENTION - We will demonstrate a commitment to extend the number and impact of quality research programmes, initiating research focussed on improving the health of our local community, burdened by high incidences of common disease

We will cultivate priority areas of translational and applied health services research, which have clear potential to inform commissioning, service improvement and transformation to benefit our local patient population.

This will involve:

- Securing a commitment across all Divisions to develop their own local research strategic priorities and demonstrate excellence in both the volume and quality of their clinical research portfolio
- Provide skilled support for the development of innovative research ideas into well designed and competitive research proposals, eligible for external funding
- Continuing to support national and local initiatives for the translations of our research achievements into healthcare practice and service innovation, ensuring rapid translation of research findings into clinical practice, linking with Public Health and wider healthcare partners accordingly
- Explore areas of shared research interest with other NHS organisations, charities and local universities, aligning likeminded individuals to take forward agendas relevant to our local population and to maximise the chances of successful grant applications

Accountability and timescales

Objective 1:

- **Engage** our staff and patients to increase the quality, breadth and volume of research output

Challenge:

- Undertake a considered approach to workforce planning and development, developing our R&D infrastructure responsibly in line with emerging workforce need
- Maximise the research potential of our multi-disciplinary staff with the full support of Divisions
- Develop a clear marketing strategy to considerably increase research visibility to both staff and patients alike

Action:

- Refine and utilise our existing Research Champion network and identify key 'link nurses' to drive research agenda at operational level
- Develop an internal database mapping the research interests of our Medic staff base to allow the focussed pursuit of relevant opportunities by R&D
- Engage medical trainees and other clinical students to increase direct research capacity
- Ensure equity of access to all our patients by facilitating placement of NIHR Portfolio research across all service lines
- Deliver tailored initiatives to increase research capacity across the healthcare professional base, ensuring clear opportunities for engagement in both qualitative and quantitative research
- Establish clear communication channels for the rapid dissemination of research opportunities and initiatives, with routine circulation to our healthcare professionals
- Promote and publicise research activity and outputs via all relevant channels with the full support of the Communication and Engagement team
- Hold local 'Research For You' events with support of our regional health care partners
- Increasingly deliver research across all Trust sites, operate an appropriate 'hub and spoke' model from Doncaster Royal Infirmary

- Introduce performance reports to ensure transparency of research performance against Divisional strategic plans

Outcome:

- Attract, develop and retain a highly skilled health research workforce
- Increased research capacity across the organisation demonstrated through:
    - Increased participant recruitment across research portfolio
    - Increased number of staff members acting in Chief Investigator, Principal Investigator and Co-Investigator capacity
- Wider engagement opportunities for healthcare professionals, resulting in increased research participation
- Staff members feel research is increasingly relevant to them and their role
- Enhanced research profile both internal and external to the Trust
- Increased research capacity across the organisation with clear expansion into novel areas

Objective 2:

- **Develop** our Chief Investigator base to increase grant capture potential

Challenge:

- Ensure robust structures and systems in place to support the initiation, delivery and management of grant applications and the associated sponsorship responsibilities
- Increase engagement across multi-disciplinary staff base to act in Chief Investigator capacity
- Maximise our academic research potential in partnership with Teaching and Education colleagues
- Ensure dedicated clinical facilities for research are available to increase organisation credibility and likelihood of grant placement

Action:

- Mapping exercise to ascertain appetite for research leadership interest and identify and support emerging talent
- Establish dissemination channels to enable the rapid dissemination of open, themed and commissioned funding calls
- Ensure specialist services available to staff members to develop quality research proposal, including support to navigate regulatory landscape and provision of statistical advice
- Collaborate with NIHR Research Design Service where appropriate
- Establish Patient and Public Involvement panel/s to inform quality, relevance and impact of research proposals
- Undertake an organisational review to understand the resource requirement for extending sponsorship capabilities to include Clinical Trials of Investigational Medicinal Products (CITMPs)
- Explore commercial collaborations to develop staff members as national 'key opinion leaders' to further develop Chief Investigator base and enhance Trust research profile
- Increasingly submit applications for high quality research grants from research partners
- Collaborative pursuit with Teaching and Education colleagues to establish Clinical Academic Directorates and create academic posts to deliver successful joint funding applications with academic partners
- Work with Estates and Facilities colleagues to ensure R&D is a continued consideration in respect to relevant site development plans for development of Clinical Research Facility (CRF) and source funding appropriately

Outcome:

- Increased staff members from across the professions acting in Chief Investigator capacity resulting in increased publications in peer reviewed journals, citation rates and broader opportunities for dissemination and knowledge transfer
- Increased R&D investment from external research funders through grants for discrete applied research projects
- Enhanced research profile with potential to further attract research placement and new partnership opportunities
- Healthcare gains associated with delivering a tailored 'own account' research portfolio, specifically targeted towards meeting the healthcare needs of our local population
- Occupancy of dedicated R&D space with provision for both non-clinical and clinical staff

Objective 3:

- **Deliver** economic benefit to underpin further research growth

Challenge:

- Deliver a balanced and diverse research portfolio to maximise funding avenues across public, charitable and commercial sectors
- Enhance our research reputation to attract increasing investment from external agencies

Action:

- Consistently meet all contractual obligations in respect to research delivery to maintain partner confidence and continued research placement
- Establish clear processes in respect to Intellectual Property management to maximise the commercialisation potential of Trust innovations
- Capitalise on opportunities to excel in research delivery, particularly in respect to pharmaceutical collaborations with potential to recruit the first UK, European or International participant
- Establish new collaborations with regional Medical Technology companies to jointly deliver innovative research initiatives
- Maximise the potential for NIHR Research Capability Funding through the successful award of NIHR research programme funding
- Develop collaborative research proposals with local healthcare organisations to maximise the potential impact for our local population
- Agreed financial growth markers

Outcome:

- Increased income available for reinvestment in research services
- Enhanced financial capability in respect to large scale grant management
- Stablished funding structures

Evaluation and Monitoring

Evaluation and monitoring of performance against this strategy will be coordinated by the R&D management team, working in close partnership with relevant clinical and corporate colleagues. An annual delivery plan will be developed, with clearly defined timescales against the actions to be taken to deliver strategy objectives.

Process Measures
• Number of studies meeting prearranged targets • Number of individuals with pre-defined roles within research studies • Number of research studies in each clinical specialty • Number of Good Clinical Practice (GCP) trained staff

• Number of specialties with active Research Champions • Number of successful funding applications and partnerships
Learning Measures
• Review of research partnerships initiated but not progressed to delivery stage • Analysis of patient satisfaction surveys • Analysis of staff survey • Review of ad hoc study-specific delivery issues • Review of activity at Divisional level
Outcome Measures
• Achievement of agreed research action plans each year • Review of annual achievements in relation to NIHR CRN priorities • Valid contributions toward regional initiatives to better understand the broader impacts of research and communicate this effectively with research stakeholders • Continued financial security and growth • Actions taken as a result of learning from surveys to refine service delivery • Measurable improvements in patient outcomes attributable to R&D

Clearly defined reporting mechanisms will ensure the implementation of and compliance with the strategy can be readily assessed. Delivery of the R&D strategy will be appropriately supported and monitored via the following reporting structure:

Board of Directors
The Board has overall responsibility for the activity, integrity and strategy of the Trust and has a statutory duty to ensure high standards of research activity and regulatory compliance. The Chief Executive has overall accountability for R&D, delegating the executive responsibility to the Director of Nursing, Midwifery and Allied Health Professionals, who is responsible for reporting to the Trust Board on the R&D agenda and ensuring that any supporting strategy documents are implemented and evaluated effectively. R&D Strategy delivery will also be reported annually in Trust Quality accounts.

Quality and Effectiveness Committee (QEC)
The QEC provides assurance to the Trust Board on progress and performance relating to the delivery of the R&D Strategy, with regards the continuous and measurable improvement in R&D activities.

Workforce and Education Committee (WEC)
The WEC has recently been expanded in order to provide assurance to the Trust Board via the QEC in relation to the delivery of R&D plans, activities and performance, receiving a report on a biannual basis.

Research Advisory Group (RAG)
The RAG is a supportive forum of DBTH staff members, Trust Research Patient Ambassador/s and wider R&D partners involved or with an interest in clinical research at DBTH. The role of the RAG is to provide active oversight and constructive challenges on R&D plans, activities, performance and reports in order to support DBTH to achieve its objectives for clinical research in accordance with the R&D Strategy. Specific Task and Finish Groups are established as required. Delivery against the R&D Strategy is a standing item on the biannual agenda.

Division Responsibility and Accountability
Division Management teams have a responsibility to ensure that research is embedded within their annual planning process, and a key consideration within their reporting structure.

Communication and Engagement

This strategy was informed and shaped by undertaking a thorough organisational analysis, and has been influenced using feedback from our partners, stakeholders and staff. Key messages, in respect to the vision for research, were collated and incorporated into this strategy which draws upon interdependencies with other Trust enabling strategies, particularly shared ambitions pertaining to staff development in respect to research, skills, innovation and leadership. Additionally, consideration has been given in respect to delivery against the previous R&D Strategy (2013-2018), in order to determine which elements required carrying forward and how the Trust's refreshed Strategic Direction has influenced priorities for this new R&D Strategy.

The staff survey conducted prior to the finalisation of this strategy provided an interesting insight in relation to further opportunities to understand staff priority areas in respect to research, as well as suggestions for how to capitalise on opportunities for wider engagement. Continued engagement initiatives will inform and refine the annual action plans moving forward, underpinned by a shared ownership of the research agenda by relevant clinical leads.

Progress will be reported biannually via the aforementioned reporting structure, with the reports detailing highlights of R&D achievements and the associated impacts. Wider dissemination of these achievements will be supported by Communication and Engagement colleagues, utilising appropriate internal and external communication channels, including the Foundations for Health publication.

Finally, an annual R&D showcase event will include a report of progress against the strategy, and provide wider engagement opportunities with our research partners.

References & Bibliography

NHS England Research Plan
https://www.england.nhs.uk/wp-content/uploads/2017/04/nhse-research-plan.pdf

KPMG report - NIHR Clinical Research Network: Impact and Value Assessment
https://www.nihr.ac.uk/life-sciences-industry/documents/NIHR%20CRN%20Impact%20and%20Value%20FINAL%20REPORT_vSTC_160908_FOR%20EXTERNAL%20USE.pdf

National Institute for Health Research (NIHR)
https://www.nihr.ac.uk/

Academic Health Science Network (AHSN) for Yorkshire and the Humber
https://www.yhahsn.org.uk/

Involve - Public Involvement in NHS Research
http://www.invo.org.uk/

NIHR Collaboration for Leadership in Applied Health Research and Care (CLAHRC)
http://clahrc-yh.nihr.ac.uk/

NIHR Clinical Research Network Allied Health Professionals Strategy 2018-2020
https://www.nihr.ac.uk/our-faculty/clinical-research-staff/Allied%20Health%20Professionals/Allied%20Health%20Professionals%20Strategy%202018_20.pdf

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Title	Annual Statement of Compliance against the NHS Core Standards for Emergency Preparedness, Resilience and Response (2018-19)		
Report to	Board of Directors	**Date**	25 September 2018
Author	David Purdue, Deputy Chief Executive, 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 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 attached report outlines the self-assessment process and Trust compliance.

The declaration for 2018-19 is of substantial compliance against the Core Standards.

A copy of the Board report was received and noted by the Audit and Non-Clinical Risk Committee at its meeting on 20 September 2018.

The Audit and Non-Clinical Risk Committee recommended that:

- **The Board of Directors approve the statement of compliance at Appendix A for submission to NHS England; and that**

- **The Board of Directors approve the Improvement Plan at Appendix B for submission to NHS England.**

Key questions posed by the report

Based on the recommendation of the Audit and Non-Clinical Governance Committee, is the Board satisfied that it may approve:

- **The Statement of Compliance?**
- **The Improvement Plan?**

How this report contributes to the delivery of the strategic objectives

Compliance with EPRR standards supports the Trust in its strategic objectives to:

- Patients: Work with patients to continue to develop accessible, high quality and responsive services;
- People: As a Teaching Hospital we are committed to continuously developing the skills, innovation and leadership of our staff to provide high quality, efficient and effective care;
- Performance: We will ensure our services are high performing, developing and enhancing elective care facilities at Bassetlaw Hospital and Montagu Hospital and ensuring the appropriate capacity for increasing specialist and emergency care at Doncaster Royal Infirmary;
- Partners: We will ensure our services are high performing, developing and enhancing elective care facilities at Bassetlaw hospital and Montagu Hospital and ensuring the appropriate capacity for increasing specialist and emergency care at Doncaster Royal Infirmary;
- Prevention: Support the development of enhanced community based services, prevention and self-care.

How this report impacts on current risks or highlights new risks

Compliance with EPRR standards supports the Trust in addressing the risk:

- A 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 One Responder under the Civil Contingencies Act 2004.

Recommendation(s) and next steps

The Board is requested:

- **To note the self-assessment process undertaken for 2018-19.**
- **To approve the statement of compliance at Appendix A for submission to NHS England (Yorkshire and the Humber).**
- **To approve the Improvement Plan at Appendix B for submission to NHS England (Yorkshire and the Humber).**

Steps Following Approval

- The Statement of Compliance will be submitted to NHS England (Yorkshire and the Humber) by 31 October 2017.

- By 31 December 2018, LHRP and regional confirm and challenge processes will have taken place and, by 28 February 2019, national EPRR confirm and challenge processes will be completed.

- By 31 March 2019 the National Health Services' submission will be submitted to the NHS England Board.

- The Trust's confirmed level of compliance will be included in its Annual Report and Accounts for 2018-19.

BOARD OF DIRECTORS

ANNUAL STATEMENT OF COMPLIANCE

AGAINST

NHS ENGLAND CORE STANDARDS FOR EMERGENCY PREPAREDNESS RESILIENCE AND RESPONSE

2018-19

David Purdue, Deputy Chief Executive, Chief Operating Officer and Accountable Emergency Officer
25 September 2018

1. Introduction

As part of NHS England Emergency Preparedness, Resilience and Response (EPRR) Framework, providers and commissioners of NHS funded services must show that they can effectively respond to major, critical and business continuity incidents whilst maintaining services to patients.

NHS England has an annual statutory requirement to formally assure its own, and the NHS in England's, EPRR readiness. To do this NHS England asks providers of NHS funded care to complete an annual assurance process. The first step in this process is organisational self-assessment.

The NHS England Core Standards for (EPRR) are the minimum requirements commissioners and providers of NHS funded services must meet. The NHS Core Standards for EPRR have been reviewed this year. Changes include an increased number of standards, an expanded focus on Business Continuity, revised formatting/a requirement for greater detail and the removal of the CBRNe (decontamination) equipment list.

The number of standards for organisations is dependent on function and statutory requirements. For acute Trusts the number of Core Standards for 2018-19 is 64.

Declaration is via a self-assessment of fully compliant, partially compliant or not compliant against each Core Standard. An overall assurance rating is then assigned to the organisation on the percentage of Core Standards for EPRR which the organisation has assessed itself as being 'fully compliant' with (see section 3 below).

Each year a 'deep dive' is conducted to gain additional assurance into a specific area. The 'deep dive' area of focus for 2018-19 is on Command and Control. The self-assessment against the deep dive standards does not contribute to the organisation's overall EPRR assurance rating and is reported separately to NHS England (see section 5 below).

2. Statutes and Guidance Underpinning EPRR

The Civil Contingencies Act (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);
- NHS England Emergency Preparedness Framework 2015;
- National Standard Contract SC30;
- NHS Improvement;
- Care Quality Commission.

3. Self-Assessment Process – Compliance and Assurance Ratings

Organisations rate their compliance for each standard as:

Compliance Level	Definition
Fully compliant	Fully compliant with the Core Standard.
Partially compliant	Not compliant with the Core Standard. The organisation's EPRR work programme demonstrates evidence of progress and an action plan to achieve full compliance within the next 12 months.
Not compliant	Not compliant with the Core Standard. In line with the organisation's EPRR work programme, compliance will not be reached in the next 12 months.

An overall assurance rating is assigned to the organisation on the percentage of Core Standards for EPRR which the organisation has assessed itself as being 'fully compliant' with.

The possible overall assurance ratings are:

Compliance Level	Evaluation and Testing Conclusion
Fully	The organisation is 100% complaint with all standards it is expected to achieve. The organisation's Board has agreed with this position statement.
Substantial	The organisation is 89-99% compliant with the Core Standards it is expected to achieve. For each non-compliant Core Standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months.
Partial	The organisation is 77-88% compliant with the Core Standards it is expected to achieve. For each non-compliant Core Standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months.
Non-compliant	The organisation is compliant with 76% or less of the Core Standards the organisation is expected to achieve. For each non-compliant Core Standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months. The action plans will be monitored on a quarterly basis to demonstrate progress towards compliance.

4. Performance Against the Core Standards for 2018-19

The 64 Core Standards applicable to Acute Trusts are based on the duties of Category One Responders under the Civil Contingencies Act (CCA) 2004. They are split into ten domains (seen in the table below).

Performance Statement on Core Standards

Domain	No of Standards	Fully Compliant	Partially Compliant	Not Compliant
Governance	6	6	0	0
Duty to Assess Risk	2	2	0	0
Duty to Maintain Plans	14	14	0	0
Command and Control	2	2	0	0
Training and Exercising	3	2	1	0
Response	7	6	1	0
Warning and Informing	3	3	0	0
Co-operation	4	4	0	0
Business Continuity	9	5	3	0
CBRNe	14	14	0	0
Total	64	59	5	0

The working paper (excel spreadsheet) provided for the self-assessment which includes the detailed requirements and examples can be seen at appendix D.

The Trust is fully compliant with 59 of the Core Standards.

There are five standards which have been assessed as amber.

The details relating to non-compliance and actions for improvement are included on the working paper and in the Improvement Plan at appendix B (page 9) for the Board's attention.

5. Performance Against the Deep Dive Standards for 2018-19

Each year a 'deep dive' is conducted to gain additional assurance into a specific area. The 'deep dive' area of focus for 2018-19 is on Command and Control. The self-assessment against the deep dive standards does not contribute to the organisation's overall EPRR assurance rating and is reported separately to NHS England.

Performance Statement on Command and Control Standards

The Trust has assessed itself as fully compliant with all eight of the Command and Control standards.

6. Actions and Progress from the 2017-18 Assessment

Appendix C shows that actions arising from the 2017-18 self-assessment have been completed to deadline with in-year progress updates provided to the Trust's Business Continuity Steering Group (BRSG).

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 five of the Core Standards are amber.

The declaration is of substantial compliance against the 2018-19 Core Standards.

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

8. Recommendations

- **The Board is requested to note the self-assessment process undertaken for 2018-19.**
- **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, Deputy Chief Executive, Chief Operating Officer and Accountable Emergency officer
25 September 2018

APPENDIX A

Yorkshire and the Humber Local Health Resilience Partnership (LHRP)
Emergency Preparedness, Resilience and Response (EPRR) assurance 2018-2019

STATEMENT OF COMPLIANCE

Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust has undertaken a self-assessment against required areas of the EPRR Core standards self-assessment tool v1.0.

Where areas require further action, Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust will meet with the LHRP to review the attached core standards, associated improvement plan and to agree a process ensuring non-compliant standards are regularly monitored until an agreed level of compliance is reached.

Following self-assessment, the organisation has been assigned as an EPRR assurance rating of Substantial (from the four options in the table below) against the core standards.

Overall EPRR assurance rating	Criteria
Fully	The organisation is 100% compliant with all core standards they are expected to achieve. The organisation's Board has agreed with this position statement.
Substantial	The organisation is 89-99% compliant with the core standards they are expected to achieve. For each non-compliant core standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months.
Partial	The organisation is 77-88% compliant with the core standards they are expected to achieve. For each non-compliant core standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months.
Non-compliant	The organisation compliant with 76% or less of the core standards the organisation is expected to achieve. For each non-compliant core standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months. The action plans will be monitored on a quarterly basis to demonstrate progress towards compliance.

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

25/09/2018

Date signed

25/09/2018	25/09/2018	TBC (2019)
Date of Board/governing body meeting	Date presented at Public Board	Date published in organisations Annual Report

APPENDIX B

Yorkshire and the Humber EPRR Core Standards Improvement Plan 2018-19

Organisation: Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

ACTIONS ARISING FROM 2018-2019 ASSURANCE PROCESS (CORE STANDARDS)

Core standard reference	Core standard description	Improvement required to achieve compliance	Actions to deliver improvement	Lead	Target date
28	Training and Exercising Strategic and tactical responders must maintain a continuous personal development portfolio demonstrating training in accordance with the National Occupational Standards, and / or incident / exercise participation.	Central records of training are maintained on the OLM system and training is discussed with individuals at appraisal however there is currently no format for a continuous personal development portfolio for senior managers.	• Provide a format for personal records. • Roll this out to on-call managers to ensure that individual records are maintained.	Emergency Planning Officer	31 March 2019
31	Response Version controlled, hard copies of all response arrangements are available to staff at all times. Staff should be aware of where they are stored; they should be easily accessible.	Update action cards (current work in progress).	• Complete action card audit. • Update action cards for all areas as required. • Check access and rights to shared drives.	Emergency Planning Officer	31 December 2018
49	Business Continuity The organisation annually assesses and documents the impact of disruption to its services through Business Impact Analysis(s).	Update business continuity processes and plans throughout the organisation (current work in progress, also accounting for any changes required by reorganisation).	• Finalise the update of the processes for business impact analysis (BIA). • Provide training on the BIA process. • Facilitate workshops with divisions and departments to update BIAs.	Emergency Planning Officer	31 March 2018

51	Business Continuity The organisation has established business continuity plans for the management of incidents. Detailing how it will respond, recover and manage its services during disruptions to: • people • information and data • premises • suppliers and contractors • IT and infrastructure These plans will be updated regularly (at a minimum annually), or following organisational change.	Update business continuity processes and plans throughout the organisation (current work in progress, also accounting for any changes required by reorganisation).	• Complete business continuity plan audit. • Finalise the update of the processes for business continuity plans (BCPs). • Provide training on BCP processes. • Facilitate workshops with divisions and departments to update BCPs. Undertake exercises to test BCPs - locally and Trust wide. • Check access and rights to shared drive.	Emergency Planning Officer	30 June 2019
55	Business Continuity The organisation has in place a system to assess the business continuity plans of commissioned providers or suppliers; and are assured that these providers arrangements work with their own.	Update business continuity processes and plans throughout the organisation (current work in progress, also accounting for any changes required by reorganisation).	• Ensure that BCMs include information on supplier arrangements where these are highlighted as critical in the BIAs.	Emergency Planning Officer	30 June 2019

APPENDIX C

Yorkshire and the Humber EPRR Core Standards Improvement Plan 2018-19

Organisation: Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

ACTIONS AND PROGRESS FROM 2017-2018

Actions arising from the 2017/18 self-assessment have been completed to deadline with in-year progress updates provided to the Trust's Business Continuity Steering Group (BRSG).

Core standard reference	Core standard description	Improvement required to achieve compliance	Action to deliver improvement	Target Date	Update on progress since last year
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	The review was undertaken by the Trust's Emergency Planning Officer. An update on the status of plans was provided to the Business Resilience Steering Group meeting on 19 July 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. Emergo Exercise Mohawk - 12th December 2017. Exercise Larissa (Outbreak Exercise) – late 2017.	31 July 2017	The Trust participated in each of the four 2017-18 exercises.
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.	Include the EPRR results in future Annual Reports.	26 September 2017	The information was included in the Trust's Annual Report for 2017-18 (page 85).
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.	Identify the Non-Executive Director who formally holds the EPRR portfolio in future Annual Reports.	26 September 2017	This information was included on the Trust's website in a separate file next to the Annual Report. This fulfils the requirements of the Foundation Trust Annual Reporting Manual, with which compliance is mandatory.

APPENDIX D - CORE STANDARDS SELF ASSESSMENT

Please select type of organisation: **Acute Providers**

Core Standards	Total standards applicable	Fully compliant	Partially compliant	Non compliant
Governance	0	6	0	0
Duty to risk assess	0	2	0	0
Duty to maintain plans	0	14	0	0
Command and control	0	2	0	0
Training and exercising	0	2	1	0
Response	0	6	1	0
Warning and informing	0	3	0	0
Cooperation	0	4	0	0
Business Continuity	0	6	3	0
CBRN	0	14	0	0
Total	0	59	5	0

Deep Dive	Total standards applicable	Fully compliant	Partially compliant	Non compliant
Incident Coordination Centres	0	4	0	0
Command structures	0	4	0	0
Total	0	8	0	0

Ref	Domain	Standard	Detail	Evidence - examples listed below	Self assessment RAG	Action to be taken	Lead	Timescale	Comments (including organisational evidence)
1	Governance	Appointed AEO	The organisation has appointed an Accountable Emergency Officer (AEO) responsible for Emergency Preparedness Resilience and Response (EPRR). This individual should be a board level director, and have the appropriate authority, resources and budget to direct the EPRR portfolio. A non-executive board member, or suitable alternative, should be identified to support them in this role.	• Name and role of appointed individual	Fully compliant	None			
2	Governance	EPRR Policy Statement	The organisation has an overarching EPRR policy statement. This should take into account the organisation's: • Business objectives and processes • Key suppliers and contractual arrangements • Risk assessment(s) • Functions and / or organisation, structural and staff changes. The policy should: • Have a review schedule and version control • Use unambiguous terminology • Identify those responsible for making sure the policies and arrangements are updated, distributed and regularly tested • Include references to other sources of information and supporting documentation.	Evidence of an up to date EPRR policy statement that includes: • Resourcing commitment • Access to funds • Commitment to Emergency Planning, Business Continuity, Training, Exercising etc.	Fully compliant	None			
3	Governance	EPRR board reports	The Chief Executive Officer / Clinical Commissioning Group Accountable Officer ensures that the Accountable Emergency Officer discharges their responsibilities to provide EPRR reports to the Board / Governing Body, no less frequently than annually. These reports should be taken to a public board, and as a minimum, include an overview on: • training and exercises undertaken by the organisation • business continuity, critical incidents and major incidents • the organisation's position in relation to the NHS England EPRR assurance process.	• Public Board meeting minutes • Evidence of presenting the results of the annual EPRR assurance process to the Public Board	Fully compliant	None			
4	Governance	EPRR work programme	The organisation has an annual EPRR work programme, informed by lessons identified from: • incidents and exercises • identified risks • outcomes from assurance processes.	• Process explicitly described within the EPRR policy statement • Annual work plan	Fully compliant	None			
5	Governance	EPRR Resource	The Board / Governing Body is satisfied that the organisation has sufficient and appropriate resource, proportionate to its size, to ensure it can fully discharge its EPRR duties.	• EPRR Policy identifies resources required to fulfill EPRR function; policy has been signed off by the organisation's Board • Assessment of role / resources • Role description of EPRR Staff • Organisation structure chart • Internal Governance process chart including EPRR group	Fully compliant	None			
6	Governance	Continuous improvement process	The organisation has clearly defined processes for capturing learning from incidents and exercises to inform the development of future EPRR arrangements.	• Process explicitly described within the EPRR policy statement	Fully compliant	None			
7	Duty to risk assess	Risk assessment	The organisation has a process in place to regularly assess the risks to the population it serves. This process should consider community and national risk registers.	• Evidence that EPRR risks are regularly considered and recorded • Evidence that EPRR risks are represented and recorded on the organisations corporate risk register	Fully compliant	None			
8	Duty to risk assess	Risk Management	The organisation has a robust method of reporting, recording, monitoring and escalating EPRR risks.	• EPRR risks are considered in the organisation's risk management policy • Reference to EPRR risk management in the organisation's EPRR policy document	Fully compliant	None			
9	Duty to maintain plans	Collaborative planning	Plans have been developed in collaboration with partners and service providers to ensure the whole patient pathway is considered.	Partners consulted with as part of the planning process are demonstrable in planning arrangements	Fully compliant	None			
11	Duty to maintain plans	Critical incident	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to a critical incident (as per the EPRR Framework).	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	Fully compliant	None			
12	Duty to maintain plans	Major incident	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to a major incident (as per the EPRR Framework).	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	Fully compliant	None			
13	Duty to maintain plans	Heatwave	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to the impacts of heat wave on the population the organisation serves and its staff.	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	Fully compliant	None			

14	**Duty to maintain plans**	**Cold weather**	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to the impacts of snow and cold weather (not internal business continuity) on the population the organisation serves.	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	Fully compliant	None			
15	**Duty to maintain plans**	**Pandemic influenza**	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to pandemic influenza as described in the National Risk Register.	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	Fully compliant	None			
16	**Duty to maintain plans**	**Infectious disease**	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to an infectious disease outbreak within the organisation or the community it serves, covering a range of diseases including Viral Haemorrhagic Fever. These arrangements should be made in conjunction with Infection Control teams; including supply of adequate FFP3.	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	Fully compliant	None			
17	**Duty to maintain plans**	**Mass Countermeasures**	In line with current guidance and legislation, the organisation has effective arrangements in place to distribute Mass Countermeasures - including the arrangement for administration, reception and distribution, eg mass prophylaxis or mass vaccination. There may be a requirement for Specialist providers, Community Service Providers, Mental Health and Primary Care services to develop Mass Countermeasure distribution arrangements. These will be dependant on the incident, and as such requested at the time. CCGs may be required to commission new services dependant on the incident.	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	Fully compliant	None			
18	**Duty to maintain plans**	**Mass Casualty - surge**	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to mass casualties. For an acute receiving hospital this should incorporate arrangements to increase capacity by 10% in 6 hours and 20% in 12 hours.	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	Fully compliant	None			
19	**Duty to maintain plans**	**Mass Casualty - patient identification**	The organisation has arrangements to ensure a safe identification system for unidentified patients in emergency/mass casualty incident. Ideally this system should be suitable and appropriate for blood transfusion, using a non-sequential unique patient identification number and capture patient sex.	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	Fully compliant	None			
20	**Duty to maintain plans**	**Shelter and evacuation**	In line with current guidance and legislation, the organisation has effective arrangements in place to place to shelter and / or evacuate patients, staff and visitors. This should include arrangements to perform a whole site shelter and / or evacuation.	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	Fully compliant	None			
21	**Duty to maintain plans**	**Lockdown**	In line with current guidance and legislation, the organisation has effective arrangements in place safely manage site access and egress of patients, staff and visitors to and from the organisation's facilities. This may be a progressive restriction of access / egress that focuses on the 'protection' of critical areas.	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	Fully compliant	None			
22	**Duty to maintain plans**	**Protected individuals**	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to manage 'protected individuals'; including VIPs, high profile patients and visitors to the site.	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	Fully compliant	None			

23	**Duty to maintain plans**	**Excess death planning**	Organisation has contributed to and understands its role in the multiagency planning arrangements for excess deaths, including mortuary arrangements.	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	Fully compliant	None			
24	**Command and control**	**On call mechanism**	A resilient and dedicated EPRR on call mechanism in place 24 / 7 to receive notifications relating to business continuity incidents, critical incidents and major incidents. This should provide the facility to respond or escalate notifications to an executive level.	• Process explicitly described within the EPRR policy statement • On call Standards and expectations are set out • Include 24 hour arrangements for alerting managers and other key staff.	Fully compliant	None			
25	**Command and control**	**Trained on call staff**	On call staff are trained and competent to perform their role, and are in a position of delegated authority on behalf on the Chief Executive Officer / Clinical Commissioning Group Accountable Officer. The identified individual: • Should be trained according to the NHS England EPRR competencies (National Occupational Standards) • Can determine whether a critical, major or business continuity incident has occurred • Has a specific process to adopt during the decision making • Is aware who should be consulted and informed during decision making • Should ensure appropriate records are maintained throughout.	• Process explicitly described within the EPRR policy statement	Fully compliant	None			
26	**Training and exercising**	**EPRR Training**	The organisation carries out training in line with a training needs analysis to ensure staff are competent in their role; training records are kept to demonstrate this.	• Process explicitly described within the EPRR policy statement • Evidence of a training needs analysis • Training records for all staff on call and those performing a role within the ICC • Training materials • Evidence of personal training and exercising portfolios for key staff	Fully compliant	None			
27	**Training and exercising**	**EPRR exercising and testing programme**	The organisation has an exercising and testing programme to safely test major incident, critical incident and business continuity response arrangements. Organisations should meet the following exercising and testing requirements: • a six-monthly communications test • annual table top exercise • live exercise at least once every three years • command post exercise every three years. The exercising programme must: • identify exercises relevant to local risks • meet the needs of the organisation type and stakeholders • ensure warning and informing arrangements are effective. Lessons identified must be captured, recorded and acted upon as part of continuous improvement.	• Exercising Schedule • Evidence of post exercise reports and embedding learning	Fully compliant	None			
28	**Training and exercising**	**Strategic and tactical responder training**	Strategic and tactical responders must maintain a continuous personal development portfolio demonstrating training in accordance with the National Occupational Standards, and / or incident / exercise participation	• Training records • Evidence of personal training and exercising portfolios for key staff	Partially compliant	Provide a format for personal records. Roll this out to on-call managers to ensure that individual records are maintained.	Emergency Planning Officer	31-Mar-19	Central records of training for are maintained on the OLM system and training is discussed with individuals at appraisal however there is currently no format for a continuous personal development portfolio for senior managers.
30	**Response**	**Incident Co-ordination Centre (ICC)**	The organisation has a preidentified an Incident Co-ordination Centre (ICC) and alternative fall-back location. Both locations should be tested and exercised to ensure they are fit for purpose, and supported with documentation for its activation and operation.	• Documented processes for establishing an ICC • Maps and diagrams • A testing schedule • A training schedule • Pre identified roles and responsibilities, with action cards • Demonstration ICC location is resilient to loss of utilities, including telecommunications, and external hazards	Fully compliant	None			
31	**Response**	**Access to planning arrangements**	Version controlled, hard copies of all response arrangements are available to staff at all times. Staff should be aware of where they are stored; they should be easily accessible.	Planning arrangements are easily accessible - both electronically and hard copies	Partially compliant	Complete action card audit. Update action cards for all areas as required. Check access to shared drives.	Emergency Planning Officer	31-Dec-18	This is a work in progress - to update action cards.
32	**Response**	**Management of business continuity incidents**	The organisations incident response arrangements encompass the management of business continuity incidents.	• Business Continuity Response plans	Fully compliant	None			
33	**Response**	**Loggist**	The organisation has 24 hour access to a trained loggist(s) to ensure decisions are recorded during business continuity incidents, critical incidents and major incidents.	• Documented processes for accessing and utilising loggists • Training records	Fully compliant	None			
34	**Response**	**Situation Reports**	The organisation has processes in place for receiving, completing, authorising and submitting situation reports (SitReps) and briefings during the response to business continuity incidents, critical incidents and major incidents.	• Documented processes for completing, signing off and submitting SitReps • Evidence of testing and exercising	Fully compliant	None			
35	**Response**	**Access to 'Clinical Guidance for Major Incidents'**	Emergency Department staff have access to the NHSE 'Clinical Guidance for Major Incidents' handbook.	Guidance is available to appropriate staff either electronically or hard co	Fully compliant	None			
36	**Response**	**Access to 'CBRN incident: Clinical Management and health protection'**	Clinical staff have access to the PHE 'CBRN incident: Clinical Management and health protection' guidance.	Guidance is available to appropriate staff either electronically or hard co	Fully compliant	None			

37	**Warning and informing**	**Communication with partners and stakeholders**	The organisation has arrangements to communicate with partners and stakeholder organisations during and after a major incident, critical incident or business continuity incident.	• Have emergency communications response arrangements in place • Social Media Policy specifying advice to staff on appropriate use of personal social media accounts whilst the organisation is in incident response • Using lessons identified from previous major incidents to inform the development of future incident response communications • Having a systematic process for tracking information flows and logging information requests and being able to deal with multiple requests for information as part of normal business processes • Being able to demonstrate that publication of plans and assessments is part of a joined-up communications strategy and part of your organisation's warning and informing work	Fully compliant	None			
38	**Warning and informing**	**Warning and informing**	The organisation has processes for warning and informing the public and staff during major incidents, critical incidents or business continuity incidents.	• Have emergency communications response arrangements in place • Be able to demonstrate consideration of target audience when publishing materials (including staff, public and other agencies) • Communicating with the public to encourage and empower the community to help themselves in an emergency in a way which compliments the response of responders • Using lessons identified from previous major incidents to inform the development of future incident response communications • Setting up protocols with the media for warning and informing	Fully compliant	None			
39	**Warning and informing**	**Media strategy**	The organisation has a media strategy to enable communication with the public. This includes identification of and access to a trained media spokespeople able to represent the organisation to the media at all times.	• Have emergency communications response arrangements in place • Using lessons identified from previous major incidents to inform the development of future incident response communications • Setting up protocols with the media for warning and informing • Having an agreed media strategy which identifies and trains key staff in dealing with the media including nominating spokespeople and 'talking heads'	Fully compliant	None			
40	**Cooperation**	**LRHP attendance**	The Accountable Emergency Officer, or an appropriate director, attends (no less than 75%) of Local Health Resilience Partnership (LHRP) meetings per annum.	• Minutes of meetings	Fully compliant	None			
41	**Cooperation**	**LRF / BRF attendance**	The organisation participates in, contributes to or is adequately represented at Local Resilience Forum (LRF) or Borough Resilience Forum (BRF), demonstrating engagement and co-operation with other responders.	• Minutes of meetings • Governance agreement if the organisation is represented	Fully compliant	None			
42	**Cooperation**	**Mutual aid arrangements**	The organisation has agreed mutual aid arrangements in place outlining the process for requesting, co-ordinating and maintaining resource eg staff, equipment, services and supplies. These arrangements may be formal and should include the process for requesting Military Aid to Civil Authorities (MACA).	• Detailed documentation on the process for requesting, receiving and managing mutual aid requests • Signed mutual aid agreements where appropriate	Fully compliant	None			
46	**Cooperation**	**Information sharing**	The organisation has an agreed protocol(s) for sharing appropriate information with stakeholders.	• Documented and signed information sharing protocol • Evidence relevant guidance has been considered, e.g. Freedom of Information Act 2000, General Data Protection Regulation and the Civil Contingencies Act 2004 'duty to communicate with the public'.	Fully compliant	None			
47	**Business Continuity**	**BC policy statement**	The organisation has in place a policy statement of intent to undertake Business Continuity Management System (BCMS).	Demonstrable a statement of intent outlining that they will undertake BC - Policy Statement	Fully compliant	None			
48	**Business Continuity**	**BCMS scope and objectives**	The organisation has established the scope and objectives of the BCMS, specifying the risk management process and how this will be documented.	BCMS should detail: • Scope e.g. key products and services within the scope and exclusions from the scope • Objectives of the system • The requirement to undertake BC e.g. Statutory, Regulatory and contractual duties • Specific roles within the BCMS including responsibilities, competencies and authorities. • The risk management processes for the organisation i.e. how risk will be assessed and documented (e.g. Risk Register), the acceptable level of risk and risk review and monitoring process • Resource requirements • Communications strategy with all staff to ensure they are aware of their roles • Stakeholders	Fully compliant	None			
49	**Business Continuity**	**Business Impact Assessment**	The organisation annually assesses and documents the impact of disruption to its services through Business Impact Analysis(s).	Documented process on how BIA will be conducted, including: • the method to be used • the frequency of review • how the information will be used to inform planning • how RA is used to support.	Partially compliant	Finalise the update of the processes for business impact analysis (BIA). Provide training on the BIA process. Facilitate workshops with divisions and departments to update BIAs.	Emergency Planning Officer	31-Mar-18	This is a work in progress - to update business continuity processes and plans throughout the organisation, accounting for any changes required by reorganisation.
50	**Business Continuity**	**Data Protection and Security Toolkit**	Organisation's IT department certify that they are compliant with the Data Protection and Security Toolkit on an annual basis.	Statement of compliance	Fully compliant	None			
51	**Business Continuity**	**Business Continuity Plans**	The organisation has established business continuity plans for the management of incidents. Detailing how it will respond, recover and manage its services during disruptions to: • people • information and data • premises • suppliers and contractors • IT and infrastructure These plans will be updated regularly (at a minimum annually), or following organisational change.	• Documented evidence that as a minimum the BCP checklist is covered by the various plans of the organisation	Partially compliant	Complete business continuity plan audit. Finalise the update of the processes for business continuity plans (BCPs). Provide training on BCP processes. Facilitate workshops with divisions and departments to update BCPs. Undertake exercises to test BCPs - locally and Trust wide. Check access to shared drives.	Emergency Planning Officer	30-Jun-19	This is a work in progress - to update business continuity processes and plans throughout the organisation, accounting for any changes required by reorganisation.

