Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

The meeting of the Board of Directors

To be held on Tuesday, 29 January 2019 at 10:00am in the Boardroom, Doncaster Royal Infirmary

AGENDA
Part I

		Enclosures	Time
1.	Apologies for absence	(Verbal)	10:00am
2.	Declarations of Interest Members of the Board and others present are reminded that they are required to declare any pecuniary or other interests which they have in relation to any business under consideration at the meeting and to withdraw at the appropriate time. Such a declaration may be made under this item or at such time when the interest becomes known.	(Verbal)	
3.	Actions from the previous meeting	Enclosure A	
4.	Bassetlaw Integrated Care Partnership Update Nicole Chavaudra – ICP Programme Director	Enclosure B	10:05am
	Reports for Decision		
5.	Use of Trust Seal Gareth Jones – Trust Board Secretary	Enclosure C	10:25am
6.	Audit and Risk Committee Terms of Reference / Workplan Kath Smart – Chair of Audit and Risk Committee	Enclosure D	10:30am
7.	Electronic Patient Record Business Case Simon Marsh – Chief Information Officer	Enclosure E	10:35am
	Reports for assurance		
8.	Finance Report as at 31 December 2018 Jon Sargeant – Director of Finance	Enclosure F	10:45am
9.	Control Total 2019/20 Jon Seargant – Director of Finance	Enclosure G	11:00am
10.	NHS Long Term Plan Richard Parker – Chief Executive https://www.longtermplan.nhs.uk/	Verbal	11:20am
	BREAK		11:30am

11.	Annual Planning Priorities Marie Purdue – Director of Strategy and Transformation	Presentation	11:40am
12.	Performance Report – 31 December 2018 Led by David Purdue – Chief Operating Officer	Enclosure H	12:00pm
13.	Widening Participation Framework Karen Barnard – Director of People and Organisational Development	Enclosure I	12:10pm
14.	Estates Quarterly Performance Report Kirsty Edmondson Jones – Director of Estates and Facilities	Enclosure J	12:20pm
15.	Chairs Assurance Logs for Board Committee held 22 January Neil Rhodes – Chair of Finance and Performance Committee	Enclosure K	12:30pm
16.	CQC Inspection Update Moira Hardy – Director of Nursing	Verbal	12:40pm
	Reports for information		
17.	Chair and NEDs' Report Suzy Brain England – Chair	Enclosure L	12:50pm
18.	Chief Executive's Report Richard Parker –Chief Executive	Enclosure M	
19.	Minutes of Management Board, 10 December 2018 Richard Parker – Chief Executive	Enclosure N	
20.	Minutes of Finance and Performance Committee, 23 November 2018 and 17 December 2018 Neil Rhodes – Chair of Finance and Performance Committee	Enclosure O	
21.	Integrated Care System Update Richard Parker – Chief Executive	Enclosure P	1:05pm
22.	Board of Directors Agenda Calendar Gareth Jones – Trust Board Secretary	Enclosure Q	
Minutes			
23.	To approve the minutes of the previous meeting held 18 December 2018	Enclosure R	
24.	**Any other business (to be agreed with the Chair prior to the meeting)**		
25.	**Governor questions regarding the business of the meeting**		1:10pm
26.	**Date and time of next meeting** Date: 26 February 2019 Time: 10.00am Venue: Boardroom, Bassetlaw Hospital		

27. Withdrawal of Press and Public 1:30pm

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

Suzy Brain England
Chair of the Board

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Action Notes

Meeting: Board of Directors

Date of meeting: 18 December 2018

Location: Boardroom, DRI

Attendees: SBE, RP, KB, AC, PD, MH, SMc, LP, DP, NR, JS, SS, KSm, MP, AT, GJ

Apologies: None

No.	Minute No	Action	Responsibility	Target Date	Update
1.	**18/9/51**	QEC to deep dive cancelled operations.	**DP**	~~**December 2018**~~ **Deferred to February 2019**	Not yet due
2.	**18/11/…**	Brexit Preparations - Ensure Brexit is incorporated in to consideration of risk by Board Committees.	**Chairs QEC/F&P/ANCR**	**Future Committee meetings**	Update to be provided at meeting.
3.	**18/11/…**	Audit & Risk Committee (ARC) ToRs to be approved by Board.	**GJ/KS**	**January 2019**	On the agenda

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No.	Minute No	Action	Responsibility	Target Date	Update
4.	**18/11/…**	Board to have clear sight of top clinical risks - Report to be taken to next QEC and update provided at next Board.	**GJ/SS**	**December 2018**	Discussed at QEC and BoD in December 2018. Action completed.
5.	**18/11/…**	**P&OD** - Leadership & Development Framework to next meeting	**KB**	**December 2018**	Completed
		- Agenda for Change - Details of cost to the Trust of transition of Band 1 staff to Band 2 through – To F&P	**KB/JS**	**TBC**	Move to F&P Workplan

Date of next meeting: 29 January 2019
Action notes prepared by: G Jones
Circulation: SBE, RP, KB, MH, DP, JS, SS, MP

Better in Bassetlaw:
Place Plan 2019-2021

DRAFT




BCVS Bassetlaw Community and Voluntary Service

Bassetlaw District Council — North Nottinghamshire —

healthwatch Nottingham & Nottinghamshire

NHS Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

NHS Nottinghamshire Healthcare NHS Foundation Trust

Nottinghamshire County Council

NHS Bassetlaw Clinical Commissioning Group

Bassetlaw Primary Care Homes

Contents

Introduction

This Bassetlaw Place Plan sets out how partners will work together to **deliver improvement in experiences, health and wellbeing for Bassetlaw citizens by 2021, through simpler, integrated, responsive and well understood services.** The Plan describes how we will achieve this ambition through a programme of priority work streams to ensure we are better in Bassetlaw:

Integrated support for the wellbeing of Bassetlaw citizens, including community-based, person-centred approaches, encompassing welfare, housing, social activities, employment and health support

Providing the right support at the right time, through integrated health and care pathways in community and acute settings

Joined-up communications and engagement, using shared approaches and putting Bassetlaw people at the heart of service design

Joint Transport strategy, to better understand community needs, make best use of collective resources and improve efficiency and experience.

Sustainable and effective services, enabled by an integrated workforce, digital and estates infrastructure and making the best use of the Bassetlaw £.

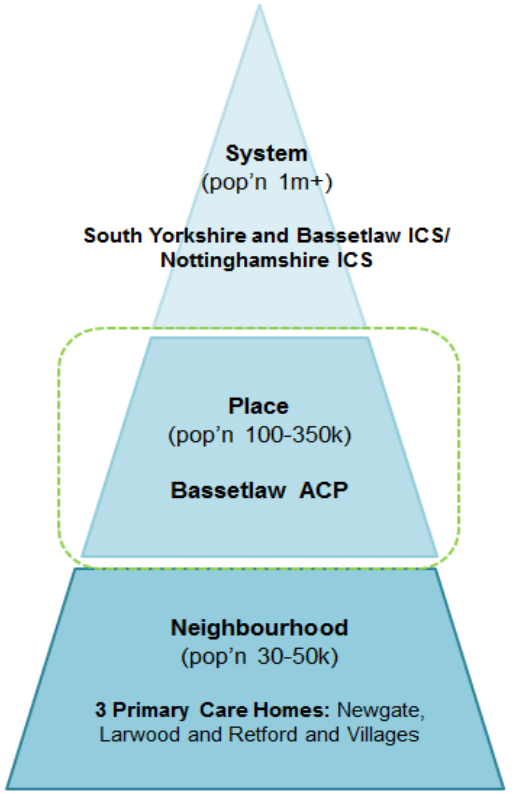
This plan describes the Integrated Care Partnership, how it will use a population management approach, and a collaborative partnership approach to engagement of partners and the public to inform detailed plans. It then describes what the partnership will do, and its measures of success.

Catherine Burn

Director of BCVS, and Chair of Bassetlaw Accountable Care Partnership

The Vision for the Bassetlaw Place

This Bassetlaw Place Plan is the document which sets out the vision for the Bassetlaw Integrated Care Partnership (ICP). **The ICP will deliver improvement in experiences, health and wellbeing for Bassetlaw citizens by 2021, through simpler, integrated, responsive and well understood services which ensure people get the right support at the right time.** This will support local people to stay well in their own homes and communities.



Health improvement populations

The ICP in Bassetlaw is a partnership of chief executives and senior leaders from BCVS, Bassetlaw District Council, Bassetlaw NHS CCG, Doncaster and Bassetlaw Hospitals NHS Trust, Nottinghamshire County Council, Nottinghamshire Healthcare NHS Foundation Trust and three Primary Care Homes.

Underpinned by a memorandum of understanding, through the ICP the partners support the district's three Primary Care Homes, supporting developments and strategy best delivered at place level, for all Bassetlaw's 116,000 residents. Primary Care Homes seek to link staff from general practice, community-based services, hospitals, mental health services, social care and voluntary organisations to deliver joined-up care for populations of approximately 30,000-50,000. In Bassetlaw, there are 3 Primary Care Networks (also known as Primary Care Homes):

- Retford and Villages;
- Newgate;
- Larwood and Bawtry.

The ICP also locates place-based developments within the South Yorkshire and Bassetlaw shadow Integrated Care System (sICS) which brings together the partners that plan and deliver health and care services from across Bassetlaw, Doncaster, Rotherham, Barnsley and Sheffield, and the Nottinghamshire Sustainability and Transformation Partnership. This Place Plan sets out the strategic direction for the ICP in Bassetlaw, and focuses on priorities most appropriately led at place level.

Population Health Improvement in Bassetlaw

Bassetlaw takes a population health improvement approach which involves three interdependent pillars:

- **Infrastructure:** the structure of the Bassetlaw Integrated Care Partnership (ICP), described on page 9), and a collaborative partnership approach (see page 14) ensures that partners are involved, and support and challenge each other, in all elements of population health improvement;
- **Intelligence:** Partners collate their insights and data at place and primary care home levels, and by population, to form a collective understanding of the needs of Bassetlaw people;
- **Interventions:** Interventions are planned and analysed using a population segmentation approach.

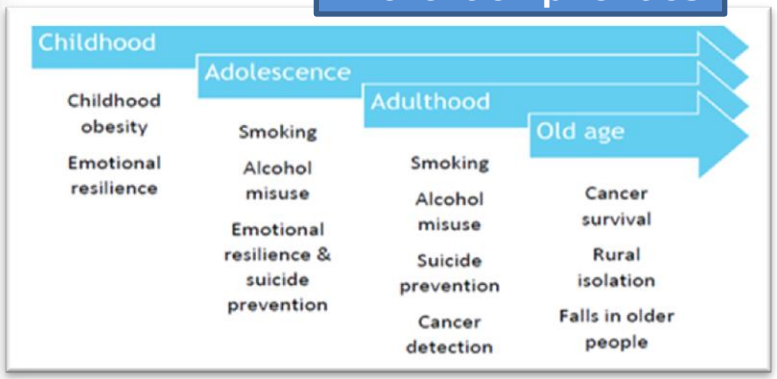
Population segmentation tool template

	Generally well/good wellbeing	LTCs/ social needs	Complex LTCs/ social needs/ disability
Children and young people	We know:	We know:	We know:
	We do:	We do:	We do:
Working age adults	We know:	We know:	We know:
	We do:	We do:	We do:
Older people	We know:	We know:	We know:
	We do:	We do:	We do:

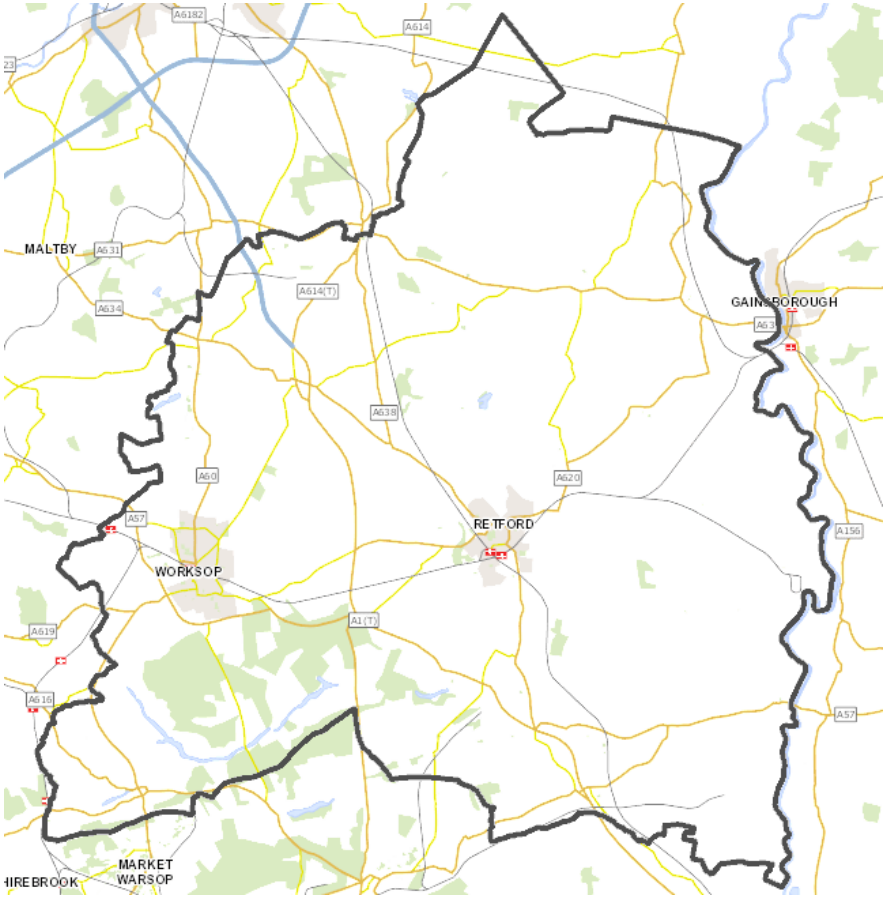
Population needs

- Alcohol-related hospital admissions are above the national average, particularly for women
- In young people mental health problems (e.g. depression, anxiety) and substance misuse now account for 1/3rd all ill health
- 9% of reception year children (and 20.6% of year 6 children) locally are classified as obese
- Bassetlaw life expectancy is below regional and national average for both men and women
- No. of patients living with dementia expected to increase by 20% between 2015-21: dementia is the leading cause of death in women nationally
- Nationally, number of people with diabetes expected to increase by 1million to 5million by 2035 – Bassetlaw has a high incidence of recorded diabetes
- Bassetlaw has higher incident rates of depression, hypertension, obesity, dementia, CKD compared with regional or national rates
- The % of people diagnosed with cancer and still alive a year later is lower than national average (breast, lung, colorectal)
- 33% of Bassetlaw population have at least 1 long term condition – 13% have at least 3
- Bassetlaw has higher % of over 80yr olds than footprint average: nationally, people can on average expect to live to about 63yrs in good health
- Smoking prevalence in Bassetlaw above 20% compared to the national average of 18.4%