52	**Business Continuity**	**BCMS monitoring and evaluation**	The organisation's BCMS is monitored, measured and evaluated against the Key Performance Indicators. Reports on these and the outcome of any exercises, and status of any corrective action are annually reported to the board.	• EPRR policy document or stand alone Business continuity policy • Board papers	Fully compliant	None			
53	**Business Continuity**	**BC audit**	The organisation has a process for internal audit, and outcomes are included in the report to the board.	• EPRR policy document or stand alone Business continuity policy • Board papers • Audit reports	Fully compliant	None			
54	**Business Continuity**	**BCMS continuous improvement process**	There is a process in place to assess and take corrective action to ensure continual improvement to the BCMS.	• EPRR policy document or stand alone Business continuity policy • Board papers • Action plans	Fully compliant	None			
55	**Business Continuity**	**Assurance of commissioned providers / suppliers BCPs**	The organisation has in place a system to assess the business continuity plans of commissioned providers or suppliers; and are assured that these providers arrangements work with their own.	• EPRR policy document or stand alone Business continuity policy • Provider/supplier assurance framework • Provider/supplier business continuity arrangements	Partially compliant	Ensure that BCMs include information on supplier arrangements where these are highlighted as critical in the BIAs.	Emergency Planning Officer	30-Jun-19	This is a work in progress - to update business continuity processes and plans throughout the organisation, accounting for any changes required by reorganisation.
56	**CBRN**	**Telephony advice for CBRN exposure**	Staff have access to telephone advice for managing patients involved in CBRN exposure incidents.	Staff are aware of the number / process to gain access to advice through appropriate planning arrangements	Fully compliant	None			
57	**CBRN**	**HAZMAT / CBRN planning arrangement**	There are organisation specific HAZMAT/ CBRN planning arrangements (or dedicated annex).	Evidence of: • command and control structures • procedures for activating staff and equipment • pre-determined decontamination locations and access to facilities • management and decontamination processes for contaminated patients and fatalities in line with the latest guidance • interoperability with other relevant agencies • plan to maintain a cordon / access control • arrangements for staff contamination • plans for the management of hazardous waste • stand-down procedures, including debriefing and the process of recovery and returning to (new) normal processes • contact details of key personnel and relevant partner agencies	Fully compliant	None			
58	**CBRN**	**HAZMAT / CBRN risk assessments**	HAZMAT/ CBRN decontamination risk assessments are in place appropriate to the organisation. This includes: • Documented systems of work • List of required competencies • Arrangements for the management of hazardous waste.	• Impact assessment of CBRN decontamination on other key facilities	Fully compliant	None			
59	**CBRN**	**Decontamination capability availability 24 /7**	The organisation has adequate and appropriate decontamination capability to manage self presenting patients (minimum four per hour), 24 hours a day, 7 days a week.	Rotas of appropriately trained staff availability 24 /7	Fully compliant	None			
60	**CBRN**	**Equipment and supplies**	The organisation holds appropriate equipment to ensure safe decontamination of patients and protection of staff. There is an accurate inventory of equipment required for decontaminating patients. • Acute providers - see Equipment checklist: https://www.england.nhs.uk/ourwork/eprr/hm/ • Community, Mental Health and Specialist service providers - see Response Box in 'Preparation for Incidents Involving Hazardous Materials - Guidance for Primary and Community Care Facilities' (NHS London, 2011) (found at: http://www.londonccn.nhs.uk/_store/documents/hazardous-material-incident-guidance-for-primary-and-community-care.pdf) • Initial Operating Response (IOR) DVD and other material: http://www.jesip.org.uk/what-will-jesip-do/training/	Completed equipment inventories; including completion date	Fully compliant	None			
61	**CBRN**	**PRPS availability**	The organisation has the expected number of PRPS (sealed and in date) available for immediate deployment. There is a plan and finance in place to revalidate (extend) or replace suits that are reaching their expiration date.	Completed equipment inventories; including completion date	Fully compliant	None			
62	**CBRN**	**Equipment checks**	There are routine checks carried out on the decontamination equipment including: • Suits • Tents • Pump • RAM GENE (radiation monitor) • Other decontamination equipment. There is a named individual responsible for completing these checks	Record of equipment checks, including date completed and by whom.	Fully compliant	None			
63	**CBRN**	**Equipment PPM**	There is a preventative programme of maintenance (PPM) in place for the maintenance, repair, calibration and replacement of out of date decontamination equipment for: • Suits • Tents • Pump • RAM GENE (radiation monitor) • Other equipment	Completed PPM, including date completed, and by whom	Fully compliant	None			
64	**CBRN**	**PPE disposal arrangements**	There are effective disposal arrangements in place for PPE no longer required, as indicated by manufacturer / supplier guidance.	Organisational policy	Fully compliant	None			
65	**CBRN**	**HAZMAT / CBRN training lead**	The current HAZMAT / CBRN Decontamination training lead is appropriately trained to deliver HAZMAT / CBRN training	Maintenance of CPD records	Fully compliant	None			

66	**CBRN**	**Training programme**	Internal training is based upon current good practice and uses material that has been supplied as appropriate. Training programme should include training for PPE and decontamination.	Evidence training utilises advice within: • Primary Care HAZMAT/ CBRN guidance • Initial Operating Response (IOR) and other material: http://www.jesip.org.uk/what-will-jesip-do/training/ • A range of staff roles are trained in decontamination techniques • Lead identified for training • Established system for refresher training	Fully compliant	None			
67	**CBRN**	**HAZMAT / CBRN trained trainers**	The organisation has a sufficient number of trained decontamination trainers to fully support its staff HAZMAT/ CBRN training programme.	Maintenance of CPD records	Fully compliant	None			
68	**CBRN**	**Staff training - decontamination**	Staff who are most likely to come into contact with a patient requiring decontamination understand the requirement to isolate the patient to stop the spread of the contaminant.	Evidence training utilises advice within: • Primary Care HAZMAT/ CBRN guidance • Initial Operating Response (IOR) and other material: http://www.jesip.org.uk/what-will-jesip-do/training/ • Community, Mental Health and Specialist service providers - see Response Box in 'Preparation for Incidents Involving Hazardous Materials - Guidance for Primary and Community Care Facilities' (NHS London, 2011). Found at: http://www.londonccn.nhs.uk/_store/documents/hazardous-material-incident-guidance-for-primary-and-community-care.pdf • A range of staff roles are trained in decontamination technique	Fully compliant	None			
69	**CBRN**	**FFP3 access**	Organisations must ensure staff who may come into contact with confirmed infectious respiratory viruses have access to FFP3 mask protection (or equivalent) 24 / 7.		Fully compliant	None			

Ref	Domain	Standard	Detail	Evidence - examples listed below	Self assessment RAG	Action to be taken
Deep Dive - Command and control						
Domain: Incident Coordination Centres						
1	**Incident Coordination Centres**	**Communication and IT equipment**	The organisation has equipped their ICC with suitable and resilient communications and IT equipment in line with NHS England Resilient Telecommunications Guidance.		Fully compliant	None
2	**Incident Coordination Centres**	**Resilience**	The organisation has the ability to establish an ICC (24/7) and maintains a state of organisational readiness at all times.	Up to date training records of staff able to resource an ICC	Fully compliant	None
3	**Incident Coordination Centres**	**Equipment testing**	ICC equipment has been tested every three months as a minimum to ensure functionality, and corrective action taken where necessary.	Post test reports Lessons identified EPRR programme	Fully compliant	None
4	**Incident Coordination Centres**	**Functions**	The organisation has arrangements in place outlining how it's ICC will coordinate it's functions as defined in the EPRR Framework.	Arrangements outline the following functions: Coordination Policy making Operations Information gathering Dispersing public information.	Fully compliant	None
Domain: Command structures						
5	**Command structures**	**Resilience**	The organisation has a documented command structure which establishes strategic, tactical and operational roles and responsibilities 24 / 7.	Training records of staff able to perform commander roles EPRR policy statement - command structure Exercise reports	Fully compliant	None
6	**Command structures**	**Stakeholder interaction**	The organisation has documented how its command structure interacts with the wider NHS and multi-agency response structures.	EPRR policy statement and response structure	Fully compliant	None
7	**Command structures**	**Decision making processes**	The organisation has in place processes to ensure defensible decision making; this could be aligned to the JESIP joint decision making model.	EPRR policy statement inclusive of a decision making model Training records of those competent in the process	Fully compliant	None
8	**Command structures**	**Recovery planning**	The organisation has a documented process to formally hand over responsibility from response to recovery.	Recovery planning arrangements involving a coordinated approach from the affected organisation(s) and multi-agency partners	Fully compliant	None

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Title	**Freedom to Speak Up Self Assessment and Action Plan**		
Report to	**Board of Directors**	**Date**	**September 2018**
Author	**Karen Barnard, Director of People & Organisational Development**		
Purpose			Tick one as appropriate
	Decision		x
	Assurance		
	Information		

Executive summary containing key messages and issues
Trusts have been required to undertake a self assessment with regard to Freedom to Speak Up - the tool developed by NHS Improvement states: 'Effective speaking up arrangements help to protect patients and improve the experience of NHS workers. Having a healthy speaking up culture is evidence of a well-led trust. NHS Improvement and the National Guardian's Office have published a guide setting out expectations of boards in relation to Freedom to Speak Up (FTSU) to help boards create a culture that is responsive to feedback and focused on learning and continual improvement. This self-review tool accompanying the guide will enable boards to carry out in-depth reviews of leadership and governance arrangements in relation to FTSU and identify areas to develop and improve. The Care Quality Commission (CQC) assesses a trust's speaking up culture during inspections under key line of enquiry (KLOE) 3 as part of the well-led question. This guide is aligned with the good practice set out in the well-led framework, which contains references to speaking up in KLOE 3 and will be shared with Inspectors as part of the CQC's assessment framework for well-led. Completing the self-review tool and developing an improvement action plan will help trusts to evidence their commitment to embedding speaking up and help oversight bodies to evaluate how healthy a trust's speaking up culture is.' In completing this self assessment the appointment of a new Non Executive Director lead has been noted as has the change in Board membership since the introduction of the Trust's approach to Freedom to Speak Up. The lead FTSU Guardian will present an update to the Board of Directors at its November meeting. Key actions arising from this self assessment are: • The development of a refreshed strategy for Freedom to Speak Up to include the introduction of divisional FTSU champions to support the Guardians • The extension of Freedom to Speak Up to the role of the Trust's Diversity & Inclusion group to ensure that any barriers are removed for those in more vulnerable groups

- A refreshed communications plan to ensure staff are familiar with how to raise concerns on an ongoing basis
- Refresh of the leadership development programme to ensure that all managers and leaders across the Trust are aware of the importance of the culture of speaking up and learning from concerns raised

Key questions posed by the report

Does the Board of Directors agree with the self assessment and proposed action plan?

How this report contributes to the delivery of the strategic objectives

People – As a Teaching Hospital we are committed to continuously developing the skills, innovation and leadership of our staff to provide high quality, efficient and effective care – this report details to work in place to ensure staff undertaken their SET training, receive an appraisal and agree a personal development plan

How this report impacts on current risks or highlights new risks

Ensuring the Trust has a supportive approach to staff being able to raise concerns will facilitate positive staff morale

Recommendation(s) and next steps

Board of Directors are asked to endorse this self assessment and action plan.

National Guardian
Freedom to Speak Up

NHS
Improvement

Freedom to Speak Up self-review tool for NHS trusts and foundation trusts

May 2018

How to use this tool

Effective speaking up arrangements help to protect patients and improve the experience of NHS workers. Having a healthy speaking up culture is evidence of a well-led trust.

NHS Improvement and the National Guardian's Office have published a guide setting out expectations of boards in relation to Freedom to Speak Up (FTSU) to help boards create a culture that is responsive to feedback and focused on learning and continual improvement.

This self-review tool accompanying the guide will enable boards to carry out in-depth reviews of leadership and governance arrangements in relation to FTSU and identify areas to develop and improve.

The Care Quality Commission (CQC) assesses a trust's speaking up culture during inspections under key line of enquiry (KLOE) 3 as part of the well-led question. This guide is aligned with the good practice set out in the well-led framework, which contains references to speaking up in KLOE 3 and will be shared with Inspectors as part of the CQC's assessment framework for well-led.

Completing the self-review tool and developing an improvement action plan will help trusts to evidence their commitment to embedding speaking up and help oversight bodies to evaluate how healthy a trust's speaking up culture is.

Self review indicator (Aligned to well-led KLOEs)	To what extent is this expectation being met?	What are the principal actions required for development?	How is the board assured it is meeting the expectation? Evidence
Our expectations			
Leaders are knowledgeable about FTSU			
Senior leaders are knowledgeable and up to date about FTSU and the executive and non-executive leads are aware of guidance from the National Guardian's Office.	New non-executive lead recently appointed; Executives knowledgeable Visit by National FTSU Guardian Henrietta Hughes Refresh required due to new members of the Board Presentation to BOD 30 January 2018. Next planned for November 2018 Dedicated intranet resources	Update session planned as part of Board Development programme due to new NEDs joining the Board New SID to have introductory meeting with FTSUG and lead Executive Director Recirculate the guidance as part of induction of new Non Executive Directors	Bi-annual reports to the Board by the FTSUG Included as item in governors timeout National guardian visit Recent CQC inspection and internal audit report (plus previous well led review by Deloittes)
Senior leaders can readily articulate the trust's FTSU vision and key learning from issues that workers have spoken up about and regularly communicate the value of	Senior leaders sighted on issues arising from concerns raised by workers. 2 cases have had regular discussions	Reframing of FTSU vision required	Bi-annual reports to the Board. Any ongoing action fed into Board committees.

speaking up.	at Executive Team meetings and one at Board and Board sub-committee meetings. Themed reports included in Board updates		Regular audit reports. Annual report to Audit and Non clinical risk committee
They can provide evidence that they have a leadership strategy and development programme that emphasises the importance of learning from issues raised by people who speak up.	The importance of FTSU is included in induction for all staff and management skills passport.	Leadership development programme being refreshed to ensure all levels of leaders and managers are sighted on the importance of staff being able to raise concerns	Management skills passport programme FTSUG provides support at induction programmes for all staff Regular discussions with Director of P&OD, Chief Executive and lead NED
Senior leaders can describe the part they played in creating and launching the trust's FTSU vision and strategy.	Those in post at the time familiar with approach taken to have staff governors undertake the role of FTSU Guardians with one acting in lead role. There has been a change in Board members since the launch of the Trust's approach to FTSU therefore refresh required – to be	Inclusion of FTSU in Board development programme Reviews of the FTSU vision will be included in senior leadership teams' development sessions.	Presentation to Board of Directors, Governors and Management Board

	included in board development programme		
Leaders have a structured approach to FTSU			
There is a clear FTSU vision, translated into a robust and realistic strategy that links speaking up with patient safety, staff experience and continuous improvement.	Clear refresh of policy undertaken and launch of the policy and approach. Involvement of FTSU Guardians in concerns raised	Refreshed vision required following appointment of new SID/lead NED for FTSU and revised managerial arrangements Refresh of patient experience strategy and P&OD strategy to include explicit reference to speaking up Explicit reference to be included in the Sharing How we Care newsletter	Involvement of FTSU guardians in supporting managers and staff when concerns have been raised e.g. joining listening events with staff when raising concerns (maternity)
There is an up-to-date speaking up policy that reflects the minimum standards set out by NHS Improvement.	Confirmed through audit report Raising concerns policy to	Will be refreshed in line with policy review timescales	Audit report provided positive comments on policy and pathway

	Board September 2016		
The FTSU strategy has been developed using a structured approach in collaboration with a range of stakeholders (including the FTSU Guardian)and it aligns with existing guidance from the National Guardian.	No explicit documented strategy; however positive feedback through audit, CQC visit and visit by national guardian of the approach taken by the Trust	Refreshed strategy required	Audit report; CQC report
Progress against the strategy and compliance with the policy are regularly reviewed using a range of qualitative and quantitative measures.	Regular reports to Board and committees regarding the themes arising from concerns raised. However no explicit measures in place	KPIs to be developed	Reports to Board/committees
Leaders actively shape the speaking up culture			
All senior leaders take an interest in the trust's speaking up culture and are proactive in developing ideas and initiatives to support speaking up.	Strategy refresh – bug bears/bright ideas received Listening to feedback from governors from ward visits Governors genuinely engaged in the process and want to lead the process Staff engagement forums used as opportunities to raise	Following revised management structure a divisional champion approach to be developed	CEO's listening events Departmental listening events e.g. maternity Positive assurance to NGO, KPMG and CQC

	the FTSU role		
They can evidence that they robustly challenge themselves to improve patient safety, and develop a culture of continuous improvement, openness and honesty.	Examples of how this takes place: NHSI Improvement Practice Patient experience strategy and committee Clinical Governance Strategy Committee structure Link with guardian for safe working for junior doctors	No action identified	Outcome of NGO inspection
Senior leaders are visible, approachable and use a variety of methods to seek and act on feedback from workers.	Chief Executive Listening events and other listening events eg maternity Director visits to areas. Buddy arrangements between Executive and Non-Executive Directors. Regular weblogs and items in Buzz 'You said, we did' posters	Continue programme of engagement with staff	CQC Well Led highlighted visibility of leaders

	around the Trust		
Senior leaders prioritise speaking up and work in partnership with their FTSU Guardian.	FTSU Guardians are staff governors and so there is regular contact with Board members Regular meetings involving CEO and staff governors Director of P&OD meeting with FTSU Guardians on regular basis	As above	Audit report Annual report to Board Item at Governors' Timeout
Senior leaders model speaking up by acknowledging mistakes and making improvements.	Acknowledgement of heavy finance focus during turnaround Lessons learned presented in PEEC reports and at PEEC committee	Programme of quality improvement through NHSI Improvement Practice	Board and committee reports
The board can state with confidence that workers know how to speak up; do so with confidence and are treated fairly.	Audit reports; Board reports; CQC report Recognise that need to continuously refresh communications Guardian for safe working	Refresh communications strategy Introduce random questionnaires	Reports

	reports received regularly		
Leaders are clear about their role and responsibilities			
The trust has a named executive and a named non-executive director responsible for speaking up and both are clear about their role and responsibility.	Executive lead in place for 2 years; recent new appointment to non executive lead due to change in NEDs. Introductory meeting with FTSUG planned	Appointment of new NED to speak up role August 2018 Induction planned	Report to Board Guardians clear to staff through posters in key locations
They, along with the chief executive and chair, meet regularly with the FTSU Guardian and provide appropriate advice and support.	Regular meetings scheduled		Diary/feedback to committees
Other senior leaders support the FTSU Guardian as required.	Confirmed.		Recent evidence of Medical Director involvement
Leaders are confident that wider concerns are identified and managed			
Senior leaders have ensured that the FTSU Guardian has ready access to applicable sources of data to enable them to triangulate speaking up issues to proactively identify	FTSUG is also a staff governor and therefore readily accesses Board and other papers; regular meetings with Director of		Feedback from NGO visit to DBTH. Reports to Board. Involvement in key

potential concerns.	People & OD (exec lead). FTSU attends annual national conference, receives weekly FTSUG bulletins, can access NGO telephone advice clinic and training. Also attended Whistleblowers Support Conference: NHS Employers Event paid for by the Trust Staff governors regularly meet with the Chief Executive		cases
The FTSU Guardian has ready access to senior leaders and others to enable them to escalate patient safety issues rapidly, preserving confidence as appropriate.	As a staff governor and senior nurse within the Trust the FTSUG has ready access to senior leaders inc the Chair and fellow governors		Examples of where matters have been escalated to executive directors/Chief Executive
Leaders receive assurance in a variety of forms			
Workers in all areas know, understand and support the FTSU vision, are aware of the policy and have confidence in the speaking	Earlier Deloitte's well led review provided positive assurance; however most	Plans to develop champions in each Division and Directorate	Audit report and CQC inspection

up process.	recent audit and CQC assessment indicated that a reduced level of awareness.	post change to management structure Refresh of communications strategy required	
Steps are taken to identify and remove barriers to speaking up for those in more vulnerable groups, such as Black, Asian or minority ethnic (BAME), workers and agency workers	Little explicit work undertaken	To be added explicitly as an extension to the role of the Trust's Diversity & Inclusion Group Introduce effective communication pathways for minority staffing groups; e.g., BME, disabled, learning difficulties, staff limited computer access (and / or) skills.	
Speak up issues that raise immediate patient safety concerns are quickly escalated	Examples can be provided		Trust governance process provides avenues through which issues can be raised and escalated

Action is taken to address evidence that workers have been victimised as a result of speaking up, regardless of seniority	No evidence of victimisation within the Trust		Raising concerns policy and disciplinary process
Lessons learnt are shared widely both within relevant service areas and across the trust	Themes shared as part of Board report and Management Board presentation	Explicit inclusion within the Sharing how we Care bulletin	Items on Board and Management Board agendas
The handling of speaking up issues is routinely audited to ensure that the FTSU policy is being implemented	Regular topic for audit reviews		See recent audit report and CQC
FTSU policies and procedures are reviewed and improved using feedback from workers	Regular policy review	Next review scheduled September 2019	Policy in place and publicised via intranet
The board receives a report, at least every six months, from the FTSU Guardian.	Confirmed		Board agendas
Leaders engage with all relevant stakeholders			
A diverse range of workers' views are sought, heard and acted upon to shape the culture of the organisation in relation to speaking up; these are reflected in the FTSU vision and	At inception governors involved in the development of the approach taken.	Development of champions will facilitate this approach.	

plan.			
Issues raised via speaking up are part of the performance data discussed openly with commissioners, CQC and NHS Improvement.	Confirmed		NHSI quarterly meetings
Discussion of FTSU matters regularly takes place in the public section of the board meetings (while respecting the confidentiality of individuals).	Confirmed through Board report		Board presentation January 2018
The trust's annual report contains high level, anonymised data relating to speaking up as well as information on actions the trust is taking to support a positive speaking up culture.	Confirmed		Annual report 2017/18
Reviews and audits are shared externally to support improvement elsewhere.	Fed into regional network FTSU Guardian part of Y & H Network, meetings held every two months (DBTH hosted meeting in January 2018) Train the Trainers in place to cascade within the regional networks		Evidence through Guardian

	Peer support		
Senior leaders work openly and positively with regional FTSU Guardians and the National Guardian to continually improve the trust's speaking up culture	Confirmed. Presentation by regional lead at regional Social Partnership Forum attended by Director of People & OD		Regular meetings with Chief Executive, SID and Director of People & OD
Senior leaders encourage their FTSU Guardians to develop bilateral relationships with regulators, inspectors and other local FTSU Guardians	Regular contact with Neighbouring Trust's FTSUG and regional network		NGO and CQC reports
Senior leaders request external improvement support when required.	RCOG report Appropriate SI investigations		RCOG report and action plan
Leaders are focused on learning and continual improvement			
Senior leaders use speaking up as an opportunity for learning that can be embedded in future practice to deliver better quality care and improve workers' experience.	PEEC and PE strategy	'Sharing how we care' bulletin NHS I improving practice work	Carol's Story and other patient stories
Senior leaders and the FTSU Guardian engage with other trusts to identify best	The FTSUG attends the regional and national events.		Feedback from Guardian

practice.	The Trust held a regional event in January 2018.		
Executive and non-executive leads, and the FTSU Guardian, review all guidance and case review reports from the National Guardian to identify improvement possibilities.	Quarterly meeting takes place between the executive lead and the FTSU guardians to review national reports. Regular updates are received at regional HRD and SPF meetings CEO meetings with staff governors		Evidence of meetings taking place
Senior leaders regularly reflect on how they respond to feedback, learn and continually improve and encourage the same throughout the organisation.	Appraisal process; 360 feedback Board report January 2018		Board development programme Board papers
The executive lead responsible for FTSU reviews the FTSU strategy annually, using a range of qualitative and quantitative measures, to assess what has been achieved and what hasn't; what the barriers have been and how they can be overcome; and whether the right indicators are being	No explicit strategy	Strategy required with KPIs	

used to measure success.			
The FTSU policy and process is reviewed annually to check they are fit for purpose and realistic; up to date; and takes account of feedback from workers who have used them.	Audit confirmed that policy in line with best practice	Next review scheduled September 2019	Policy in place and available to all staff
A sample of cases is quality assured to ensure: • the investigation process is of high quality; that outcomes and recommendations are reasonable and that the impact of change is being measured • workers are thanked for speaking up, are kept up to date though out the investigation and are told of the outcome • Investigations are independent, fair and objective; recommendations are designed to promote patient safety and learning; and change will be	Low numbers of cases to date. More detailed work taking place within Maternity services.		Themes arising from cases reported to Board, Further work within maternity; electronic noticeboard being developed

monitored			
Positive outcomes from speaking up cases are promoted and as a result workers are more confident to speak up.	Feedback to areas where concerns raised	Review of communications strategy	Evidence from Guardians
Individual responsibilities			
Chief executive and chair			
The chief executive is responsible for appointing the FTSU Guardian.	Approach agreed by Board of Directors and Council of Governors		Governor appointment process
The chief executive is accountable for ensuring that FTSU arrangements meet the needs of the workers in their trust.	Feedback through staff survey		Staff survey report
The chief executive and chair are responsible for ensuring the annual report contains information about FTSU.	Confirmed		Annual report
The chief executive and chair are responsible for ensuring the trust is engaged with both the regional Guardian network and the National Guardian's Office.	Visit from National guardian		

Both the chief executive and chair are key sources of advice and support for their FTSU Guardian and meet with them regularly.	CE meets regularly. Access to Chair readily available		Schedule of meetings
Executive lead for FTSU			
Ensuring they are aware of latest guidance from National Guardian's Office.	Confirmed		
Overseeing the creation of the FTSU vision and strategy.	Original approach toe FTSU developed jointly by Board of Directors and Council of Governors	Development of a formal strategy required	
Ensuring the FTSU Guardian role has been implemented, using a fair recruitment process in accordance with the example job description and other guidance published by the National Guardian.	Confirmed.		
Ensuring that the FTSU Guardian has a suitable amount of ring fenced time and other resources and there is cover for planned and unplanned absence.	Reviewed at each meeting. Review taking place following changes to Divisional structure	Refresh of approach with consideration of the introduction of champion roles within Divisions and Directorates	Feedback from Guardians

Ensuring that a sample of speaking up cases have been quality assured.	Low numbers of cases		Discussion re key cases
Conducting an annual review of the strategy, policy and process.	Review of policy as part of audit review process		Audit report
Operationalising the learning derived from speaking up issues.	Themes arising from cases reported to Board on regular basis – this includes lessons to be learnt	Will be included within Sharing how we Care bulletin	Board reports
Ensuring allegations of detriment are promptly and fairly investigated and acted on.	No allegations received but process in place		
Providing the board with a variety of assurance about the effectiveness of the trusts strategy, policy and process.	Through Board, ANCR and QEC		Board reports Reports to ANCR
Non-executive lead for FTSU			

Ensuring they are aware of latest guidance from National Guardian's Office.	Recent new appointment. Will be undertaken as part of induction into the role Included in Board report, August 2018	Induction for new NED plus inclusion in Board development programme	Board report, August 2018
Holding the chief executive, executive FTSU lead and the board to account for implementing the speaking up strategy.	Confirmed with previous postholder	Will evolve as new NED lead spends more time in the role	
Robustly challenge the board to reflect on whether it could do more to create a culture responsive to feedback and focused on learning and continual improvement.	As above	As above	
Role-modelling high standards of conduct around FTSU.	Development of governors charter	As above. The FTSU NED is also the SID as roles are complementary	Board report, August 2018
Acting as an alternative source of advice and support for the FTSU Guardian.	Confirmed	As above	
Overseeing speaking up concerns regarding board members.	Confirmed	As above	

Human resource and organisational development directors			
Ensuring that the FTSU Guardian has the support of HR staff and appropriate access to information to enable them to triangulate intelligence from speaking up issues with other information that may be used as measures of FTSU culture or indicators of barriers to speaking up.	Regular communication between FTSUG and the case work team FTSU reports to Director responsible for HR		Regular meetings held. Interface between concerns raised to Guardians and HR issues
Ensuring that HR culture and practice encourage and support speaking up and that learning in relation to workers' experience is disseminated across the trust.	FTSUG presentation at P&OD timeout	Refresh of communications plan	
Ensuring that workers have the right knowledge, skills and capability to speak up and that managers listen well and respond to issues raised effectively.	Embedded within management skills passport	Greater focus on values based recruitment across the Trust	Programme details
Medical director and director of nursing			
Ensuring that the FTSU Guardian has appropriate support and advice on patient	Confirmed – readily available support		Maternity case

safety and safeguarding issues.			
Ensuring that effective and, as appropriate, immediate action is taken when potential patient safety issues are highlighted by speaking up.	Example of Maternity and an issue raised by a Consultant		QEC reports, Children & Family Board
Ensuring learning is operationalised within the teams and departments that they oversee.	Ongoing work within Maternity is an example		As above

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Title	**Winter Planning**		
Report to	**Board of Directors**	**Date**	**25.09.2018**
Author	**David Purdue, Chief Operating Officer**		

Purpose		Tick one as appropriate
	Decision	
	Assurance	
	Information	X

Executive summary containing key messages and issues
NHSE/I have reviewed the elements which affected winter performance in 2017/18. The following paper identifies the key areas which need to be put in place to improve patient outcomes and experience. The Trust plan to address these issues is presented in this paper.
Key questions posed by the report
Are the Board assured that the winter plan meets the requirements for the Trust to meet its targets and outcomes for patients? Are all the elements of the NHSE/I plan being addressed?
How this report contributes to the delivery of the strategic objectives
The report identifies the actions being undertaken to support the Trusts objectives
How this report impacts on current risks or highlights new risks
The actions identified mitigate the risk of the impact of winter on patient quality and performance
Recommendation(s) and next steps
For the Board to be assured that the actions identified will improve patient outcomes.

Winter Plan Doncaster and Bassetlaw Teaching Hospital 2018/19.

National context; Learning from winter.

The “NHS review of winter, 2017-18” from NHS Improvement, highlights the complex nature of Urgent and Emergency Care delivery, particularly through the winter period. It outlines the range of factors that impact on Trusts ability to deliver care in a volatile and changing environment, using an econometric analysis to identify the key issues and actions apparent from previous winter delivery.

The review describes issues that occur in Type 1 A&E departments and identifies similar events to those identified locally; including internal and external factors that impact on flow and management of A&E, bed occupancy, workforce availability and experience and the need to maintain quality patient care.

The paper describes a tipping point above 92% bed occupancy as impacting on A&E flow and delivery, including stranded patients and those with Delayed Transfer of Care, (DToC) reducing the available beds, with reduced or delays in discharge further impacting on patient flow.

Data analysis highlights lower discharge rates over the weekend, with the impact of additional admissions on Monday, increasing pressure in the system by up to 10%. This then reduces the ability of A&E to cope with influx of patients as there are few beds to transfer patients into. Timing of admission and discharge is also critical to ensuring flow and the ability to identify available suitable beds, at points throughout the day.

Within A&E departments, teams can impact on the management of patient flow, there needs to be clear processes and system wide resilience when under pressure. The knowledge and experience of the team and access to broader clinical teams impacts on the ability of staff to manage the patients attending. Flu related illness increased attendance in A&E by 1/3rd nationally.

Local learning from last winter.

A number of approaches have been taken to understand and build on the learning from winter 2017/18:

- Initial feedback was gathered from all partners mid -winter, and shared with NHSE, as part of the early winter evaluation in July 2018.
- An evaluation was undertaken of the winter #System Perfect to identify the impact of the specific actions taken as part of the #System Perfect (March 2018)
- At the end of the winter period, a more detailed analysis was undertaken to draw together the learning across the system, this was then reviewed by the Doncaster System Resilience Group

- The October #System Perfect will see a series of consultation events with staff across all health and social care organisations to seek their personal views about what went well, what didn't go well and what could be done differently in planning for winter 2018/19.

The key themes:

- Last winter was the most successfully managed winter period in recent years due to the system wide approach that has been fostered as a result of the first #System Perfect

- Effective and timely identification of potential key issues and requirements as well as communication is required both within and between organisations and this will continue to be a focus as we head into winter 2018/19.

- The relationship building and partnership working that initially developed during the first #System Perfect between clinical teams, has continued to be built on and has become "business as usual". For example RDASH older people's mental health team continue to support early senior review in ED.

Risks and Mitigations

The Winter Workshop on 23 August 2018 enabled all partners to raise the key risks to delivery over winter 2018/19. Discussions included the risks and opportunities across the Health and Social Care system and determined the mitigating actions that need to be put in place. The key features of the plans are noted below; the supporting detail can be found in the presentations that are referenced.

- DBH focus on workforce; specifically within the middle-grade tier in ED, the availability of beds and patient flow out of the hospital.

  NOTE; Junior doctors change rotation on 5th December this year – may impact on SPR staff and decision making in ED. Previous rotation take final leave, new rotation have induction, settling in etc – slows the process through ED and increases pressure on SPR workforce just as winter weather / Christmas is approaching . Plans are in place to manage this.

- RDASH focus on support to the acute trust board rounds for respiratory and frailty, older peoples mental health support in ED, attendance at ops meetings.

- FCMS focus on flexing call handling and staffing across the Urgent Treatment Centre and the Same Day Health Centre, management of flu patients within the home, fit for purpose fleet for community based services

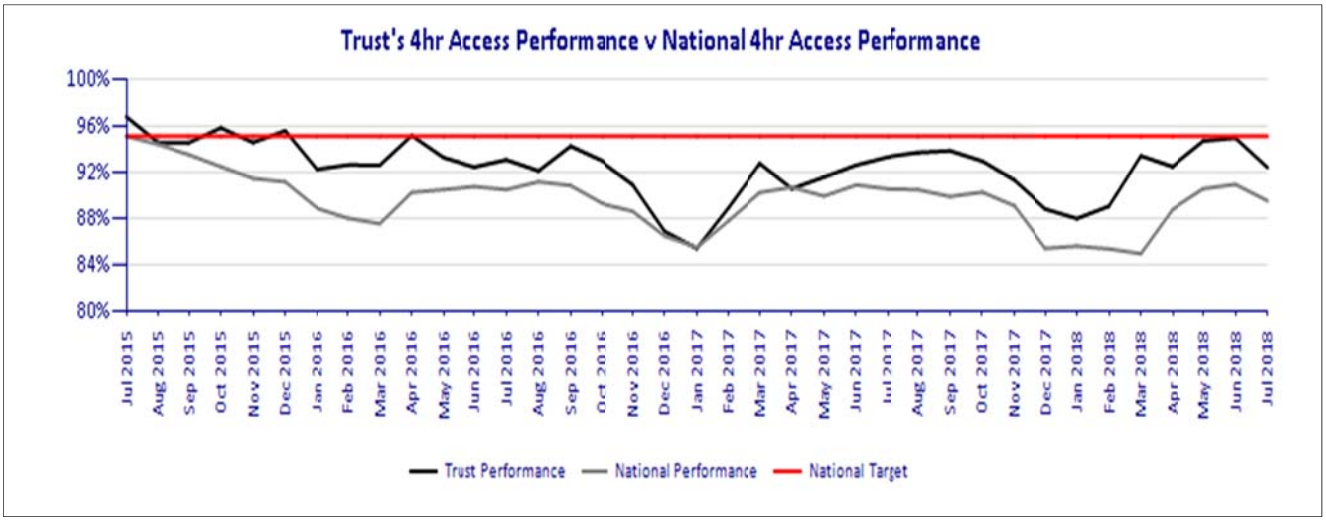
- Social Care Re-ablement: Door sensors are be installed at Positive Steps; this will enable a significantly greater flex in beds to ensure that all rooms can be used by males and females

The risks are summarised below;

- Nursing and medical workforce vacancies
- Surges in demand
- Capacity to manage flu vaccinations
- Surges in repeat medication requests

Winter and the link to Performance

The proportion of patients being treated or admitted within 4 hours in the Doncaster and Bassetlaw system, overall remained above the national average throughout last winter, spring and summer to date; with performance narrowly lower than the NHS Constitution target of 95% during May and June 2018. This was despite higher attendances in these months compared to the rest of the previous 12 months. Further, DBTHFT performance was in the top quartile of Type 1 providers, for the period Apr-July 2018.



During winter 2017/18 a higher proportion of patients were treated or admitted in 4 hours than in winter 2016/17, despite higher attendances in December to February. May and June 2018 similarly saw much improved performance despite higher volumes of attendances than the previous two years. This indicates that the initiatives implemented in the A&E departments and in partnership with the wider Health and Social Care system, have contributed to improved efficiency and lower waiting times for patients, without a drop in quality.

Streaming at the DRI site in particular has contributed to the improvements in performance, with the monthly streaming rate to both the UTC and to other departments above 15%.

Delayed Transfers of Care (DTOC) has also had a significant focus across the local Health and Social Care systems and the improvements made in Doncaster and Bassetlaw Local Authority areas has impacted positively on flow through DBTH.

Regular analysis, reporting and escalation:

Detailed analysis is undertaken regularly to understand demand on the urgent care system by looking at attendance numbers by site and service, by major/minor pathways, by age group, by presenting condition and by GP practice; to understand where peaks and pressures come from. This is done on a daily, weekly, monthly and on an ad-hoc basis.

Daily data is submitted by the Doncaster system and shared across all partners, showing the latest demand and capacity information. This supports understanding of where pressures are and where additional capacity is, that could be utilised. This is in addition to the Integrated Discharge Team working with partners daily, reviewing where capacity is in the system on a live basis, to manage discharges and flow through the various pathways.

The Surge and Operations groups, that includes partners from all services across Doncaster and Bassetlaw, reviews demand and capacity and known or predicted pressure points on a weekly basis; enabling services to prepare, change rotas, and offer support.

On a monthly basis data is analysed and presented to SRG and A&E Delivery Board meetings. Longer term trends are reviewed and updates received on system issues, with further challenge and support provided, as necessary.

Throughout winter 2016/17 and 2017/18, attendance figures, performance and presenting conditions were analysed by day and by hour during unexpected pressure points to understand the causes of the pressure. This helped to determine whether further action could be taken across the system to support A&E and across the Trust. This information resulted in a variety of reasons/conclusions, which fed into weekly operational meetings and actions for the system. This information will continue to be reviewed and inform actions during winter 2018/19.

DBTHFT develops its A&E rotas and bed plan based on analysis of demand at a daily level using historical data, and therefore if pressure is experienced beyond anticipated pressure points, the Trust Escalation Plan and then the Doncaster Escalation Plans are evoked.

Capacity at the acute Trust is delineated between elective and non- elective care. Winter planning includes management of and an expected decrease in elective activity. DBTHFT plans to ensure that elective and non- elective demand can be delivered during winter. This will be achieved through a focus on managing elective activity during the autumn, with an emphasis on day case activity during the winter period and maximising use of the Mexborough and Bassetlaw Hospital sites.

Analysis ahead of winter 2018/19:

- Quarter 1 2018/19 saw a 6.32% increase in attendances at the three Trust A&E sites compared to the same quarter last year

- Patient use of NHS 111 and GP OOH has changed profile. Calls to NHS 111 were higher than GP OOH for the first time in 2017/18 (NHS 111 +14.9%, GP OOH -28.1%). There was overall a slight reduction in the number of patients calling NHS 111 instead of GP OOH in 2017/18 compared to 2016/17; however more patients attending the Same Day Health Centre (+11.5%), resulting in little significant difference in the total of these between 2017/18 and the previous year (-1.52%).

- Known pressure points from analysis of historical data include Mondays, the day following a bank holiday day or two days following multiple bank holiday days (e.g. over Christmas), Christmas Eve, and New Years Eve. Analysis has also been done by hour of day and therefore the pressure points of attendances at A&E throughout each day of the week are also known. Pressure points from closed beds and the weather are less predictable ahead of time.

- An in depth piece of work has been undertaken to understand the population that use urgent care services and to map this across services where possible. This has shown that a surprisingly high proportion of the population that attend A&E are aged 20-35, particularly when compared to the population using other services such as GP OOH.

  As a result of this finding, the next #System Perfect event will focus on understanding patient behaviours, in order to address those behaviours differently. We will be engaging with partners about the services that are currently available.

  A survey is currently being undertaken to gain some understanding for the reasons for attendance to A&E. The strongest messages are currently around GP appointment availability (both assumed and actual), use of Google to determine the right course of action and the "drama" of going to A&E, that can be shared on Facebook or other social media.

  The conditions with which patients present at Urgent Care and the arrival mode have also been analysed over the last two years to inform the pathways which are streamed away from the main A&E Department in Doncaster, including some paediatrics, respiratory and eye conditions.

- Monday Surge Analysis has been completed using the national tool which shows that whilst DBTHFT does see a surge in attendance, the levels are around average for the size of the Trust.

- Work is underway to understand why patients attend A&E in Doncaster on a Monday, including reviewing patient attendances by GP practice and working with GP's to improve/ manage visit times to Care Homes (known to create surges at A&E). GP Peer Review, using a system developed in-house, compares GP practices on a number of measures including their patients A&E attendances.

- GP extended hours commences in October on both sites in Primary Care to increase out of hours GP capacity

- Super-stranded patients, DBTH, was in cohort 4 out of 5, 5 being the best. BDTH were tasked with freeing 28 beds up due to long stay patients by the 1st of December. At this point we have reduced by 27 beds.

Planning for Surges and system escalation

A system wide Escalation Framework has been developed in Doncaster and Bassetlaw and builds on the OPEL levels. Daily information is collated across health/social care providers in the Daily Pressures report; this is aligned to the escalation framework and enables the level of pressure to be identified across the system each day. There are agreed triggers and actions for each level which are used to escalate and de-escalate as appropriate, these are based on provider input and YAS historic activity. This has been in place since November 2016 and has been refined each year as lessons are learned from winter. The escalation framework is refreshed at least twice each year to ensure that the contact and escalation points remain accurate.

Communication and Wider Engagement

The main focus of learning and communications in the run up to winter is the next #System Perfect event: #System Perfect, the Prequel, which will take place 2-9 October 2018. The focus for this week includes increasing understanding of the younger patient cohort that use A&E services; as noted above this cohort are higher than expected users of A&E.

A number of actions will therefore form part of #System Perfect, both during the actual week and in the weeks preceding October:

- Survey of A&E usage – aimed at understanding why individuals attend A&E
- A suite of videos – explaining our urgent care system and where to go for urgent care, will be available to the public through a variety of systems.
- Working with Doncaster and Bassetlaw major employers, particularly those with a high proportion of employees in the age bracket 20-35.We will support visits to workplaces during the week to undertake the survey and to provide education about what urgent care services offer and provide information about alternative support.
- The “Health bus” will be visiting numerous locations across Doncaster and Bassetlaw to undertake the survey and provide education to individuals about urgent care services and alternatives.
- A basic education course with regards to healthcare services is currently under development with the Workforce Education Authority
- The Doncaster “Choose Well” App has been revamped, with significant consultation with the Learning Disability community in particular and it is due to be launched in support of #System Perfect
- Each organisation will produce its own winter information communications plan, however providers and commissioners are working together to share key messages and ensure that our health and care messages are consistent
- As the winter period progresses communications are planned via local newspapers, radio, internet and social media. The plans developed are sufficiently flexible in nature to respond to changes in weather, pressures in the system etc, ICS wide urgent care communications are also under development.

Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust
Winter Planning 2018/19

The elements of this plan have been set nationally by NHSi/NHSE to support the NHS through winter, with the aim of improving patient experience and the 4hr access target.

The wider plan incorporates the use of 111 and ambulance systems and the extension of GP Primary Care hours, as well as the "Whole system" approach to managing additional patient attendances and meeting needs.

The Acute Trust requirements of the National Plan are identified in the following report.

Internal Flow and Bed Occupancy	The Trust-wide bed plan has been reviewed and updated including; • The increases in ED attendances since April 2018 • Consideration of the reductions in length of stay over the past year specifically in acute medicine. Now rated 23/138 nationally • The need for focused work on length of stay in rehabilitation and trauma pathways. • Equipment and space for additional attendances has been reviewed and planned for. • Patient flows for elective care has been mapped to maximise the use of elective beds available on the Bassetlaw/Mexborough site and to free capacity on DRI. • Escalation beds to be utilised for surges in activity Additional 32 on Medicine at DRI Additional 14 on Medicine at BDGH Additional 8 on surgery at DRI • Daily predictor tool to be used to ensure correct bed capacity
	Each elective speciality has reviewed the demand for elective work over winter to hit contracted levels. Elective capacity will be ring fenced to maintain patient pathways Elective work will stop for the first 10 days of January, with the exception of clinically urgent, cancer and day-case activity.
	To support staffing of additional beds and increased activity for Clinical Support services A review of education and training over winter has been undertaken and a plan has been developed by the education team to enable staff to be released to work clinically Nurse specialist/ Out-patient nurse, availability reviewed to provide additional support to wards. ED Junior doctor rotation Dec 5th – plan in place to manage switch over period and induction
	Non-medicine junior Drs are to review outliers on their base wards when reduced elective work, to ensure early discharge. This will be discussed with leads in services to ensure expectations are understood.
	Outlier plan for specialities agreed with medicine to support specific wards .
Admission avoidance	• DRI FDASS model reviewed with CCG, plans to increase percentage streamed to UCC. Staffing model to be agreed with CCG. • Extension of minors area at DRI to stream patients away from ED. • Additional ambulatory pathways on-site support from community services. Older Peoples Mental Health, Rapid Response • BDGH model, new model developed with NHCT, awaiting BCCG decision, model will stream to primary care advanced practitioner and incorporate on site Out of Hours Service.

Workforce Plans	Acute medical support will be provided into ED daily to review medical patients with the plan to increase admission avoidance pathways
	Surgical speciality specific plans developed, to enable medical/ACP staffing to support workforce in ED each afternoon
	An Orthopaedic Registrar to be located in ED at Doncaster 10am-10pm
	Local ED improvement pathway work is being undertaken, with support from the Strategy and improvement team, to optimise flow and efficiency within the department
	The existing RAPT service will be reviewed in order to best use the resource available to meet the needs of patients in ED and CDU
	Ongoing support and involvement in the expansion of the Intermediate Care Rapid Response programme to avoid ED attendance and admission
	Additional middle-grade to support paediatric twilight shifts on COU and to support ED
Length of Stay	The effective use of EDD and criteria for discharge will be embedded across all wards
	Daily MDT board rounds to be undertaken within all specialties by matrons
	Teams are to monitor and manage internal delays in care through the wider implementation of Red and green days in acute medicine and through ARC in Care of the Elderly and orthopaedics Daily review of internal delays through the operational meeting at 12pm with plans in place to address delays Introduction of electronic bed management system at BDGH
	A predictor tool developed and tested for implementation in September
	The use of the Trust dashboard will be incorporated into the 4 times daily operational management processes to inform decision making
	Current weekly LOS meetings will be optimised to escalate delays and facilitate discharge. Dedicated Strategic meetings w, with key senior stakeholders will be held on both Doncaster and Bassetlaw sites.
	A review of transport arrangements is being undertaken for September 2017, ensuring sufficient capacity to manage additional workload through winter
Stranded and Super-stranded patients	DTOC monitoring - a period of monitoring will commenced to ensure all delays are identified and patients supported Transfer to assess model in place in both communities Trusted assessors trained in both Trusts DBTH has reviewed the plans for the spend of additional Social Care monies and agreed the areas of spend at the A&E delivery Board. Trust agreed trajectory to reduce DTOCs Intermediate Care facilities being reviewed to ensure beds are utilised appropriately. Opportunities for Therapy led care, areas to enable patients in system waits to remain well and fit
Ambulance Handover	Dedicated ambulance liaison managers now identified to work with the Trust to support the departments at times of surge.
Perfect Week - System Wide	System Perfect' to be held 2nd to 10th of October Undertaking to understand why 19-45 year olds attend ED, to review current urgent care offer.

Escalation	Internal escalation triggers for both type 1 departments have been reviewed. Key triggers to be identified onto the ED dashboard, to escalate to the ops lead for the day. Operational lead for the day to be available on site until 8pm daily The Urgent care Network assessing the need for a South Yorkshire wide escalation tool.
Flu Planning	Plan to vaccinate 100% of front line staff in line with National guidance. Point of care testing in AMU/ATC/FAU

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Title	**Chairs Assurance Logs for Board Committees held 20 September 2018**		
Report to	**Board of Directors**	**Date**	**25 September 2018**
Author	**Matthew Kane, Trust Board Secretary**		
Purpose			Tick one as appropriate
	Decision		
	Assurance		X
	Information		

Executive summary containing key messages and issues
Attached as appendices are the reports from the chairs of the two board committees held 20 September 2018: • Finance and Performance Committee • Audit and Non-clinical Risk Committee The reports set out assurances obtained during the meetings plus any new risks and escalations to Board.
Key questions posed by the report
N/A
How this report contributes to the delivery of the strategic objectives
The work of the board committee structure supports the Trust's five strategic aims.
How this report impacts on current risks or highlights new risks
Any new risks are highlighted in the reports.

Recommendation(s) and next steps
To note.

Chair's Log - Finance and Performance Committee 20.9.18

Overview

A very full meeting, including two strategy reviews, Finance & Commercial and People and OD. We had a deep dive in relation to Cancer Performance and a presentation in relation to the Strategic Service Change CIP.

We welcomed a strong presentation, supported by Trust Lead Cancer Nurse Stacey Nutt that gave assurance around the work in this important area, including some far sighted process changes that the committee felt sure would enhance the patient experience and lift the profile of the Trust nationally.

The overview of progress to our (red rated) CIP Strategic Service Change highlighted significant opportunities to realise £915k circa savings between DBTH and RDASH if certain facility and theatre sharing was to take place. The committee was keen to see the work progress to shape detailed and compelling plans to deliver the work outlined and asked for an update at the next meeting.

In terms of papers, in addition to the performance report, finance report, Board Assurance Framework and workforce report, we also received a Provision of Outpatient Dispensing Services paper that we are able to commend to the Board.

There continues to be an issue with the timeliness of papers. Performance information, in particular, is not available until 10 working days after month end. The report is critical to the work of F+P and if NEDs are to be able to give proper scrutiny they need to have a realistic amount of reading and research time. The Board is asked to reflect upon the timing of meetings to allow this to happen.

Assurance area – Performance

Performance Report

The Board meeting will receive a separate performance report which will give a more granular appreciation of the picture. In broad terms Trust performance remains sound.

NEDs are to meet with the Director of Finance and his performance staff on 25 October to discuss recrafting the performance report to better align with NHSi requests for activity, and also presenting a commentary with an independent perspective, whilst still utilising the core 'Ward to Board' Business Intelligence Report as its foundation.

Assurance area – Workforce Management

We considered a report that addressed –

- The profile of vacant posts
- Agency spend

- Staff sickness
- Appraisals and SET

Alignment has now been achieved between the Agency data in this report and in the Finance Report. Synching the timing of the data involved a good deal of work which was appreciated.

Targets for Agency spend have now been set, disaggregated to divisional level. An initial overview demonstrated their value to the committee and we discussed how the divisional picture could best be represented to us.

Agency spend continues to be a here and now issue. We have commissioned a deep dive next month, seeking reassurance that there will be real grip and solid plans at a divisional level. Control of Agency spend we see as critical to Trust financial stability.

Assurance area – Overall Financial Picture and Closing the Financial Gap

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

Jon Sargeant shared a candid and detailed appraisal of the financial challenges and potential trajectories, the core of which is summarised in the report before this Board meeting.

In essence, there is still a realistic prospect of meeting our control total provided certain activity is delivered. The Trust has currently slipped off the delivery trajectory by around £2m and also carries real areas of risk in its CIP plans to deliver £17m of savings this year. The backloading of plans and the fact that over £2m of CIP remains unidentified makes us particularly vulnerable. F+ P had a detailed discussion of the current position, where shortfalls might occur and potential action. Our executive colleagues appear to be exerting grip and making progress.

Assurance area – Governance and Risk

F+P received and noted the current risk register.

Assurance area – Strategy and Planning

As part of our periodic review of strategies in which the committee plays a key role, F+P reviewed the Finance & Commercial strategy and the People and OD.

Appropriate progress was being made in the development and delivery of both strategies.

Neil Rhodes
Chair – Finance and Performance Committee

Chair's Log – Audit and Non Clinical Risk Committee 20 September 2018

Overview

It was pleasing to note full NED member attendance at this ANCR along with the 2 Governor representatives and representatives from all the subject matters under consideration.
It was also noted this was Matt Kane's last ANCR and the Committee's thanks were passed to Matt for his support of ANCR.

Assurance area – Internal Audit

a) Internal Audit – Significant assurance was given regarding progress of the delivery of the Internal Audit Plan to date.

b) Internal Audit Reports Issued – 4 Audit Reports have been issued as below. All have agreed action plans and dates in place and will be followed up by ANCR. The 2 Audit Reports which only had Partial Assurance were discussed and although this was in line with management's expectation, require delivery to mitigate the identified risks.

HSDU Contract Review	Consultancy work, no assurance level assigned
Cost Improvement Programme (CIP) Review	Significant Assurance with minor improvement opportunities
Financial Grip and Control	Partial Assurance with improvements required
Workforce Planning Phase 2	Partial Assurance with improvements required

c) Internal Audit Recommendations Follow up – There has been improvement in closing Audit Recommendations, with 11 medium and high recommendations (less 1 closed at the ANCR meeting). Work will continue to follow up those recommendations and improve the closure rate of IA Recs, as well as working with the QEC and F&P Chair to ensure Audit Recommendations relating to their TORs have oversight via the relevant Committees.

Assurance area – Governance

BAF and Risk Register – The BAF changes were noted by ANCR and discussions held around updating some of the risks which have older implementation dates on; the challenge of achieving target risks; and how to using the BAF and Risk register to further drive Sub Committee (F&P & QEC) agendas. The ANCR Chair agreed to pick this up with the relevant Chairs. The reviewed BAF and RR were noted by the Committee.

Compliance with the Code of Governance – The Committee gained significant assurances from the compliance with the new Code and recommended that at the next review of the Trust's constitution that the wording for the appointment of the SID is re-aligned to the code.

Assurance area – NHS Core Standards for Emergency Resilience

The self-assessment of compliance with the standards for Emergency Preparedness, Resilience and Response were considered and it was recommended to the Board to APPROVE the Statement of Compliance and Improvement Plan as presented within the paper, confirming the Trust were declaring 'substantial' compliance against the standards.

Assurance area – Counter Fraud (LCFS), Security Management (LSMS) and IT Security Reports

LCFS - Significant Assurance was given to the Committee that workplans, standards & outcomes in relation to LCFS are being delivered to plan.

LSMS - Assurances were received that arrangements for monitoring delivery of Trust security were in place, and it was pleasing to note some investment in areas deemed to be a higher risk. Further work on the learning themes following incidents was requested by ANCR.

IT Security – Limited assurances were provided to ANCR regarding physical penetration testing improvements & Phishing testing. There had been improvement since previous reviews, and ANCR requested IT publish reminders to staff around access to buildings and identification of phishing emails. A further update to come to November ANCR.

Assurance area –Compliance with Standing Financial Instructions and Standing Orders

Reports on Losses, Compensations and Single Tender Waivers showed compliance with those areas of SFI's/SOs.

Assurance area – Health & Safety Bi-annual report

Assurances were received that arrangements for monitoring delivery of Trust H&S were in place. Further work on other areas included within the H&S portfolio (compliance with Legionella, Asbestos, etc) and learning themes following incidents was requested by ANCR.

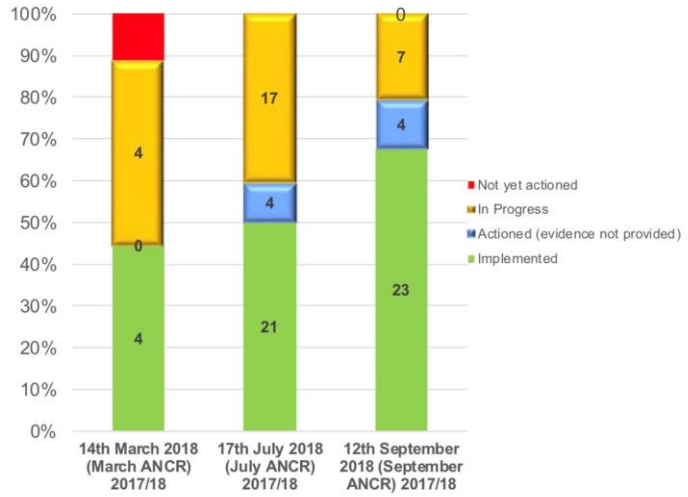
Meeting evaluation

- Look at re-ordering agenda to enable grouped subject matters to be reported together eg; Security, H&S, IT Security, CounterFraud;
- Clearly identify items for Assurance, Information & Decision in building the Agenda;
- Dial In/ virtual meeting arrangements could be improved, spider phone less effective in large meetings

Kath Smart
Chair – Audit and Non Clinical Risk Committee

Section three

Progress against recommendations due (high/medium priority recommendations only)



Interpretation

This chart shows the proportion of recommendations which have been actioned, partially completed, or remain incomplete as at the due dates shown. The dates represent the cut off points applied to our work on tracking recommendations, rather than the dates of the Audit and Non-Clinical Risk Committee that our reports were presented to, although the dates of the relevant ANCR Committees are shown for clarity.

These number reflect the status of the recommendation tracker for those reports where follow up has been carried out. Details of additional outstanding recommendations which are not yet due are provided in the table on page 3 .

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Title	**Financial Performance – Month 5 (August 2018)**		
Report to	**Trust Board**	**Date**	**25 September 2018**
Author	**Jon Sargeant - Director of Finance**		
Purpose	To update the Board on the financial position for the month of August 2018.		Tick one as appropriate
	Decision		
	Assurance		
	Information		X

Executive summary containing key messages and issues

The Trust's deficit for month 5 (August 2018) was £3.4m, which is an adverse variance against plan in month of £1,008k. The cumulative position to the end of month 5 is a £10.9m deficit, which is £1.1m adverse to plan. However the Trust needs to achieve a £6.6m deficit to deliver the year end control total, and therefore needs to essentially achieve a better than break even position for the rest of the year.

There are significant risks to delivery of the forecast and the financial control total, including:

- Delivery of CIP which has been back loaded in the plan and significant savings are still required to be identified and delivered. Whilst work continues the gap in the plan is not being closed quickly enough. The Trust needs to implement NHSI quality improvement findings at pace and scale.
- There is a significance variance on income growth assumptions of £3.5m between the Trust's financial plan and commissioner assumptions and contract values. Levels of over performance and the further modelling of RTT suggest that with our main commissioners the budget assumptions are fairly robust. Also the financial plan assumes £2m of Commissioner QIPP plans are not delivered. The continued under performance against associate CCG's is of concern. Robust plans are required from Divisions to deliver in line with plan for elective and outpatients.
- Control and reduction of agency and additional sessions spend linked to challenging and robust capacity plans and following SOPs.
- A release of funds from the balance sheet relating to aged accruals of £1.4m was

required to ensure delivery of the Q1 control total.

- The Trust has assumed full achievement of PSF in its position. However part of this (30%) is tied to A&E 4hr access performance, which is a challenge to achieve in Q2.
- The Trust has identified a historical depreciation issue which was discussed at F&P in further detail.

Key questions posed by the report

- Are the Board assured by actions taken to bring the financial position back in line with plan?

How this report contributes to the delivery of the strategic objectives

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

How this report impacts on current risks or highlights new risks

Update relating to delivery of 2018/19 financial plan.

Recommendation(s) and next steps

The Board is asked to note:

- The Trust's deficit for month 5 (August 2018) was £3.4m, which is an adverse variance against plan in month of £1,008k. The cumulative position to the end of month 5 is a £10.9m deficit, which is £1.1m adverse to plan.
- The progress in closing the gap on the Cost Improvement Programme.
- The risks set out in this paper.

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

FINANCIAL PERFORMANCE

Month 5 (August 2018)

DONCASTER AND BASSETLAW TEACHING HOSPITALS NHS FOUNDATION TRUST

P5 August 2018

1. Income and Expenditure vs. Forecast

Performance Indicator	Monthly Actual £'000	Performance Variance to budget £'000	YTD Actual £'000	Performance Variance £'000	Annual Plan £'000
I&E Perf Exc Impairments	3,381	947 A	10,952	1,043 A	6,900
Income	(31,612)	(1,660) F	(153,634)	637 A	(371,473)
PSF (previously STF)	(1,083)	0	(4,600)	0	(16,238)
Donated Asset Income	37	61 A	(90)	29 A	(285)
Operating Expenditure	35,040	2,708 A	163,579	460 A	380,996
Pay	23,708	(728) F	109,216	1,296 A	256,187
Non Pay & Reserves	11,332	3,436 A	54,364	(835) F	124,808
Financing costs	1,035	(101) F	5,607	(55) F	
I&E Perf Exc 16/17 STF & Donated Asset Income	**3,418**	**1,008 A**	**10,862**	**1,072 A**	**6,615**

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 to budget £'000	YTD Performance Actual £'000	YTD Performance Variance £'000	Annual Plan £'000
Employee Expenses	187	109 A	755	193 A	4841
Drugs	65	(6) F	319	(27) F	700
Clinical Supplies	27	17 A	94	48 A	584
Non Clinical Supplies	0	0 A	0	0 A	0
Non Pay Operating Expenses	157	56 A	432	192 A	9787
Income	132	29 A	415	13 A	1913
Total	**569**	**206 A**	2,014	**419 A**	**17,825**

3. Statement of Financial Position

All figures £m	Opening Balance	Current Balance	Movement in year
Non Current Assets	**209,108**	**206,444**	**2,664**
Current Assets	49,291	39,611	9,680
Current Liabilities	-54,834	-46,715	-8,119
Non Current liabilities	-81,105	-87,212	6,107
Total Assets Employed	**122,460**	**112,128**	**10,332**
Total Tax Payers Equity	**-122,460**	**-112,128**	**-10,332**

4. Other

Performance Indicator	Monthly Performance Plan £'000	Monthly Performance Actual £'000	YTD Performance Plan £'000	YTD Performance Actual £'000	Annual Plan £'000
Cash Balance	2,238	11,418	2,238	11,418	1,900
Capital Expenditure	873	322	3593	1618	13,979

5. Workforce

	Funded WTE	Actual WTE	Bank WTE	Agency WTE	Total in Post WTE
Current Month	5932.94	5471.16	149.11	117.33	5737.60
Previous Month	5903.87	5429.76	134.97	86.87	5651.60
Movement	-29.07	-41.40	-14.14	-30.46	-86.00

** Please note the in month I&E position includes adjustments for the pay award £2.1m paid in month 5 and the allocation of the agency budget £1.5m (This is analysed in more detail in the pack)*

Key

Income		Expenditure	
Over-achieved	F	Overspent	A
Under-achievement	A	Underspent	F

1. Executive Summary

The Trust's deficit for month 5 (August 2018) was £3.4m, which is an adverse variance against plan in month of £1,008k. The cumulative position to the end of month 5 is a £10.9m deficit, which is £1.1m adverse to plan. However the Trust needs to achieve a £6.6m deficit to deliver the year end control total, and therefore needs to essentially achieve a better than break even position for the rest of the year.

The YTD income position at the end of Month 5 is £2,397k adverse to plan, (excluding the pay award funding of £1,760k). In month 5, NHS Clinical Income (including non-PbR drugs) was £153k behind plan. Doncaster CCG has an adverse variance against the Trust's plan of £314k (favorable variance against contract of £1,328k) and Bassetlaw CCG has a favorable income variance of £552k against plan (£1,076k favorable against contract). Non NHS Clinical Income and Other Income is £53k ahead of plan in month 5 and YTD £143k adverse to plan (excluding impact of pay award funding). PSF is assumed at 100% in the position.

Income Group	Annual Budget	In Month Budget	In Month Actual	In Month Variance		YTD Budget	YTD Actual	YTD Variance	
Commissioner Income	-312,482	-25,121	-25,103	18	A	-129,714	-128,938	776	A
Drugs	-24,089	-1,951	-1,815	135	A	-10,055	-8,577	1,478	A
STF	-16,238	-1,083	-1,083	0	F	-4,600	-4,600	0	F
Trading Income	-34,903	-2,880	-4,693	-1,813	F	-14,503	-16,120	-1,617	F
Grand Total	**-387,711**	**-31,034**	**-32,695**	**-1,660**	**F**	**-158,871**	**-158,234**	**637**	**A**
Pay Award Adjustment			1,760	1,760	A		1,760	1,760	A
Revised Total	**-387,711**	**-31,034**	**-30,935**	**100**	**A**	**-158,871**	**-156,474**	**2,397**	**A**

The YTD expenditure position at Month 5 was £460k higher than budgeted levels, however employee expenses were £1,296k higher than plan, driven by agency spend. Pay expenditure in month was c.£0.5m higher compared with July (after excluding the impact of the pay award) with bank staff expenditure increasing by £160k in August and a net increase in substantive staff in month (76). Non-PbR drugs were significantly lower than planned levels (c.£1.5m which is offset by underperformance on income). Please note that the YTD position reflects the release of non-recurrent monies in Month 3 of (£1.4m against reserves) following the review of prior year accruals being held. This mainly relates to accruals for agency doctors (through Holt).

Subjective Code	In Month Budget	In Month Actual	In Month Variance	* Restated in month variance	YTD Budget	YTD Actual	YTD Variance	Annual Budget
1. Pay	24,436	23,708	-728 **F**	794 **A**	107,920	109,216	1,296 **A**	**256,187**
2. Non-Pay	9,702	10,647	945 **A**	775 **A**	50,452	52,537	2,085 **A**	**117,596**
3. Reserves	-1,806	685	2,491 **A**	-621 **F**	4,747	1,827	-2,920 **F**	**7,212**
Total Expenditure Position	**32,332**	**35,040**	**2,708 A**	**948 A**	**163,119**	**163,579**	**460 A**	**380,996**

**Note*

The in-month variance has been restated in the table above to help with comparisons against previous months. This is because in month a number of significant adjustments which mainly include:

- *Pay award £2.1m paid in month*
- *The allocation of the agency budgets to Divisions of £1.5m in month*

The difference between the in-month variance (£2,708k) and the restated in month variance (£948k) is £1,760k which is the pay award adjustment on the income table above.

Capital expenditure YTD is £1,618k against the YTD plan of £3,593k (£1,975k behind plan). Following the approval at Board of the reprioritised capital plan, a revised forecast was produced. Year to date actuals against this forecast shows the Trust as £275k behind plan.

The cash balance at the end of August was £11.4m against a plan of £2.2m. This is largely due to the receipt of Q4 STF funds (£8.4m), delayed capital expenditure and movements in trade receivables and payables.

CIP savings of £569k (last month £449k) are reported, against a plan profile of £774k. For the year to date this makes savings of £2,014k against the target of £2,433k, a variance of £419k.

2. Conclusion

The Trust's year to date financial position at Month 5 is a £1,072k adverse variance compared to plan (£1,008k adverse in month). There are significant risks to delivery of the forecast and the financial control total, including:

- Delivery of CIP which has been back loaded in the plan and significant savings are still required to be identified and delivered. Whilst work continues the gap in the plan is not being closed quickly enough. The Trust needs to implement NHSI quality improvement findings at pace and scale.
- There is a significance variance on income growth assumptions of £3.5m between the Trust's financial plan and commissioner assumptions and contract values. Levels of over performance and the further modelling of RTT suggest that with our main commissioners the budget assumptions are fairly robust. Also the financial plan assumes £2m of Commissioner QIPP plans are not delivered. The continued under performance against associate CCG's is of concern. Robust plans are required from Divisions to deliver in line with plan for elective and outpatients.
- Control and reduction of agency and additional sessions spend linked to challenging and robust capacity plans and following SOPs.
- A release of funds from the balance sheet relating to aged accruals of £1.4m was required to ensure delivery of the Q1 control total.
- The Trust has assumed full achievement of PSF in its position. However part of this (30%) is tied to A&E 4hr access performance, which is a challenge to achieve in Q2.
- The Trust has identified a historical depreciation issue which was discussed at F&P in further detail.

3. Recommendation

The Board is asked to note:

- The Trust's deficit for month 5 (August 2018) was £3.4m, which is an adverse variance against plan in month of £1,008k. The cumulative position to the end of month 5 is a £10.9m deficit, which is £1.1m adverse to plan.
- The progress in closing the gap on the Cost Improvement Programme.
- The risks set out in this paper.

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Title	**Performance Report**		
Report to	**Board of Directors**	**Date**	**25th September 2018**
Author	**David Purdue, Chief Operating Officer** **Sewa Singh, Medical Director** **Moira Hardy, Director of Nursing, Midwifery and AHPs** **Karen Barnard, Director of People and Organisational Development**		

Purpose		Tick one as appropriate
	Decision	
	Assurance	x
	Information	

Executive summary containing key messages and issues

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

The report focuses on the 3 main performance area for NHSi compliance:

Cancer 62 day classic, measured on average quarterly performance
4hr Access, measured on average quarterly performance
18 weeks measured on monthly performance against active waiters, performance measured on the worst performing month in the quarter
Diagnostics performance against 14 key tests
Infection control measures, CDiff and MRSA Bacteraemia

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

The Workforce report identifies progress against key workforce metrics.

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

PERFORMANCE REPORT – August 2018

Cancer Performance

The following information relates to Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust performance in July. The Trust has updated the action plan to improve 62 day and 2 week wait performance.