Prevention priorities

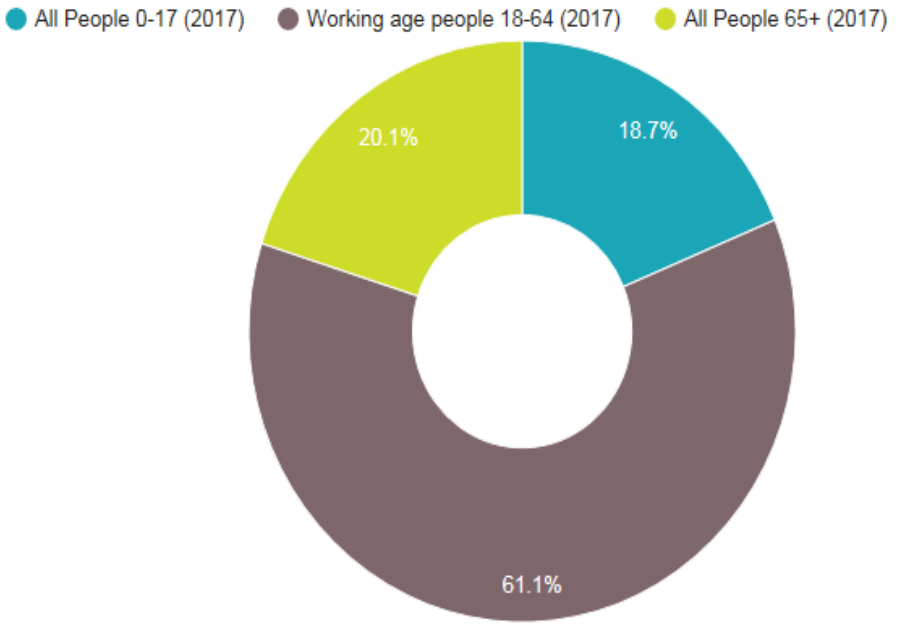


About Bassetlaw



With a population of approximately 116,300, Bassetlaw has a higher birth rate than the average for the county (63.9 per 1000 women, compared to 51.6).

Crime rates and educational achievement are comparable to the wider county, however there are a higher proportion of people living with a long term limiting condition (21.8% compared to 20.32%), and in social rented accommodation (12.9% compared to 9.3%) than in the rest of Nottinghamshire.



Bassetlaw is located as the northernmost district in the county of Nottinghamshire. Median earnings for Bassetlaw people are lower than for the wider county, at £458.70 a week, compared to £494.90 for Nottinghamshire.

Bassetlaw citizens benefit from excellent primary care services, a vibrant voluntary and community sector, 'good' children's services and schools and an established social prescribing offer. Local people have on average a higher happiness score, and for feeling satisfied with life than either the East Midlands or national average (ONS 2012-2015).

However, Bassetlaw people experience lower life expectancy than for people in the wider East Midlands (78.8 compared to 79.3 for males, and 81.8 compared to 82.9 for females). The numbers of people who view their own health as 'very bad' is high. Incidence of excess weight in Bassetlaw children is too high, with almost 9% of reception year children (and 20.6% of year 6 children) locally are classified as obese.

Compared to other areas, emergency admissions are high. National data identified that 2-16% of all older people experience regular loneliness which increases to approximately 50% in the over 80s – with a large elderly population and many rural communities, rural and social isolation and loneliness is a concern in Bassetlaw.

Smoking prevalence in Bassetlaw is estimated to be above 20% (measured as 22.5% in 2013) compared to the national average of 18.4% [ACP, 2017]. Alcohol-related hospital admissions in Bassetlaw are above the national average. The percentage of people diagnosed with any form of cancer who are still alive a year later is also low (67.9% compared to 69.6% nationally).

There are also significant inequalities within the district. For example, life expectancy for a female born in Worksop South East ward (77.4 years) is almost 9 years less than for a female born in East Markham ward (86.3 years). Over 48% of households Sutton are economically inactive, compared to 24% in Worksop North ward, and 12.7% of people in Sutton have their day to day activities limited by long term health conditions, compared to only 8.6% in East Retford West ward.

The local population is increasing, nationally demand and expectations of health and care services are rising whilst there is a reduced financial envelope for public services. Much has been achieved in Bassetlaw but there is more to do.

The Journey and Challenge

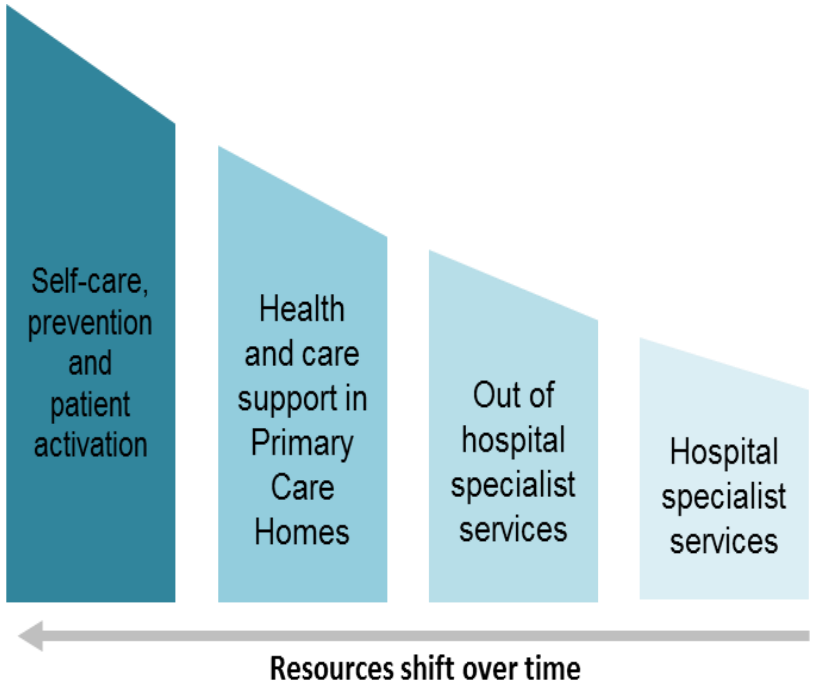
Bassetlaw integration journey began in 2013 when partners began working together, sharing strategic plans, service priorities and cross-sector programs through the Bassetlaw Integrated Care Board. In 2015, the NHS Five Year Forward View in 2015 then set a clear vision for the NHS, underpinned by strong collaboration across health and care systems and the necessity to develop new models of care. Bassetlaw responded to this through the establishment of social prescribing, three primary care networks and a range of integration initiatives, followed by the creation of the Accountable Care Partnership Board in 2016. The joint commitment, aligned plans and clear vision has successfully driven forward a number of service improvements that have improved outcomes and experience for local. These include:

- Innovation through primary care networks, including pharmacy in care networks, teenage counselling and engagement with schools;
- Integrated community health and social care teams aligned to primary care networks;
- Further integration of hospital discharge teams to include community services, and covering weekends;
- Development of interoperable information sharing systems between Bassetlaw Hospital and social care.

However, there remains more to do, and new challenges are emerging. The Bassetlaw population is projected to increase by just over 2% to 2021. Population growth in the over 65's is an estimated 10.6% between 2016 and 2021. The number of people over 65 with living with dementia is anticipated to increase by 20% between 2015 and 2021. The number of patients with a long term limiting illness is projected to increase by 20.8% between 2015 and 2025.

All statutory partners within Bassetlaw, including the CCG, County and District Councils, and the community acute NHS providers are subject to finite financial envelopes with which to respond to increase in expected demand for health and care services

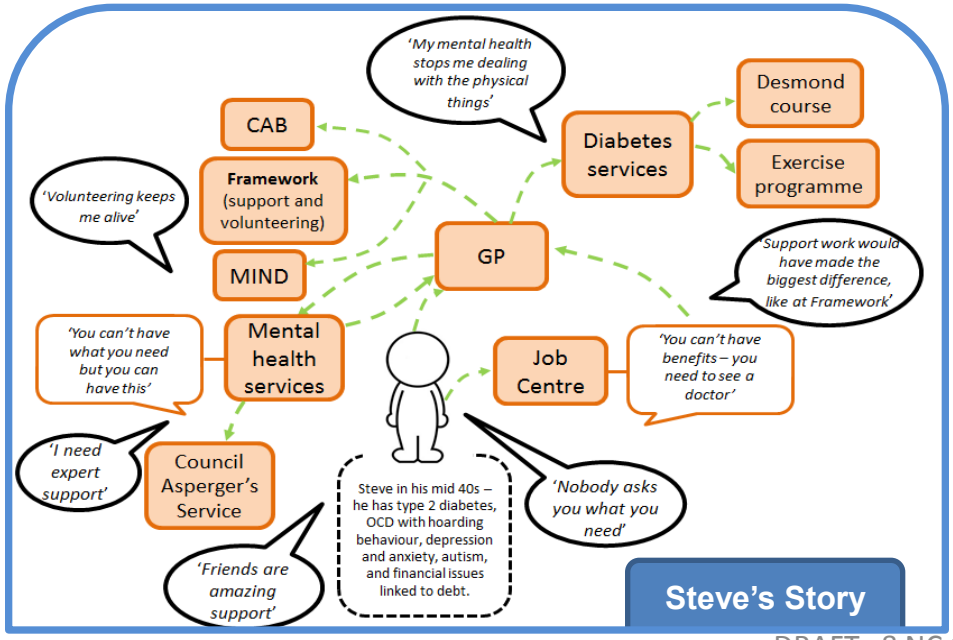
Our collective challenge is to identify how we work differently and better together so that Bassetlaw people get the right support at the right time, so that we improve health and wellbeing, and make best possible use of the Bassetlaw £.

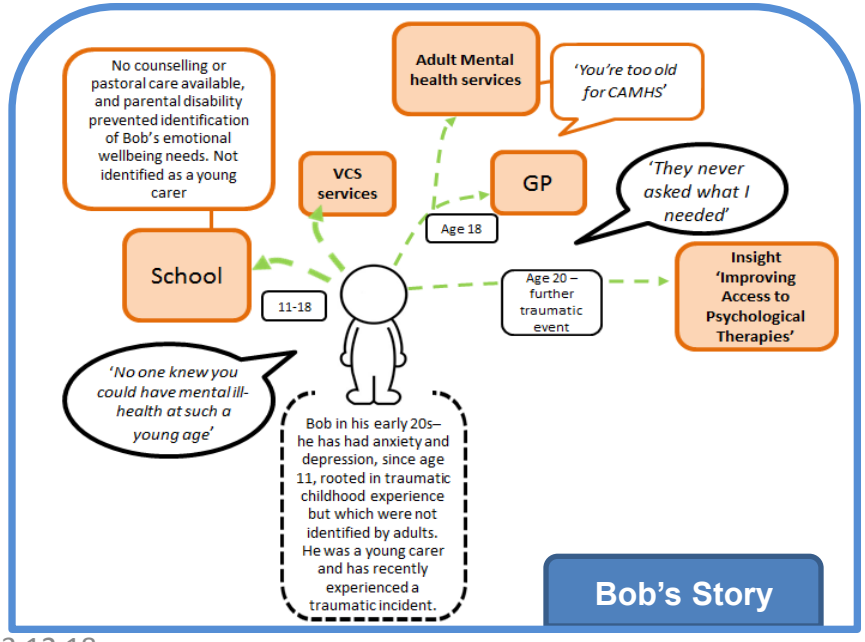


Bassetlaw ICP Priorities

The ICP priorities are those identified by Bassetlaw partners as those where by working across NHS, local government and voluntary sectors and beyond, the greatest impact on the ambitions for healthy individuals families and communities can be achieved, that would not be possible without such collaboration. This will realise the vision for the Bassetlaw place, to **deliver improvement in experiences, health and wellbeing for Bassetlaw citizens by 2021, through simpler, integrated, responsive and well understood services which ensure people get the right support at the right time.** Using the lived experience of Bassetlaw people, partners are working together on shared projects and initiatives on the following priorities:

- **Integrated support for the wellbeing of Bassetlaw citizens**, including community-based, person-centred approaches, encompassing welfare, housing, social activities, employment and health support
- **Providing the right support at the right time**, through integrated health and care pathways
- **Joined-up communications and engagement**, using shared approaches and putting Bassetlaw people at the heart of service design
- **Joint Transport strategy**, to better understand community needs, make best use of collective resources and improve efficiency and experience
- **Sustainable and effective services** enabled by an integrated workforce, digital and estates infrastructure and making the best use of the Bassetlaw £.





Bassetlaw's unique geography means that it spans two Integrated Care System footprints – South Yorkshire and Bassetlaw, and Nottinghamshire.

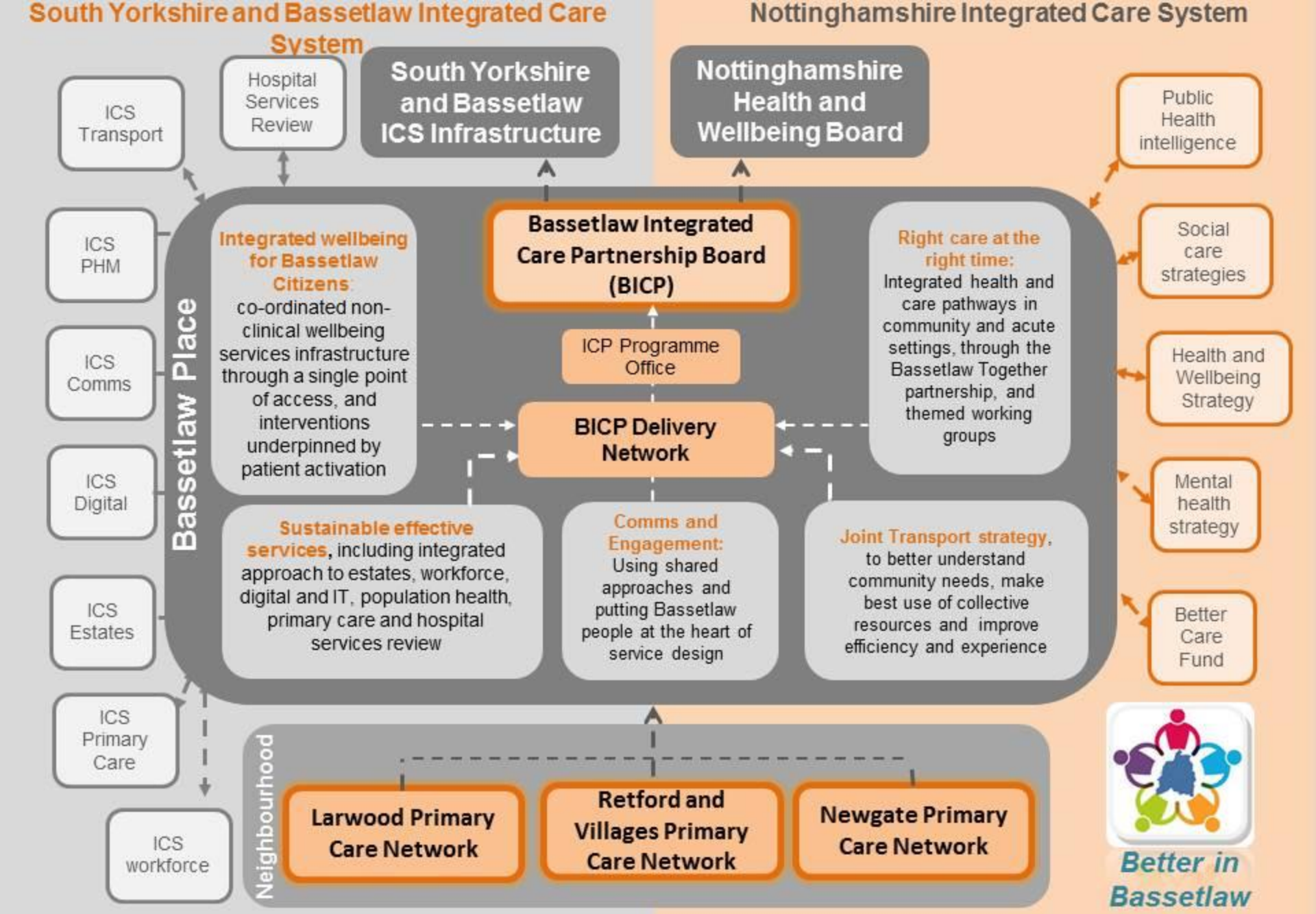
South Yorkshire and Bassetlaw ICS

The Bassetlaw Place

Nottinghamshire ICS

As described on page 11, as part of the two integrated care systems, and working with its three primary care networks, the Bassetlaw place has identifies the priorities that will support delivery of the ICP's strategic objectives which are:

- To reduce health and wellbeing inequalities;
- To improve health and wellbeing outcomes;
- Secure sustainable and effective services, and;
- To support independence and people's personal goals.



To reduce health and wellbeing inequalities Bassetlaw's primary care networks and all ICP partners will:

- Enable integrated service delivery, targeted in areas of highest need, ensuring all partners are trained and skilled in supporting those hardest to engage, and with the poorest outcomes;
- Target support with self-care/ patient activation with segments of the population with the poorest health and wellbeing;
- Reduce disadvantages faced by rural communities, particularly those experiencing economic deprivation, housing issues and poor transport links, to improve equality of access to services through transport initiatives;
- Identify communities and individuals where loneliness and isolation is a particular factor, and targeting of schemes and interventions;
- Support and enable engagement and communications with target populations and communities, to ensure health and care services and messages are responsive to the needs of Bassetlaw people most likely to experience poor health, using an integrated approach;
- Deliver themed summits related to local inequality issues, such as rural isolation and transport;
- Identify and implement opportunities to use digital solutions to improve access and engagement with prevention, early intervention and other health and care services, in particular for communities most likely to experience poor health, including with children.
- Enable employment initiatives which support people into work to tackle disadvantages caused by worklessness to individuals and communities;
- Design public spaces and buildings which meet the needs of different communities, and which encourage healthy behaviours.

Indicators of success

The gap in under 75 standardised mortality ratios for deaths from circulatory, respiratory and coronary heart disease between the best and worst performing wards closes

The percentage of children living in out of work families, and childhood obesity, reduces

More people with long term conditions are supported back in to work

The number of 'healthy options takeaways' in target communities increases;

Indicators of success

The number of people participating in sport and physical activity increases

More people benefitting from person-centred care, using patient activation measures

Improved cancer waits and survival

Fewer suicides, and better mental ill-health prevention

To improve the health and wellbeing Bassetlaw's primary care networks and all ICP partners will:

- Enable local, accessible integrated health and care services which provide the right support at the right time
- Create a shared workforce strategy approach and practice model, underpinned by person-centred care and patient activation;
- Support better self-care and emotional resilience so that risky health behaviours are reduced across the life course
- Improve access to services through transport initiatives, targeted at communities with poor health outcomes and transport links
- Reduce the impact of loneliness on poor mental and physical health through increasing social capital and contact for the most isolated, including through social prescribing
- Communicate the shared service offer and developments across partners so all services and practitioners are aware of the spectrum of services available, and people use the most appropriate service for their needs, including social prescribing and non-clinical sources of support.
- Enable engagement with the public that shapes commissioning and design of health and care services.
- Commission creatively to manage demand, including for crisis, emergency and intermediate care.
- Developing interoperable recording systems to support all agencies to give the right support at the right time with the right information to inform effective decision making.
- Enabling Bassetlaw people to have access to information and support where they are, such as via online services.

To enable sustainable and effective services the ICP will:

- Understand how the Bassetlaw £ is spent, and plan for future services better together;
- Link effectively to the ICS, and influence transformation approaches in the best interests of Bassetlaw;
- Enable integrated delivery, provision and commissioning of services which reduce duplication and increase efficiency, by optimising the sharing of functions, people and resources;
- Reduce preventable demand for health services in the medium to longer term through early intervention and patient activation;
- Ensure there is value for money by focusing on return on investment in high quality, early intervention and prevention services;
- Support more cost effective, sustainable and fair transport availability in communities;
- Secure a sufficient workforce, with a diverse skill mix that offers best value for the Bassetlaw £, and high quality services.
- Enable engagement with the public that shapes commissioning and design of health and care services that are responsive to local needs.
- Reduce administrative burden, inefficiency and preventable hospital stays caused by insufficient interoperability and lack of shared care records
- Make best use of public buildings, reducing duplication, and sharing resources
- Improved wellbeing at work offer across partners and through local employers
- Increased joint commissioning across local government and health sectors.

Indicators of success

More efficient workforce, with improved staff experience and better recruitment and retention

The rise in Accident and Emergency attendances is reduced

Better community and partner engagement

Reduced prescribing spend in primary care homes

Indicators of success

Fewer falls and hip fractures

Low levels of delayed transfer of care from hospital, with people receiving personalised support to remain independent

Fewer people admitted to adult social care services

More people receiving personal budgets

To people to stay well and independent for longer, Bassetlaw's primary care networks and all ICP partners will:

- Enable local, accessible integrated health and care services which provide the right support at the right time, to prevent escalation of needs and early intervention where support is required
- Supporting better self-care and emotional resilience so that more challenging health and care issues are delayed or prevented, enabling people to live well for longer.
- Reduce delayed transfers of care, and ensure appropriate support packages are in place to prevent re-admission;
- Reduce the demand burden on health and care services from loneliness and isolation through increasing social capital and contact for the most isolated
- Ensuring the workforce is trained and skilled in prevention and early intervention, including patient activation, to support people to stay well at home for longer
- Identifying and implementing opportunities to use digital solutions to improve access and engagement with prevention, early intervention and other health and care services, in particular for communities most likely to experience poor health.
- Work together to address housing issues, and prevent falls
- Increase the use of personal budgets;
- Embed person-centred care as an approach across partners
- Develop effective intermediate care provision
- Working jointly to optimise the potential of investments via the Better Care Fund.

The ICP has endorsed the use of a collaborative partnership model, developed by one of its partners, Nottinghamshire Healthcare NHS Foundation Trust, working with the King's Fund. The model sets out our ambition to work collaboratively with our communities, our staff and our partners to develop and change services. It outlines the principles and processes so we can work successfully together. We will use all our skills, knowledge, experience and learning to develop the best services possible within the finances available. The model sets out the principles for partnership working in Bassetlaw.

The partnership will:

- Listen to and understand others' views and agendas
- Build mutual trust and respect
- Work in a way that emphasises dialogue rather than debate
- Think, talk, plan and reflect together
- Be open, honest and clear on the scope and purpose of the service change and what people can influence and how and by whom and by when decisions will be made.
- Make communications simple, accessible and inclusive
- Ensure the partnership will actively listen to the views of the communities we serve and represent those voices in its decision making

Better in Bassetlaw: The Bassetlaw Place Plan

Authorised by: [To follow]

For more information, visit:

http://www.bassetlawccg.nhs.uk/about-us/accountable-care-partnership

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Title	**Use of Trust Seal**		
Report to:	**Board of Directors**	Date:	**29 January 2019**
Author:	**Gareth Jones, Trust Board Secretary**		
For:	**For approval**		

Purpose of Paper: Executive Summary containing key messages and issues

The purpose of this report is to advise of use of the Trust Seal in accordance with section 14: Custody of Seal and Sealing of Documents of the Standing Orders of the Board of Directors:

Seal No.	Description	Signed	Date of sealing
103	Agreement for the installation and operation of Automated Teller Machines, between National Westminster Bank PLC and DBTH, Doncaster Royal Infirmary Site.	Richard Parker Chief Executive	23 January 2019
		Jon Sargeant Director of Finance	
104	Agreement in relation to a private patient unit at Park Hill Hospital, between DBTH and Ramsay Health Care UK Operations Limited.	Richard Parker Chief Executive	23 January 2019
		Jon Sargeant Director of Finance	
		Jon Sargeant Director of Finance	

Recommendation(s)

The Board is requested to approve use of the Trust Seal.