July Performance

Standard	Local Performance %	Position from Previous Month
TWW	87.1%	
31 day	99.3%	
62 day	86.2 %	
31 day Sub – Surgery	100%	
31 day Sub – Drugs	100%	
31 day Sub – Other	100%	
62 day Screening	100%	
62 day Con Upgrades	90%	
Breast Symptomatic	93.7%	

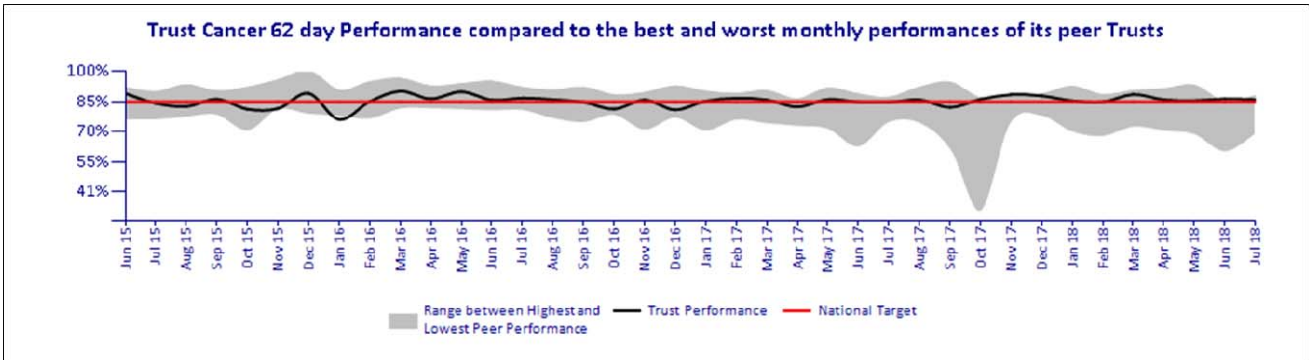
62 day Cancer performance

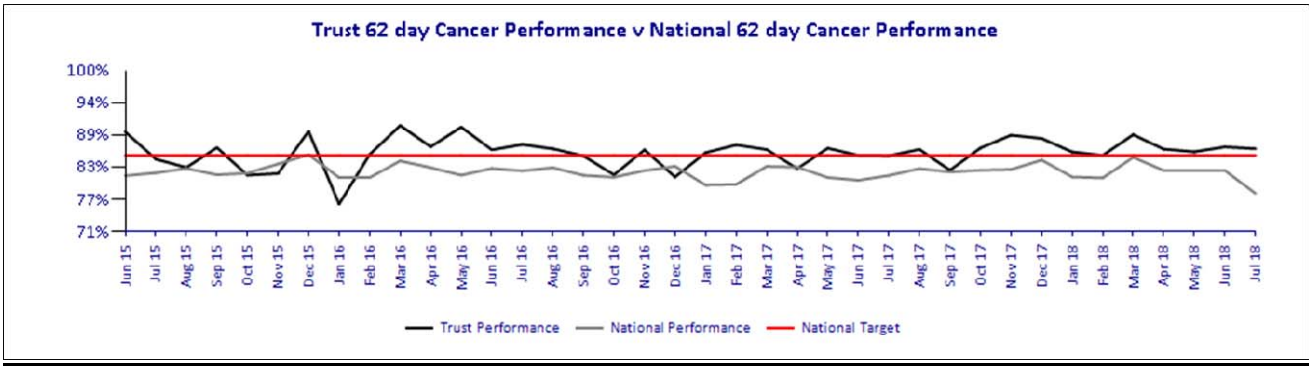
The 62 day standard was achieved by the Trust in July at 86.2%, this maintains performance seen in June. The One Stop Prostrate Clinic is on target to commence on the 1st of October to coincide with the latest guidance release for 2 week wait.
A pilot of Straight to test for colonoscopy has been partially funded by the Cancer Alliance for lower GI cancers, which will commence in April 2019.

The Cancer management team has been restructured to support operational delivery of cancer, including a Cancer governance lead, who will monitor performance against all targets including 104 day breaches.

PERFORMANCE REPORT – August 2018

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





Two Week Wait Performance

The July position for two week wait was 87.1% which was not compliant with the national target of 93%. This is however, an improved position compared with June.

The Capacity and Demand tool continues to be developed, providing a planning tool based on previous referral trends, activity and capacity. Care groups are now using the tool proactively in order to plan two week wait capacity.

Weekly PTL meetings with each specialty are ongoing to jointly track patient booking, pathways and to review breaches. The two week wait process has been value stream mapped and the new process will be implemented over the next 6 weeks. In the interim the planning of colorectal pathways is now being piloted back in the service. A straight to MRI pilot for prostate cancer is being planned for BDGH.

PERFORMANCE REPORT – August 2018

TWW Performance by specialty

	2ww	Non 2ww Symptomatic Breast Referrals	31 Day - Classic	31Day Sub - Surgery	31 Day Sub - Drugs	31 Day Sub - Palliative	62 Day - Classic	62 Day Screening	62 Day Consultant Upgrades
Operational Std	93%	93%	96%	94%	98%	94%	85%	90%	TBA
Breast	98.2%	93.7%	100%	100%	100%		100%	100%	100%
Gynaecology	91.6%		100%				91.7%		100%
Haematology	100%		100%		100%		90%		100%
Head & Neck	57.1%			100%			25%		0%
Lower GI	71.4%		100%	100%		100%	100%		100%
Lung	95.8%		100%				71.4%		100%
Sarcoma									
Skin	91.7%		94.7%				91.7%		100%
Upper GI	93%		100%				93.8%		100%
Urological	79.3%		100%	100%	100%	100%	61.5%		80%

EXCEPTIONS

62 DAY

There were delays in Head and Neck, Urology and Lung with reasons for the breaches predominantly due to shared care pathways, complex diagnostic pathways or patient choice.

TWO WEEK WAIT

Head and Neck, lower GI, skin, Gynaecology and Urology did not achieve the standard in July. Capacity issues were predominantly the issues in Lower GI, Dermatology and Urology as a result in a continued increase in referrals. The current process for oral/maxillary/facial cancers is being reviewed with Sheffield Teaching Hospital due to ongoing capacity issues.

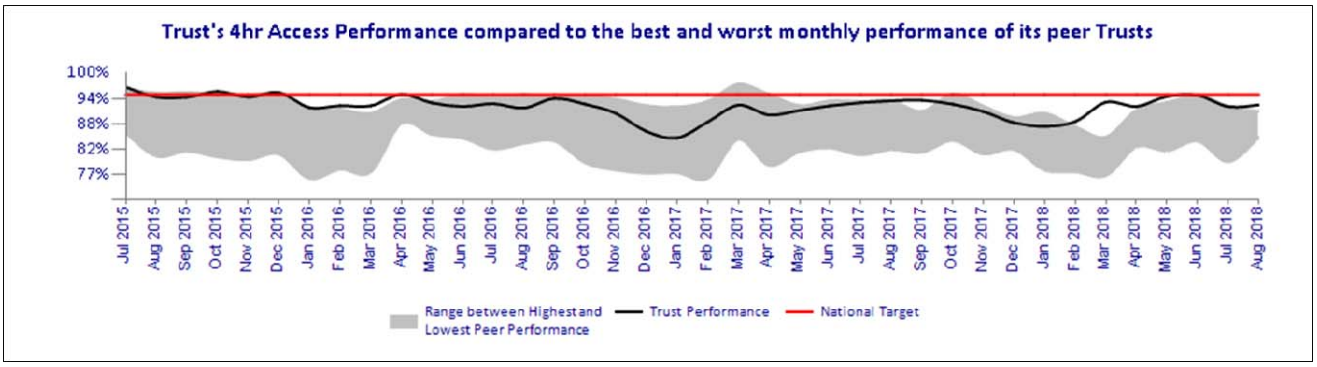
The reasons for breaches in relation to two week wait appointments can be seen in the table below:

CWT Standard	Tumour Group	Performance against CWT standard	High Level View
Two Week Wait	Gynae	91.6%	11 patients – 10 patient choice, 1 administrative delay
	H&N	57.1 %	36 patients – 10 patient choice, 19 administrative delay, 2 clinic cancellation, 5 capacity
	Lower GI	71.4%	65 breaches – 19 patient choice, 28 capacity, 18 administrative delay
	Skin	91.7%	24 breaches – 12 patient choice, 3 capacity, 1 administrative delay, 8 clinic cancellations
	Urology	79.3%	36 breaches – 19 patient choice, 6 capacity, 6 administrative delay, 5 clinic cancellations
31 day	Skin	94.7%	1 patient – local treatment – patient choice
62 day	H&N	16.4%	5 patients – All shared care - 1 treatment planning, 4 capacity issues (OPD @ DBTH)
	Lung	80%	2 patients – Both shared care – 1 Complex diagnostic pathway, 1 adherence to clinical trial
	Urology	80.7%	8 patients – 3 local pathways and 5 shared care. Local all capacity issues (OPD @ DBTH). Shared Care – 1 patient choice, 4 pathway delays
62 day Con Upgrade	H&N	0%	
	Urology	80%	1 patient – local treatment – patient choice

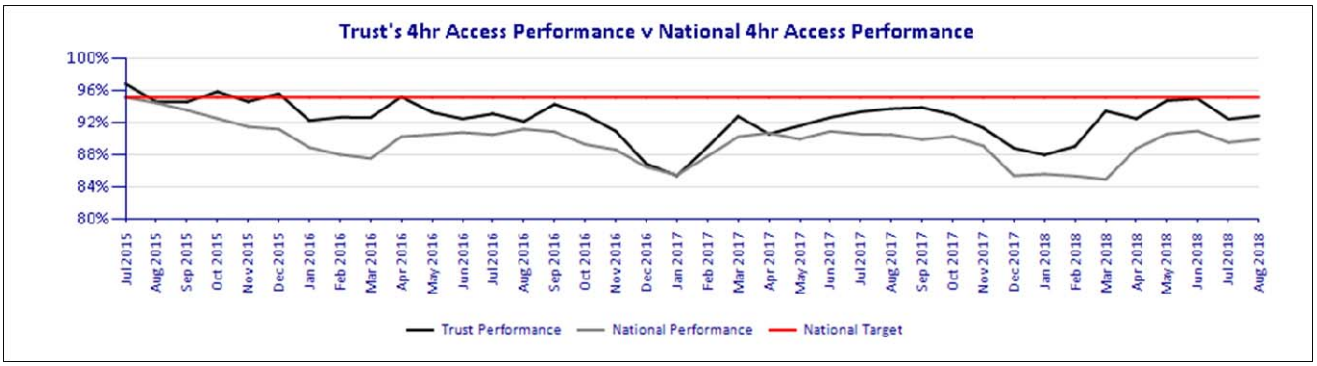
4hr Access Target

The Trust achieved 92.64% in August 2018, against the 4hr access standard of 95%.

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



PERFORMANCE REPORT – August 2018



The Trust saw 14173 attendances in August, which is 336 more than in August 2017 and 1621 less than July 2018.

The 3rd National Action on A&E programme has commenced with a focus on one of 4 key work-streams. We are focussed as a system, on understanding the highest attendance age groups 20-35s and 45-60s and then developing alternative pathways to be streamed to. System Perfect will be held from 2-9 October 2018. Work is continuing with both CCGs to understand the recent increases in attendances.

Streaming

Doncaster FDASS
The number of patients streamed directly from the front door in August was 14.4%.

Bassetlaw
Streaming commenced at Bassetlaw on 1 October 2017. The % streamed for June was 6.69%.

EXCEPTIONS

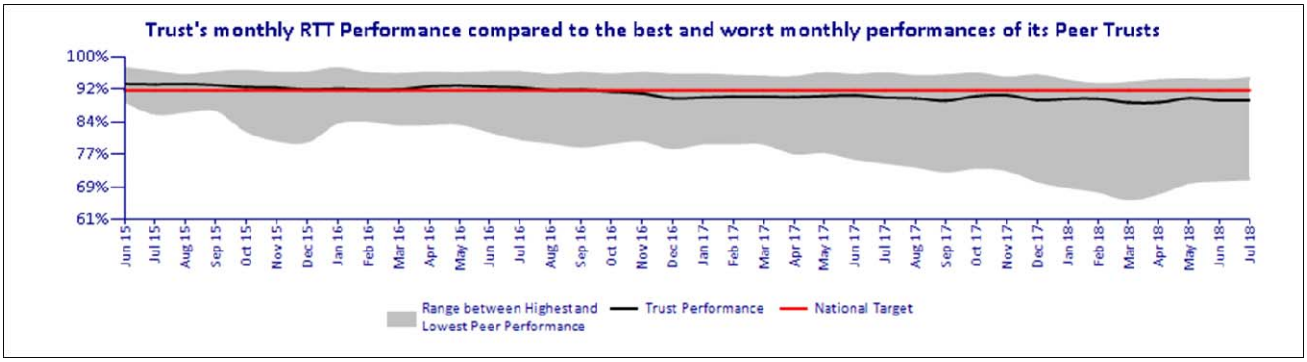
In August, 1043 patients failed to be treated in 4hrs, with the main breach reason was wait to see ED doctor/ ED review which accounted for 601 of the 1043 breaches. The week of doctor changeover was planned and performance for the week was maintained over 95%. The issues followed in the 2 weeks after with breaches due to A&E review. 161 breaches were due to bed pressures.

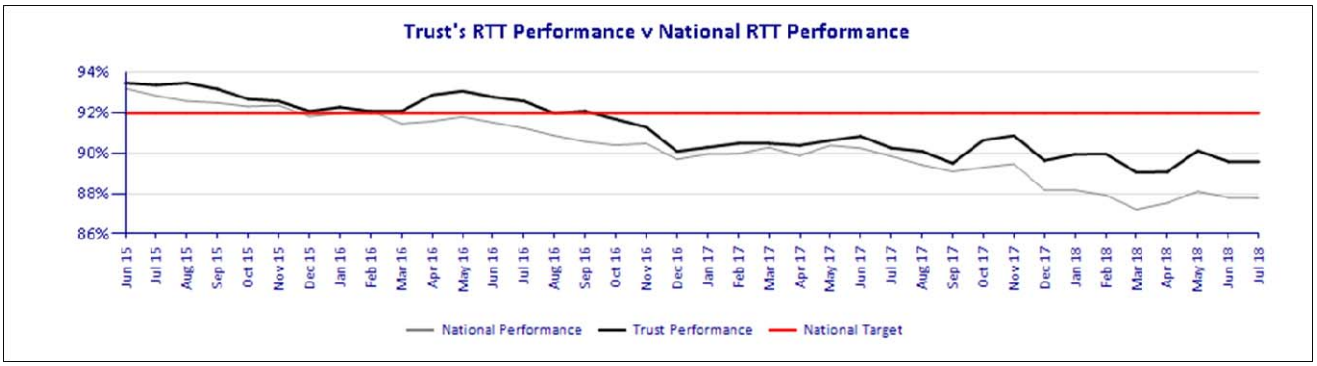
PERFORMANCE REPORT – August 2018

Referral to Treatment (RTT)

The Referral to Treatment Target, active waiters below 18 weeks set at 92%. DBTH contract for 2018/19 expects to Trust to maintain the March position of 89.1% and the waiting list size to be lower than at the end of March 2018. Though performing above the National average, the Trust position remains at 88.5% in August.

The graphs below and on the next page show Doncaster and Bassetlaw's performance compared with the National picture:





The total number of Incomplete Pathways has increased by 291 between July and August, and the number of incomplete pathways over 18 weeks increased by 407 hence the drop in performance. The total number of Incomplete Pathways with a decision to admit for treatment has gone down by 33 between July and August 2018.

All acute Trusts have received correspondence from NHSE/I, to manage the waiting list size by the end of quarter 3. DBTH has developed an action plan with the 7 key areas which has seen growth in the waiting list size. Oral surgery accounts for approximately 46% of the increased waiting list size. A plan to deal with these patients is developed.

PERFORMANCE REPORT – August 2018

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

Specialty Group	Under 18 Weeks	18 Weeks & Over	Total	Percentage
General Surgery	2672	385	3057	87.4%
Urology	1496	168	1664	89.9%
T&O	5349	699	6048	88.4%
ENT	2800	745	3545	79.0%
Ophthalmology	3051	291	3342	91.3%
Oral Surgery	1671	80	1751	95.4%
General Medicine	1688	416	2104	80.2%
Cardiology	1737	252	1989	87.3%
Dermatology	1839	112	1951	94.3%
Thoracic Medicine	794	91	885	89.7%
Rheumatology	769	195	964	79.8%
Geriatric Medicine	216	31	247	87.4%
Gynaecology	1665	82	1747	95.3%
Others	3814	309	4123	92.5%
Trust Total	**29561**	**3856**	**33417**	**88.5%**

At the end of August 2018 there were 4 Incomplete Pathways over 52 Weeks. No patients came to harm.

Diagnostics

The Trust has achieved the Diagnostic performance standard of 99% in August at 99.58%. In August there were 232 breaches overall out of 7670 patients.

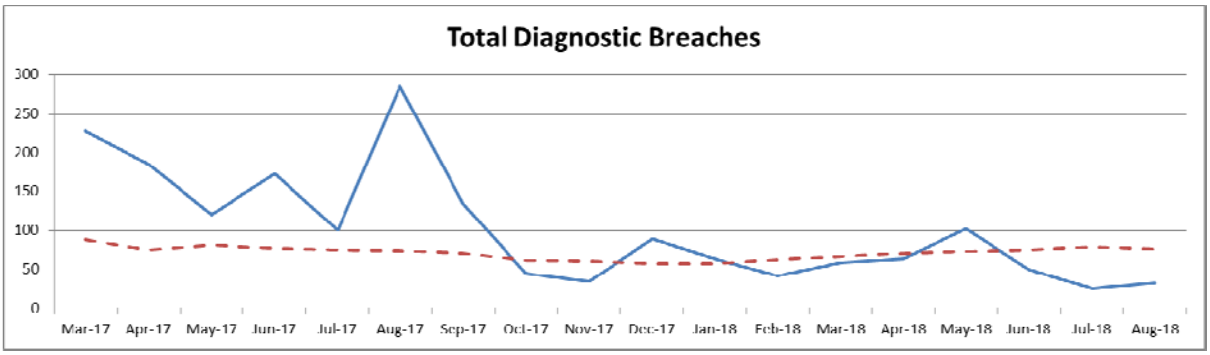
	Waiters <6W	Waiters >=6W	Total	Performance
Trust	7638	32	7670	99.58%
NHS Doncaster	5053	23	5076	99.55%
NHS Bassetlaw	1825	6	1831	99.67%

Most exam types achieved the target individually this month, with 10 of the 13 achieving more than 99%, and 7 of these achieving 100%.

EXCEPTIONS:

The 99% target was missed in:

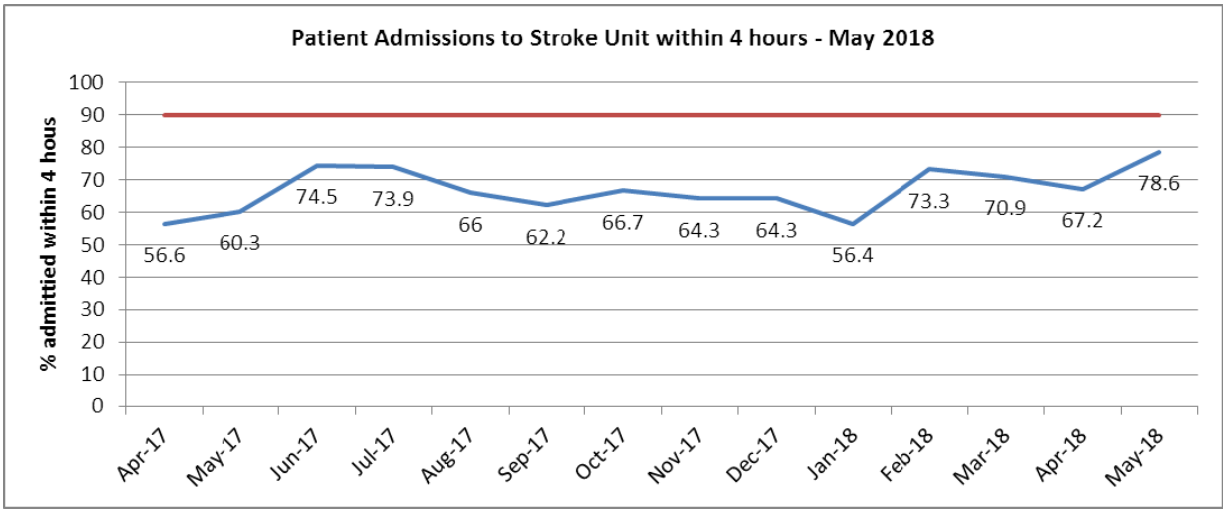
- Audiology - 97.17% - 16 breaches out of 565 waiters
- Urodynamics - 87.27% - 7 breaches out of 55 waiters
- Cystoscopy - 97.04% - 4 breaches out of 135 waiters



Stroke

Performance in June

The Trust level percentage for direct admission to the Stroke Unit was73.3% in June.



Performance in June was compliant with the 1 hour to scan standard at 62.2% compared to 66.7% for May.

The overall SSNAP performance for Stroke Dec-March 2018 outcomes has improved to A. Benchmarking against peer group trusts is presented in the table below.

PERFORMANCE REPORT – August 2018

Trust	Barnsley Hospital NHS Foundation Trust	Bradford Teaching Hospitals NHS Foundation Trust	Calderdale and Huddersfield NHS Foundation Trust	Doncaster and Bassetlaw Hospitals NHS Foundation Trust	Rotherham NHS Foundation Trust	Sheffield Teaching Hospitals NHS Foundation Trust
Team	Barnsley Hospital	Bradford Royal Infirmary	Calderdale Royal Hospital	Doncaster Royal Infirmary	Rotherham Hospital	Royal Hallamshire Hospital
SSNAP level	D	E	B	A	C	B
SSNAP score	54	38	75	83	63	72.2
Case ascertainment band	A	A	A	A	A	A
Audit compliance band	A	A	A	A	A	B
Combined indicator level	D	E	B	A	C	B

EXCEPTIONS

In terms of exceptions, there were 5 patients originally admitted at Bassetlaw who had very long waits for transport to DRI. There were also pathway delays in ED at DRI with patients not immediately assessed as strokes. There were some late requests for CT scans that prevented patients from being scanned within 1 hour.

<u>Direct admissions within 4hrs, target 90%</u>

	CCG			
Direct Admission within 4 Hours	Bassetlaw	Doncaster	Other	**Total**
Yes	7	24	2	**33**
No	5	6	1	**12**
Grand Total	**12**	**30**	**3**	**45**
Performance	58.3%	80.0%	66.7%	**73.3%**

Category	Sub Category	Total
Organisational	Beds	
	Pathway	9
	Staff Availability	1
Clinical	Patient Presentation	1
	Patient Needs	1
Patient Choice	Declined	
Awaiting further validation		

PERFORMANCE REPORT – August 2018

Scan within 1hr, target 48%

	CCG			
Scan 1 hr	Bassetlaw	Doncaster	Other	**Total**
Yes	6	20	2	**28**
No	6	10	1	**17**
Grand Total	**12**	**30**	**3**	**45**
Performance	50.0%	66.7%	66.7%	**62.2%**

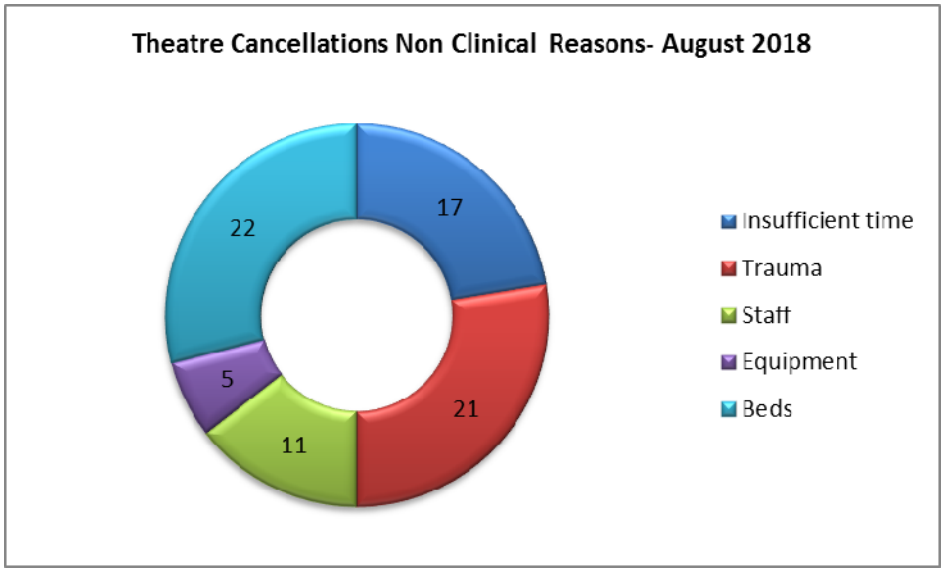
Category	Sub Category	Total
Organisational	Scanner	
	Pathway	11
	Staff Availability	1
Clinical	Criteria	
	Patient Needs	1
	Patient Presentation	4
Patient Choice	Declined	
Awaiting further validation		

Cancelled Operations

In August, 1.69% of Trust operations were cancelled. This demonstrates deterioration in performance compared with the previous month with 80 patients cancelled out of a total of 4733.
72 patients were cancelled for theatre reasons and 8 for non theatre reasons.

Indicator	**Standard**	**Jun-18**	**Jul-18**	**Aug-18**
Cancelled Operations (Total)	1.0%	1.19%	1.46%	1.69%
Cancelled Operations (Theatre)		1.08%	1.23%	1.52%
Cancelled Operations (Non Theatre)		0.10%	0.23%	0.17%
Cancelled Operations-28 Day Standard	0	1	0	1

The reasons for the non-clinical cancellations are displayed in the graph on the following page:



DNA and CNA Rates

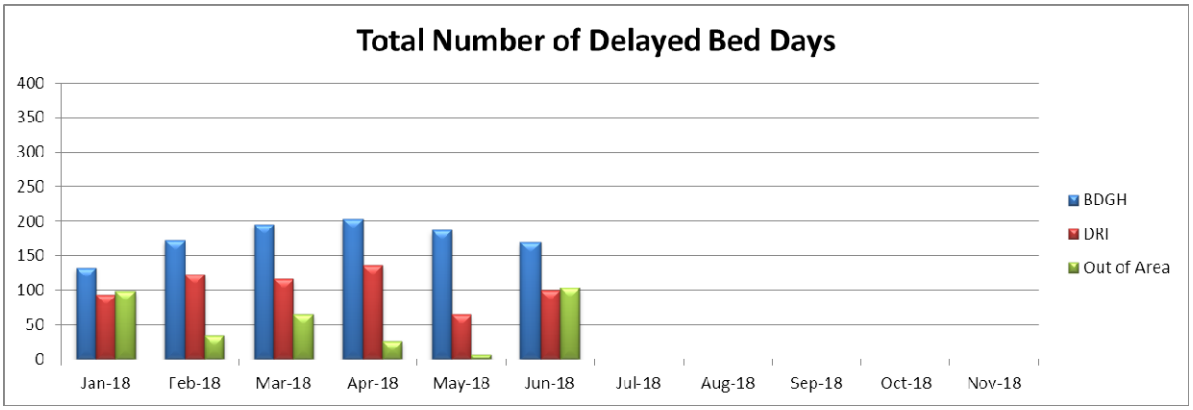
Indicator	June	July	Aug
Outpatients: DNA Rate Total	9.41%	9.78%	9.70%
Outpatients: Hospital cancellation Rate	5.19%	5.66%	5.41%

In August, the overall DNA rate across the Trust reduced slightly to 9.70% compared with the previous month's position at 9.78%.

Delayed Transfers of Care

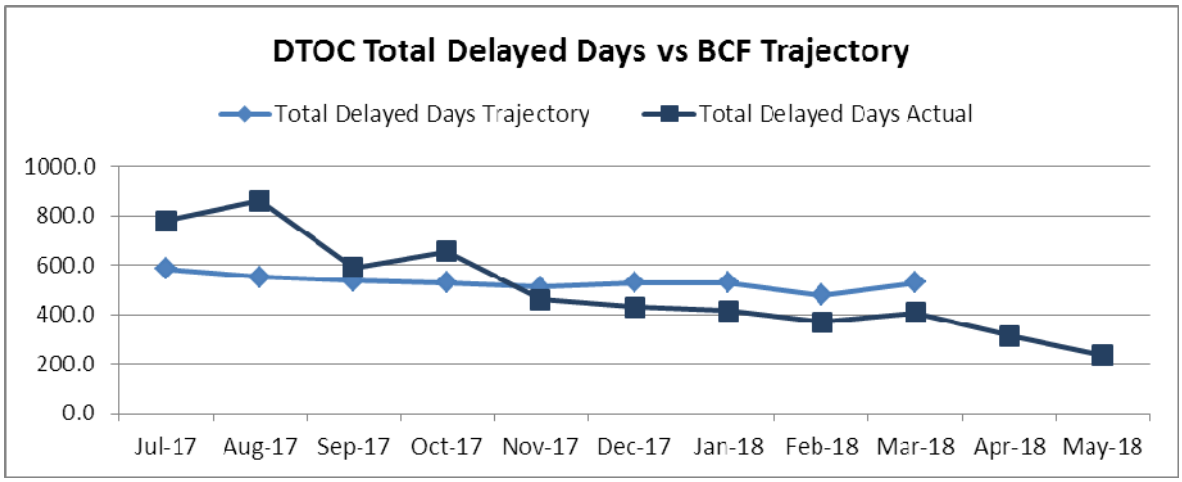
Significant work has been underway in Doncaster and Bassetlaw to improve patient discharge processes, and to reduce the number of medically fit patients waiting in hospital. This work will also impact on the number of formally reported Delayed Transfers of Care (DTOCs).

The chart below shows the number of reported delayed bed days by site.



Performance against the Better Care Fund trajectory for 2017/18 into 2018/19 is shown by the chart below. Confirmation of the trajectory from April 2018 onwards is awaited. Data up to May 2018 has been published and included within the report.

The data includes all Doncaster patients at all providers. Total delay days for Doncaster improved again during May by 76 days to 236 days, the lowest all year. The rate per 100,000 population has now fallen below 100. Social Care attributable days decreased to 32, NHS attributable days decreased to 176 with joint delays decreasing to 28.



The top 10 reasons for formally reported delays across Doncaster are:

- Out of area social care
- Care package
- Continuing Healthcare (CHC)
- Awaiting PSU bed
- Social Care DMBC
- Family Delay

- Discharge to assess bed
- Awaiting adaptations
- Independent Mental Capacity Advocates (IMCA)
- Fast track care

Super Stranded Patients

Beds occupied by long stay patients:

Ambition: **24% reduction** from **127** to **96 beds**

Occupied beds: **97**
Reduction achieved to date: **29 beds (23%)**
Reduction remaining to meet ambition: **1 beds (1 percentage points)**

Occupied bed numbers are calculated from decimals but rounded to whole numbers, so the bed reduction remaining figure may display as 1 bed higher or lower than expected.

Performance Executive Summary Board of Directors September 2018

The performance report is against operational delivery in June, July and August 2018.

Provide the safest, most effective care possible

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

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

Referral to Treatment

The Referral to Treatment Target, active waiters below 18 weeks set at 92%, the Trust has been commissioned to achieve 89.1% by the end of March with no growth to the waiting list size.

Though performing above the National average, the Trust position remains below the target at 88.5%.

The total number of Incomplete Pathways has increased by 291 between July and August, and the number of incomplete pathways over 18 weeks increased by 407 hence the drop in performance. The total number of Incomplete Pathways with a decision to admit for treatment has gone down by 33 between July and August 2018.

The 2 specialities with the largest deterioration in performance were ENT and gastroenterology.

All acute Trust received correspondence from NHSI and similar letters were received by CCGs from NHSE in month to address the issue of increases in waiting list size. DBTH waiting list has increased by 1200 since April as a result of increased referrals from CCGs and NHSE. The referral increases are 3% for BCCG, 4.4% from DCCG, 8% from others. The key waiting list growth has been in oral surgery which equates to 46% of the increase.

DBTH have developed an action plan to deal with the waiting list issues focussed on 7 specialities with the largest growth. This plan has been given low risk, high confidence by NHSE.

The progress against the plans will be monitored by the weekly PTL meeting.

An OPD booking for firsts was improved in August.

There were 4 patients over 52 weeks at the end of August. No patient came is any harm and all have treatment plans in place.

Diagnostics

The Trust has achieved the Diagnostic performance standard of 99% in August at 99.58%. In August there were 232 breaches overall out of 7670 patients.

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 92.7%, including alternative pathways 93.3**%.**

Quarter 2 92.37% (93.1% including alternative pathways)

The Trust saw 14173 attendances in August, which is 336 more than in August 2017 and 1621 less than July 2018. 1043 patients failed to be treated in 4hrs, with the main breach reason was wait to see ED doctor/ ED review which accounted for 601 of the 1043 breaches. The week of doctor changeover was planned in advance with additional consultant cover and performance for the week was maintained over 95%. The issues followed in the 2 weeks after with breaches due to A&E review.

161 breaches were due to bed pressures.

The 3rd National Action on A&E programme has commenced with a focus on one of 4 key work-streams. We are focussed as a system, on understanding the highest attendance age groups 20-35s and 45-60s and then developing alternative pathways to be streamed to. System Perfect will be held from 2-9 October 2018. Work is continuing with both CCGs to understand the recent increases in attendances.

Streaming

Doncaster FDASS

The number of patients streamed directly from the front door in August was 14.4%.

Bassetlaw

Streaming commenced at Bassetlaw on 1 October 2017. The % streamed for June was 6.69%.

NHSI Additional Reporting Requirements

18.1% of all of DRI discharges take place at a weekend and 15.2% at BDGH

If the rest of the week was at the same level as Mondays then we would see an extra 174 patients a week at DRI and an extra 109 patients at BDGH

A&E attendances on a Monday at DRI account for 15.6% of weekly activity rising to 15.9% at BDGH

Non Elective Admissions on a weekday that GP admissions account for is 20.6% of all Emergency Admissions on a weekday at DRI but only 8.0% at BDGH.

When we move into the weekend this drops to 11.3% at DRI and 2.4% at BDGH

Cancer Performance

July

62 day performance 86.2%

The 62 day standard was achieved by the Trust in July at 86.2%, this maintains performance seen in June. The One Stop Prostrate Clinic is on target to commence on the 1st of October to coincide with the latest guidance release for 2 week wait.
A pilot of Straight to test for colonoscopy has been partially funded by the Cancer Alliance for lower GI cancers, which will commence in April 2019.

The Cancer management team has been restructured to support operational delivery of cancer, including a Cancer governance lead, which will monitor performance against all targets including 104 day breaches.

Two Week Wait Performance 87.1%

The July position for two week wait was 87.1% which was not compliant with the national target of 93%. This is however, an improved position compared with June.

The Capacity and Demand tool continues to be developed, providing a planning tool based on previous referral trends, activity and capacity. Care groups are now using the tool proactively in order to plan two week wait capacity. Since April there has been an overall increase of referrals for 2 week wait of 12%.

Weekly PTL meetings with each specialty are ongoing to jointly track patient booking, pathways and to review breaches. The two week wait process has been value stream mapped and the new process will be implemented over the next 6 weeks. In the interim the planning of colorectal pathways is now being piloted back in the service. A straight to MRI pilot for prostate cancer is being planned for BDGH.

Stroke Performance

June stroke discharges 45

Direct admission 73.3%

CT within 1 hour 62.2%

In terms of exceptions, there were 5 patients originally admitted at Bassetlaw who had long waits for transport to DRI. There were also pathway delays in ED at DRI with patients not immediately assessed as strokes.

There were some late requests for CT scans that prevented patients from being scanned within 1 hour.