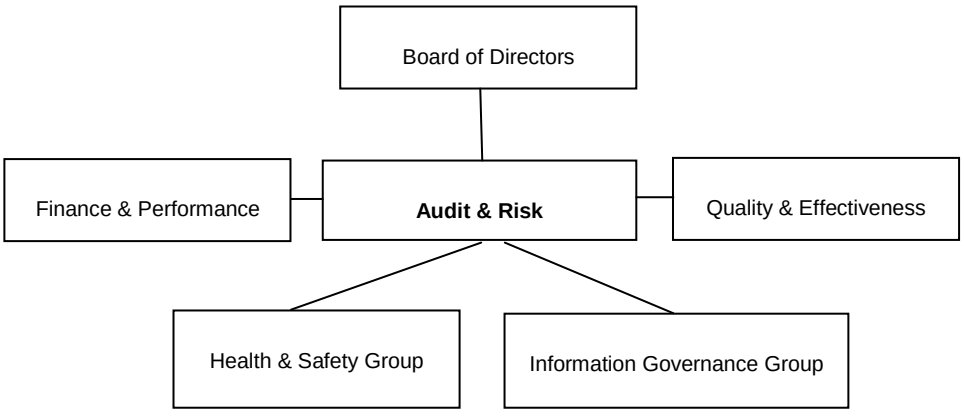
Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Title	**Audit & Risk Committee – Terms of reference and workplan review**		
Report to	**Board of Directors**	**Date**	**29th January 2019**
Author	**Kath Smart – NED and Chair of Audit & Risk Committee**		
Purpose			Tick one as appropriate
	Decision		X
	Assurance		
	Information		

Executive summary containing key messages and issues
The Audit Committee reviewed and approved a revised Terms of Reference at its last Committee meeting and requires Board approval. The main changes are:- • Audit Committees role in reviewing risk management processes in a holistic manner – removal of reference to "non-clinical" from the TOR and title to reflect reference to all risk; • Removal of the requirement for Audit Committee to review Whistleblowing processes after consultation with the Chair of QEC, Director of HR, and FTSU Guardian. This is now carried out at QEC and Board; • Clarified in more detail the Audit Committees responsibilities for CounterFraud; • The workplan re-aligned to the TOR The TOR and workplan have been reviewed by Internal and External Audit, based on their wider knowledge of Audit Committees and the HFMA Audit Committee Handbook, which sets the standards for Audit Committees.
Key questions posed by the report
Is the Board assured of the completeness of the TOR for the Audit Committee to discharge its purpose on behalf of the Board?
How this report contributes to the delivery of the strategic objectives
The Audit Committee reviews risks and controls in place to support the achievement of all Strategic Objectives

How this report impacts on current risks or highlights new risks
The Internal Audit Plan is designed to review areas of risk and concern and changes. The TOR mitigates against ANCR 1 – Risk of Fraud leading to impact on Trust Finance/ reputation; F&P 11 – Failure to protect against Cyber attack
Recommendations
Board of Directors is asked to APPROVE the Terms of Reference & Workplan of the Audit & Risk Committee

Audit and Risk Committee (ARC)
Terms of Reference

Name	Audit and l Risk Committee ("the committee")
Purpose	To provide the Board of Directors ("the Board") with a means of independent and objective review of internal controls and risk management arrangements relating to: • Financial systems • The financial information used by the Trust • Controls and assurance systems, • Risk management arrangements • Compliance with law, guidance and codes of conduct • Counter fraud activity
Responsible to	Board of Directors. The Chair of the committee is responsible for reporting assurance to the Board on those assurance matters covered by these Terms of Reference. The minutes of the committee shall be submitted to the Board of Directors. The Chair of the committee will report to the Board after each meeting and shall draw to the attention of the Board any issues that require disclosure to the Council of Governors, or require executive action. The committee will present a written annual report to the Board summarising the work carried out during the financial year and outlining its work plan for the future year.
Delegated authority	The committee is a non-executive committee and holds no executive powers other than those specifically delegated in these Terms of Reference.  The committee is authorised to investigate any activity within its Terms of Reference. It is further authorised to seek any information it requires from any employee of the Trust and all employees are directed to co-operate with any request made by the committee.

	The committee is authorised by the Board to secure legal or independent professional advice, or to request the attendance of external advisers with relevant experience and expertise if it considers this necessary.
Duties and work programme	1 <u>Integrated Governance, Risk Management and Control</u> 1.1 The committee shall review the effectiveness of the system of integrated governance, risk management and internal controls, to satisfy the Board that its approach to integrated governance remains effective. 1.2 Determine the actions, controls and audits/reviews required to provide non-executives and the Board with robust assurance regarding the reported financial position going forward; and to maintain the confidence of governors, regulators and the public. Undertake ongoing review of the implementation and effectiveness of these. 1.3 The committee will review the adequacy of: i. all risk and control related disclosure statements (in particular the Annual Governance Statement and Declarations of Compliance made to NHSI) together with any accompanying Head of Internal Audit statement, external audit opinions or other appropriate independent assurance, prior to endorsement by the Board; ii. the underlying assurance processes that include the degree of achievement of corporate objectives, the effectiveness of the management of principal risks and the appropriateness of related disclosure statements; iii. the policies and procedures for ensuring compliance with relevant regulatory, legal and code of conduct requirements; and iv. the arrangements, policies and procedures for all work related to fraud and corruption (but shall not be responsible for the conduct of individual investigations); and v. The operating of, and proposed changes to, the Board of Directors standing orders, standing financial instructions, the constitution, codes of conduct, scheme of delegation and standards of business conduct. 1.4 In carrying out this work the committee will primarily utilise the work of Internal Audit, External Audit and other assurance functions, but will not be limited to these audit functions. It will also seek reports and assurance from executive directors and managers as appropriate, concentrating on the overarching systems of integrated governance, risk management and internal control, together with indicators of their effectiveness.

2 Internal Audit

2.1 The committee shall monitor the effectiveness of the internal audit function established by management that meets mandatory *Public Sector Internal Audit Standards* and provides appropriate independent assurance to the committee, Chief Executive and Board. This will be achieved by:

i. consideration of the provision of the Internal Audit service, the cost of the audit and any questions of resignation and dismissal;
ii. review and approval of the Internal Audit strategy, operational plan and more detailed programme of work, ensuring that this is consistent with the audit needs of the organisation as identified in the Assurance Framework;
iii. consideration of the major findings of internal audit work (and management's response), and ensure co-ordination between the Internal and External Auditors to optimise audit resources;
iv. oversee the effective implementation of internal and external audit recommendations;
v. ensuring that the Internal Audit function is adequately resourced and have appropriate standing within the organisation; and
vi. Annual review of the effectiveness of Internal Audit.

3 External Audit

3.1 The committee shall review the work and findings of the External Auditor whom are appointed by the Council of Governors and consider the implications of and management's responses to their work. This will be achieved by:

i. consideration of the appointment and performance of the External Auditor in accordance with the Trust specification for an External Audit Service, informed by NHSI's Audit Code for NHS Foundation Trusts;

ii. discussion and agreement with the External Auditor, before the audit commences, of the nature and scope of the audit as set out in the Annual Plan ensuring co-ordination, as appropriate, with other External Auditors in the local health economy;

iii. discussion with the External Auditors of their local evaluation of audit risk and assessment of the Trust and associated impact on the audit fee;

iv. review of all External Audit reports, including agreement of the annual audit letter, before submission to the Board and review of any work carried outside the annual audit plan, together with the appropriateness of management responses; and

v. Review of the annual audit letter and the audit representation letter before consideration by the Board.

4 Other Assurance Functions

4.1 The committee shall review the findings of other significant assurance functions, both internal and external to the organisation, and consider their implications to the governance of the organisation. These may include, but will not be limited to: any reviews by Department of Health Arms Length Bodies or Regulators/Inspectors (e.g. Care Quality Commission, NHS Resolution, Health and Safety, Shared Business Services etc.); professional bodies with responsibility for the performance of staff; or functions (e.g. accreditation bodies, etc.) relevant to the Terms of Reference of this committee.

4.2 In addition, the committee will review the work of the other committees within the organisation whose work can provide relevant assurance to the committee's own scope of work.

5 Management

5.1 The committee shall request and review reports and assurance from directors and managers on the overall arrangements for governance, risk management and internal control.

5.2 They may also request reports from individual functions from within the organisation as appropriate.

6 Financial Reporting

6.1 The committee shall review the Annual Report and Financial Statements before recommendation to the Board, focusing particularly on:

i. the wording in the Annual Governance Statement and other disclosures relevant to the Terms of Reference of the Committee;
ii. compliance with, accounting policies and practices;
iii. unadjusted mis-statements in the financial statements;
iv. major judgemental areas;
v. significant adjustments resulting from the audit;
vi. the clarity of disclosures; and
vii. the going concern assumption

6.2 The committee should also ensure that the systems for financial reporting to the Board, including those of budgetary control, are subject to review as to completeness and accuracy of the information provided to the Board.

7 Counter Fraud Arrangements

7.1 The committee shall ensure that there is an effective counter fraud function established by management that meets the NHS Counter Fraud standards and provides independent assurance to the ARC, Chief Executive and Board. This will be achieved by:

7.2 Review the adequacy of the policies, procedures and plans for all work related to fraud, bribery and corruption;
7.3 Ensuring effective co-operation with the Counter Fraud function and that it has appropriate standing within the Trust;
7.4 Receipt of quarterly reports and an annual report from the Local Counter Fraud Specialist (LCFS) on counter fraud activity and investigations;
7.5 Ensuring compliance with Section 24 of the NHS National Contract regarding fraud and NHS Standards for Providers as required by the NHS Counter Fraud Authority.

8 Other areas of work

1 Information Governance: - The committee shall receive reports and review assurance from directors and managers on the overall arrangement for compliance with Information Governance Standards.

2 Health and safety, fire and security: - The committee shall receive reports from relevant directors and officers, including the Local Security Management Specialist, on the arrangements for compliance with relevant health and safety, fire and security standards.

9. Special Assignments

The committee shall commission and review the findings of any special assignments required by the Board.

10. Performance

The committee shall request and review reports and assurance from directors and managers on the overall arrangements for reporting compliance with:

i. the Trust's corporate objectives;
ii. NHSI's governance standards and declarations, including the review of areas of non-compliance in the context of NHSI's "comply or explain" philosophy; and
iii. key performance objectives as appropriate but not to duplicate the work of QEC or F&P

11. Risk Management

The ARC will provide assurance to the Board that the Risk Management Strategy is being complied with, including, but not limited to reviewing Risk

	Registers. The committee shall request and review reports and assurance from directors and managers on effects of arrangements to identify and monitor risk. The Board will retain the responsibility for routinely reviewing specific risks 12 Work plan The committee's annual work plan is an appendix to these Terms of Reference, and is subject to annual review by the committee.
Policy approval	The Committee has responsibility for approving the following policies: - Fraud, Bribery & Corruption Policy and Response Plan - Standards of Business Conduct and Employees Declarations of Interest Policy
Chair	A Non-executive Director, appointed by the Board of Directors, will chair the Committee.
Membership	Four non-executive directors. • One of the non-executives shall have recent and relevant financial experience. • Each non-executive shall normally not serve more than three years as a committee member, unless the requirement for one of the members to have recent and relevant financial experience is compromised. • The Trust Chair shall not be a member of the Committee
In attendance	• Director of Finance • Deputy Director of Finance • Trust Board Secretary • Local Counter Fraud Specialist • Appropriate internal and external audit representatives • Security Management Specialist • Other trust staff as appropriate / requested The Chief Executive, executive directors or other officers will be required to attend at the request of the committee, for issues relevant to their areas of responsibilities. Two public governors, nominated by the Council of Governors, will be invited to attend the committee, as observers. The Chair and Chief Executive of DBTH will be invited to attend at least annually.
Secretary	Trust Board Secretary
Voting	Matters will generally be decided by way of consensus. Where it is necessary to decide matters by a vote then each member will have one vote. The Chair will have a casting vote.

Quorum	Two members.
Attendance requirements	Committee members must attend at least 50% of meetings.
Frequency of meetings	No less than quarterly and more frequently as required. At least once per year, the Committee should meet with the external and internal auditors, without management being present, to discuss matters relating to its responsibilities and issues arising from the audit. The External Auditor and Head of Internal Audit may request a private meeting if they consider that one is necessary. They will also have direct access to the Chair of the committee.
Papers	Papers will be distributed a minimum of five clear working days in advance of the meeting.
Permanency	The committee is a permanent committee.
Reporting committees	Health and Safety Committee Information Governance Steering Group
Circulation of minutes and other reporting requirements	The Governor observers shall report to the Council of Governors on a quarterly basis regarding the work of the committee, any matters needing action or improvement and the corrective actions to be taken. Following the Council of Governors appointment of the External Auditors, the committee shall report to the Council of Governors regarding the reappointment, termination of appointment and fees of the External Auditors.
Date approved by the committee:	
Date approved by the Board of Directors:	
Review date:	

AUDIT AND RISK – Committee Work-plan
(Updated 24/01/19)

		Mar	May EGM	June	Sept	Dec
1.	**Management and Control**					
1.1	Review Board Assurance Framework and Corporate Risk Register	√		√	√	√
1.2	Review Draft Annual Governance Statement (AGS) *(Prior to Submission to Monitor)* [(i)]		√			
1.3	Receive Independent Assurance Statements for AGS from Internal Audit *(prior to finalisation of Annual Report)*		√			
1.4	Review Risk Management Strategy	√				
1.5	Review of compliance with Code of Governance arrangements. *(In the context of Monitor's "comply or explain" approach).*				√	
1.6	Annual review of constitution, Standing Orders, SFI's, ***standards of business conduct*** and powers reserved for the Board.	√				
1.7	Review Hospitality Register			√		
~~1.8~~	~~Review security report~~	~~√~~		~~√~~	~~√~~	~~√~~
2.	**Internal Audit**					
2.1	Review the effectiveness and appointment of Internal Audit	√				
2.2	Consider and review a three year risk based Audit Strategy for the Committee				√	
2.3	To receive and consider the Annual Internal Audit Report *(incorporating the Head of Internal Audit opinion)*		√			
2.4	Approve Internal Audit Plan for the forthcoming year	√				
2.5	Internal Audit update	√		√	√	√