David Purdue Chief Operating Officer June 2018

At a Glance August 2018 (Month 5)

Doncaster & Bassetlaw Teaching Hospital NHS Foundation Trust

	Indicator	Standard	Current Month	Month Actual	Direction of travel compared to previous Month	NHS England %	DBTHFT	Month	Peer Groups %	DBTHFT	Month
Monitor Compliance Framework	31 day wait for second or subsequent treatment: surgery	94.00%	July	94.40%	↗	93.80%	94.40%	July	92.10%	94.40%	July
	31 day wait for second or subsequent treatment: anti cancer drug treatments	98.00%		100.00%	↔	99.40%	100.00%		99.40%	100.00%	
	31 day wait for second or subsequent treatment: radiotherapy	94.00%		100.00%		97.00%	100.00%		Not Available	100.00%	
	62 day wait for first treatment from urgent GP referral to treatment	85.00%		86.00%	↘	78.20%	86.00%		77.90%	86.00%	
	62 day wait for first treatment from consultant screening service referral	90.00%		100.00%	↑	89.10%	100.00%		78.30%	100.00%	
	31 day wait for diagnosis to first treatment- all cancers	96.00%		99.40%	↗	97.10%	99.40%		96.30%	99.40%	
	Two week wait from referral to date first seen: all urgent cancer referrals (cancer suspected)	93.00%		87.10%	↑	91.90%	87.10%		90.00%	87.10%	
	Two week wait from referral to date first seen: symptomatic breast patients (cancer not initially suspected)	93.00%		93.70%	↑	88.20%	93.70%		93.60%	93.70%	
	A&E: Maximum waiting time of four hours from arrival / admission / transfer / discharge (Trust)	95.00%	August	92.60%	↗	89.70%	92.60%	August	88.10%	92.60%	August
	Maximum time of 18 weeks from point of referral to treatment- incomplete pathway	92.00%	August	88.50%	↘	87.80%	89.60%	July	83.63%	89.60%	July
	% of Patients waiting less than 6 weeks from referral for a diagnostics test	99.00%	August	99.58%	↘	97.20%	99.35%	July	95.20%	99.35%	July
Ambulance Handover Times	Ambulance Handovers Breaches -Number waited over 15 & Under 30 Minutes		July	815	↗	UCL: 796 & LCL: 659					
	Ambulance Handovers Breaches-Number waited over 30 & under 60 Minutes			56	↗	UCL: 122 & LCL: 56					
	Ambulance Handovers Breaches -Number waited over 60 Minutes			10	↗	UCL: 29 & LCL: 2					
Stroke	Proportion of patients scanned within 1 hour of clock start (Trust)	48.00%	June	62.20%	↘	SSNAP performance for December to March improved to A rating.					
	Proportion of patients directly admitted to a stroke unit within 4 hours of clock start (Trust)	90.00%		73.30%	↘						
	Percentage of eligible patients (according to the RCP guideline minimum threshold) given thrombolysis (Trust)	20.00%		6.70%	↘						
	Percentage of patients treated by a stroke skilled Early Supported Discharge team (Trust)	40.00%		67.40%	↗						
	Percentage of those patients who are discharged alive who are given a named person to contact after discharge (Trust)	95.00%		88.40%	↘						
	Implementation of Stroke Strategy - TIA Patients Assessed and Treated within 24 Hours	60.00%	August	32.60%	↓						
Theatres & Outpatients	Cancelled Operations	0.80%	August	1.69%	↗	No Benchmarking available					
	Cancelled Operations-28 Day Standard	0		1	↗						
	Out Patients: DNA Rate			9.70%	↗	7.62%	9.41%	June	6.96%	9.41%	June
	Out Patients: Hospital Cancellation Rate			5.41%	↗	No Benchmarking available - data not submitted to Secondary Uses Service by all Trusts					
Effective	Emergency Readmissions within 30 days (PbR Methodology)		June	6.60%	↘	7.20%	6.40%	May	8.02%	6.40%	May

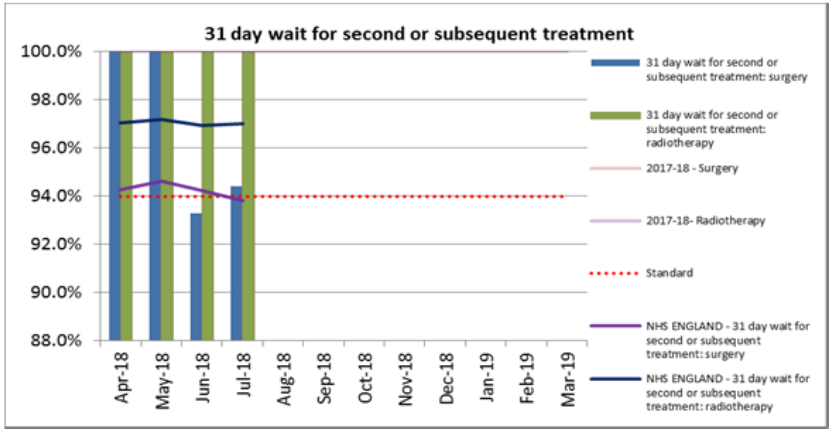
	Indicator	Current Month	Month Actual (TRUST)	Month Actual (DRI)	Month Actual (BDGH)	Data Quality RAG Rating
Fractured Neck of Femur	% of patients achieving Best Practice Tariff Criteria	Aug-18	45.20%	50.00%	38.50%	
	Best Practice Criteria					
	36 hours to surgery Performance	Aug-18	48.39%	50.00%	46.15%	
	72 hours to geriatrician assessment Performance		90.32%	100.00%	76.92%	
	% of patients who underwent a falls assessment		96.77%	100.00%	92.31%	
	% of patients receiving a bone protection medication assessment		96.77%	100.00%	92.31%	
	Mortality-Deaths within 30 days of procedure		6.50%	5.60%	7.70%	

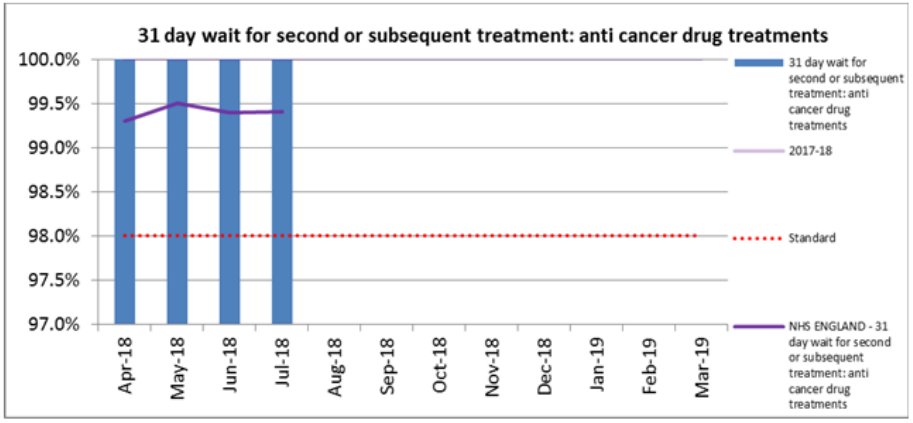
	Indicator	Standard (Local, National Or Monitor)		Current Month	Month Actual	Data Quality RAG Rating
Safe	Infection Control C.Diff	4 Per Month - 45 full year	M	Aug-18	1	
	Infection Control MRSA	0	L		0	
	HSMR (rolling 12 Months)	100	N	May-18	90.95	
	Never Events	0	L	Aug-18	0	
	VTE	95.0%	N	Jul-18	95.0%	
	Avoidable Pressure Ulcers Cat 3&4	21 Full Year	L	May-18	2	
	Falls that result in a serious Fracture	2 Per Month 23 full Year	L	Aug-18	0	
	Catheter UTI	Snap shot audit			0.30%	

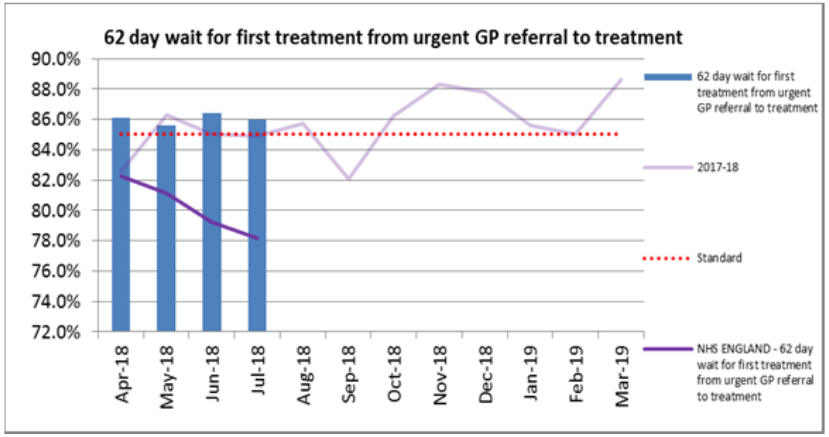
	Indicator	Current Month	Month Actual	Data Quality RAG Rating
Complaints & Claims	Complaints received (12 Month Rolling)	Aug-18	419	
	Concerns Received (12 Month Rolling)		569	
	Complaints Performance		86.0%	
	Clinical Negligence Scheme for Trusts (CNST)		11	
	Liabilities to Third Parties Scheme (LTPS)		6	
	Claims per 1000 occupied bed days		0.49	

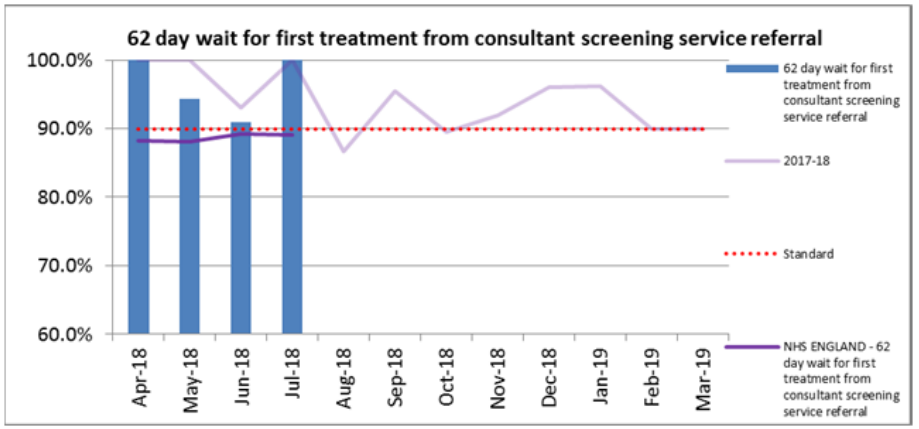
	Indicator	Current Month	YTD (Cumulative)	Data Quality RAG Rating
Workforce	Appraisals	Aug-18	78.85%	
	SET Training		82.49%	

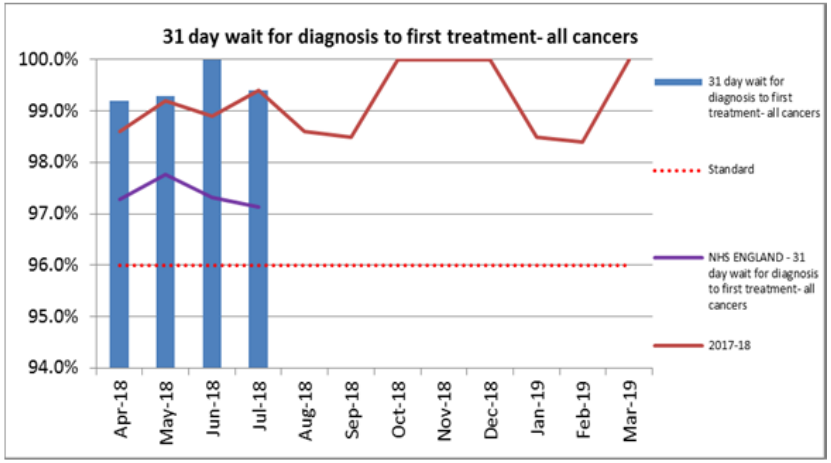
Monitor Compliance Framework: Cancer - Graphs - July 2018 (Month 4)

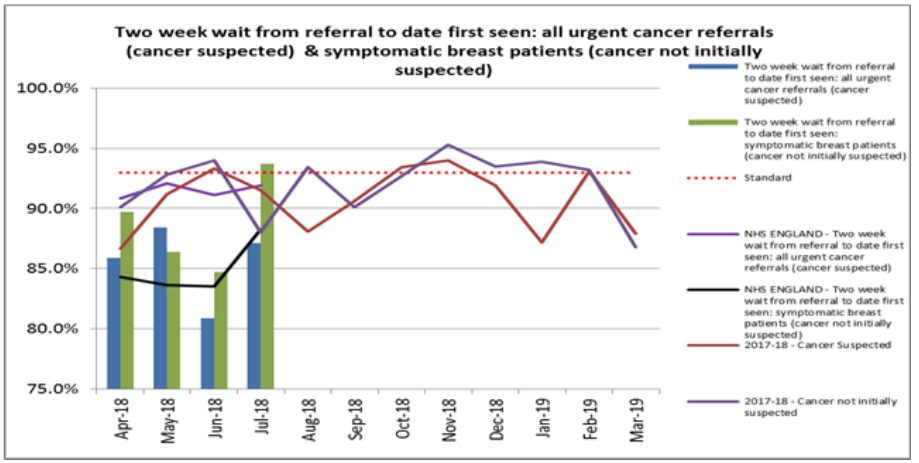




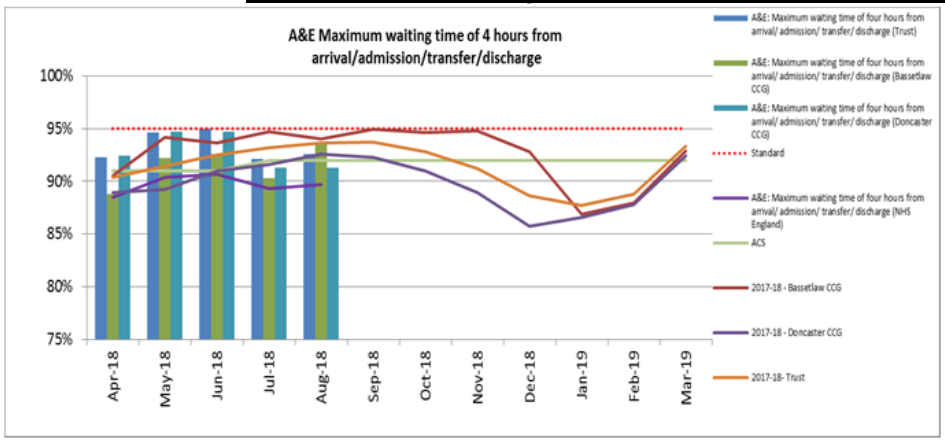


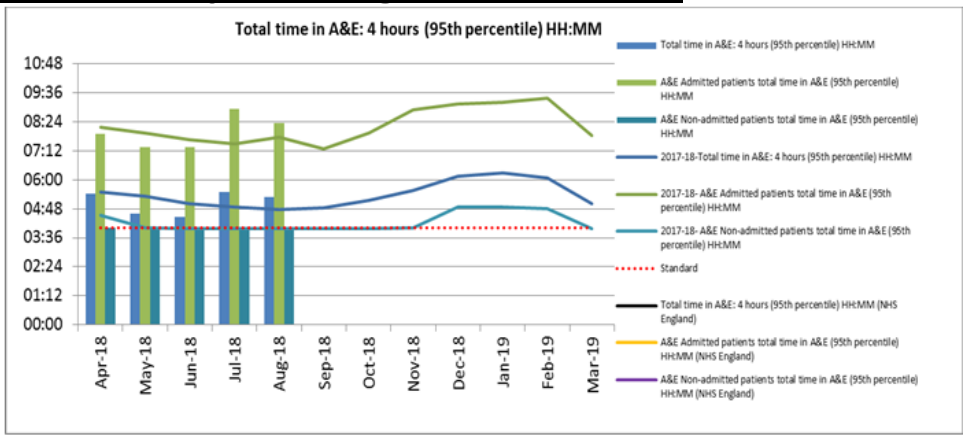


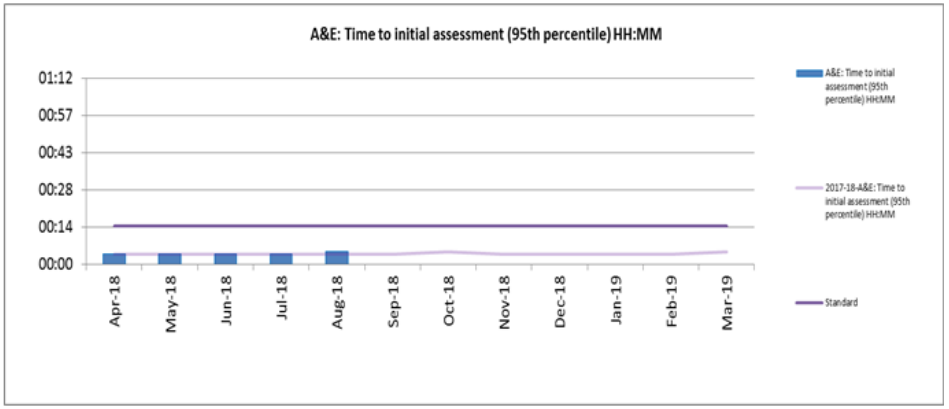


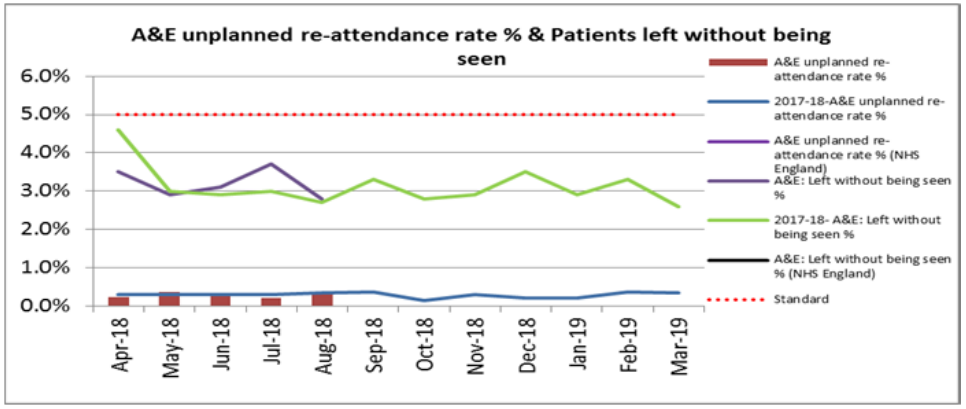


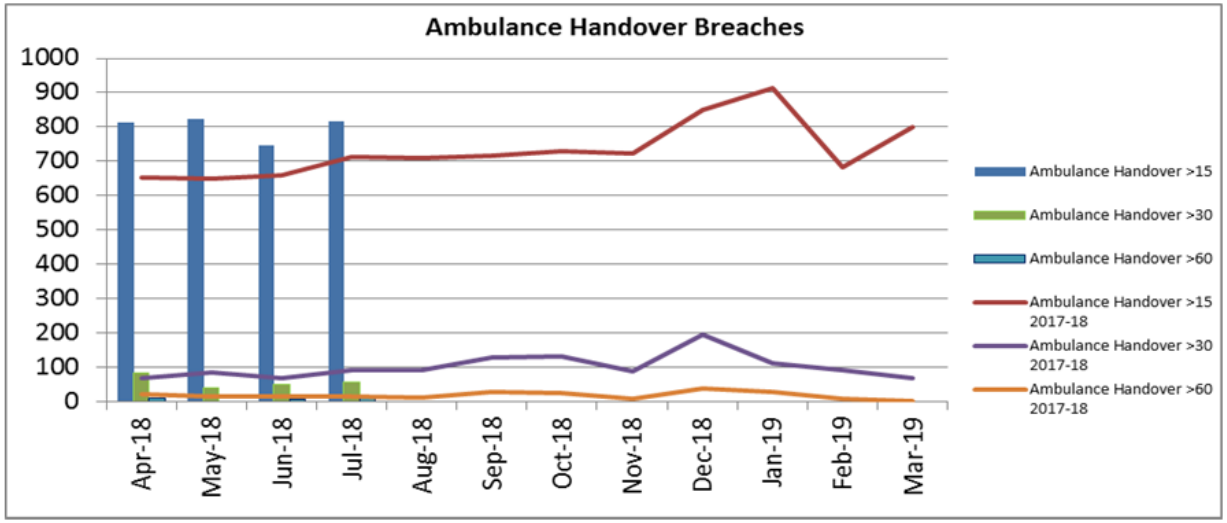
Monitor Compliance Framework: A&E - Graphs - August (Month 4)



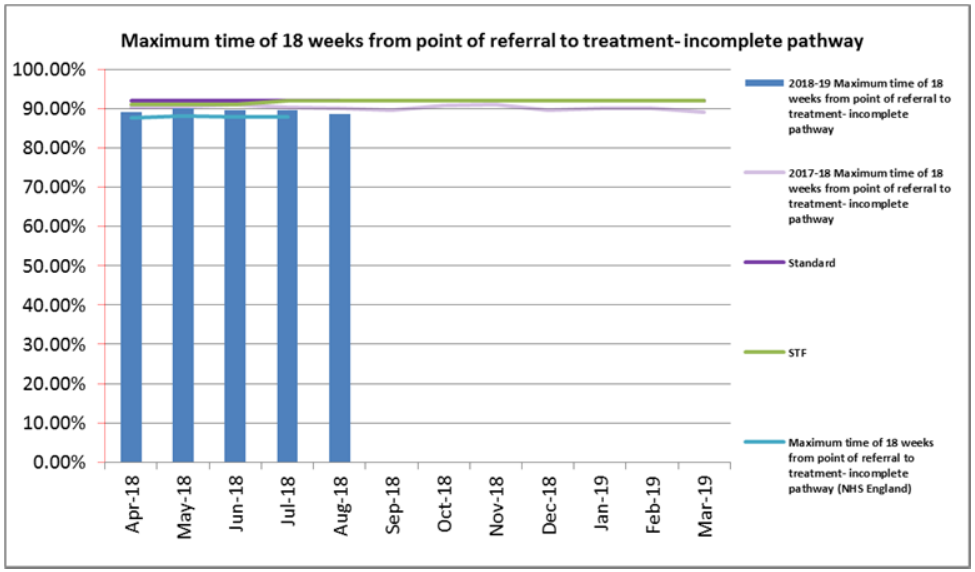


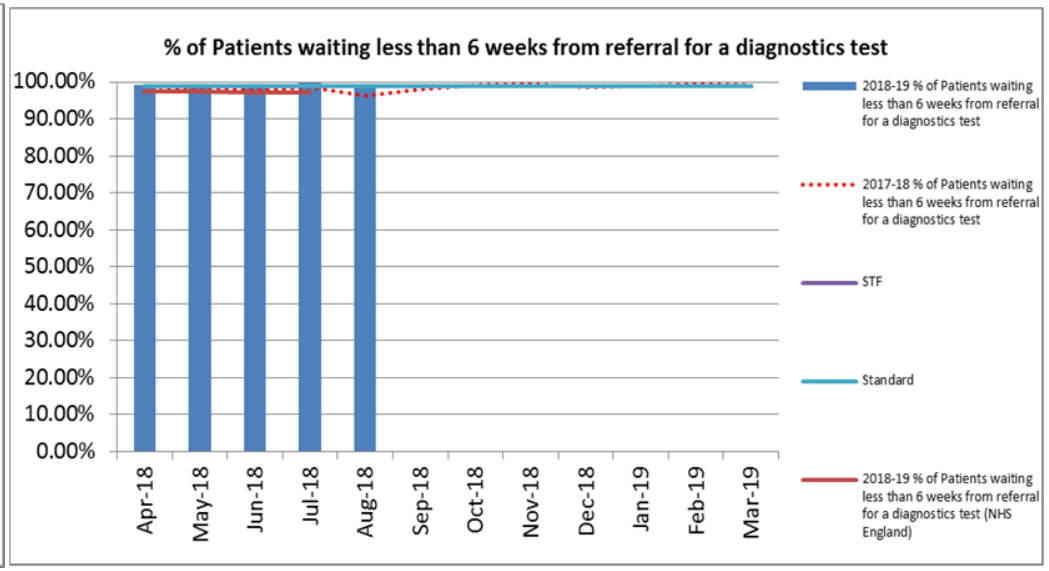


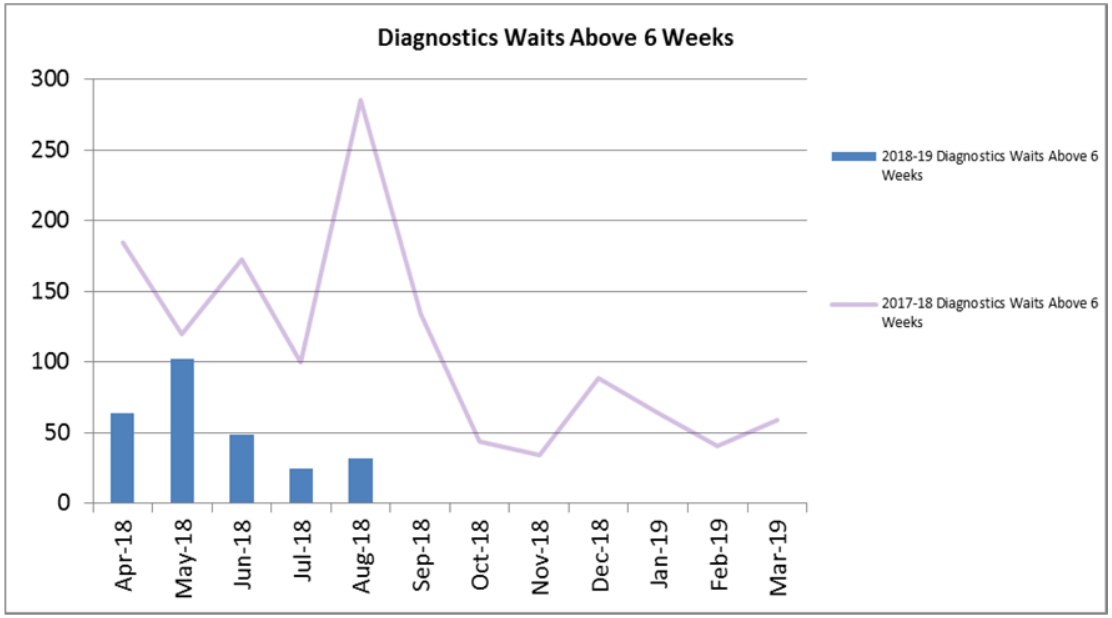




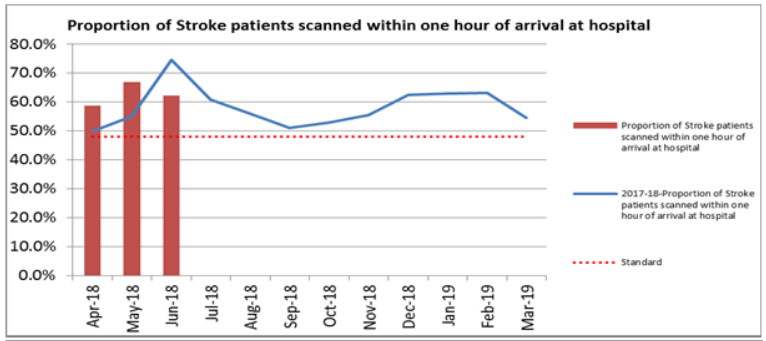
Monitor Compliance Framework: 18 Weeks & Diagnostics -August (Month 5)

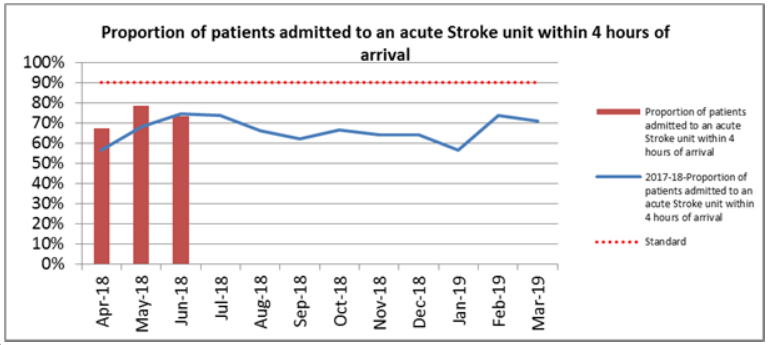


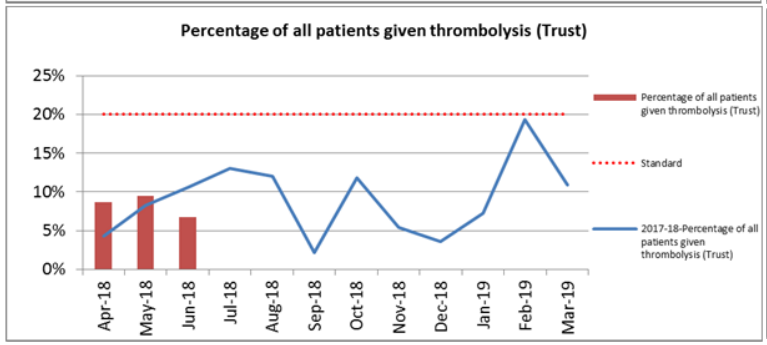


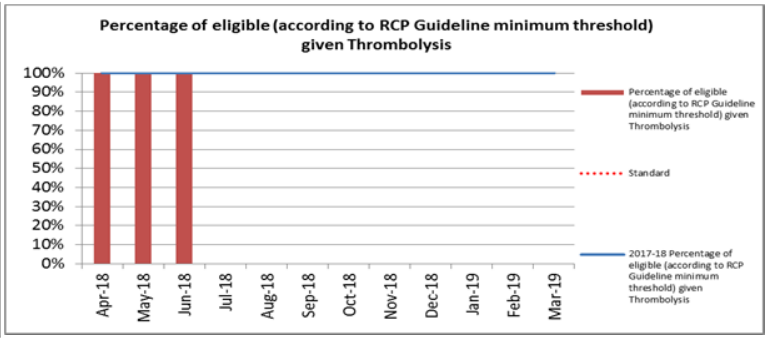


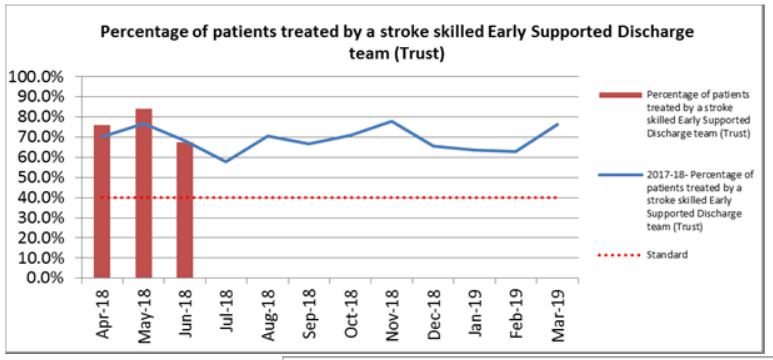
Stroke - Graphs June 2018 (Month 3)

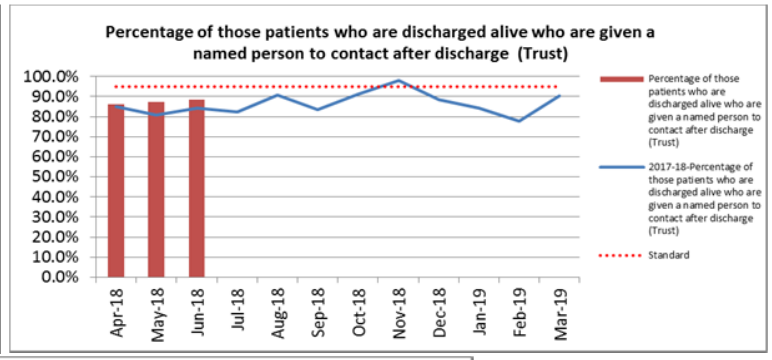


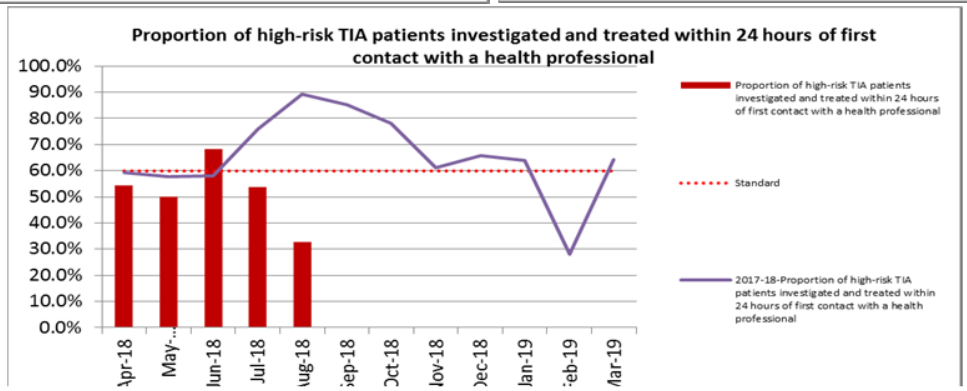












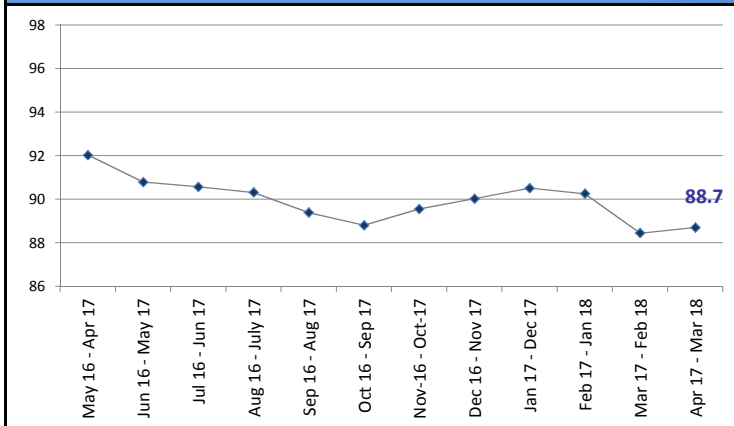
Executive Summary - Safety & Quality - July 2018 (Month 4)

HSMR:	HSMR data for April and May is not available as yet. Data presented is that presented at last Board meeting
Fractured Neck of Femur:	Focused attention on getting patients into theatre as early as possible has seen a significnt improvement in BPT achievement. The national benchmark sits at 60%.
Serious Incidents:	6 SIs reported in month. Two of these were HAPUs. Four arising out of care issues are being reviewed. There were no serious falls in month
Executive Lead: **Mr S Singh**	

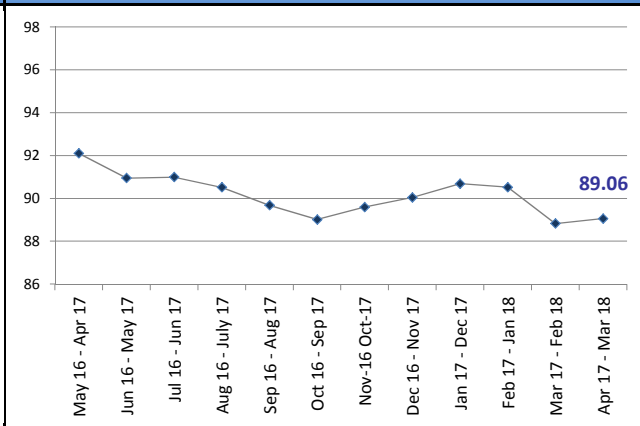
C-Diff	The rate is below that of the same period last year and the national trajectory
Fall resulting in significan harm:	The rate is the same for the month of July 2018, but higher than YTD
Hospital Acquired Pressure Ulcers:	The data for HAPU's has been reviewed and revised this month so that only validated HAPUs are reported to Board. This will result in a lag in data being available to Board and processes are being reviewed in minimise this. The revalidated position shows a higher number of HAPUs for both April and May.
Complaints and Concerns	The number of complaints and concerns remain within normal variation. Complaints resolution has improved in July to 84%.
Friends & Family Test:	Response rates for both inpatients and ED patients has fallen in June whilst positivity of responses continues to be higher than the national average for both inpatients and ED
Executive Lead: **Mrs M Hardy**	

Hospital Standardised Mortality Ratio (HSMR) - March 2018 (Month 12)

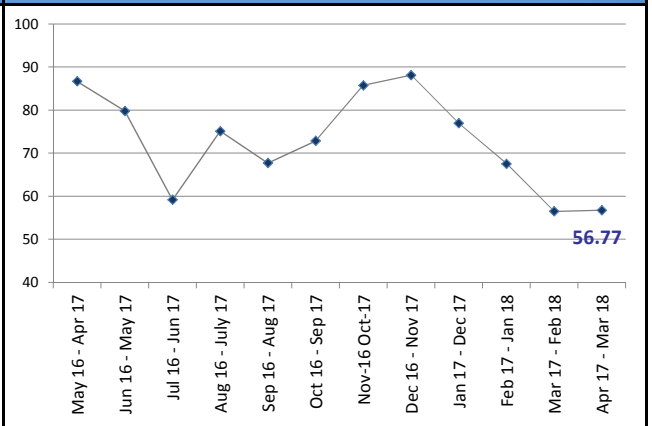
Overall HSMR (Rolling 12 months)



HSMR - Non-elective Admission (Rolling 12 months)



HSMR - Elective Admission (Rolling 12 months)

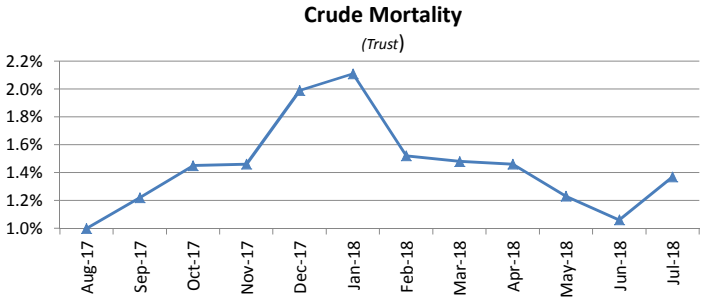


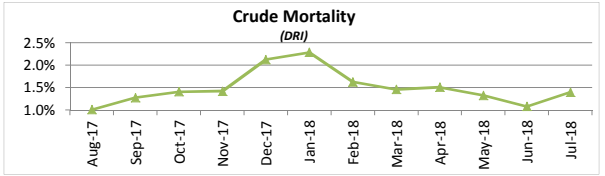
HSMR Trend (monthly)

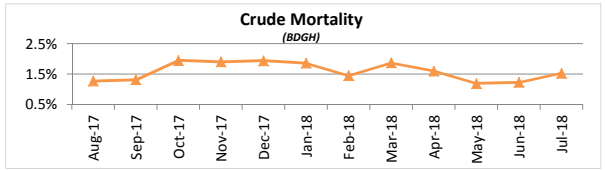
	2015	2016	2017	2018
January	116.80	99.21	94.86	92.70
February	99.94	97.73	105.44	84.77
March	90.54	97.37	82.66	84.52
April	105.91	88.50	83.85	
May	101.15	96.60	82.47	
June	80.27	93.67	90.60	
July	92.56	97.73	94.70	
August	100.27	87.52	74.31	
September	90.26	95.34	87.55	
October	90.29	88.66	98.35	
November	88.98	82.30	87.54	
December	82.30	93.52	98.79	

Crude Mortality (monthly) - July 2018 (Month 4)

(number of deaths/number of patient discharged)