		Mar	May EGM	June	Sept	Dec
3.	**External Audit**					
3.1	Review the appointment and performance of External Audit *(To then make a recommendation to the Board of Governors)*	√				
3.2	Agreement of External Audit Plans and Fees *(for the forthcoming year)*					√
3.3	Receive External Audit Progress Report	√	√	√		
4.	**Internal and External Audit**					
4.1	Best Practice *(to discuss and consider areas of best practice in other Trusts)*	√		√	√	√
4.2	*Oversee implementation of audit recommendations*	√		√	√	√
5.	**Finance Reporting**					
5.1	To consider and adopt the Draft Annual Accounts and Financial Statements (including the presentation of a schedule of late adjustments/journals).		√			
5.2	Agree final accounts timetable and plan	√				
5.3	Receive the "ISA 260" Report from External Audit and supplementary controls *(a report from External Audit to those charged with Governance)*		√			
5.4	Report and monitor any recommendations from IAS260					√
5.5	Consider the letter of representation *(to External Audit)*		√			
5.6	Review of ~~Accounting~~ ~~C~~compliance with Accounting Policy changes~~ies~~ *(if required)*	√				
5.7	~~Review financial reporting arrangements~~ Annual Statement from Shared Business Services	X			~~√~~	
6.	**Counter Fraud**					
6.1	Review Draft Annual Counter Fraud Report *(for the year completed)*			√		
6.2	Review Annual Counter Fraud Work Plan *(for the*			√		

		Mar	May EGM	June	Sept	Dec
	year ahead)					
6.3	Receive update from LCFS	√		√	√	√
6.4	Receive the Self Review Toolkit (SRT) for submission to Quality Assurance Directorate, NHS Protect. (To CFS)	√				
7.	**Other Areas**					
7.1	Review assurances regarding the overall arrangements for compliance with IG Standards	√				
7.3	Information Governance Steering Group (IGSG) Bi-annual Update					√
7.4	Health & Safety / Fire & Security Update – Bi-annual	√		√	√	√
8.	**Other**					
8.1	Review losses and compensation payments and write offs since the last meeting	√		√	√	√
8.2	Review occasions when the Trust's standing orders are waived	√		√	√	√
8.3	Private meeting with Internal and External Auditors (iii)				√	
8.4	Agree method for self-assessment of committee effectiveness					√
8.5	Review terms of reference and work plan				√	
8.6	Produce annual committee report			√	√	

Notes

(i) Chief Executive to attend the meeting to present the Draft AGS.

(ii) The Chair of the Committee will, following the meeting, document the meeting and advise the Chair of the Board of any issues arising from the meeting. This private meeting does not prevent separate meetings taking place between the Committee and Internal or External Audit, nor does it affect the rights of direct access to the Chairman of the Committee.

(iii) On an ad hoc basis.

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Title	**DBTH Composite Electronic Patient Record (EPR): Task Management, Bed Management, e-Observations, Clinical Noting and Fax-decommissioning**		
Report to	**Board Of Directors**	**Date**	**29th January 2019**
Author	**Simon Marsh**		
Purpose			Tick one as appropriate
	Decision		✓
	Assurance		
	Information		

Executive summary containing key messages and issues

There are significant gaps in the digitally enabled hospital ecosystem that are currently reliant on paper and manual processes.

This business case seeks funding of £1.926m for capital with recurrent revenue of circa £0.52m. The project is expected to deliver recurrent benefits in excess of £1m (cash and non-cash releasing) and demonstrates a ROI (Return on Investment) of 20.1%, with a payback period of 9 years. For a range of specific digital outcomes to replace these paper based systems, automate processes (particularly alerting for medical conditions) and generally fill in the gaps within the digital environment.

Delivering these outcomes digitally will increase patient safety, improve quality of care, reduce costs and make manual processes more efficient through the use of automation. This latter benefit will release significant nursing time back to the care of patients.

Experiences at other Trusts from EPR implementation clearly demonstrate the primary benefits are derived from improved quality, safety and societal outcomes rather than financial benefits, especially in the short to medium term.

Digital technology is continually changing and investment is required on an annual basis both in support and maintenance for software (revenue) and then periodic refresh of the underlying hardware and data storage (capital and revenue). As the Trust increases the use of digital technology and becomes wholly reliant on it being available 24/7/365, then the investment necessary to retain a resilient and secure environment becomes equal to that required in other facilities.

It is anticipated there will be at least 3 distinct phases for the EPR over five years and this business case seeks £1.926m of capital funding and recurrent revenue of circa £0.52m for Phase1.

EPR Phase 1 development and implementation aims to address those gaps in DBTH current digital capability and challenges that are core to the prevention of avoidable deterioration: vital signs, sepsis, handover and bed management. These are common contributors to clinical incidents, extended length of stay and clinical negligence claims.

This proposal is wholly consistent with the wider SYB ICS objectives and seeks to secure part-funding via a National Health System Led Investment (HSLI) Programme.

Key questions posed by the report

Is the Board content that the proposal is consistent with the Trusts strategic vision for 2017 – 2022 and that appropriate assurance has been given in terms of delivering the EPR?

How this report contributes to the delivery of the strategic objectives

As a DBTH 'enabling strategy', this business case directly supports both the NHS vision for digital technology and the Trusts Strategic Vision for 2017-2022 as outlined below.

'The creation of a full Electronic Patient Record across the Trust remains a strategic objective for 2020 in line with the Five Year Forward View requirement as published by NHS Digital. The Trust's previous 'best of breed' strategy for the purchase of replacement time-expired systems means that patient data now resides in multiple systems.

An appropriate approach will be identified and designed to bring the data sources together, along with the digitisation of relevant historic paper based patient information, to create a single patient overview that can be used by clinical staff and the wider health community. While not a full and complete Electronic Patient Record (EPR), it will have the same outcomes and benefits.'

How this report impacts on current risks or highlights new risks

This business case directly mitigates the gaps in assurance related to Q&E4 points (i) Electronic Patient Record System, (ii) Development of a business case for EPR.

F&P13 is partially addressed through the business case seeking to secure external funding from NHSE for capital investment.

F&P approved the business case on January 22nd 2019.

Recommendation(s) and next steps

To seek a recommendation to approve the business case at Board and to enable drawdown of capital funds from NHSE.

Project Title:

DBTH Composite Electronic Patient Record (EPR): Task Management, Bed Management, e-Observations, Clinical Noting and Fax-decommissioning

Lead manager – Mike Whiteside, CCIO

VERSION HISTORY

Version	Date Issued	Brief Summary of Change	Owner's Name
0.01	10/10/18	1st Draft Version	Mike Whiteside / Ken Anderson
0.02	11/10/18	2nd Draft Version	Nick Mallaband
0.03	12/10/18	3rd Draft Version	Simon Marsh/ Ken Anderson/ Justin Fowler
0.04	16/10/18	4th Draft version	Simon Marsh
0.05	28/12/18	5th Draft version	Simon Marsh / Ken Anderson
0.06	31/12/18	6th Draft Version	Simon Marsh
0.06	03/12/18	7th Draft Version	Ken Anderson
0.08	07/01/19	8th Draft Version	Justin Fowler
0.09	08/01/19	9th Draft Version	Ken Anderson/ Jo Hutchinson
0.10	08/01/19	10th Draft Version	Jo Hutchinson/ Justin Fowler
1.0	09/01/19	Final Version	Simon Marsh

CONTENTS

1. Executive summary

The Government has committed to making all patient and care records digital, real-time and interoperable by 2020. The NHS Forward View, published in October 2014, promoted digital technology as a key enabler of the change required to make the NHS sustainable in the long term. It made a commitment to establish 'fully interoperable electronic health records so that patients records are paperless'.

In September 2016, an independent review, led by Professor Robert Wachter, published 'Making IT work: harnessing the power of health information technology to improve care in England'. The review concluded that 'To those who wonder whether the NHS can afford an ambitious effort to digitise in today's environment of austerity and a myriad of ongoing challenges, we believe the answer is clear: the one thing the NHS cannot afford to do is to remain a largely non-digital system. It is time to get on with IT'.

The Secretary of State for Health and Social Care Matt Hancock outlined his vision for a more tech-driven NHS at NHS Expo 2018.

He expressed, 'I can understand why leadership would shy away from grappling with technology given the history, but we must get back to driving this transformation. We must drive this agenda and you need to know that I've got your back. The biggest risk is not driving digital transformation. The biggest risk is not doing digital transformation'.

NHSE and NHSI published the first part of the 2019/20 planning guidance on Friday 21 December 2018. Key elements within this guidance included providers being asked to deliver 1.1% efficiency over the next 5 years, with the guidance flagging a number of priorities from the Carter review that should be prioritised including:

- Digitally-enabled outpatient operational models
- Improved availability of mobile devices and digital services for staff

DBTH has a large number of digital systems, both at holistic Trust level (for instance the CAMIS PAS system, Medisec for outpatient letters) and at departmental level (for instance Symphony within ED, JAC for Electronic Prescribing). Patient centred information from these systems is collated within the Trusts internally developed clinical portal (2017-ongoing). However there remains significant gaps in the digitally enabled hospital ecosystem that are currently reliant on paper and manual processes.

This business case seeks funding of £1.926m for capital with recurrent revenue of circa £0.52m. The project is expected to deliver recurrent benefits in excess of £1m (cash and non-cash releasing) and demonstrates a ROI (Return on Investment) of 20.1%, with a payback period of 9 years. For a range of specific digital outcomes to replace these paper based systems, automate processes (particularly alerting for medical conditions) and generally fill in the gaps within the digital environment. To do so requires a range of functional software, mobile devices, training and other infrastructure. Delivering these outcomes digitally will increase patient safety, improve quality of care, reduce costs and make manual processes more efficient through the use of automation. This latter benefit will release significant nursing time back to the care of patients.

Experiences at other Trusts from EPR implementation clearly demonstrate the primary benefits are derived from improved quality, safety and societal outcomes rather than financial benefits, especially in the short to medium term. A full EPR with integration to other providers delivers these quality and safety benefits almost immediately. Over time, as the organisation evolves its processes and procedures to better use the new functionality and the associated patient data, financial outcomes accelerate due to efficiencies in patient

care. This business case describes a range of financial and non-financial benefits derived from discussions with numerous other NHS trusts and their experiences in implementing an EPR. These benefits are therefore deliberately conservative but built on a stable foundation using external benchmark data. While it is expected the new systems at DBTH will be delivered at pace, changes to working practices that deliver financial benefits take time to embed into the organisation and the benefits are phased accordingly.

Furthermore, significant opportunity exists to join patient data from primary, secondary, mental health community services within the NHS and adult and children's social care data from the various council's within the Trust's operational boundaries of Doncaster / Bassetlaw, including acute services across the South Yorkshire and Bassetlaw Integrated Care system (SYB ICS). Work is already being undertaken with both Doncaster and Bassetlaw CCG's on exposing patient data at cross organisational level providing there is a legal basis to do so under the regulations within GDPR and DPA 2018.

The near-future requirement to change the outpatient model to move from acute to GP requires the availability of near real-time digital data within the Trust. This can only be achieved through investment in relevant systems to ensure data are collected once, at source, and are immediately available to other care providers.

This business case is not the end of the digital journey for the Trust. While the Trust's clinical portal collates existing digital information, binding decisions still need to be made relating to digitising historical clinical notes and the introduction of an Electronic Document Management System (EDMS). This will be the subject of a second business case in 2020-21.

Digital technology is continually changing and investment is required on an annual basis both in support and maintenance for software (revenue) and then periodic refresh of the underlying hardware and data storage (capital and revenue). As the Trust increases the use of digital technology and becomes wholly reliant on it being available 24/7/365, then the investment necessary to retain a resilient and secure environment becomes equal to that required in other facilities.

Introduction and Background

It is anticipated there will be at least 3 distinct phases for the EPR over five years and this business case seeks £1.926m of capital funding and recurrent revenue of circa £0.52m for Phase1.

Phase 2 will be proposed following a further period of analysis and discovery and will incorporate an electronic digital management (EDM) solution. Functionality across Paeds and Maternity will be introduced, outpatient clinical noting, assessments and internal referrals.

Phase 3 is **consideration** of a replacement or continuation of systems procured as part of the iHospital Programme in 2013/15. This includes patient administration, emergency department, picture archiving / communications, radiology and information systems.

In addition, the functional clinical and administration software, hardware and operating systems require a periodic refresh when they reach end of life or unsupported by the manufacturer.

Appendix 5 explains these phases and the potential financial and operational impact over the next 5-7 years. This is not an exhaustive view but an overview against what is known today. Future requirements associated with the ICS strategy and other operational requirements are not included.

NHS Providers will soon have their digital maturity measured by the Health Information and Management Systems Society (HIMSS). HIMSS is a global non-profit organisation whose goal is to promote the best use of information technology and management systems in the health care industry. HIMSS has definitions ranging from 1-7 with 7 being the most digitally advanced hospitals. An EPR and its adoption within the Trust against a set of defined criteria are expected to enable DBTH to reach HIMSS level 5. This is a standard goal across the South Yorkshire and Bassetlaw ICS.

EPR Phase 1

This EPR Phase 1 development and implementation aims to address those gaps in DBTH current digital capability and challenges that are core to the prevention of avoidable deterioration: vital signs, sepsis, handover and bed management. These are common contributors to clinical incidents, extended length of stay and clinical negligence claims. A mobile solution to these challenges will rapidly deliver quality benefits to patients and financial benefits to the Trust. Furthermore, as experienced via the introduction of hospital@ and bed management at Bassetlaw, the introduction of easy to use, intuitive, integrated and reliable technology will drive broad and positive adoption from doctors and nurses alike.