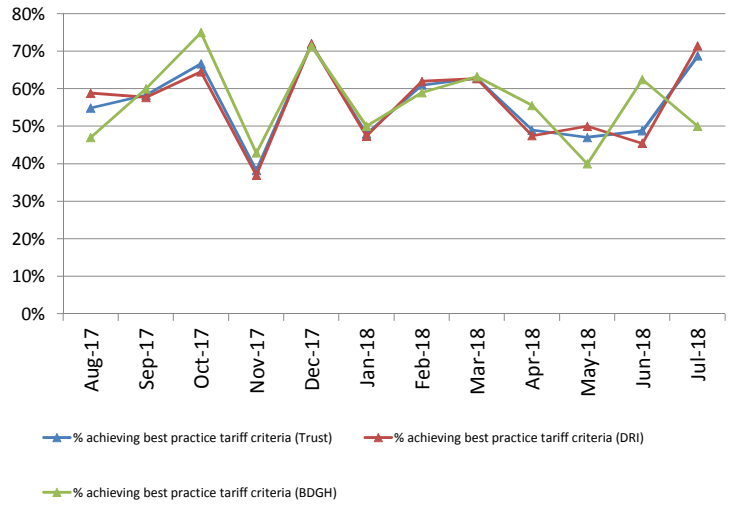




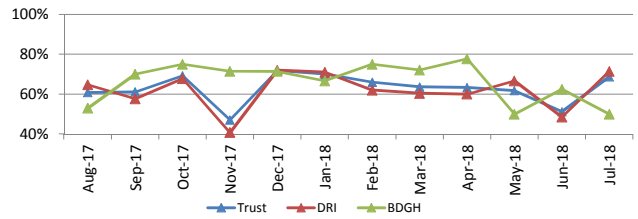
	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18
Trust	1.01%	1.22%	1.45%	1.46%	1.99%	2.11%	1.52%	1.48%	1.46%	1.23%	1.06%	1.37%
Donc	1.01%	1.28%	1.41%	1.42%	2.13%	2.29%	1.63%	1.46%	1.51%	1.33%	1.08%	1.40%
Bass	1.27%	1.31%	1.95%	1.90%	1.94%	1.86%	1.45%	1.87%	1.60%	1.19%	1.23%	1.53%

NHFD Best Practice Pathway Performance - July 2018 (Month 4)

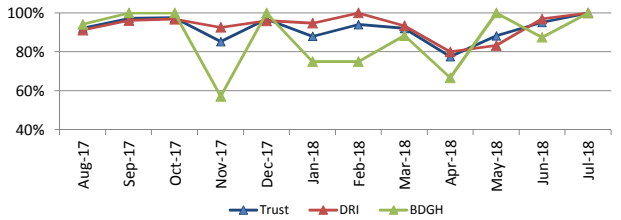
Best Practice Criteria Performance



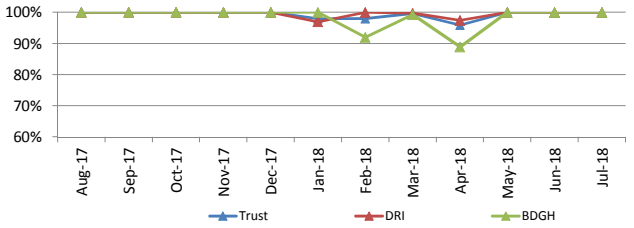
36 Hours to Surgery Performance



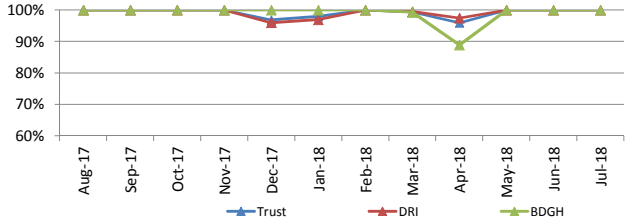
72 hours to Geriatrician Assessment Performance



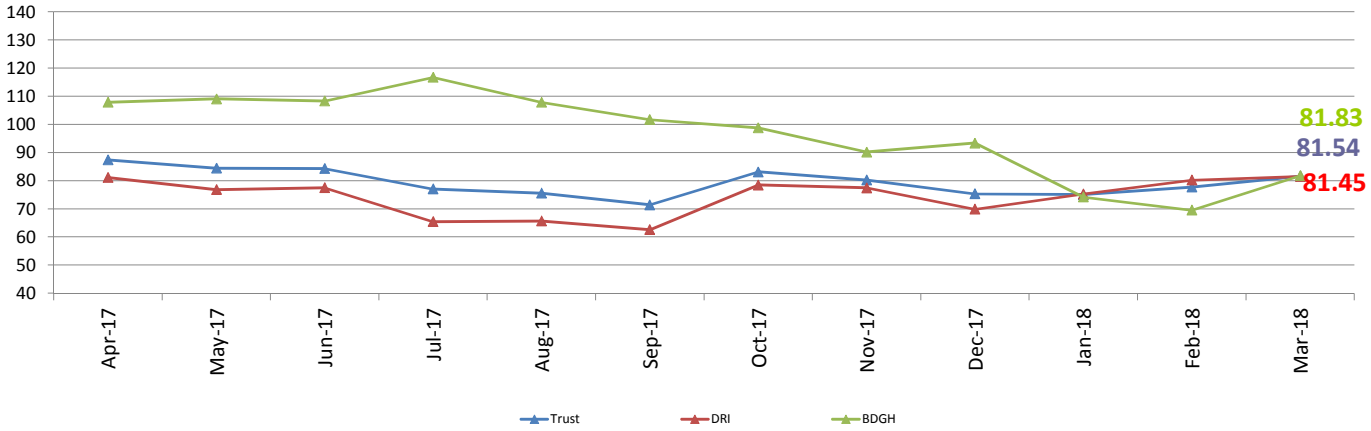
Bone Protection Medication Assessment



Falls Assessment Performance



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



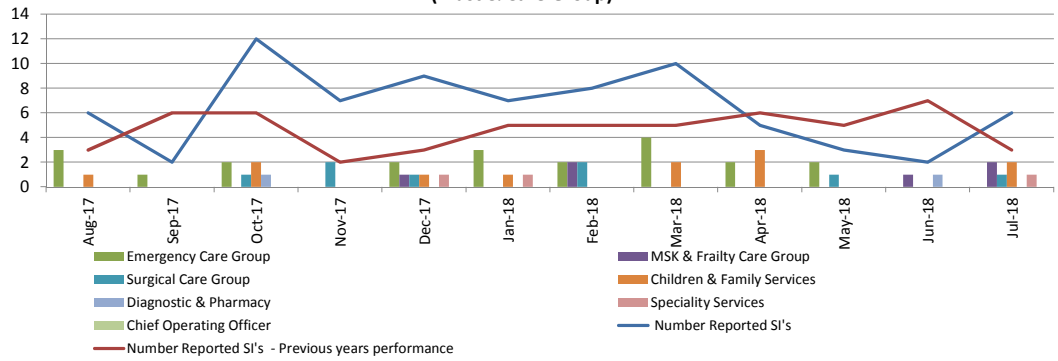
Serious Incidents - July 2018 (Month 4)

(Data accurate as at 10/08/2018)

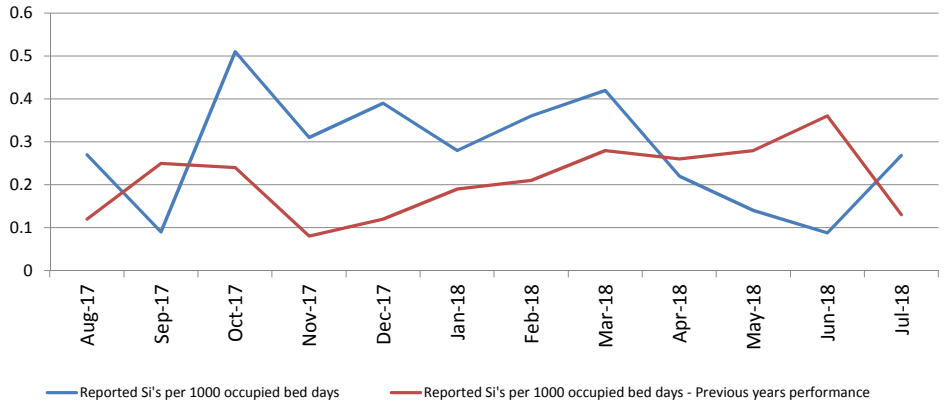
Please note: At the time of producing this report the number of serious incidents reported are prior to the RCA process being completed.

Overall Serious Incidents

Number Serious Incidents Reported
(Trust & Care Group)



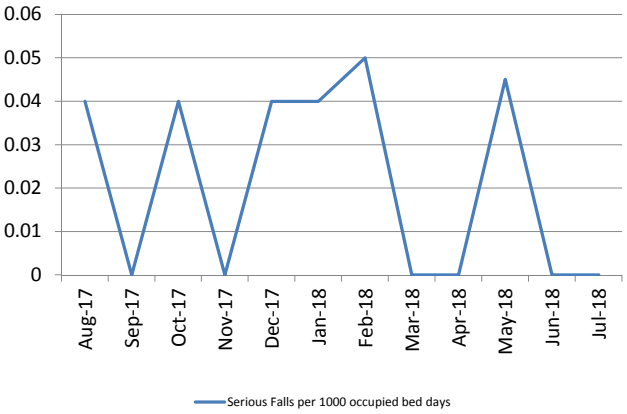
Serious Incidents per 1000 occupied bed days



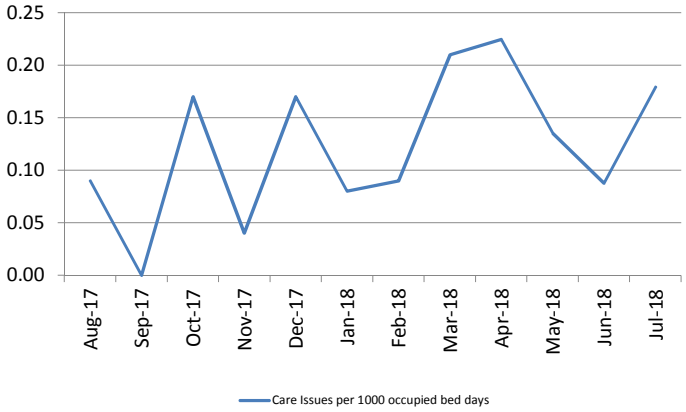
Current YTD reported SI's (April-July 18)	16	Number reported SI's (Apr-July 17)	21
Current YTD delogged SI's (April-July 18)	0	Number delogged SI's (Apr-July 17)	13

Themes

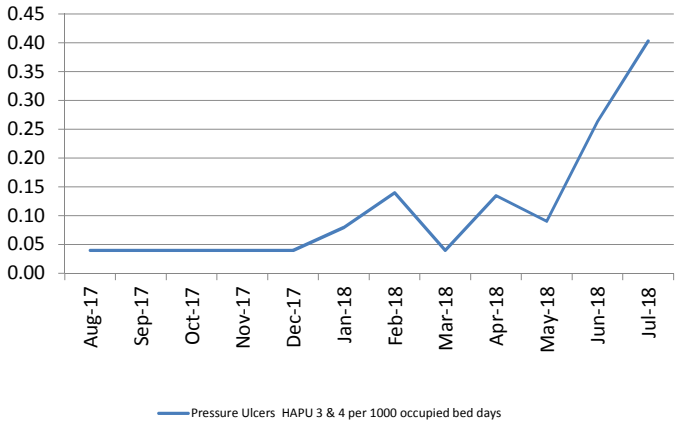
Serious Falls



Care Issues

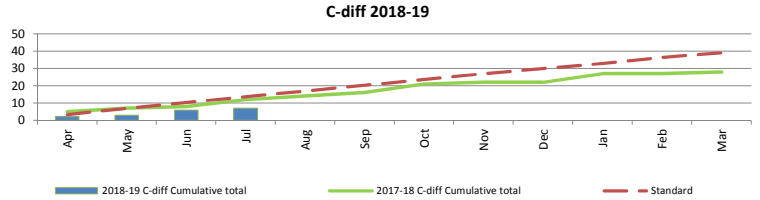


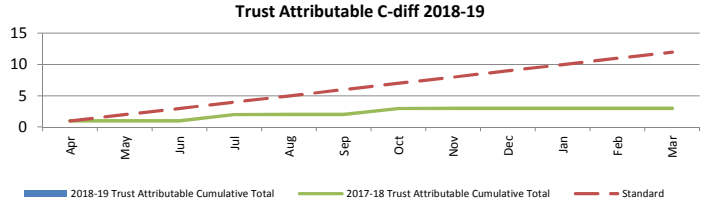
Pressure Ulcers - Category 3 & 4 (HAPU)



Monitor Compliance Framework: Infection Control C.Diff - July 2018 (Month 4)
(Data accurate as at 09/08/2018)

	Standard	Q1	Jul	YTD
2018-19 Infection Control - C-diff	39 Full Year	6	1	7
2017-18 Infection Control - C-diff	40 Full Year	7	4	11
2018-19 Trust Attributable	12	0	0	0
2017-18 Trust Attributable	12	1	1	2

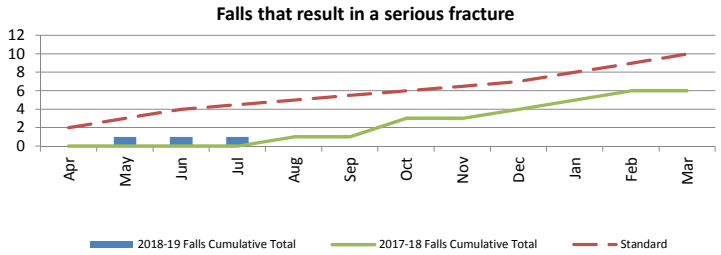




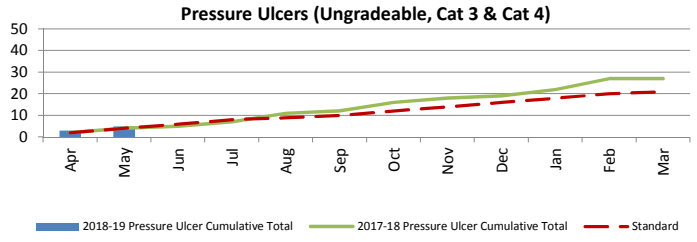
Pressure Ulcers & Falls that result in a serious fracture - July 2018 (Month 4)
(Data accurate as at 09/08/2018)

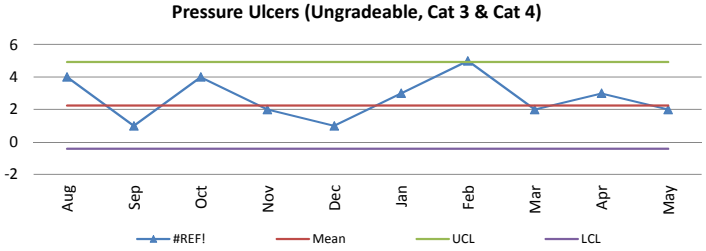
	Standard	Q1	Jul	YTD
2018-19 Serious Falls	10 Full Year	1	0	1
2017-18 Serious Falls	6 Full Year	0	0	0

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



	Standard	Apr	May	YTD
2018-19 Pressure Ulcers	21 Full Year	3	2	5
2017-18 Pressure Ulcers	27 Full Year	2	2	4





Hard Truths - July 2018 (Month 4)

(Data accurate as at 15/08/2018)

				Planned v Actual		Safe	Effective	Caring	Responsive	Well Led	Profile	
Care Group	Matron	Ward	No of Funded Beds	CHPPD	Variance	Total score	Total score	Total score	Total score	QM total score	Work-force	Quality
Surgical	NS	B6	16	7.3	100%	2.0	0.0	0.5	1.5	4.0		
	NS	20	27	5.9	120%	1.0	0.0	0.5	1.5	3.0		
	NS	21	27	4.7	95%	1.0	0.0		1.0	2.0		
	LM	S12	20	5.7	103%	0.5	0.0	1.0	1.5	3.0		
	RF	SAW	21	8.3	97%	0.0	2.0	3.0	1.5	6.5		
	LC	ITU DRI	20	26.9	91%	1.0	0.0	0.0	1.0	2.0		
	LC	ITU BDGH	6	29.7	86%	0.5	0.0	3.0	0.5	4.0		
					97%							
MSK and Frailty	SS	A4	24	6.0	98%	0.0	0.0	1.0	2.0	3.0		
	SS	B5	30.7	7.5	100%	0.5	0.5	0.0	1.5	2.5		
	AH	St Leger	35	6.9	101%	1.5	2.5	1.0	1.0	6.0		
	AH	1&3	23	8.3	99%	1.0	0.0	0.5	2.0	3.5		
	SS	Mallard	16	8.8	107%	2.0	0.0	1.0	1.5	4.5		
	SS	Gresley	32	5.8	100%	2.0	0.5	1.0	2.0	5.5		
	SS	Stirling	16	7.8	104%	1.0	1.0	1.0	2.0	5.0		
	KM	Rehab 2	19	5.5	100%	3.0	0.0	0.0	2.0	5.0		
	KM	Rehab 1	29	4.9	102%	0.5	0.0	0.0	1.5	2.0		
					101%							
Specialty Service	JP	18	12	7.3	101%	2.0	0.0	2.0	1.0	5.0		
	JP	18 CCU	12	7.5	99%	2.0	0.0	0.0	2.0	4.0		
	AW	32	18	6.3	96%	1.5	0.0	2.0	1.5	5.0		
	AW	16	24	7.6	95%	1.5	0.0	0.0	1.0	2.5		
	RM	17	24	6.7	101%	0.0	0.0	0.5	3.0	3.5		
	JP	CCU/C2	18	7.0	114%	2.0	0.0	0.0	2.0	4.0		
	RM	S10	20	5.1	97%	1.0	0.0	1.0	1.0	3.0		
	RM	S11	19	5.7	103%		0.0	0.0	1.5	1.5		
					100%							
Emergency	MH	ATC	21	7.3	93%	2.0	2.0	3.0	2.0	9.0		
	SS	AMU	40	8.8	105%	0.0	0.0	1.0	2.0	3.0		
	MH	C1	16	6.7	118%	0.5	0.0	1.0	2.0	3.5		
	SC	24	24	6.0	107%	0.0	0.0	3.0	1.5	4.5		
	SC	25	16	7.8	118%	1.0	0.0	0.5	1.0	2.5		
	SC	Respiratory unit	56	6.6	108%	1.5	1.5	3.0	1.0	7.0		
					107%							
Children and Families	AB	SCBU	8	18.9	98%	0.0	0.0	0.5	0.0	0.5		
	AB	NNU	18	12.5	96%	0.0	0.0	0.0	0.0	0.0		
	AB	CHW	18	11.8	98%	0.0	0.0	0.0	0.5	0.5		
	AB	COU/CSU	21	9.4	98%	0.5	0.0	1.0	1.0	2.5		
	SS	G5	24	7.6	89%	1.0	0.0	1.0	0.5	2.5		
	SS	M1	26	15.8	88%	0.0	1.0	1.0	1.0	3.0		
	SS	M2	18	7.2	84%	1.0	2.0	2.0	1.0	6.0		
	SS	CDS	14	23.2	87%	1.0	0.0	1.0	1.0	3.0		
	SS	A2	18	13.7	87%	1.0	2.0	1.0	0.5	4.5		
	SS	A2L	6	23.3	89%	1.0	0.0	1.5	1.0	3.5		
					91%							

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

The data for July 2018, demonstrates that the actual available hours compared to planned hours were;

- Within 5% 22 wards (55%) 3 less than June
- Between 5-10% 7 wards (17.5%) the same as June
- Surpluses over 10% 4 wards (10%) 1 less than June
- Deficits over 10% 7 wards (17.5%) 4 more than June

The wards where there were deficits in excess of 10% of the planned hours in July 2018, are ITU at BDGH, Ward G5 and all of Maternity Unit locations. When there have been lower levels of bed occupancy these areas have supported safe staffing in other departments. ITU at BDGH had a reduced occupancy so staff were redeployed. Ward G5 and the maternity locations have an increased sickness absence rate and vacancies, some of which will be improved over September and October with newly qualified recruitment.

The wards with surpluses in excess of 10% in July were Wards 20, CCU/C2, C1 and 25. These are due to enhanced care needs.

Quality and Safety Profile

There are no wards flagging as Red on Quality in the May Quality Metrics data.

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Care Hours Per Patient Day (CHPPD) - July 2018 (Month 4)

(Data accurate as at 14/08/2018)

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

Site Name	Registered midwives/ nurses	Care Staff	Overall
BASSETLAW HOSPITAL	4.85	3.56	8.41
DONCASTER ROYAL INFIRMARY	4.47	3.44	7.90
MONTAGU HOSPITAL	2.47	2.66	5.13
TRUST	4.41	3.41	7.82

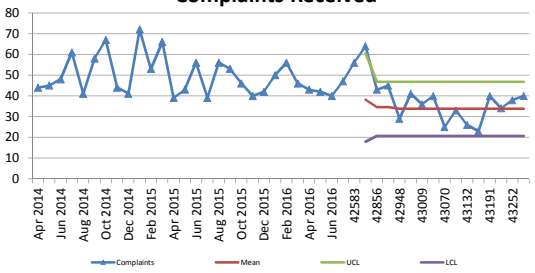
The CHPPD care hours data for July 2018 shows a slight improvement from June 2018 across the registered and non-registered workforce and across all sites

Complaints & Claims - July 2018 (Month 3)

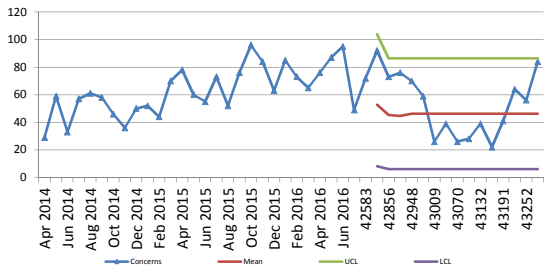
(Data accurate as at 09/08/2018

Complaints

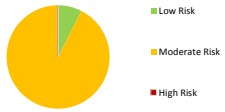
Complaints Received



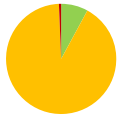
Concerns Received



July 2018 Complaints Received Risk Breakdown



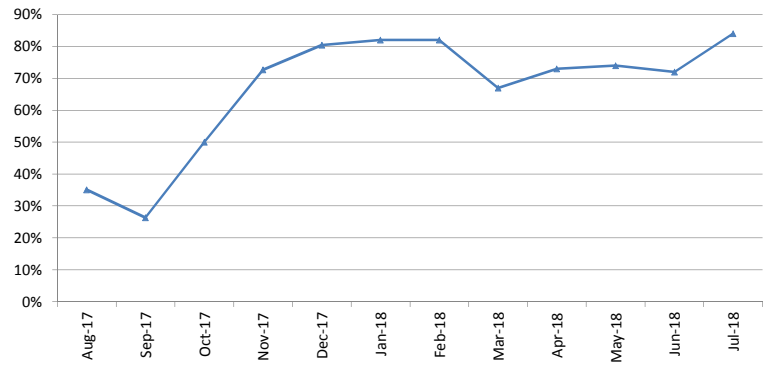
Year to Date Complaints Received Risk Breakdown



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 (PHSO)

Month	Number of cases referred for investigation	Number Currently Outstanding
Jul-18	3	3

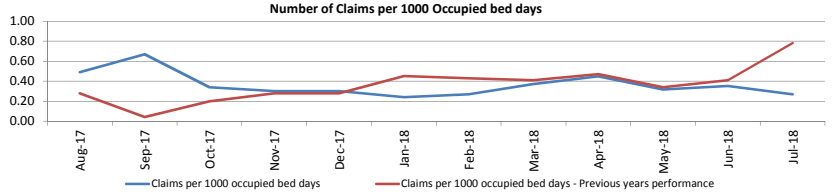
	Number referred for investigation YTD	Outcomes YTD	
2016/17	8	Outstanding	0
2017/18	7	Fully / Partially Upheld	2
		Not Upheld	1
		No further Investigation	0
		Case Withdrawn	0
		Not Investigated	2
		Outstanding	2
2018/19	3	Fully / Partially Upheld	0
		Not Upheld	0
		No further Investigation	0
		Case Withdrawn	0
		Outstanding	3

Claims

		Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	YTD
Clinical Negligence Scheme for Trusts (CNST) Not including Disclosures	2018/19	10	7	8	6									31
	2017/18	11	8	8	18	11	15	8	9	7	6	6	9	116
Liabilities to Third Parties Scheme (LTPS)	2018/19	1	6	2	1									10
	2017/18	2	3	1	1	1	1	1	3	1	2	2	2	20

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

Number of Claims per 1000 Occupied bed days

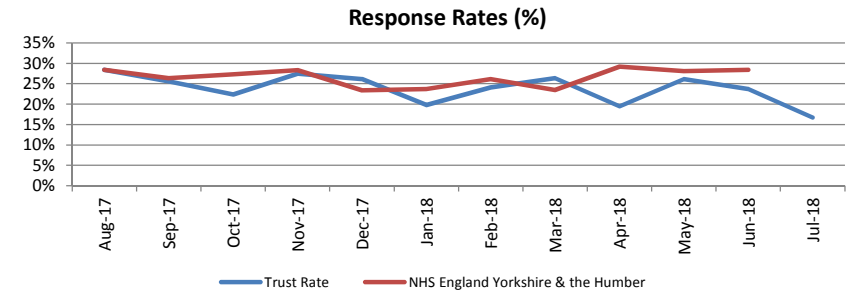


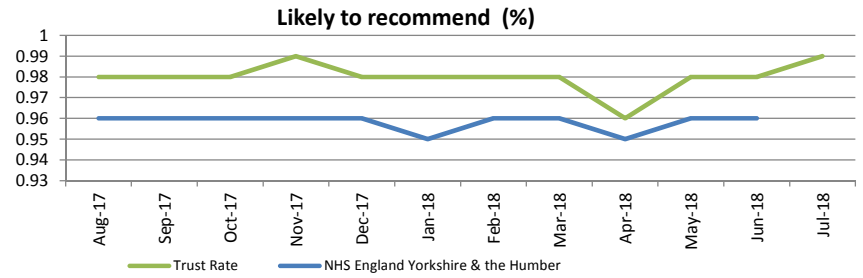
Friends & Family - July 2018 (Month 4)

(Data accurate as at 09/08/2018)

Inpatients

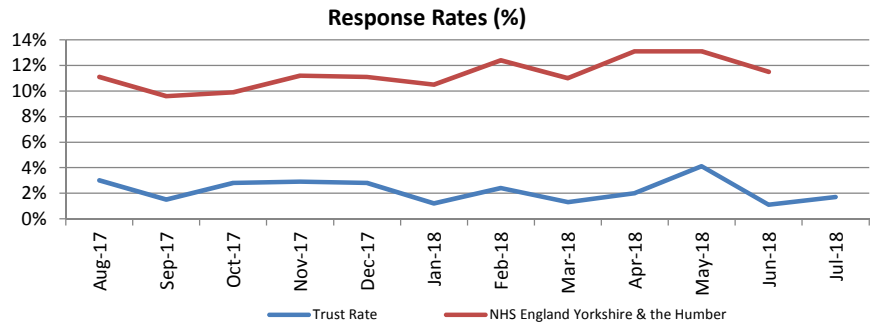
Please note: At the time of producing this report no further benchmarking data is available from NHS England.

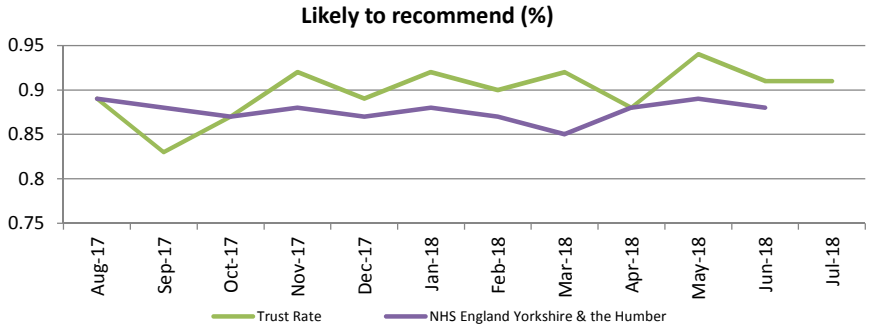




Accident & Emergency

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





Executive summary - Workforce - August 2018 (Month 5)

Sickness absence

Following a rise in rates in July rates have reduced in August to 4.11% (similar to the same period last year) with a cumulative figure of 4.17%. There has been a drop in long term cases ie those in excess of 6 months absence and also a reduction in numbers of staff with a Bradford factor in excess of 1000. Both these measures are pleasing to see.

Appraisals

The Trusts appraisal completion rate has maintained at 78.85% as at the end of August 2018 following the end of the appraisal season with all Care Groups and Directorates bar one now above 70% . As some areas had appraisals already scheduled for September we will continue to review the data and provide updates. Plans are now commencing for next year's appraisal season whcih will also take account of the national work in respect of the national approach to pay progression following this year's Agenda for change pay framework.

SET

SET compliance is currently 82.49% as at the end of August. Specific focus continues on topics where compliance rates are lower and with the new Divisions where compliance rates are low and is included in the CQC action plans.

Staff in post

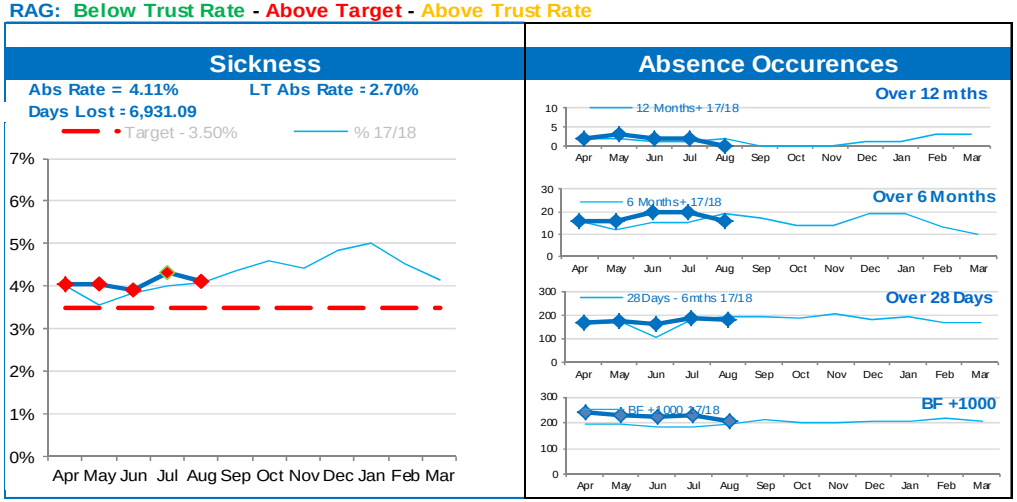
Please see attached tab covering staff in post by staff group. Vacancy rates are provided to both Finance & Performance and Quality & Effectiveness Committees.

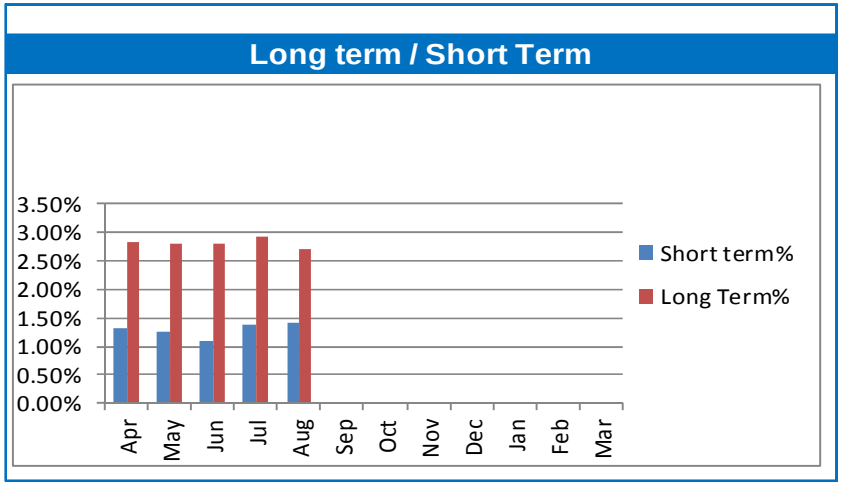
Next month the data will be provided by Divisional structure.