This proposal is wholly consistent with the wider SYB ICS objectives and seeks to secure part-funding via a National Health System Led Investment (HSLI) Programme. The phrase 'Health System Led' signifies the prioritisation of initiatives to receive investment should be undertaken at ICS level with the objective of:

- Advancing the digital maturity of secondary care providers.
- Enabling information to be shared across local healthcare systems.
- Allowing the ICS to harness digital technology to help realise their transformation goals to significantly increase patient care / safety and increase efficiency in the use of scarce resource.
- Achieving the recognised international standard for electronic health records set by HIMMS at Level 5. Level 5 is the planned minimum requirement for the ICS and includes the following components are delivered digitally throughout the provider Trusts:
    - Full clinical documentation (e.g. progress notes, consult notes, discharge summaries, problem / diagnosis list, etc.) with structured templates and discrete data is implemented for at least 50% of the hospital.
    - Capability must be in use in the ED, but ED is excluded from 50% rule.
    - Hospitals can track and report on the timeliness of nurse order/task completion.
    - Cyber intrusion prevention system is in use to not only detect possible intrusions, but also prevent them.
    - Hospital-owned portable devices are recognized and properly authorized to operate on the network, and can be wiped remotely if lost or stolen.

It is worth noting that no two EPRs are the same and there are multiple routes to providing this functionality. In fact, every provider in the ICS has different systems to provide the core patient record. The ICS recognise this challenge and the need to achieve common capability facilitated via integrating data regardless of the underlying system and / or vendor. This integrated data will be provided by Fast Health Interoperability Resource (FHIR) standards based messaging as defined by NHS Digital for the Health and Social Care Sector.

In 2018 DBTH introduced a number of the core components associated with a full EPR and extended digital functionality including:

- Task Management (Hospital@) July 18 (Bassetlaw)
- Bed Management October 18 (Bassetlaw)
- Order Communications out-patients (ICE) October 18
- Clinical Portal v1 December 18

Details of the time line are outlined in Appendix 3. The delivery of phase 1b and phase 2 are dependent on funding drawdown and dependencies from phase 1a being met

Phase 1 of the EPR (this business case) will be delivered in two discreet parts with the aim of):

- Maintaining staff engagement and momentum by regular incremental changes which build upon each other.
- Minimising the disruption to business as usual activity, especially during winter pressure periods.
- Utilising internal and external financial investment where available
- Using Bassetlaw hospital as a pilot site to embed functionality and process change before implementing the same processes to DRI and MMH (a tried and trusted method).
- Increasing data quality and the subsequent use of data for decision making and 'calls to action' at all levels of clinical decision making and management to improve efficiencies to enable the Trust to reach 'outstanding' status.

The total financial investment for phase 1 is:

- £1.926m capital investment over a 3 year period commencing 2018/19
- £0.52m recurrent revenue from year 2 following full implementation (pay £0.26m, non-pay £0.26m), plus overheads including depreciation of circa £0.27m and capital charges of £0.07m.
- Projected recurrent cash releasing benefits of £0.5m start to be realised in year 2 (2019/20) rising to £1.3m by year 6 (2023/24). See Table 3 - Cash and Non-Cash Releasing Benefits and Appendix 1 for full financial details.
- Project payback period is calculated at 9 years (taking 2018/19 as year 1) with a ROI (Return on Investment) of 20.1%.

Phase 1a: at a cost of £1.046m capital investment in 2018/19, this phase will extend the work already carried out at Bassetlaw into DRI and MMH and introduce e-observations across all sites. This phase will run over a 12-month period from March 2019 and will start delivery of the following (note timelines are dependent on funding drawdown):

- Task Management (Hospital@ to DRI and MMH)
- Bed Management (DRI and MMH)
- eObservations (all sites)

Capital investment is required for functional software licences, implementation costs, hardware and mobile devices and associated licences.

Phase 1b: at a cost of £0.88m capital investment in 2019/20 and 2020/21, this phase will run over a 12-18 month period from September 2019 and will deliver the following:

- Clinical Noting (*includes eHandover, SNOMED, Clerking and Discharge Forms, Clinical Photography, Care Plans, Pre-Admission and Discharge Summaries for inpatients)*
- Sepsis (all sites) *(excludes Paeds and Maternity)*
- Fax Decommissioning

Note – Fax decommissioning requires digital development of standardised workflows, templates and forms derived from internal development or via third party software.

During phase 1 there will be continuing developments to the DBTH clinical portal. This will seek to make the portal the single point of access to VIEW digital patient information held by the Trust and extend the functionality and usage across DBTH. The portal data will also be made securely available to staff engaged in ongoing and integrated patient care across other providers. This may include ambulance and NHS111 staff, mental health, community care, primary care and social care as appropriate and allowed under GDPR and DPA 2018 regulations

Phase 2: will be covered by a separate business case and deliver the following:

- Sepsis Paeds and Maternity
- Fluid Balance
- Additional Risk Assessment (inc. AKI)
- Daily Case Notes (Advanced Clinical Noting)
- Outpatient Clinical Noting
- Electronic Document Management (EDM)
    - EDM is likely to be phased in-parallel with, and overlap, the latter stages of phases 1 over the period March 2020 to March 2021 (or earlier depending on funding). This requires binding clinical decisions concerning the continuing use and potential scanning of historical paper.
    - While the Trust has previously invested in Ideagen EDM software and scanning hardware which was not installed, further discovery work is necessary to understand how and where scanning will take place within the Trust. Analysis is being undertaken as to whether the recent installation of the Konica Multi-Function Devices (MFD) can be used / modified to create a more holistic and Trust wide scanning capability, at departmental level, that will add to a patient's clinical record.
    - The discovery work will seek advice and guidance from other Trusts across the ICS concerning the efficacy of scanning, the associated cost/benefits and the medical/legal position associated with patient notes.
    - There needs to be an internal binding agreement at Trust clinical level as to how to deal with the 1.3m historical patient notes and whether / how to digitise them. Much of the information held within these notes that is pertinent to ongoing care is included in the current digital records available via the portal. This includes discharge letters, referrals, diagnostic results and pathology results.
    - It is accepted that some specialities/patients who treat/have long term conditions may need information that extends beyond the existing digital data and these need to be considered as part of this EDM solution.

2. Strategic Case

The Government's target is to introduce a comprehensive system of electronic health records which will deliver accurate, up-to-date, and complete information about patients at the point of care in England by 2020. The recommendations that followed the 2016 Wachter Review have become the foundation for the IT strategy that forms a key part of the Five Year forward View.

Enabling Strategies

As a DBTH 'enabling strategy', this business case directly supports both the NHS vision for digital technology and the Trusts Strategic Vision for 2017-2022 as outlined below.

'The creation of a full Electronic Patient Record across the Trust remains a strategic objective for 2020 in line with the Five Year Forward View requirement as published by NHS Digital. The Trust's previous 'best of breed' strategy for the purchase of replacement time-expired systems means that patient data now resides in multiple systems.

An appropriate approach will be identified and designed to bring the data sources together, along with the digitisation of relevant historic paper based patient information, to create a single patient overview that can be used by clinical staff and the wider health community. While not a full and complete Electronic Patient Record (EPR), it will have the same outcomes and benefits.'

In this context, bed management, Hospital@, e-Obs, clinical noting, development of the clinical portal and decommissioning fax machines (to replace with workflow based forms digital functionality) are the underpinning components of the Trust's EPR strategy.

Implementing and embedding this functionality will transform health care at DBTH by improving all aspects of patient care, including safety, effectiveness, patient-centeredness, internal and external communication between clinical specialities and providers, patient communications especially around outpatient bookings, timeliness and overall trust workforce and financial efficiency. In other words, if we do not know where the patient is, and cannot communicate effectively between Trust staff, this makes clinical decision making / treatment more difficult and inefficient.

The desired outcome of the investment into an EPR is increased data quality. Introducing functionality with standardised Trust processes and working practices across all three sites will reduce waste and significantly improve data quality and reporting, patient pathways and internal patient flow. In turn, this will lead to improvement on the key operational metrics including ED 4 hour wait targets, RTT and 2WW and improve Trust financial performance. It will lead to a fundamental improvement in patient care at both Trust level and care within the community / GP care and ultimately enable the Trust to reach Outstanding CQC status.

The overall programme of work will deliver better patient care by integrating patient information from multiple internal and external sources, making it available for use elsewhere in the health and social care community for ongoing patient care and potentially for enabling population health management. Such use and access is governed by GDPR and DPA 2018 regulation. The programme builds upon the work undertaken within the past 12 months to introduce more digital ways of working, including the clinical portal, task

management (Hospital@) and bed management (Bassetlaw). It will incrementally culminate in a consolidated and integrated EPR by 2020.

The post-script to all of this, is that patients ***expect*** the clinician treating them at the point of care, should have access to their health records from whatever source for their ongoing care.

3. List of options

1: Do nothing – no amendment to the current service

Advantages

- Will not incur any financial expenditure
- Will not require ward staff to be released for training

Disadvantages

- Failure to achieve on of the Trust's key enabling strategies as outlined in the Trust's Strategic Vision for 2017-2022.
- Failure to support different outpatient models as defined in 2019 NHS futures.
- Will not meet the Integrated Care System (ICS) objectives of deploying EPR solutions to HIMSS Level 5 at scale across systems to allow provider digitisation to go further, faster, and more cost-effectively.
- Clinicians, support workers and community staff continue to use patient information which is frequently not available, out-of-date and incomplete at the point of care leading to inefficiencies in care and inability to seamlessly transfer between departments/providers.
- Clinicians' source patient information from disparate paper based and IT systems in an uncoordinated manner which distracts from efficient patient care.
- Inability to reduce overall costs via a decrease in paperwork and a continuation of effort throughout the patient journey.
- Inability to reduce clinical admin staff and records storage associated with patient notes.
- Continuing challenges with data quality, 'getting it right first time' (GIRFT) and inefficient processes.
- An adverse impact upon the Trust's reputation making it more difficult to recruit personnel.
- Projected income degradation from non-compliance with CQUINs and central government initiatives.
- Continuing issues meeting performance targets for RTT, ED Wait times and 2WW
- Inability to get to Outstanding CQC rating.

Option 2 – Big bang implementation of bed management, eObs and nursing handover as part of the Trust's EPR deployment

Advantages

- Will meet the Integrated Care System (ICS) objectives of deploying EPR solutions at scale across systems to allow provider digitisation to go further, faster, and more cost-effective.

- Will support the achievement of one of the Trust's key enabling strategies as outlined in the Trust's Strategic Vision for 2017-2022.
- Will streamline processes making them more efficient
- Will deliver at pace enabling faster implementation across all three sites.
- Will release nursing time to direct nursing care (e.g. data capture, completing charts).
- Will provide accurate, up-to-date and complete information about patients at the point of care.
- Will facilitate the secure sharing of electronic information about patients at the point of care.
- Will facilitate the reduction in costs by eliminating paperwork, reducing duplication of tests and improved patient health.
- Enables information to be shared seamlessly across local healthcare systems, laying the foundations for integrated care.

Disadvantages

- Will incur significant up-front financial expenditure
- Will require ward staff to be released for training with additional bank and agency expense
- Will result in extended disruption by introducing multiple new ways of working (e.g. adoption of new standard operating procedures). With the added risk of overwhelming users and technology adverse healthcare workers and conversely reducing efficiency and adversely impacting on patient care.
- No learning curve – just a steep cliff. Jeopardising future acceptance of new ways of working.
- Potential to lose delivery efficiency as other programmes of work become priorities
- Lack of technical and business change project management capability to run a diversely large programme at pace.

Option 3 – Incremental deployment at pace

Advantages

- Will allow a short period of time for new systems to embed in the 'culture' and build on these by demonstrating continued improvements and realisation of benefits e.g. time releases for clinical care, reduction in unexpected arrest calls, decreased length of stays, fewer adverse events
- Will spread the upfront financial investment over 2 financial years
- Utilises an incremental modular approach (working in partnership with a single supplier with a successful NHS delivery track record) maintaining momentum to enthuse users and drive engagement
- Will streamline cross Trust processes making them more efficient and improving data quality.
- Will meet the Integrated Care System (ICS) objectives of deploying EPR solutions at scale to HIMMS level 5 across systems to allow provider digitisation to go further, faster, and more cost-effectively.
- Will support the achievement of one of the Trust's key enabling strategies as outlined in the Trust's Strategic Vision for 2017-2022.
- Will release nursing time for direct patient care (e.g. data capture, completing charts).

- Will provide accurate, up-to-date and complete information about patients at the point of care
- Will facilitate the secure sharing of electronic information about patients at the point of care.
- Will facilitate the reduction in costs through by eliminating paperwork, reducing duplication of testing and improved patient health.
- Enables information to be shared seamlessly across local healthcare systems, laying the foundations for integrated care.

Disadvantages

- Will incur significant up-front capital and recurrent revenue expenditure
- Will require ward staff to be released for training
- Will require the disruption of introducing multiple new ways of working (e.g. adoption of new standard operating procedures) albeit in a more controlled way than a 'big-bang' approach
- Full benefit realisation will be delayed

4. Identification of preferred option

Option 3 is the preferred option. It is wholly aligned with national, ICS and Trust strategic objectives and is realistically deliverable in the timeframes suggested without massive disruption to existing operations across the Trust.