Workforce: Sickness Absence - June (Month 3)

CG & Directorate Sickness Absence - August 2018 (Q2)

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



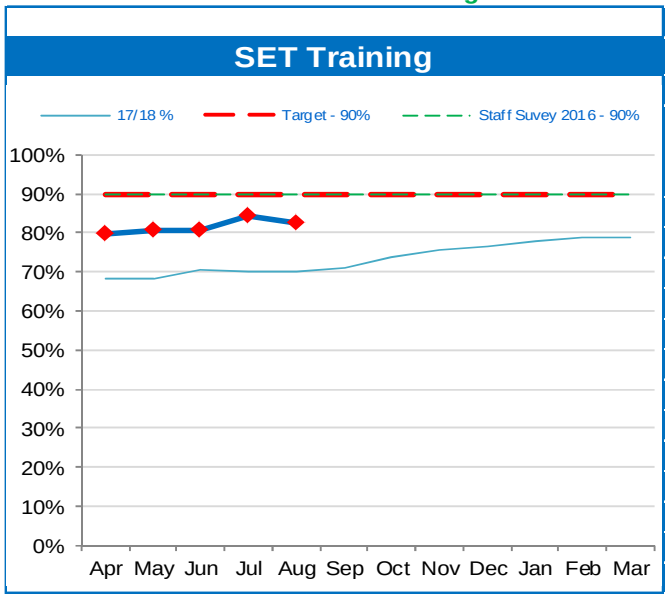


	Apr-18		May-18		Jun-18		Jul-18		Aug-18		Cumulative	
	Days Lost	% Rate	Days Lost	% Rate	Days Lost	% Rate	Days Lost	% Rate	Days Lost	% Rate	Days Lost	% Rate
Doncaster & Bassetlaw Teaching Hospitals NHS FT	**6573.09**	**4.05%**	**6782.86**	**4.05%**	**6343.29**	**3.91%**	**7225.51**	**4.32%**	**6931.09**	**4.11%**	**34,540.51**	**4.17%**
Chief Executive Directorate	14.00	2.83%	27.76	5.43%	18.80	3.86%	0.00	0.00%	0.00	0.00%	60.56	2.40%
Children & Family Care Group	854.61	4.72%	878.00	4.73%	653.38	3.68%	770.54	4.20%	811.08	4.42%	3,882.14	4.26%
Diagnostic & Pharmacy Care Group	388.08	2.23%	408.78	2.27%	450.51	2.61%	597.21	3.36%	585.13	3.25%	2,492.52	2.82%
Directorate Of Strategy & Improvement	0.00	0.00%	2.00	1.72%	0.00	0.00%	1.00	0.80%	0.00	0.00%	3.00	0.49%
Emergency Care Group	907.84	4.25%	1030.66	4.64%	844.54	3.96%	918.24	4.17%	868.97	3.91%	4,632.27	4.25%
Estates & Facilities Directorate	813.73	5.72%	764.00	5.20%	739.59	5.18%	878.47	5.94%	830.77	5.70%	4,045.93	5.57%
Recharge Medics	0.00	0.00%	1.00	0.07%	2.00	0.14%	0.00	0.00%	0.00	0.00%	3.00	0.04%
Finance & Healthcare Contracting Directorate	79.92	3.03%	36.00	1.35%	60.27	2.35%	29.07	1.13%	14.60	0.56%	227.78	1.74%
IT Information & Telecoms Directorate	40.58	1.26%	100.89	3.07%	92.50	2.87%	135.81	4.02%	94.93	2.80%	558.73	3.39%
MSK & Frailty Care Group	847.65	3.47%	937.93	3.69%	772.42	3.13%	754.40	2.98%	890.03	3.52%	4,190.71	3.35%
Medical Director Directorate	0.00	0.00%	7.70	1.32%	23.40	4.17%	23.15	4.15%	23.15	4.15%	94.43	3.35%
Nursing Services Directorate	78.80	4.49%	54.03	3.03%	100.60	5.80%	111.84	6.18%	92.40	5.03%	462.21	5.18%
People & Organisational Development Directorate	127.60	4.25%	93.36	2.97%	76.80	2.55%	93.69	2.98%	3.51	0.11%	453.51	2.95%
Performance Management Directorate	116.15	2.22%	83.90	1.57%	151.34	2.93%	277.01	5.23%	200.33	3.85%	1,176.70	4.48%
Speciality Services Care Group	771.57	4.23%	864.56	4.56%	778.92	4.24%	889.51	4.71%	883.90	4.67%	4,230.53	4.53%
Surgical Care Group	1532.57	5.12%	1492.29	4.83%	1578.22	5.24%	1745.58	5.60%	1632.29	5.25%	8,026.47	5.24%

Workforce: SET Training - July (Month 4)

CG & Directorate SET Training - August 2018 (Q2)

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

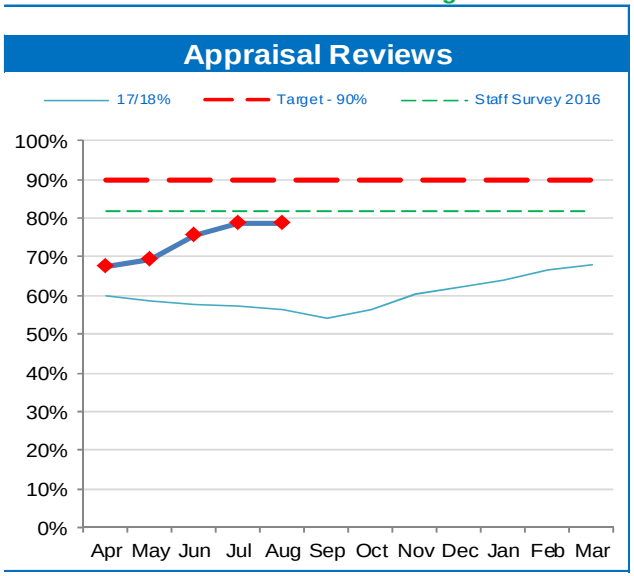


	% Compliance
Doncaster & Bassetlaw Teaching Hospitals NHS FT	**82.49%**
Chief Executive Directorate	**89.44%**
Children & Family Care Group	**85.58%**
Diagnostic & Pharmacy Care Group	**90.99%**
Directorate Of Strategy & Improvement	**95.00%**
Emergency Care Group	**74.61%**
Estates & Facilities	**77.60%**
Finance & Healthcare Contracting Directorate	**93.47%**
IT Information & Telecoms Directorate	**88.97%**
MSK & Frailty Care Group	**84.69%**
Medical Director Directorate	**95.24%**
Nursing Services Directorate	**91.89%**
People & Organisational Directorate	**97.21%**
Performance Directorate	**79.41%**
Speciality Services Care Group	**81.25%**
Surgical Care Group	**79.93%**

Workforce: Appraisals - July (Month 4)

CG & Directorate Appraisals - August 2018 (Q2)

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



Trust Total

	% Completed
Doncaster & Bassetlaw Teaching Hospitals NHS FT	**78.85**
Chief Executive Directorate	**100.00**
Children & Family Care Group	**79.34**
Diagnostic & Pharmacy Care Group	**79.93**
Directorate Of Strategy & Improvement	**100.00**
Emergency Care Group	**72.78**
Estates & Facilities	**94.07**
Finance & Healthcare Contracting Directorate	**98.61**
IT Information & Telecoms Directorate	**91.82**
MSK & Frailty Care Group	**81.36**
Medical Director Directorate	**77.27**
Nursing Services Directorate	**89.39**
People & Organisational Directorate	**95.40**
Performance Directorate	**79.48**
Speciality Services Care Group	**66.61**
Surgical Care Group	**73.39**

Workforce: Staff in post - June (Month 3)

	FTE	Headcount	FTE	Headcount	FTE	Headcount	FTE	Headcount	FTE	Headcount	FTE	Headcount	FTE	Headcount	FTE	Headcount	FTE	Headcount	FTE	Headcount	FTE	Headcount	FTE	Headcount
Staff Group	**Sep-17**		**Oct-17**		**Nov-17**		**Dec-17**		**Jan-18**		**Feb-18**		**Mar-18**		**Apr-18**		**May-18**		**Jun-18**		**Jul-18**		**Aug-18**	
Add Prof Scientific and Technic	171.70	187.00	171.90	187.00	171.47	187.00	170.77	185.00	173.47	189.00	172.47	189.00	172.21	189.00	168.86	187.00	160.58	177.00	169.69	187.00	170.63	188.00	172.02	190.00
Additional Clinical Services	1,135.30	1,373.00	1,123.63	1,361.00	1,118.74	1,357.00	1,106.22	1,340.00	1,128.45	1,364.00	1,126.47	1,363.00	1,131.05	1,367.00	1,145.20	1,384.00	1,133.01	1,370.00	1,158.83	1,401.00	1,171.05	1,414.00	1,172.67	1,415.00
Administrative and Clerical	1,084.51	1,327.00	1,085.93	1,323.00	1,067.20	1,300.00	1,057.48	1,287.00	1,068.60	1,301.00	1,060.57	1,291.00	1,064.98	1,296.00	1,058.77	1,289.00	1,034.25	1,261.00	1,046.56	1,275.00	1,047.67	1,278.00	1,045.17	1,272.00
Allied Health Professionals	336.40	389.00	333.98	385.00	334.55	386.00	333.48	385.00	333.95	386.00	336.83	389.00	331.95	385.00	329.92	381.00	311.78	360.00	324.52	377.00	321.56	375.00	323.12	376.00
Estates and Ancillary	565.03	821.00	567.59	826.00	569.05	828.00	564.44	820.00	492.84	701.00	492.83	701.00	488.71	695.00	483.68	688.00	478.88	680.00	485.34	692.00	480.84	686.00	476.40	680.00
Healthcare Scientists	122.23	136.00	125.30	139.00	124.90	139.00	122.70	137.00	126.30	141.00	129.10	143.00	125.70	141.00	125.50	141.00	121.30	137.00	124.92	141.00	122.66	139.00	120.78	137.00
Medical and Dental	499.65	633.00	505.78	637.00	504.89	628.00	500.29	597.00	504.54	598.00	509.05	601.00	509.11	600.00	510.17	600.00	500.36	574.00	510.07	583.00	508.07	581.00	554.01	633.00
Nursing and Midwifery Registered	1,568.02	1,821.00	1,580.79	1,831.00	1,577.99	1,829.00	1,559.68	1,809.00	1,603.22	1,862.00	1,598.79	1,859.00	1,598.70	1,861.00	1,591.07	1,856.00	1,530.70	1,792.00	1,578.72	1,846.00	1,573.47	1,840.00	1,564.47	1,828.00
Students	1.44	2.00	8.36	9.00	6.56	7.00	5.56	6.00	3.92	4.00	1.92	2.00	1.92	2.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Grand Total	**5,484.28**	**6,689.00**	**5,503.26**	**6,698.00**	**5,475.34**	**6,661.00**	**5,420.61**	**6,566.00**	**5,435.28**	**6,546.00**	**5,428.03**	**6,538.00**	**5,424.31**	**6,536.00**	**5,413.18**	**6,526.00**	**5,270.87**	**6,351.00**	**5,398.65**	**6,502.00**	**5,395.95**	**6,501.00**	**5,428.64**	**6,531.00**

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Title	**Chair's and NEDs' Report**		
Report to	**Board of Directors**	**Date**	**25 September 2018**
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 August and September 2018 and includes updates on a number of activities.
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 and NEDs' Report – September 2018

Governor election results

Following the recent elections, Bev Marshall, Phil Beavers (both returning) and Linda Espey were elected in Doncaster while Steve Marsh and Sheila Walsh were elected in Bassetlaw. Turnout was 23.1% in Bassetlaw and 14.7% in Doncaster. All those elected will serve a three year term except Sheila who will serve for two years. Their terms of office commence 22 September.

Many thanks again to Nicky Hogarth and Sharon Cook who are stepping down from their roles on 21 September.

The new intake of governors will undertake their induction on 2 October and then we will turn our attention to next year's elections where there will be eight seats up in Doncaster, two in Bassetlaw and three staff governor vacancies (medical and dental, nursing and midwifery and non-clinical).

To encourage a wide variety of candidates for these vacancies we will be holding some information sessions which existing governors are welcome to attend. These will take place on 11 December at Bassetlaw (4pm) and on 10 January at Doncaster (5pm). Further information will follow shortly.

Annual members' meeting and STAR awards

It was a busy two consecutive evenings at the Keepmoat Stadium for the Trust.

Thank you to everyone who attended and organised last Wednesday's annual members meeting and particularly to Richard, Jon, Marie, Hazel and Phil as well as everyone who displayed the work of the Trust over the past 12 months. It was a really well attended event with some excellent engagement and gave us as a Board plenty to think about.

The following day it was an honour and privilege to host the 2018 STAR Awards. Congratulations to all the winners and nominees and to those who organised another successful event.

From this month, I will be writing a regular column for Buzz with the first one focused on the STAR awards. Please keep your eyes peeled and let me have your thoughts and feedback via Adam Tingle.

Governor update

Thank you to Neil Rhodes for stepping in for me at the recent Governor Brief where Moira Hardy covered the Trust's performance in the PLACE assessments as well as the recent catering audits.

In addition, we held a successful governor timeout on 6 September. My thanks in particular to:

- Cindy Storer, Beth Cotton and Esther Lockwood from the Person-centred care team
- Steve Roberts, Malcom Waring and Trevor Burton from the Hospital Radio Team
- Linn Phipps who took the holding to account session
- David Purdue and Lesley Hammond who explored why people attend ED

The session provided lots of food for thought and we will be looking to do some further engagement, particularly with the first two sessions, at Board and with governors.

Before the Timeout, I met with governors to plan October's Council of Governors meeting.

Other meetings this month

In August I met with Andrew Morgan, our regional contact for NHS Improvement, to discuss a range of issues. This was followed by a meeting with Yvonne Woodcock of the Doncaster Cancer Detection Trust who are supporting the Trust in its purchase of a new CT scanner as part of the wider ICS work.

Other meetings in September included:

- Alasdair Strachan, Director of Education, around the widening participation agenda covered at Board of Directors in July
- Committees in common workshop for ICS governance arrangements, prior to which I held a 1-2-1 with Sir Andrew Cash in his role as ICS CEO
- Committees in common planning group for workshop on governance
- NHS Providers Board meeting
- One-to-ones with Alan, Kath and Linn
- One-to-one with David Critchton, Chair of Doncaster CCG
- Opening of the new Changing Places rooms at Bassetlaw

In addition, I have supported Yorkshire Ambulance Service in their appointments process for a new non-executive director.

NED Reports

Pat Drake

Pat Drake attended the Governors briefing and had a separate discussion with Mike Addenbrooke. She also attended a meeting with the senior sisters in the Children's Services and discussed the role of a NED with them. They are excellent role models for our services. She also took the opportunity to visit the Children's Outpatient Department and met with fellow NEDs Linn and Sheena to discuss the Quality Effectiveness Committee. She also attended the Annual Members Meeting.

Kath Smart

Kath has started with the buddying arrangements with Medicine Division, seeing one of the daily operations meetings in action which are used to manage patient flow through the Trust. She has also visited the new extended ED at DRI to see the new service and facilities and meet some of the staff, and has encouraged staff to apply to Charitable funds in order to improve the newly refurbished staff and patient environment.

She has also accompanied Trust staff on four patient food audits (mini-PLACE assessments) at DRI, Bassetlaw and Montague sites, & has provided feedback into the Director of Estates. In the main she found the food to be of a reasonable standard, with 1 or 2 exceptions which have been fed back. Issues highlighted during the audits were mainly around missing meals, incorrect meals, trolley stacked incorrectly etc and the team are working on capturing these issues and working with Sodexho to improve.

Kath has also had 1:1 meetings with Suzy Brain-England, Rob Fenton (KMPG), Mark Bishop (LCFS), and Simon Marsh, as well as attending the Annual Members Meeting.

Alan Chan

Alan met with Richard Somerset to run through CIPs and procurement exercises to improve cost and efficiency as well as intro to procurement function. Alan and Richard have agreed to meet quarterly to run through progress on CIPs and new procurement initiatives as well as key procurement exercises.

Alan met with buddies, David Purdue and Marie Purdue. AC is attending the T&O Improvement Event Report Out meeting next week. Alan and Sheena discussing charitable funds processes relating to expenditure nominations and actions list created to clarify process and create communications to Trust.

Alan has made contact with Trevor Burton, Trust AM, to discuss challenges and opportunities with the Trust radio broadcast and how we may be able to improve its reach and subsidise costs. Alan is visiting the studio in September.

Linn Phipps

Linn was very pleased to attend NHS EXPO. Lots of IT based innovations were showcased. This included dementia monitoring at home which is keeping people with UTIs out of hospital through monitoring, early detection and intervention.

Linn attended the recent Governors' timeout to be held to account by Governors. This was a really enjoyable (and challenging!) event and involved rotating round four tables and discussing contributions to the Trust and future quality vision. Lots of good ideas on quality from Governors on which to pick up.

QEC is always looking at ways to improve and innovate. Linn met up with our two new QEC NEDs to share ideas on this.

Chief Executive's Report
25 September 2018

Preparations for a 'no deal' Brexit

The Secretary of State, Matt Hancock MP, wrote to trusts on 17 August to set out an update on the Government's ongoing preparations for a March 2019 'no deal' Brexit scenario and what the health and care system needed to consider as the country steps up preparations over the autumn and in the period leading up to March 2019.

This is an issue the Board has itself considered and issues around medicines supply is also on our risk register. The key points from the letter are as follows:

- In the unlikely event Britain leaves the EU without a deal in March 2019, based on the current cross-Government planning scenario, they will ensure the UK has an additional six weeks supply of medicines in case imports from the EU through certain routes are affected.

- Hospitals, GPs and community pharmacies throughout the UK do not need to take any steps to stockpile additional medicines, beyond their business as usual stock levels. There is also no need for clinicians to write longer NHS prescriptions. Local stockpiling is not necessary and any incidences involving the over ordering of medicines will be investigated and followed up with the relevant Chief or Responsible Pharmacist directly.

- Clinicians should advise patients that the Government has plans in place to ensure a continued supply of medicines to patients from the moment we leave the EU. Patients will not need to and should not seek to store additional medicines at home.

- The Government is also putting in place measures to manage the other potential implications for the health and care sector, including, for example, future immigration rules; continuity of research funding and pan-European clinical and research collaborations; and future reciprocal healthcare arrangements.

In the meantime, David Purdue, in his capacity as Accountable Emergency Officer, is pulling together the Trust's own 'Brexit Plan' based on nine work-streams and details will be shared in due course.

Trust hosts research week

At the beginning of October, DBTH will be hosting a week-long event dedicated to raising the profile of research within the organisation.

In support of this event, a number of drop-in sessions, information boards and showcases have been organised to take place between 1 October and 5 October. These have been scheduled across our sites at Doncaster, Bassetlaw and Mexborough, so that everyone has the opportunity to take part.

The hope is that these sessions will illuminate how research is a vital function, not just within our Trust locally, but also within the NHS as a whole. Indeed, attendees will come to appreciate how- among other things- research can:

- Advance healthcare
- Enable staff recruitment and retention
- Generate income
- Enhance the Trust's reputation
- Drive and maintain efficient clinical services
- Increase evidence based practice
- Improve quality, safety and efficiency
- Facilitate better patient outcomes
- Promote clinical excellence

Winter Planning

On 13 September, the Government and other national bodies made a series of announcements related to winter planning in the NHS.

These announcements related to:

- An announcement from the Department of Health and Social Care that £145 will be made available for some trusts to improve emergency care this winter.
- Letters reiterating ambitions for this year's winter planning and guidance on levels of healthcare worker flu vaccination.
- Publication of the NHS Improvement review of 2017/8 winter pressures.

In addition, NHS Improvement have set out their winter priorities which included calling for the elimination of corridor care and better triaging of patients.

These issues will be covered in more detail in the Deputy Chief Executive and Chief Operating Officer's presentation which will be received earlier on the agenda.

Five tests for a long-term NHS

Last month we had the NHS England and NHS Improvement 10 year plan. This month we have NHS Providers' five point plan for a long term NHS.

The NHSE/ NHSI plan intends to set a bold and ambitious vision for the next ten years with investment in more integrated models of care, noting that the current model of care is no longer sustainable. At the same time, it must reset what is asked of providers so that the vast majority of trusts, performing well, can deliver the day to day operational and financial task they are set.

The plan aims to set out where the NHS needs to be and how it will get there, but be firmly grounded in the reality of where the NHS currently is, given the workforce, financial and operational challenges we currently face.

The five tests for the long-term plan are:

- The plan is centred around patients, service users, carers and families
- The plan is realistic and deliverable
- The plan is underpinned by a credible workforce strategy
- The plan lays the groundwork for a transformed, sustainable, high-performing service
- The plan supports local good governance, autonomy and accountability

These tests are focused on establishing the building blocks of an ambitious and sustainable public service. The new plan aims to present a significant opportunity for the health service and can set out a clear and achievable path for sustaining and improving patient care, cementing political and public trust in the NHS, and underpinning a high performing public service.

CQC aims to support quality improvement

Earlier in the month, the CQC published Quality improvement in hospital trusts - Sharing learning from trusts on a journey of QI.

The report is aimed at senior leaders in healthcare organisations, particularly trust boards, considering adopting organisation-wide structured quality improvement (QI) as a strategic priority, just as we have done at DBTH and some of the work we have undertaken is referenced in the document.

It focuses on leadership alongside the behavioural and cultural aspects of hospitals that have built and embedded a QI and aims to share learning to inspire and encourage wider improvement in the quality of care delivered. It contains many good examples of how trusts are using structured QI approaches.

More money for digital exemplars

At the Health and Care Innovation Expo in Manchester earlier in the month, the Secretary of State, Matt Hancock MP, announced that a further round of trusts would join the 25 already part of the flagship "global digital exemplar" programme. As part of it, a further round of £200m would be distributed to some of the most advanced digital trusts in the country.

The trusts will share the £200m, which they would be expected to match locally through to 2020-21. The intention is that they provide models for other, less advanced, trusts to follow. It is not clear how many trusts will be picked in this latest round, but they will include hospital, mental health, community and ambulance trusts.

It is the second major tranche of digital investment to be approved by the Treasury since Mr Hancock started in July. In his maiden speech, he announced a £412m digital fund for sustainability and transformation partnerships.

Mr Hancock also announced that a further five pilots of the national NHS app for patients will get underway by the end of month, ahead of a national roll out in December. It is the second round of pilots for NHS apps, with Babylon Healthcare and eConsult involved in pilots in London late last year. The new pilots are in Liverpool, Hastings, Bristol, Staffordshire and South Worcestershire. The app will allow patients to book GP appointments, share data preferences and access NHS 111. In total, the pilots will cover 239,000 people.

Sharing How We Care

This month we introduced a new newsletter, *Sharing How We Care*.

In care settings things can and will go wrong, but it is how we respond and ensure that we learn from any incidents and challenges that defines us as an organisation and team. By sharing how we care, we can understand where we have succeeded or failed and how we can form positive patterns or break bad habits.

Sharing How We Care is a monthly reminder of how, as a member of Team DBTH, we can make the difference in keeping our patients safe.

This monthly newsletter will also form part of the annual Sharing How We Care Conference. This year we heard from Dr Kate Allatt, while also sharing innovations and best practice in and around the Trust.

Next year's conference is already in the planning stage and will be on 5 April 2019.

The first edition of *Sharing How We Care* has seen 2000 unique readers with an average reading time of 4min50sec.

Listening events

Last week I began the latest round of listening events. The events were well attended with some great engagement from staff. The next event is on 28 September at 3.30pm in the Lecture Theatre at DRI. Anyone is welcome to join it.

Lord Prior appointed NHS England Chair

David Prior will take over as chairman of NHS England this autumn.

He served as MP of north Norfolk between 1997 and 2001, and in 2002 was made chairman of the Norfolk and Norwich University Hospital. He also held a top job as chairman at the regulator the Care Quality Commission from 2013, before being appointed as parliamentary under-secretary of state for health in David Cameron's government.

STAR Awards

Finally, congratulations to everyone who was a winner or was nominated at this year's STAR Awards, to everyone who was involved in its organisation, to our presenters and our sponsors.

DONCASTER & BASSETLAW TEACHING HOSPITALS NHS FOUNDATION TRUST

Minutes of the Finance & Performance Committee
held at 9:00am Monday 20 August 2018
in the Boardroom, DRI

PRESENT	:	Neil Rhodes, Non-Executive Director (Chair) Pat Drake, Non-Executive Director (part from 11am) Kath Smart, Non-Executive Director Jon Sargeant, Director of Finance Karen Barnard, Director of People & Organisational Development David Purdue, Chief Operating Officer
ALSO IN ATTENDANCE:		Ruth Bruce, Head of Performance (part) Matthew Kane, Trust Board Secretary Alex Crickmar, Deputy Director of Finance Marie Purdue, Director of Strategy & Transformation Richard Somerset, Acting Head of Procurement Kate Sullivan, Corporate Governance Officer
OBSERVERS	:	Bev Marshall, Governor Observer Rob Fenton, Internal Audit Rob Elston, HSDU Manager
APOLOGIES	:	None

Action

Apologies for Absence

18/8/1 Pat Drake would arrive at 11am. Introductions were made around the table.

Action Notes from Previous Meeting

18/8/2 18/4/18 – Non-executive Directors (NEDs) would meet to consider how NEDs future oversight and understanding of CIPs including the balance of oversight versus involvement would take place. **NEDS**

18/7/19 – It had been agreed to provide an update on non-medical waits in the performance report; it was agreed this would be done quarterly commencing from October. **DP**

Any Other Business

18/8/3 None raised.

Hospital Sterilisation and Decontamination Unit (HSDU)

18/8/4 The Committee received the report of the Director of Facilities & Estates which proposed the outsourcing of HSDU services for the Trust. She gave an overview of the background to the proposal and the case for change; the project came about in response to the requirement for the Trust to ensure its decontamination

service provided the best quality and value. In late 2015, a high level internal review made the case for the market testing of the HSDU at the Doncaster Royal Infirmary (DRI). The drivers for the review were that the decontamination service model had not been reviewed for nearly two decades and there was a belief that the Trust's surgical instrument stock was not being used resourcefully. There was a need for significant capital investment in replacement washers and sterilisers and the Trust needed to ensure the sustainability of the decontamination service and meet current and reasonably foreseeable regulatory requirements. In May 2017 the Trust issued an Official Journal of the European Union (OJEU) advertisement for the provision of decontamination services. Following a lengthy and detailed evaluation, STERIS Instrument Management Services (STERIS IMS) had been selected as the preferred bidder.

18/8/5 The Trust had undertaken significant validation to ensure it would not be exposed to financial risk going forward. The case had been reviewed by Internal Audit (IA) twice; on both occasions the Trust had received significant assurance. By outsourcing the service the Trust would transfer all risks associated with the decontamination of surgical instruments, and release valuable space within a clinical area adjacent to theatres. The bid represented cost avoidance benefit of £4.8m over the life of the contract when compared to the Public Sector Comparator (PSC). Although the contract gave rise to a direct cost pressure from overheads of £912k over the life of the contract or £61k per annum, there was the opportunity to mitigate this with savings generated from variant bids for Pre-Sterile Consumables and Loan Kits. Savings initiatives had been identified and risk assessed at 50%, totalling £823k over the life of the contract, which would therefore reduce the cost pressure to £90k over the life of the contract, or £6k per annum.

18/8/6 It was noted that 38 whole time equivalent (WTE) staff would TUPEd over to STERIS. One member of staff would be retained in the structure and this has been costed in to the model.

18/8/7 Pat Drake had been delayed; she had shared her questions on the proposal with the Chair who raised them on her behalf.

18/8/8 The Committee considered the report in detail. They reviewed the original four options and probed for the rationale behind deciding upon the option to outsource the service and why the Trust considered this to be the best option and this was discussed in detail. The option to outsource gave the maximum resilience in terms of capacity to meet existing and future decontamination demand and backup arrangements in terms of utility supply and it was the most cost-effective way of providing a compliant decontamination service for the next 15 years. It also avoided capital investment on equipment replacement as well as offering a substantial improvement in instrument traceability and the maximum legal and financial transfer of risk. Additionally it opened up a considerable amount of space on the Trust estate for patient services and service reconfiguration.

18/8/9 A key issue identified had been the level of fast tracking requests for sterilised equipment; if this were to continue when the service moved to STERIS it could present a significant cost pressure to the Trust and the Committee asked for

assurance that that the current levels of fast tracking would be mitigated. It was noted that fast tracking requests would not be charged for in the first year of the contract. Currently fast track requests were 1%, the case assumed the worst case scenario assuming fast track requests at 3%. Significant work had been undertaken to triangulate and understand the levels of fast tracking including speaking directly to staff in order to understand the reasons for the behaviour. The Trust had looked at two key questions; have we got enough instrumentation and do we need the level of fast tracking being requested? The investigations showed that there was often sufficient equipment and that the current levels of fast tracking were not required. By tracing when fast tracked items had actually been used the Trust had been able to make an assessment of what the real fast tracked levels should have been. There was now an increased understanding of why that behaviour was happening and as part of work up to mobilisation the Trust would continue to work on changing that behaviour.

18/8/10 There was a detailed and wide ranging discussion during which the Committee asked for assurance and further information on a number of areas including; the extent of senior clinician buy-in, staff training arrangements, whether staff transferred over to STERIS would retain their NHS Agenda for Change (AfC) terms and conditions, whether the risk of the Trust being liable for future redundancies had been mitigated and, how well STERIS was known to have performed at other trusts, management reporting arrangements and what learning the Trust had taken from previous outsourcing projects, for example the recent outsourcing of catering and payroll.

18/8/11 The Committee was advised that one of the divisional directors was part of project team and work was underway to bring together project mobilisation teams to include senior clinicians. A senior theatre manager and a full time theatre sister were also included in the mobilisation structure to liaise with clinicians. However it was noted that, in spite of being invited to take part in various groups and evaluations, so far, there had been low engagement with clinicians and the Trust. The Chief Operating Officer felt consultant engagement was vital, the lack of engagement should have been escalated to him and the Medical Director; this was discussed and it was agreed to escalate any concerns in future.

18/8/12 In terms of those staff that would be TUPEd over to STERIS the Director of Facilities and Estates gave assurance that the contract set out that staff would retain their AfC terms and conditions. The Committee enquired about how staff felt about the proposals, particularly in terms of relocating to Sheffield or Grimsby and this was discussed. Some staff did not want to transfer to another location and the Trust would do all it could to find them alternative roles in the Trust. STERIS had a good track record with another local Trust and were known to be a reputable company who had looked after staff. The Chief Executive had worked at Sheffield Teaching Hospitals at the time they had outsourced HSDU to STERIS and had been able to provide some valuable feedback on the implementation. Lessons had been learnt from the outsourcing of catering in terms of the level of staff consultation. Assurance was given that this had been built in to mobilisations plans; It was noted that the date for transfer had been deferred from February to April to allow time for, amongst other things, sufficient time for

HR matters to be dealt with. During further discussion it was agreed to provide details of the number of staff that made up the 38WTEs. **KEJ**

18/8/13 The Committee asked for assurance that the contract was based on a secure financial basis and this was discussed. The preferred bid had been evaluated to ensure that it satisfied the requirements of the service specification and that the risk transfer was realisable, fair, and value for money. Advice and opinion on the bid had also been taken from the Trust's Technical Consultant who was familiar with the Department of Health's former National Decontamination Programme, the Trust's legal agents, KPMG (Internal Audit), Sheffield Teaching Hospitals contract management team who had a current decontamination contract with Steris IMS, together with Trust stakeholders from Human Resources, Finance, Estates and Facilitates. The Director of Finance gave assurance that he was comfortable with the financial modelling and KPMG had concurred with this overall. He gave details of a series of meetings that had taken place to review and amend the contract. The biggest concern had been to understand the level of fast track requests and good progress had been made with this. The Deputy Director of Finance gave details of work undertaken which had included a sensitivity analysis and a review of potential risks and variances to KPMGs analysis of the worst case scenario.

18/8/14 Bev Marshall commented that he found it disappointing that the option to retain the service on site had been discounted early on in the project. There was a lot of work to do to bed in the required behavioural changes, particularly in terms of mitigating the financial risk of continued fast track requests, and the Board must ensure that work was done to ensure this happened and that the transition was as smooth as possible. He felt governors needed to understand the case for change, the expected service improvement benefits to the Trust as well as clarity in terms of cost avoidance, savings and ongoing cost pressures for the Trust. Should the Business Case be approved by Board it was agreed to arrange a presentation for Governors. **MK/KEJ**

18/8/15 Reflecting on the case the Committee acknowledged the depth of scrutiny undertaken by executives which was welcomed. The Committee were assured that the case would deliver an outsourced service that was better than the current service with better information and significant capital spend avoidance. A significant area of space would be released on the DRI site and this would potentially be a real enabler for other projects and elements of future proofing the Trust. There had been a lot of discussion and concern about staff and the Committee was assured that a fair deal had been secured for existing Trust staff. It appeared that STERIS were a good partner and the mobilisation plan seemed sensible with a level of retained staff that seemed pragmatic. Clinical buy in was a concern but this had been acknowledged and work would take place to address this. The Chair thanked the Director of Facilities and Estates, Internal Audit and all staff for their hard work on the project.

18/8/16 The Committee SUPPORTED the recommendation to Board of Directors to award a 15year contract to STERIS IMS for the decontamination of surgical instruments and associated products.

CIP Work Stream – Procurement

18/8/17 The Committee received a presentation from Richard Somerset, Acting Head of Procurement, which provided an update on the Procurement CIP Work Stream.

18/8/18 The presentation was included in the papers and it provided an overview of the following:

Outline of the Scheme – The scheme had been to work with all Care Groups and Departments to identify budget releasing saving opportunities whilst maintaining the right level of quality and to review working practices for efficiency savings, analysing opportunities for standardisation and rationalisation.

Objectives - To obtain the best value for money, standardisation and rationalisation of product groups and suppliers, to benchmark existing processes / products in order to incorporate best practice and drive best pricing, to collaborate with neighbouring Trusts to maximise buying power examples.

Outline of the Scheme - The scope of the scheme included all non-pay spend within every area of the Trust. In response to a query from Kath Smart about the level of oversight of non-pay expenditure, Richard Somerset gave assurance that the Trust had good visibility of all non-pay spend including agency costs.

Benefits included financial efficiencies (£1m forecast against a £1.4m target), improved patient experience through providing the right products, an expert procurement team offering support to the Trust, contract management to ensure savings are achieved and monitoring KPIs, Trust wide standardisation of goods and services, enhanced spend data and reports, training and development around SFIs, Single Tender Waivers, obtaining quotes, ability to drive future financial savings through increased work with Working Together Group, to have defined points of contact with procurement team.

Milestones / target / methodology - Forecast savings target of £1.4m in 2018/19, current identified opportunities circa £1m, over 70 CIP projects, over 100 projects in total. An outline of the methodology to identify savings and the largest potential savings was provided.

18/8/19 Clinical Engagement had been an issue but it was getting better. The procurement department had employed a member of the Team who had been a nurse for 20 years. The staff member was working with departmental clinical specialists and this had made a significant difference in terms of the levels of engagement.

18/8/20 Other issues included finding additional saving opportunities which was becoming harder. There were currently £400k unidentified savings to achieve. Work was underway to look at system change work, stock levels and processes to reduce costs.

18/8/21 The Procurement CIP Work Stream presentation was DISCUSSED and NOTED.

Performance Report

18/8/22 The Committee received the report which focussed on the three main performance areas for NHSI compliance; cancer, 4hr access and 18 weeks Referral to Treatment (RTT). It also included performance updates for diagnostics, stroke, cancelled operations and delayed transfers of care. The report also highlighted the ongoing work with care groups and external partners to improve patient outcomes. The Chief Operating Officer (COO) presented the report by exception focussing on challenges. The repot now included clearer exception reporting for each performance area and further data as requested at previous meetings and the Committee welcomed this.

18/8/23 Cancer - The 62 day standard was achieved by the Trust in June at 86.4%, this was an improvement on May's position however there had been delays in Lower GI, Head and Neck, Urology, Lung and Haematology with reasons for the breaches predominantly due to shared care pathways, complex diagnostic pathways or patient choice. June two week wait (2ww) performance had been disappointing at 80.9%; Head and Neck, lower GI, skin, Upper GI and Urology did not achieve the standard in June. Capacity issues were predominantly the issues in Lower GI, Dermatology and Urology as a result of a continued, in some cases significant, increase in referrals. A large number of breaches were carried forward from May due to loss of capacity over the bank holiday. The Capacity and Demand tool continued to be developed, providing a planning tool based on previous referral trends, activity and capacity. Care groups were now using the tool proactively in order to plan 2ww capacity. Weekly Patient Treatment List (PTL) meetings with each specialty were ongoing to jointly track patient booking, pathways and to review breaches. Reflecting on the report the Committee asked for a deep dive in to cancer performance and it was agreed to schedule this for the next meeting. **DP**

18/8/24 4hr Access - The Trust achieved 92.1% in July 2018 against the 4hr access standard of 95%. The Trust saw 15794 attendances in July, which was 1259 more than in July 2017 and 935 more than June 2018. The main reason for breaches at both DRI and Bassetlaw had been waits to see an Emergency Department (ED) doctor, predominantly due to a shortfall in middle grades, 147 breaches were due to bed pressures. The Chief Operating Officer gave details of a survey to be undertaken to understand why people came to ED. This was being supported by partners across PLACE including Ledger Homes who would be surveying its customers.

18/8/25 Referral to Treatment (RTT) - The RTT Target, active waiters below 18 weeks was set at 92%. The DBTH contract for 2018/19 expected the Trust to maintain the March position of 89.1% and the waiting list size to be lower than at the end of March 2018. Though performing above the national average, the Trust position remained at 89.6% in July; the waiting list continued to grow due to number of referrals in to system.

18/8/26 Delayed Transfers of Care - Significant work had been underway in Doncaster and Bassetlaw to improve patient discharge processes, and to reduce the number of medically fit patients waiting in hospital. This work would also impact on the number of formally reported Delayed Transfers of Care (DTOCs). A chart

illustrated the number of reported delayed bed days by site. In terms of super-stranded patients Kath Smart asked if the Trust had found any delays to be inappropriate and this was discussed. A monthly meeting took place to review all patients with a length of stay (LOS) of over 7 days and this included matrons and partners in the community. One of the key issues when it was felt that patients should be discharged was social care, for example housing was a key issue with the reasons for delays in discharge relating to whether it was safe to discharge the patient. He gave assurance that the Trust monitored this and had good oversight of these cases.

18/8/27 Stroke - The Trust level percentage for direct admission to the Stroke Unit had improved significantly to 78.6% in May and this was commended. Performance in May also saw an improvement in the one hour to scan at 66.7% compared to 58.6% for April.

18/8/28 DNAs - In July, the overall did not attend (DNA) rate across the Trust increased to 9.78% compared with the previous month's position at 9.41%.

18/8/29 The Committee reflected on the report in the context of the needs of the Committee and its role in terms of escalating issues to Board. There was good information in the report in terms of analysis of the current position but it would be helpful to think about future trajectories, what issues were anticipated and to include more information about future plans. It was agreed for NEDs to consider this in more detail outside of the meeting and to outline the kind of information that would be helpful to the Committee. This would then be shared with Executives who would develop the report. **NEDs**

18/8/30 The Performance Report was DISCUSSED and NOTED.

Workforce Report

18/8/31 The Director of People and Organisational Development provided an update to the Committee in relation to month 3 (June 2018) including vacancy levels, agency spend and usage, sickness rates, appraisals, SET training, turnover and retention rates and rostering data. The vacancy rate in month 3 was 6.4% against a target of 5%; when taking into account the use of temporary staff there was a 3.5% vacancy rate, although this varied by staff group. Agency spend was now showing a rise which required further investigation. Further analysis of the NHSI benchmarking data was being undertaken and would be included in a future report.

18/8/32 Month 3 sickness levels were 3.91% (and 4.1% cumulative). The report provided a comparison between Care Groups and Directorates and included a comparison of short and long term absences – the cumulative position being 1.11% short term and 2.8% for long term. It was of concern that the number of absences in excess of 6 months had risen and work to understand this was being undertaken. The report continued to provide data from the nursing roster system which was discussed within grip and control meetings and the roster steering group. The extent to which this could be provided for other staff groups will be explored.

18/8/33 Due to timing of availability of data the workforce report used data a month in arrears to the finance report; this was discussed and in response to a request from the Chair it was agreed to take this away and look at whether it would be possible to align the reports in future. **KS/JS**

18/8/34 The Committee focused on the 'at a glance' report which provided details by staff group. The Committee discussed the basis upon which vacancy targets had been set and the Deputy Director of Finance explained how this had been arrived at. There was some more work to do to sense check the data but this was nearly completed. There was also work to do to realign the work to the new divisions and this was being taken forward.

18/8/35 Discussions had taken place with Executive Team colleagues around apportionment of target agency spend based on the target from NHSI. A further iteration of the proposal was being worked on and therefore it was anticipated that targets would be included in next month's at a glance. The NHSI Model Hospital portal had now introduced a temporary staffing section which enabled comparisons with various peer groups including the ICS footprint and regional footprint; the data was not refreshed on a regular basis such that the portal continued to show February and March data. In terms of spend the ICS footprint had a lower median value than the regional; however the data for total spend and specifically medical spend indicated a higher reliance of temporary staff locally than the national position. This now required further analysis and more detail would be received in future reports. Whilst acknowledging that it was a complex issue Kath Smart felt the Committee needed to understand and receive assurance on this issue and this was discussed. The Director of Finance acknowledged this; work was underway to pull all the information together and an action plan would be brought to a future meeting.

18/8/36 Consultant recruitment update - a number of interviews had recently taken place with improving numbers of candidates being shortlisted. Offers had been made to a Stroke Physician, three Orthopaedic Consultants, an Anaesthetist, a Gynaecologist and two Ophthalmologists.