5. Management Case

The following outlines the key functionality changes that will be introduced under the preferred option. As previously stated, no two EPR systems are the same. These components provide the core functionality that will transform health care at DBTH by: improving all aspects of patient care including safety, effectiveness, patient-centeredness, communication, timeliness and efficiency. Functionality contained within this business case will also work towards the elimination of fax machines and replaced with e-mail communication between users and / or new forms that will allow for an improved workflow with management supervision.

It is vital that staff members are trained on the new systems, the alerting functionality and more importantly the revised business processes that need to be embedded within the Trust. As previously stated, the plan is to use Bassetlaw to pilot and embed new functionality and processes so these can be transported to DRI and MMH. It is recognised that different approaches to care exist across all three sites. Adoption of standard working (in line with Qii principles) across the Trust is vital to reduce waste, improve underlying performance, data quality, clinical safety, patient pathways and financial efficiencies.

Appendix 2 outlines the functionality and business changes that will be delivered in the phases outlined in this business case.

It is proposed, subject to agreement with operational departments, estates and facilities, that a 'model hospital' is established at MMH during this project. This will be set up to demonstrate the full set of processes for inpatient and outpatient services and the underlying functional software and hardware and how it will be used. This will be a powerful real life model that will allow staff to track a patient's digital journey including referrals from third parties, internal process management and the transfer of care to other providers as

part of the patient journey and pathway management. The ‘model hospital’ will extend beyond the initial phase 1 of the project into phase 2 and then into longer term usage so changes to patient care can be digitally mapped and trained in context to ensure continuity and maximisation of the EPR.

Impact on Workforce

Having recently used Bassetlaw as a pilot site and the successful deployment of Hospital@ and bed management, a similar approach will be adopted for the delivery of functionality outlined in this business case. Once embedded at Bassetlaw the solutions will be rolled out at DRI and MMH.

The deployment will be led by a dedicated clinical lead who will be responsible for co-ordinating the stakeholder engagement, training and standard operating procedures for each set of functionality which will provide a seamless, staff and patient experience. Each business unit will identify a champion who will be responsible for local engagement and training. This tried and tested model has served the Trust well to-date, although there is an appreciation that the size of the task will be significantly greater at DRI.

Training will be provided via a blended approach of face-to-face, on-line (e-learning) and via designated local champions ‘on-the-job’. It is essential that the training is delivered ‘just-in-time’ to ensure individuals can put it into practice as soon as possible.

It is recognised that training on such a scale can have an impact on staffing models. Previous rollouts of clinical functionality, such as Bloodhound, have shown how challenging training is if it is conducted away from the workplace. Every effort will be made to provide training that is scheduled to avoid additional cost or the use of bank and agency workers. However it must be recognised that staff must be released for training ahead of a go live.

E-learning packages will be the preferred method of training delivery.

It is anticipated that each module identified above will be trained on a ward by ward basis with appropriate post implementation support from a core team plus ward champions.

Impact on Finance

The preferred option proposes a £1.926m capital investment over 3 years with a recurrent revenue of circa £0.52m. The project is expected to deliver recurrent benefits in excess of £1m (cash and non-cash releasing) and demonstrates a ROI (Return on Investment) of 20.1%, with a payback period of 9 years.

Capital & Revenue		WTE	Year 0 2018/19 £'000	Year 1 2019/20 £'000	Year 2 2020/21 £'000	Year 3 2020/21 £'000	Year 4-10 £'000	Total £'000
Capital Investment		5.00	735	1,146	45		-	1,926
Recurrent Revenue	- Pay	5.99	-	247	254	261	2,053	2,813
	- Non Pay		-	94	262	267	2,026	2,648
Non Recurrent Revenue	- Pay	4.40		163	159		-	321
	- Non Pay						-	- 1
Sub-Total Revenue		*10.39*	-	*503*	*675*	*528*	*4,079*	*5,784*
Overheads	Depreciation		-	-	269	275	1,383	1,926
	Capital Charges		-	-	66	58	146	269
Total Capital & Revenue		**15.39**	**735**	**1,649**	**1,055**	**862**	**5,607**	**9,905**

Table 1 - Investment

Value for Money	
Value for Money - discounted cost/benefit ratio	1.70
Return on Investment	20.1%
Payback period	9

Table 2 - Value for money

Benefits	WTE	Year 1 2018/19 £'000	Year 2 2019/20 £'000	Year 3 2020/21 £'000	Year 4 2021/22 £'000	Year 5 2022/23 £'000	Year 6 2023/24 £'000	Recurrent £'000
Cash Releasing								
Reduction in length of stay (Assumed reduction in 8 beds)		-	465	956	984	1,013	1,042	1,042
2% saving on CNST premiums from reduced claims (Excl. Maternity)		-	-	-	-	-	146	146
Reduction in printing of paperwork		-	-	92	94	96	98	98
	0.00	-	465	1,049	1,078	1,109	1,286	1,286
Non Cash Releasing								
Senior clinical time saved due to efficiencies	0.77	-	-	-	107	110	113	113
Nursing time saved on admissions	3.08	-	-	-	134	138	142	142
	3.85	-	-	-	241	248	255	255
Total Benefits	**3.85**	**-**	**465**	**1,049**	**1,319**	**1,356**	**1,541**	**1,541**

Table 3 - Cash and Non-Cash Releasing Benefits

Savings will be realised from year 3 onwards.

Via the ICS, the Trust has applied for Public Dividend Capital (PDC) as part of the Health System-Led Investment (HSLI) transformation fund for this project. £0.73m has been requested for 2018/19 and £1.191m during 2019/20 and 2020/21. No additional revenue is available via HSLI and this remains the Trust's responsibility to fund. There are conditions associated with the PDC funding including an agreement to 100% match either in real cash or in kind (e.g. nurse training costs, management time etc).

The capital, revenue and benefits profile for the project fully meet the HSLI PDC requirements.

Currently no guarantees are provided for any year PDC funding. The DBTH case, along with other providers within the SYB ICS, has been agreed by a regional NHSE panel. These

now go to a national panel for approval prior to drawdown of PDC funds. Approvals are expected at the latest by end of February 2019 for 2018/19 funding (£0.73m).

Should the business case be approved by the end of January 2019, it is expected that the application for PDC funding through HSLI will be made to draw down funds as per the below schedule:

£0.73m in 2018/19

£1.19m in 2019/20 (Requires DBHT / Trust Fund backing until HSLI funding confirmed)

£0.05m in 2020/21 (Requires DBHT / Trust Fund backing until HSLI funding confirmed)

The Trust would need to ring-fence funding for future years (as above), as the HSLI funding is not guaranteed due to shifting priorities within the ICS, as it seeks to balance digital investment with a rising demand for services with limited investment available. The Trust should be prepared to fund this business case in full across multiple years at a cost of £1.926m with the uplift of £0.52m revenue detailed above.

PDC funding requires a 100% matched investment by the provider. This matching can be in the form of additional capital plus revenue related staff training time, training development, business change, vendor support and maintenance costs, capital charge, subsequent internal costs to support the functionality and a whole range of time related activities that can be costed. The business case recognises these costs and over the extended lifetime of the project (10 years) will meet the matching requirements.

6. Commercial Case

The capital outlay for phase 1 is £1.926m. Recurrent revenue once fully deployed is £0.52m Expected recurrent benefits once fully deployed are in excess of £1 million –Table 3 - Cash and Non-Cash Releasing Benefits for details ROI is anticipated at 20.1% Table 2 - Value for money.

The proposal is wholly consistent with the Government's commitment to make all patient records digital, real-time and interoperable by 2020. It is also consistent with the ICS objective of Trusts achieving the recognised international standard for health records set by HIMMS at level 5.

It will enhance the Trust's reputation as a progressive healthcare organisation where patient information is recorded once, digitally, at, or close to, the point of care. Clinicians will be alerted promptly to key patient events and changes in status, supported by knowledge management and decision support tools.

The proposal will be attractive to CQC and commissioners as a result of improved data quality, patient safety, actionable management of alerts and information reporting in real time.

The business case adheres to the SFI and procurement rules.

The bed management functionality has been procured from EMIS as part of the existing PAS contract. Costs are for the procurement and installation of the digital whiteboards to provide the bed management capability across 39 wards at DRI and MMH. While the bed management module can operate across a standard PC, it is clear from the pilot at Bassetlaw that large, wall mounted touch screen computers with tap and go functionality are

the far better option for usability and staff efficiency. This has been shown with the adoption rates during rollout, which are included within the business case.

The rest of the clinical functionality will be procured from Nervecentre (see Appendix 2). A full OJEU procurement exercise has already taken place during 2018 for a full stack of clinical decision software. Initially, this was for the Hospital@ functionality but with the intent to rollout additional software in modular form from the same supplier to ensure turnkey integration and a very similar look and feel at user and support level to enable faster clinical adoption. Nervecentre were the successful bidder and at the time provided a full and complete breakdown of costs for additional modular functionality. Subsequent work has taken place to negotiate costs downwards for taking multiple modules as a package of functionality and a commitment from the Trust to deploy a range of functionality over a 2-3 year period. The costs outlined in this business case reflect these discounts after careful consideration of the functionality required.

The Trust evaluated a number of Nervecentre approved devices during the Bassetlaw pilot of Hospital@, to be utilised for the hand held mobiles to be used for e-observations and clinical noting at the ward level. These will be Android devices at a relatively low cost against Apple equivalent. The Trust's IT department support the procurement of these Nervecentre approved devices and the ability to manage and maintain these securely on the Trusts Wi-Fi network. As these devices will be issued to wards and departments rather than individuals, an assumption has been made against loss or damage to such devices on an annual basis and this has been included in the recurrent revenue costs. The business case supports the initial capital purchase of 295 handheld devices including all appropriate licences.

It should be noted that Bring Your Own Device (BYOD) is not currently proposed due to patient identifiable data security concerns, the need to approve a device for Nervecentre use and the underlying technical support constraints. It should be noted that not all android devices are the same and therefore no assumptions can be made around device compatibility or ability to operate either on the Trust network or with the functional software. Future year deployments or expansion may use BYOD once these security and operational concerns are resolved.

7. Risk Analysis

Risks	**Rating**		**Overall Risk Rating**	**Mitigation Plan**
	Likelihood	Consequence		
There is the risk of conflicting priorities for the same business and technical change resource groups throughout the life cycle of the programme.	5	4	**20**	Mitigation: To manage the prioritisation of competing Trust priorities via the Executive and Management Boards. This is likely to include a change freeze or moratorium on new projects / initiatives at the peak of the deployment phase and a recognition of limited resources that can enact change on the organisation

There is a risk of a lack of engagement at all levels and across all services leading to minimal buy-in and delayed progression. As a result, business change will not be achieved and the benefits will not be realised.	4	4	**16**	Mitigation: All specialties and sites need to have a lead clinician and nurse with a vested interest/accountability in making the project work. Staff members, at all levels, need to be kept informed as to where we are going - a live roadmap will demonstrate this. Positive and visible support in all areas available to educate and encourage users. Communication is key and making all healthcare professionals share the responsibility for success will drive momentum. 'Selling the concept' by driving home the message that this will improve quality and our working environment.
There is a risk that releasing staff for training will adversely impact patient care due to lack of ward staff, or we are unable to release staff for the same reason.	3	3	**9**	Mitigation: The solution needs to be intuitive and processes changed in such a way as to allow success. A stepwise and incremental role out essential so as not to overwhelm users. Advertise training opportunities early and aim to do it on the job/ in a virtual environment. Training to be completed via e-learning wherever possible and supported by local champions.
There is a risk that the solutions cannot be integrated with our current systems e.g. PAS. This is essential to know where the patients are (the most basic requirement) and allow all aspects of the proposal to be successful.	2	4	**8**	Mitigation: All IT systems procured by the Trust must be compatible with recognised healthcare interoperability and data transfer standards (e.g. HL7 / FHIR).
There is a risk that quality and performance may dip just after implementation.	4	3	**12**	Mitigation: any new system will have teething problems. This is to be expected. By learning from other Trusts and using our own Trust experience some of these problems can be foreseen. Incremental role out with approval gateways for the next stage and choosing an easy to use solution that doesn't overwhelm systems should get over these hurdles quickly.
There is a risk that the NHSE funding will not be available for subsequent years for phase 1b and 2 due to changes in parliament and potential Brexit plans.	3	3	**9**	Mitigation: the Trust will not make any commitments to suppliers to procure modules that are not contained within the years funding from NHSE.

8. Quality Impact Assessment

The project will have minimal impact on the wards for the installation of technical equipment, such as large screens for bed management and storage for the devices. Training on the system and business process changes will be required to successfully implement each element of the EPR, as outlined in this business case.

To enable continued support each ward will identify champions who will assist staff members post go-live to use the system in line with the agreed business process. The system training will take place for staff members in a variety of locations on a drop-in basis provided by the supplier, IT Trainers, Clinical Educator or via e-learning packages.

During the implementation phases it is unlikely that there will be diminished quality in patient documentation or patient care, however the patient experience may be reduced due to the use of devices at the patient bedside.

Once fully implemented there will be benefits to patient flow, reduced delays in patient discharge, improved monitoring of patient transfers and improved communications between specialities.