18/8/37 The Workforce Report was DISCUSSED and NOTED.

Finance Report

18/8/38 The Director of Finance presented to the Committee a paper which summarised performance in month 4. In month performance was a deficit of £1.24m, which was £94k adverse to plan. The cumulative position to the end of month 4 was a £7.4m deficit which was 64k adverse to plan. However the Trust needed to achieve a £6.6m deficit to deliver the year end control total, and therefore needed to essentially achieve a better than break even position for the rest of the year.

18/8/39 A key issue was the YTD income position which stood at £2,297k adverse to plan (excluding donated asset income). In month 4, NHS clinical income (including non-PbR drugs) was £301k behind plan. There was concern around income for MSK & Frailty and work was being undertaken to understand this.

18/8/40 There were still significant risks to delivery of the Trust's financial control total, as set out at budget setting, including delivery of CIP which had been back loaded in the plan and significant savings were still required to be identified and delivered. Whilst work continued the gap in the plan was not being closed quickly enough. Also the CCGs were struggling to meet financial plans which could make achieving some of the CIPs more difficult (e.g. block contracts) and the Director of Finance gave further details of this.

18/8/41 There was a significant variance on income growth assumptions of £3.5m between the Trust's financial plan and commissioner assumptions and contract values. Levels of over performance and the further modelling of RTT suggested that with the main commissioners the budget assumptions were fairly robust. Also the financial plan assumed £2m of Commissioner QIPP plans were not delivered. It was too early in the year to determine the impact of this, however the continued under performance against associate CCG's was of concern. The Director of Finance provided details of work on capacity and demand plans. It was key that the Trust only did work it was going to be paid for.

18/8/42 Pay – This was a key area of concern; including recharges pay was £334k adverse to budget in Month 4 (£2,024k YTD); the key variances were set out in the report on page 7. Agency spend was the main area of concern; details of deep dives undertaken to understand this were provided. Issues identified though the deep dives had been escalated to the Medical Director for investigation. This was discussed and in response to a query from Kath Smart about what was involved in terms of the investigation it was clarified that Medical Directors office would bring back a plan.

18/8/43 NHS Pay Award - Details of the impact of the recent NHS pay award were provided; an analysis of the difference between the cost of the pay award and the funding provided had been undertaken. Nationally a 2% variance had been assumed and the Trust had allowed for this however the Trust's own analysis showed the potential cost pressure would be greater than this. NHS Improvement was aware of the potential cost pressure but it was expected that they would only look at the significant outliers so the Trust's gap may not be funded.

18/8/44 CIP - In July 2018, savings of £449k (£402k the previous month) were reported, against a revised plan profile of £585k. For the year to date this was £1,446k against a target of £1,657k, an adverse variance of £211k. Details of performance by work stream was set out on page 10 of the report with local Care Group schemes on page 11. Details of areas of key challenge were provided by the Director of Finance and Chief Operating Officer (COO), these included theatre scheduling and length of stay (LOS). Details of the level of cancellations in Trauma & Orthopaedics (T&O) were provided; there had been an increase when compared to the same time the previous year. This was due to an increase in the number of trauma cases which was having a significant impact on cancellations. The Deputy Director of Finance gave details gave details of a deep dive of T&O to look at levels of outsourcing to the private sector; The Trust had previously taken the decision to reduce the level of outsourcing but this may need to be reconsidered. An overview of escalation meetings with key areas was provided. It

was noted that since the appointment of the new Divisional Director for T&O eight people had come forward to ask to work as Clinical Directors for the Division; this was very encouraging and it was hoped they would being a new energy to T&O.

18/8/45 Details of the overall status of work up was set out in the report and discussed; the Efficiency and Effectiveness Committee had again met twice in the last month and the Chief Executive asked SROs to complete work-up of the larger outstanding 'amber' and 'red' schemes. However a number were still outstanding and, therefore, 1:1 meetings with the Director of Finance would continue in order to obtain finalised plans. A senior clinical lead had been appointed to take forward work with the GiRFT (Getting it Right First Time) opportunities, as part of an overall GiRFT, PLICS (Patient Level Costing) and Model Hospital work stream. Kath Smart raised concern that some work-up remained outstanding; it was key, at this stage in the year, that this work was completed and this was discussed. The Director of Finance was meeting with senior responsible officers and he would provide an update at the next meeting.

18/8/46 The Chair endorsed the new 'bubble' format that had been used to illustrate the RAG ratings for schemes against annual plan and complexity. He had found this very helpful and encouraged the use of this style of reporting more widely; he felt it would be particularly useful to illustrate how schemes were back loaded in this way

18/8/47 Reflecting on the report the Committee considered which CIP schemes it might identify for a deep dive presentation next month. This would be considered further at the F&P planning meeting in September. **Planning group**

18/8/48 The Finance Report was DISCUSSED and the Committee NOTED the risks set out in the paper and that the in-month I&E position was a deficit of £1.249m, which was 94k worse than plan.

Capital Expenditure Programme 2018/19 Update

18/8/49 The Committee considered the report of the Director of Finance (DoF) that provided an update on current performance against the capital plan and proposed a reprioritised capital plan following review of plans in quarter 1.The capital plan for 2018/19 submitted to NHS Improvement was £13,911k. This included all internally funded capital schemes and assumed the CT scanner to support the Hyper Acute Stroke Unit (HASU) changes would be approved and funded nationally. A detailed review had been undertaken by the Executive Team the same month. Key risks associated with the Capital Plan were set out in the paper; these included slippage against plan year to date. A further risk was that the capital plan was reliant on £3m of cash reserves. Failing to deliver the Trust's CIP plan and/or the Trusts Public Sustainability Funding (PSF) trajectory would impact on the available cash. Slippage against the plan was discussed and the Director of Finance gave details of the reasons for slippage with fire enforcement works. There was further discussion in the context of the recently submitted ICS capital bid, it was noted that there had been no further updates on progress.

18/8/50 The Committee NOTED the Capital Expenditure Programme 2018/19 Update.

Wholly Owned Subsidiary Update

18/8/51 An update would be provided at the September meeting. **JS**

Corporate Risk Register and BAF Highlights

18/8/52 The Trust Board Secretary updated the Committee on changes to the Board Assurance Framework (BAF) and Corporate Risk Register (CRR) since the last meeting of the Committee. A list of current risks and their alignment to the respective committees was provided for information. There had been no risks added to the Corporate Risk Register or Board Assurance Framework since the Board meeting on 31 July. Meetings with executives were planned to undertake a full review of their risks in time for ANCR on 19 September. At the last meeting of QEC, assurance was sought that all issues flagged as concerns within the quality assurance report had been risk assessed. A meeting involving the Medical Director and Trust Board Secretary took place on 12 July to review the risks highlighted in June's report to QEC and these were listed on covering page 1 of the risk report; no risks were added as a result.

18/8/53 The Committee considered how risks were linked to reports to the Committee and it was agreed to highlight relevant risks in future papers. The Corporate Risk Register and BAF Highlights was NOTED. **ALL**

Committee Effectiveness review

18/8/54 The Trust was required to evaluate the effectiveness of the board and its committees on an annual basis. Due to the changes to the Committee structure in June 2017, such a review was not undertaken in 2017/18. In 2018/19 Internal Audit would carry out an effectiveness review of the Trust's board committees. The review would consider how the committees were structured including a review of membership, terms of reference and coverage. IA would look at the three main board committees through observation and survey; Audit and Non-Clinical Risk Committee, Finance and Performance Committee, Quality and Effectiveness Committee. A paper setting out the scope of the review was appended to the paper.

18/8/55 The Committee NOTED the report and ENDORSED the review's scope attached as an appendix.

Clinical Strategy Deep Dive

18/8/56 The Committee received the Enabling Strategy Deep Dive presentation of the Clinical Site Strategy from the Chief Operating Officer. It was noted that the presentation had been considered by Management Board earlier in August. The presentation provided an overview of progress to achieve the enabling strategy key milestones. The three Steering Boards were working well. Following the new restructure to four divisions terms of reference were being renewed. An update for each steering board was provided along with details of key challenges, interdependencies, opportunities, benefits realisation, and next steps. The Committee discussed opportunities in the context of the recently submitted ICS capital bid.

18/8/57 Enabling strategy deep dive presentation of the Clinical Site Strategy was NOTED.

Sub-committee Minutes

18/8/58 The minutes of the Cash Committee meeting held on 1 June 2018 and the minutes of the Capital Monitoring Committee meeting held on 21 June 2018 were NOTED.

Minutes of the meeting held on 21 June 2018

18/8/59 The minutes of the meeting held on 21 June 2018 were APPROVED as a correct record.

Items for escalation to the Board of Directors

18/8/60 None

Time and date of next meeting:

Date: 20 September 2018
Time: 9:00am
Venue: Boardroom, DRI

Signed: **…….** **…….**
Neil Rhodes **Date**

APPROVED

Minutes of the Meeting of the Management Board
of
Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust
on
Monday 13 August 2018 at 2:00pm
in the Boardroom, DRI

Present:

Richard Parker (Chair)	Chief Executive
Karen Barnard	Director of People & Organisational Development
Antonia Durham Hall	Divisional Director – Surgical
Eki Emovon	Divisional Director - Children and Families
Moira Hardy	Director of Nursing, Midwifery and Allied Health Professionals
Nick Mallaband	Divisional Director – Emergency
David Purdue	Deputy Chief Executive & Chief Operating Officer
Alex Crickmar	Deputy Director of Finance
Claire Jenkinson	Deputy Chief Operations Officer – Clinical Specialists
Sewa Singh	Medical Director

In attendance:

Howard Timms	Deputy Director of Estates & Facilities
Matthew Kane	Trust Board Secretary
Tim Noble	Deputy Medical Director
Simon Marsh	Chief Information Officer
Gillian Payne	Deputy Medical Director
Marie Purdue	Director of Strategy & Improvement
Emma Challans	Deputy Chief Operating Officer

Apologies:

Jon Sargeant	Director of Finance
Jochen Seidel	Divisional Director – Clinical Specialists
Kirsty Edmondson-Jones	Director of Estates & Facilities

Action

Apologies

MB/18/8/1 Apologies as recorded above were noted.

Minutes of last meeting

MB/18/8/2 The minutes of Management Board on 16 July 2018 were approved as an accurate record with the deletion of Kelly Fairhurst in the list of attendees.

Matters arising and action notes

MB/18/8/3 The action log was reviewed and updated.

18/7/21 – There would be further discussions over the roles of associate specialists and the difference in duties between them and specialty doctors.

18/5/32 – Details of the national guidance in relation to ambulance transfers had been circulated and would form part of winter planning.

18/6/33 – An update would be sought in relation to the fracture clinics update. It was reported that this had been an issue at Bassetlaw with numbers of clinics reducing from five to three.

Clinical Strategy

MB/18/8/4 Management Board received a presentation from the Chief Operating Officer in relation to the Clinical Strategy.

MB/18/8/5 The meeting was advised that the clinical strategy work was underpinned by the three steering groups for urgent and emergency care, elective care and children and families. Moving forward, the terms of reference would require review and the groups would take on more responsibility for operational delivery, ensuring milestones were met.

MB/18/8/6 Details of progress in respect of the three work-streams were given. Key challenges were around the political environment, engagement with clinical staff, interdependencies with clinical specialities, finances both external and internal and links with the Hospital Services Review. The strategy also provided a number of opportunities including joint work with other providers (RDASH and Sheffield Children's), development of System 2020, increased capital development and the chance to use the Trust's improvement practice work to make a real difference operationally. The Trust was also the lead for the Accountable Care Partnership work on urgent and emergency care.

MB/18/8/7 Key benefits to be realised from the work included the move of elective services to Bassetlaw, further development of BDGH/MMH, the Bassetlaw@ work, development of the Tier 2 paediatric service and expansion of ED at DRI.

MB/18/8/8 Further to a question from Antonia Durham Hall, Management Board were updated on the work on the hosted network for chemotherapy where a model was being developed to look at having Doncaster and Weston Park as the leads with consultant led services in Barnsley and Rotherham (and Chesterfield). Such an approach would assist with ongoing oncologist workforce issues and mean some less complex work coming out of Weston Park. A haematology workstream had been considered but not taken forwards.

MB/18/8/9 There was a broader discussion about the hosted network model which had been designed to ensure all trusts in the Integrated Care System led on a particular work-stream. Management Board noted that while such a model was inclusive there was also an argument for allowing the trust who was best placed to lead a work-stream to do it.

MB/18/8/10 The update was NOTED.

Research and Development Strategy

MB/18/8/11 Management Board received the report of the Director of Nursing, Midwifery and Allied Health Professionals which presented the refreshed Research and Development (R&D) Strategy for comment. The current strategy expired in July 2018 and was now required to be refreshed in line with the new strategic direction and enabling strategies.

MB/18/8/12 The deadline for comments was the following day. Management Board were advised of some of the issues relating to R&D's accommodation and that the team had been offered accommodation at both Bassetlaw and Montagu. Further thought was required to reach a solution. In addition, the strategy required further work on the alignment between R&D and teaching and education.

MB/18/8/13 The update was NOTED.

Effective Patient Pathway

MB/18/8/14 Management Board considered a presentation from the Deputy Chief Operating Officer which set out the Trust's work in relation to effective patient pathway.

MB/18/8/15 The first phase of the clinical administration review had uncovered issues with a number of pathway issues including DQ escalation, missing information, lack of real time capture and no structured training in place. As a result, patient experience in communication and access was low and the Trust's did not attend rate was one of worst in the country.

MB/18/8/16 Work was undertaken to listen and understand the issues involved and there was consensus about the need to move to an electronic patient record system. The work also revealed a need for inclusive engagement and clinical leadership, to change the language about pathways, to personalise what it meant for patient, clinician, nurse and admin with assurance that changes through technology would lead to an electronic patient record and this needed to be achieved in the most effective and efficient way.

MB/18/8/17 An effective patient pathway was one that:

- Improved a patient's experience coming to hospital, making their journey more efficient, effective and of higher quality.
- Enhanced and developed integration of organisational systems and clinical practice.
- Introduced new ways of working, supported through digital systems and led by clinical teams.

MB/18/8/18 A short case study was provided to illustrate the key points. Taking this forward would require engagement including clinical team meetings/forums, clinical ambassadors, divisional leadership and delivery and an invested programme with tangible outcomes. It would also require a new structure which worked with the various elements of technology within the pathway.

MB/18/8/19 Key benefits of the project would be improved patient safety, better patient and staff experience, increased efficiency and income, better capacity planning, increased confidence in the waiting list position, reduced patient waiting times, strengthened divisional ownership and management of patient pathways, investment in people, systems and governance and a commitment to introduce an effective patient record system.

MB/18/8/20 Simon Marsh endorsed the project which aligned with the IT Strategy however two key barriers would continue to be funding and culture, the latter leading to unwarranted variation across the Trust. He reiterated that the effective patient pathway was not an IT project but a business project underpinned by effective IT processes.

MB/18/8/21 In response to several questions from the Chief Executive, Management Board were advised that this piece of work was about articulating a patient pathway and how the different elements knitted together. The Trust would know it was successful when it saw good clinical engagement, better DNA rates and smoother referrals. It was accepted that clear key performance indicators would need to be developed to measure outcomes.

MB/18/8/22 Antonia Durham Hall reminded Management Board that a lot of work around patient pathways was already taking place through the clinical steering groups so it was important not duplicate things. Further to a question from Eki Emovon, Management Board were advised that findings from the missed appointments work had been shared and the action plan was delivering key actions.

MB/18/8/23 Management Board thanked the Deputy Chief Operating Officer for the work put in and felt that it needed to be tied into the work being done around improvement practice.

MB/18/8/24 The presentation was NOTED.

Finance Report

MB/18/8/25 Management Board considered a report of the Director of Finance that set out the Trust's financial position at month 3, which was a deficit of £1.5m, favourable against plan in month by £445k. The cumulative position to the end of month 3 was a £6.2m deficit, which was £30k favourable to budget.

MB/18/8/26 The position was achieved after the release of non-recurrent monies of £1.4m in month following the review of prior year accruals being held. This mainly related to accruals for agency doctors (through Holt) which were no longer required following review.

MB/18/8/27 Key risks against delivery of the financial plan were set out in the report. It was noted that the Trust needed to achieve a £6.6m deficit to deliver the year end control total, and therefore needed to achieve a break even or better position for the rest of the year.

MB/18/8/28 Management Board were advised that new divisional financial statements would be sent in the coming days with initial forecasts.

MB/18/8/29 The Chief Executive highlighted the increase in agency spend in Women's and Children's and reminded Management Board that if the Trust veered off plan they could expect greater intervention levels from the centre. He again reiterated his expectation that initiatives such as Getting It Right First Time and Model Hospital would accelerate and bear fruit in terms of cash savings. It was explained that in spite of some questions about the accuracy of the data it could still make a key contribution to the Trust's CIP target.

MB/18/8/30 The Finance Report was NOTED.

Corporate Risk Register

MB/18/8/31 Management Board considered a report of the Trust Board Secretary which set out the latest corporate risk register for consideration.

MB/18/8/32 The report provided an update on the risk from the last meeting relating to lack of interpreters in endoscopy, which had also been raised by radiology in the previous week. The risk particularly related to interpreters for particular languages and meetings were being held with Procurement to look at alternatives including technology. It was anticipated that such mitigations would reduce the risk.

MB/18/8/33 One new extreme risk had been raised through Datix which related to numbers of staff trained in safeguarding which had been raised in the CQC inspection as well.

MB/18/8/34 This led to a broader discussion about the accuracy of the data and Karen Barnard gave an update on what the Trust was doing to improve data accuracy in ESR. In view of the issues around data accuracy, it was not clear whether the risk escalated was a real risk to the Trust. Further work was required to ensure the data on ESR captured the accurate picture. Meanwhile, Moira Hardy would review the risk and determine whether it was in fact a risk to the Trust. **KB / MH**

MB/18/8/35 The Corporate Risk Register was NOTED.

Information Items to note

MB/18/8/36 The Chief Executive's Report, Business Intelligence Repot and minutes from Corporate Investment Group on 2 July 2018 were all NOTED.

Any Other Business

MB/18/8/37 There was a brief discussion about the accrual of leave and the Trust's agreed policy of 'use it or lose it'.

Items for escalation from sub-committees

MB/18/8/38 None.

Date and time of next meeting

MB/18/8/39 The next meeting of Management Board would take place 17 September 2018 at 2pm in the Boardroom.

Board of Directors Agenda Calendar

STANDING ITEMS			OTHER / AD HOC ITEMS
MONTHLY	**QUARTERLY**	**BIANNUAL / ANNUAL**	
SEPTEMBER 2018			
CE Report		Winter Plan	
Performance Report		EPPR	
MB Minutes			
Finance & Performance Minutes			
Finance Report			
Chairs' Assurance Logs			
OCTOBER 2018			
CE Report	ANCR minutes	Charitable Funds minutes	
Performance Report	Executive Team's Objectives	Fred & Ann Green Legacy minutes	
MB Minutes			
Finance & Performance Minutes			
Finance Report			
Chairs' Assurance Logs			
NOVEMBER 2018			
CE Report	QEC minutes	Annual Compliance against the National Core Standards for Emergency Preparedness, Resilience and Response (EPRR)	
Performance Report	Board Assurance Framework & corporate risk register Q2		
MB Minutes	Estates Quarterly Performance		
Finance & Performance Minutes			
Finance Report			
Chairs' Assurance Logs			

As at 16 September 2018

DECEMBER 2018			
CE Report	Report from the Chair of the ANCR committee (Verbal)		
Performance Report			
MB Minutes			
Finance & Performance Minutes			
Finance Report			
Chairs' Assurance Logs			
JANUARY 2019			
CE Report	ANCR minutes (16.12.16)	Budget Setting / Business Planning / Annual Plan	Constitution
Performance Report	Executive Team's Objectives	SOs, SFI, Scheme of Delegation	CT/HASU (part 2)
MB Minutes	Complaints, Compliments, Concerns and Comments Report		Joint working
Finance & Performance Minutes			External reviews policy
Finance Report			
Chairs' Assurance Logs			
FEBRUARY 2019			
CE Report	QEC Minutes	Budget Setting / Business Planning / Annual Plan	Finance Strategy
Performance Report	Board Assurance Framework & corporate risk register Q3		
MB Minutes			
HWB Decision Summary			
Finance & Performance Minutes			
Finance Report			
Chairs' Assurance Logs			

MARCH 2019			
CE Report		Budget Setting / Business Planning / Draft Annual Plan	
Performance Report			
MB Minutes			
HWB Decision Summary			
Finance & Performance Minutes			
Finance Report			
Chairs' Assurance Logs			
APRIL 2019			
CE Report	ANCR minutes	Draft Annual Report	Mandatory training update
Performance Report	Executive Team's Objectives	Draft Quality Account	
MB Minutes	Estates Annual Report	Staff Survey	
HWB Decision Summary	Board Assurance Framework & corporate risk register Q4 (inc. annual assurance summary)		
Finance & Performance Minutes			
Finance Report			
Chairs' Assurance Logs			
MAY 2019			
CE Report	QEC Minutes	Annual Report	
Performance Report		Quality Account	
MB Minutes		Annual accounts	
HWB Decision Summary		ISA260 and quality account assurance	
Finance & Performance Minutes		Charitable Funds minutes	
Finance Report		Mixed Sex Accommodation	
Chairs' Assurance Logs			

JUNE 2019			
CE Report			
Performance Report			
MB Minutes			
Finance & Performance Minutes			
Finance Report			
Chairs' Assurance Logs			
JULY 2019			
CE Report	ANCR Minutes	ANCR Annual Report	
Performance Report	Estates Quarterly Performance		
MB Minutes	Board Assurance Framework		
Finance & Performance Minutes			
Finance Report			
Chairs' Assurance Logs			
AUGUST 2019			
CE Report	QEC minutes		Health and Wellbeing
Performance Report	ANCR Minutes		Missed Appointments
MB Minutes	Executive Team Objectives		
Finance & Performance Minutes			
Finance Report			
Chairs' Assurance Logs			

Minutes of the meeting of the Board of Directors
Held on Tuesday 21 August 2018
In the Boardroom, Doncaster Royal Infirmary

Present:	Suzy Brain England OBE	Chair of the Board
	Karen Barnard	Director of People and Organisational Development
	Alan Chan	Non-executive Director
	Pat Drake	Non-executive Director
	Moira Hardy	Director of Nursing, Midwifery and Allied Health Professionals
	Sheena McDonnell	Non-executive Director
	Richard Parker	Chief Executive
	Linn Phipps	Non-executive Director
	David Purdue	Chief Operating Officer
	Neil Rhodes	Non-executive Director
	Jon Sargeant	Director of Finance
	Kath Smart	Non-executive Director
	Sewa Singh	Medical Director
In attendance:	Kirsty Edmondson-Jones	Director of Estates and Facilities
	Marie Purdue	Director of Strategy and Transformation
	Matthew Kane	Trust Board Secretary
	Adam Tingle	Acting Head of Communications and Engagement
	Clive Tattley	Governor
	Mark Bright	Governor
	Emma Challans	Deputy Chief Operating Officer (part)

ACTION

Welcome and apologies for absence

18/8/1 The Chair welcomed Sheena McDonnell, Non-executive Director, to her first Board meeting.

Declarations of Interest

18/8/2 No interests were declared in the business of the public session of the meeting.

Actions from the previous minutes

18/8/3 The list of actions from previous meetings was noted and updated:

18/01/13 – The Board was advised that details of phase two Teaching Hospital would be contained within the Research and Development Strategy. This action would be closed.

18/7/70 – Following the previous meeting, the Chief Pharmacist had confirmed the Trust was taking all appropriate actions to reduce the impact of Brexit on medicines distribution. External guidance was also expected.

Presentation slot – Missed appointments

18/8/4 The Board considered a presentation from Emma Challans, Deputy Chief Operating Officer, on what the Trust was doing to reduce the number of missed appointments. This followed a similar presentation to Board, given in November 2017.

18/8/5 The review had resulted in four recommendations:

- Enhance communications between providers and patients
- Improve the quality of information provided to patients when attending the hospital
- Improve patient experience and enhance use of digital communication aids
- Increase and improve knowledge to further strengthen patient understanding of services and meeting expectations.

18/8/6 Actions against each of the recommendations were set out and they were all on track.

18/8/7 Further to a question from Pat Drake, the Board was advised that the cost of missed appointments were now being emphasised through social media. There was also the opportunity to make better use of patient stories. Plans for a text reminder service were on track which would potentially free up some capacity within Switchboard.

18/8/8 It was important at the same time to acknowledge that reminders were a mixed economy and that a lot of people still did not use mobile phones. It was suggested that a small card, similar to that used at dentist's surgeries, could be developed in tandem to the text service.

18/8/9 In response to a question from Sheena McDonnell, the Board were advised that availability of patient mobile numbers was a risk and the Trust was taking learning from other areas. At present time, it was important to establish a baseline to which further information could be added. Linn Phipps asked what measures the Trust has or could have of patient experience of DNAs, and of patient outcomes arising from DNAs. The Deputy Chief Operating Officer undertook to find out.

18/8/10 The Chair emphasised the Trust's approach towards inclusivity that included a lot of work around governors. It was key that the missed appointments work was fed back to governors. The Board was advised that a similar presentation was planned for Council of Governors in October.

18/8/11 The Board NOTED the update.

Hospital Sterilisation and Decontamination Unit (HSDU)

18/8/12 The Board considered a report of the Director of Estates and Facilities which sought approval for the Trust to enter into a 15-year contract with STERIS IMS for the decontamination of surgical instruments and associated products.

18/8/13 The Board were advised that, in late 2015, a high-level internal review made the case for the market testing of the Trust's run Hospital Disinfection and Sterilisation Unit (HSDU). In May 2017, the Trust issued an Official Journal of the European Union (OJEU) advertisement for the provision of decontamination services. Following a lengthy and detailed evaluation, STERIS Instrument Management Services (STERIS IMS) were selected as the preferred bidder.

18/8/14 The bid represented a total net present value (NPV) service cost for the 15 year contract of £34.1m, with a NPV benefit to the Trust of £4.8m over the life of the contract when compared to the Public Sector Comparator (PSC).

18/8/15 Board were advised that although the contract gave rise to a direct cost pressure of £912k over the life of the contract or £61k per annum, there was the opportunity to mitigate this with savings generated from variant bids for Pre-Sterile Consumables and Loan Kits. Savings initiatives had been identified and risk assessed at 50%, totalling £823k over the life of the contract, which would therefore reduce the cost pressure to £90k over the life of the contract, or £6k per annum. By outsourcing the service the Trust would transfer all risks associated with the decontamination of surgical instruments, and release valuable space within a clinical area adjacent to theatres.

18/8/16 The report had been considered by the Finance and Performance Committee the previous day and the Chair drew out the following points:

- The proposal was a quality rather than finance focussed proposal.
- Board noted that if the Trust were attempt to run the service in-house then it would need to invest approximately £4.8m. Whilst this proposal resulted in a small cost pressure (at least initially), it negated large capital investment through cost avoidance.
- There had been very good engagement from executives on a range of points. It was clear the Trust had learned lessons from previous contract management work but there was still a need to monitor the transition.
- The proposal aligned with the Integrated Care System and presented a fair deal for staff.
- The proposal, if approved, would also unlock a significant portion of estate that could be used to support transformational projects as outlined in the Trust's clinical site development strategy.

18/8/17 The Board supported the proposal, although further to a point from Alan Chan felt that a middle ground between submitting the full business case and a two-page cover paper would be beneficial for such decisions in future. Linn Phipps, in particular, emphasised the need for an examination of risks. Board was advised that the full business case had been made available to Board members.

18/8/18 Further to a question from Sheena McDonnell, Board was advised of the arrangements for major incidents. In this situation, instruments would be 'fast-tracked' and supplied within four hours for no extra charge.

18/8/19 Board was also advised of the approach to staff engagement in relation to the contract. Board were assured that the approach was different to a previous contracts it had let as STERIS had offered staff transport to the new premises and other benefits and incentives were outlined.

18/8/20 The Board APPROVED the award of the 15-year contract to STERIS IMS for the decontamination of surgical instruments and associated products.

Completion of Contract Documents for Electrical Infrastructure Phase 2 - DRI

18/8/21 The Board considered a report of the Trust Board Secretary that sought permission for the signing under deed of the Stage 3 and Stage 4 NEC3 contracts for phase 2 of the electrical infrastructure bid.

18/8/22 Board was advised that the works were part of the Trust upgrade of its critical electrical infrastructure which was essential in order to increase the supply to the site which was currently at full capacity and continuation of the replacement of High and Low Voltage site infrastructure. The works were commensurate with the programme for the eradication of backlog maintenance and addressed an element of significant risk. The increase in supply was needed to ensure that the site had spare electrical capacity.

18/8/23 Board endorsed the contract for Electrical Infrastructure Phase 2 with IHP and DELEGATED power to the Chief Executive to sign on behalf of the Trust. **RP**

Appointment of Non-executive Director for Speaking Up

18/8/24 The Board considered a report of the Director of People and Organisational Development and Trust Board Secretary that sought the appointment of Pat Drake as non-executive lead for speaking up.

18/8/25 Board was advised that national guidance for boards on Freedom to Speak Up in NHS foundation trusts, and the Trust's own Raising Concerns Policy – We Care, We Listen, We Act, required DBTH to have executive and non-executive lead directors for 'speaking up' (known in the Policy as 'raising concerns' or 'whistleblowing').

18/8/26 Following recent changes on the Board, it was proposed that Pat Drake be appointed to the non-executive position.

18/8/27 There was a brief discussion about the need for an anonymous DBTH email address through which whistle-blowers could report issues. Likewise, the NED proposed for the role was happy for Communications and Engagement to promote her own DBTH email address in correspondence with staff. **KB**

18/8/28 Board APPROVED that Pat Drake be appointed non-executive lead for speaking up with immediate effect.

Use of Trust Seal

18/8/29 Board APPROVED the use of the Trust Seal in the following instances:

Seal No.	Description	Signed	Date of sealing
96	Lease of substation accommodation and easements at Doncaster Royal Infirmary for Northern Powergrid (Yorkshire) Plc	Richard Parker Chief Executive	8 August 2018
		Alex Crickmar Deputy Director of Finance	
97	Deed of variation of the contract for the provision of sexual health services with Nottinghamshire County Council	Richard Parker Chief Executive	8 August 2018
		Alex Crickmar Deputy Director of Finance	
98	Transfer of registered title – former nurses home, Mexborough for CW	Richard Parker Chief Executive	8 August 2018
		Alex Crickmar Deputy Director of Finance	

Chairs Assurance Logs for Board Committees held 20 August 2018

18/8/30 The Board considered a report of the chairs of Finance and Performance Committee and Quality and Effectiveness Committee following their meetings on 20 August 2018.

18/8/31 The Finance and Performance Committee reported a better month financially although effectiveness and efficiency plans of £2.2m were still required. Reporting periods for finance and workforce issues would be married up in future and a discussion was held on developing a performance report that better suited the needs of the Committee and other stakeholders. The Director of Finance provided additional detail on the Performance Report that he would be pulling together in conjunction with executive colleagues.

The meeting adjourned at 11.30am and reconvened at 11.40am.

18/8/32 The Quality and Effectiveness Committee had considered a number of items including the quarter end learning from deaths report, the inpatient survey as well as the usual clinical governance update.

18/8/33 In response to a question from Kath Smart about how the Board stayed close to CQC, the Board was advised that action plans were in place that were being considered by the Clinical Governance Committee who were reporting through to Quality and Effectiveness Committee.

18/8/34 The Board was advised of work that the Executive Team was carrying out on improving its approach to closing down actions. Ultimately the action plans arising from the inspection were the minimum the Trust had to do. It was working up a further action plan to take it to 'outstanding' within two years. The non-executive directors requested sight of the various action plans.

18/8/35 Board NOTED the updates.

Finance Report – July 2018

18/8/36 The Board considered a report of the Director of Finance that set out the Trust's financial position at month 4, which was a deficit of £1.24m, an adverse variance against plan in month of £94k.

18/8/37 The cumulative position to the end of month 4 was a £7.4m deficit, which was £64k adverse to plan. However the Trust needed to achieve a £6.6m deficit to deliver the year-end control total, and therefore needed to achieve a better than break-even position for the rest of the year.

18/8/38 Effectiveness and efficiency plans were behind by £135k in month due to a variety of operational pressures. There was still an unidentified effectiveness and efficiency total of over £2m. Cash was at a comfortable level (£14.8m) following receipt of Public Sustainability Funding (PSF).

18/8/39 Board were alerted to risks against the financial plan, not least the surge in attendances at Accident and Emergency threatened to compromise the Trust's four hour target and, in turn, future PSF monies. This position had gotten more difficult due to NHS England's decision not to allow trusts to count alternative pathways.

18/8/40 Further to a question from the Chair, the Board were advised of the current position with regard to the contract position and discussions with the clinical commissioning group over additional resources to match the demand seen and which the Trust had predicted at the commencement of the year.

18/8/41 Further to a question from Linn Phipps, the Board were advised that in order to be ready for Winter, the Trust needed to be clear on what would be paid for by October 2018. The Board noted the possibility of monies from the centre for Winter but this was as yet uncertain.

18/8/42 In addition to the usual finance report, the Board was asked to approve adjustments to the capital plan. The Trust had been advised that the £3m queried by NHS Improvement could now be used for capital development. The monies required for lift refurbishment, amounting to some £210k, were included in the revised plan along with other changes affecting estates, IT and medical equipment.

18/8/43 The Board:

(1) NOTED the Trust's deficit for month 4 (July 2018) was £1.2m, which was an adverse variance against plan in month of £94k. The cumulative position to the end of month 4 was a £7.4m deficit, which was £64k adverse to plan.

(2) NOTED the progress in closing the gap on the Cost Improvement Programme.

(3) NOTED the risks set out in this paper.

(4) APPROVED the changes to the capital programme.

Performance Report as at 31 July 2018

18/8/44 The Board considered a report of the Chief Operating Officer, Medical Director, Director of Nursing, Midwifery and Allied Health Professionals and Director of People and Organisational Development that set out operational and workforce performance in month 4, 2017/18.

18/8/45 Performance against key metrics included:

- 4 hour access - In July, the Trust achieved 92.1% against the target of 95% - another positive achievement given an increase in monthly attendance of over 1,200 patients.

- RTT – In July the Trust performed better than the contract target, reaching 89.6 – the same as June.

- Cancer targets – The 62 day performance achieved the 85% standard, coming in at 86.4%.

- HSMR – The Trust's rolling 12 month HSMR remained better than expected at 88.7.

- C.Diff – One case was recorded in month and below (better than) year trajectory.

- Nursing workforce - The Trust's overall planned hours versus actual hours worked in July was 99%.

- Appraisal rate – The Trust's appraisal completion rate saw an increase to 78.85%.

- SET training – Once again, there had been an increase in compliance with Statutory and Essential Training (SET) and at the end of July the rate was 81.43%.

- Sickness absence – Year-to-date figure at 4.1%.

18/8/46 The month had seen a further (8%) increase in the number of people attending Accident and Emergency and the Trust was working with local businesses to understand why that was the case.

18/8/47 In response to a question from Linn Phipps, the Board was advised on some of the issues causing delays for two week waits. The Chief Operating Officer was scheduled to bring a deep dive on the issue to a future Finance and Performance Committee.

18/8/48 The Board NOTED the Performance Report.

Reports for Information

18/8/49 The following items were NOTED:

- Guardian for Safe Working Quarterly Report
- Chair and NEDS' report
- Chief Executive's report
- Minutes of Finance and Performance Committee, 23 July 2018
- Minutes of Quality and Effectiveness Committee, 21 June 2018
- Minutes of Management Board, 16 July 2018
- Board of Directors Agenda Calendar

18/8/50 In respect of the report from the Guardian for Safe Working, some issues with regards to not taking breaks had been uncovered and an action plan was in place to address it.

18/8/51 The Board was advised of the Trust's achievement in relation to the latest PLACE assessment with Doncaster and Bassetlaw scoring better than the national average across all of the domains, including in catering.

Items escalated from Sub-Committees

18/8/52 None.

Minutes

18/8/53 The minutes of the meeting of the Board of Directors on 31 July 2018 were APPROVED as a correct record.

Any other business

18/8/54 There were no items of other business raised.

Governors questions regarding business of the meeting

18/8/55 Further to a question from Clive Tattley, the Board was advised of the measures the Trust was taking to improve the reputation of the appointments system.

18/8/56 Mark Bright asked whether the Trust's new sterialisation provider had contamination units on its own site and whether Sheffield Teaching Hospitals (STH) would be prepared to mentor the Trust in the set up. The Chief Executive gave an account of his experience in managing the sterialisation contract at STH and confirmed the presence of sterialisation facilities at STERIS. The Board were advised that the Trust had learned from previous outsourcing exercises and were now actively managing their contracts and managing performance.

18/8/57 In response to a further question from Mark Bright about staffing impact, the Board was advised of the benefits to staff.

Date and time of next meeting

18/8/58 10.00am on Tuesday 25 September 2018 in the Boardroom, Montagu Hospital.

Exclusion of Press and Public

18/8/59 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