9. Equality impact assessment

The proposal does not affect one group more or less favourably than another based on race, age, gender etc.

10. Internal implications

The following implications have been identified:

- Systems administrators will need to configure the systems for the implementation – completed within their current role. There will be limited impact to business as usual support.
- The IT Training team will develop training materials and provide training sessions – completed within their current roles; limited impact to business as usual training availability is anticipated.
- System supplier will provide Champion training, which will require a suitable room for training to be completed.
- Informatics team will produce required reports for the project. There may be a requirement to adapt some existing reports in relation to LoS or bed management and introduce additional details into existing / create new reports.
- Ward Administrators (Ward Clerks, Co-coordinators etc.) will need to adopt new standard working processes and procedures and attend training. Training will be required at a minimal level.
- Health Care Assistants / Nurses will need to actively manage the electronic bed state to ensure that it is kept ‘live’ out of hours. They will be required to undertake observations at the patient bedside using a hand held device to record them in real time. To support this change HCA / Nurses will need to attend the required training.
- Clinicians will be required to undertake the relevant systems training provided in line with the business changes; this will include nurses, HCA, all levels of doctors and consultants.
- The flow co-ordinator role will require an element of business change due to the visibility of a ‘live’ bed state across all trust sites. Training and input into the project deliverables and business change will be required from this group of staff.
- Hospital nursing and operational management will need to provide considerable input throughout the project and continued input to ensure the required changes to business processes and procedures are embedded into ward SOP’s. It is anticipated that this will be performed within their current role. It is recognised that the current working capacity of individuals may have an impact on the roll out.

- Quality & Patient Experience: Real-time data on bed occupancy, IPC data/history will be available from one data source.
- Staff: Change to business processes, cascade train the trainer to be employed, support from Project Board members, admin groups, clinicians - particularly the nursing staff on wards will be required to implement a successful 'live' bed state. It is recognised that the capacity of the wards and individuals may have an impact on the project deliverables and success.
- The Information Management Team (Data Quality): Will spend less time checking the quality of the Care Group data, as this information will be available to be utilised by the BI project to supply information to the care groups in real time.

11. Other organisations

There is no direct external organisational impact as part of this project. However there will be improvements to the discharge arrangements working with other Health and Social Care partners across Doncaster, Bassetlaw and South Yorkshire as our patients will experience seamless and integrated care. Data will eventually be made available to other care providers if deemed appropriate under GDPR and DPA for ongoing patient care and for health planning and research purposes.

12. Outline Implementation plan

Below is a summary of the implementation plan and a detailed plan contained in Appendix 3. It is anticipated that a pilot of new functionality will take place at BDGH prior to its deployment at DRI and MMH.

Phase 1a will deploy Task Management (Hospital@) and Bed Management to DRI and MMH in Q1 2019/20 and eObservations in Q2 2019/20 to adult ward in BDGH.

Phase 1b will deploy Nursing eHandover and Sepsis at BDGH (Adult wards) in Q2 2019/20, with DRI and MMH (Adult wards) deployed by Q3 2019/20.

Clinical noting[1] will be implemented to inpatient wards on an incremental deployment; this will include three key risk assessments such as Falls, VTE, MUST etc. in Q3 2019/20.

Fax decommissioning will commence in September 2019, focusing on internal faxing for speciality consultations and referrals commencing in Q3 2019/20.

Phase 2: will review the Electronic Document Management requirements to establish standardised formats for documents that do not lend themselves to digitisation processes. Functionality across Paeds and Maternity will be introduced, outpatient clinical noting, assessments and internal referrals.

13. Benefits realisation

The benefits of the business case are outlined in Appendix 4 and Table 3 - Cash and Non-Cash Releasing Benefits.

[1] Clinical Noting for inpatients includes eHandover, SNOMED, Clerking and Discharge Forms, Clinical Photography, Care Plans, Pre-Admission and Discharge Summaries

14. Post project evaluation

The project will use a variety of evaluation methods including timing events, system audit logs (for system usability) and user feedback. Data will be assessed one month post implementation at pilot and again six months post implementation across the Trust.

15. Conclusion and Recommendation

This document has made the case for investing in a portfolio of clinical functionality to be used by clinicians to support the delivery of more effective patient care. Furthermore, those components of the solution which have been adopted in Bassetlaw have already received positive feedback in terms of ease of use and efficiency gains within the Trust. The business case has:

- Confirmed the strategic context of the investment.
- Made a robust case for change.
- Presented an options appraisal, including outline costs and benefits, sufficient to enable the Trust to make a decision on funding.
- Demonstrated the return on investment.
- Described the arrangements for the implementation plan.

The Corporate Investment Group is requested to approve the Business Case based on option 3.

16. Approvals and Sign Off

Post	***Electronic signature and comments***
Care Group/Corporate Director *- that the business case has been through the appropriate committee structures and is supported by the division*	
Senior Management Accountant *- that a quality assurance process has been undertaken to ensure sign offs are complete and that all parts of the business case template have been completed and that all financial issues are accurately recorded within the business case. There will be an internal finance department process which will require sign off by:* • *Head of income & contracts* • *Head of financial control* • *Head of procurement*	
Deputy Director of People & OD *- that all relevant HR issues are accurately recorded within the business case*	

Head of ICT *- that all IM&T implications are accurately recorded in the business case*	
Head of Estates and Facilities *- that all Estates & Facilities issues are accurately recorded in the business case*	

17. Appendices

Appendix 1 – Financial

FINANCIAL SUMMARY												
	Project year	Yr 0	Yr 1	Yr 2	Yr 3	Yr 4	Yr 5	Yr 6	Yr 7	Yr 8	Yr 9	Yr 10
	Financial year	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25	2025/26	2026/27	2027/28	2028/29
(1) COSTS	Sum of Cashflows											
Capital	1,927	735	1,146	45	-	-	-	-	-	-	-	-
Recurrent revenue	7,660	-	340	850	862	865	869	872	877	881	618	626
Recurrent revenue exc PDC and depn	*5,463*	-	340	516	528	541	555	568	582	596	611	626
Transitional & non-recurrent revenue	322	-	163	159	-	-	-	-	-	-	-	-
TOTAL	**9,909**	**735**	**1,649**	**1,055**	**862**	**865**	**869**	**872**	**877**	**881**	**618**	**626**
(2) CASH RELEASING BENEFITS												
Cash Releasing Benefits, of which:	11,964	-	465	1,049	1,078	1,109	1,286	1,321	1,357	1,394	1,433	1,472
Recurrent revenue benefits	*11,964*	-	*465*	*1,049*	*1,078*	*1,109*	*1,286*	*1,321*	*1,357*	*1,394*	*1,433*	*1,472*
TOTAL	**11,964**	**-**	**465**	**1,049**	**1,078**	**1,109**	**1,286**	**1,321**	**1,357**	**1,394**	**1,433**	**1,472**

UNDISCOUNTED TOTAL OF COSTS AND BENEFITS CHANGES	- 735	- 1,185	- 6	217	244	418	449	481	513	815	846
RECURRENT REVENUE IMPACT	-	125	533	550	568	732	753	775	798	822	846

Costs	- 735	- 1,649	- 1,055	- 862	- 865	- 869	- 872	- 877	- 881	- 618	- 626
Savings	-	465	1,049	1,078	1,109	1,286	1,321	1,357	1,394	1,433	1,472
Cumulative net impact	- 735	- 1,920	- 1,926	- 1,709	- 1,465	- 1,048	- 599	- 118	395	1,209	2,055

	2021/22	2022/23	2023/24	2024/25	2025/26
Revenue savings	1,078	1,109	1,286	1,321	1,357
Initial Capex	1,927				
Average annual revenue saving 21/22 - 25/26 (next Spending Review period)	1,230				
Revenue savings as a proportion of initial capex	64%				

Payback period	9

DSB 181123 ITEM 03iii 20181115_Value

Appendix 2 – Deliverable Descriptions

Phase 1a

Bed Management

In the context of this business case we are seeking funding to deploying bed management at DRI and MMH (it has already been implemented at Bassetlaw).

Constantly fluctuating bed occupancy, from planned and emergency admissions, discharges and transfer between ward areas means that bed occupancy is one of the most challenging areas within the Trust to effectively manage. Real-time bed state management will ensure clinicians can make more informed management care decisions.
For example: Improved discharge process, reduced lengths of stay for inpatients, easy recognition of red/green patient days and the underlying reasons. This is facilitated by real-time recording of Admission, Discharge and Transfer (ADT) activity and automated updates to CAMIS so ensuring patients can be moved through their pathway quickly and efficiently. This is especially effective outside of core ward clerk hours where ADT activity is always recorded retrospectively.

The initial focus will be on bed and patient status data to provide the information the wards and operations need to make more informed decisions on patient movements. Through increased visibility of available, closed and blocked beds in real time has increased the efficiency of the bed management processes enabling ward and site managers to carry out their primary function (i.e. non longer a slave to ops meetings) using real-time reporting and analysis of bed capacity. This will be in easy-to-use graphical dashboards which are remotely viewable in a command centre environment.

And finally, we will seek to integrate the bed management application into other Trust systems, such as clinical site manager's dashboards and clinical portal (which is currently under-development). Further development is likely to provide live state information to the discharge and transport co-ordinators.

> *Note – the launch of bed management in Bassetlaw on October 10th 2018 is already transforming ADT activity. Focus is now on blockers to discharge rather than reactive management of the bed state.*
>
> *Note – the hardware in use at Bassetlaw is a mix of touch screen large displays with an inbuilt PC using drag and drop functionality with 'tap and go' access and those run via a desktop computer. The split approach was chosen to determine the most effective use of the system and assess the cost/benefit/ease of use of each technical solution during the Bassetlaw pilot. While both solutions perform well, there is no doubt the touch screen displays are the preferred option for users and this is the option chosen for the rollout at DRI and MMH.*

Task Management (Hospital@)

The current model of working OOH and overnight at the DRI site relies on multiple clinical teams that work in silos with very little central co-ordination. This can mean that while one team struggles another could have spare capacity. The nurses currently contact the doctors via the individual wards escalation policy and through the bleep system. This leaves the individual clinicians to manage their own workloads with no central overview of the hospital workload nor patient prioritisation based on clinical need. The Trust has recurring issues in serious incidents with tasks not being appropriately prioritised or acted on. The Trust have

no system to track nor audit how busy different members of staff are when incidents do occur.

In July 2018, DBTH successfully implemented a task management system at Bassetlaw. Feedback from this project has seen a reduction in time spent waiting for bleeps to be answered and since implementation there have been no events of failed escalation or being unable to contact the correct clinician when the system is in operation. Survey monkey feedback has been very positive from all clinicians involved.

This case proposes extending the solution to DRI and MMH. DBTH will move away from a nurse directly contacting a clinician. Tasks will be raised by an electronic system and then routed and allocated to clinicians based on need of patients and capacity of individual clinicians. Tasks will not 'fall through the cracks' nor be left unanswered at end of shifts.

eObservations

Observations play a fundamental role with patients, in the prevention of deterioration in an acute hospital. To maximize safety, observations must be timely, accurate and escalated appropriately. The system removes paper observation charts. Instead observations are entered into a mobile device at the bedside by an appropriate member of staff. The system is then configured (by DBTH) to alert at different levels of NEWS. If above a 5 the observation taker has to have the patient observations viewed by a registered nurse before completing the entry. At this point the system states it will automatically alert the appropriate medical staff to the NEWS score unless the registered nurse overrides this. The escalation points are configurable within the system by the trust. This effectively means we have changed our current system, where if action is not completed by staff it is automatically escalated, within the system. This is now an auditable failsafe system and makes it easy for the staff to do the right thing at the right time.

The system is set to alert the nursing team to when observations need to be taken. This is done in line with our policies and the frequency changes based on the last NEWS score. There are configurable settings for patients with special circumstances such as respiratory disease so the algorithms can be altered and avoid constant escalation in patients that do not need it. Adult, paediatric and maternity configuration is included within the alerting system.

Other Trusts using this system have shown a 16% reduction in ICU admissions, 50% reduction in EWS incidents and 24% reduction in cardiac arrests.

Phase 1b

Sepsis (Adults)

Enhancing eObservation to include electronic documentation of Sepsis screening will improve outcomes for patients with sepsis, which is a major NHS priority. Mortality rates increase significantly with every subsequent hour that treatment is delayed; after the sixth hour, a patient only has a 30% survival rate. This solution uses vital signs, EWS and Pathology results for early diagnosis of Sepsis and then goes a crucial step further and ensures that the appropriate doctors and nurses are immediately alerted when a risk of sepsis has been identified. This has been deployed in other Trusts who have seen an increase in antibiotic prescription within the hour from 29% to 94% within the electronically screened group.

Clinical Noting (Inpatients)

The Clinical Noting solution for inpatients includes eHandover, Clerking and Discharge Forms, Clinical Photography, Care Plans, Pre-Admission and Discharge Summaries, and SNOMED CT to standardise documents in a digital format. E.g. Through transforming handover from an end of shift documentation to a real time, accurate status of the patient that can be shared by anyone, anywhere in the hospital.

SNOMED CT

The solution provides support for full SNOMED CT compliance in line with National guidelines by 2020.

Assessments

This business case will purchase and implement three key risk assessments which are currently carried out on paper for every admission e.g. Falls, MUST, VTE, Dementia. Upon completion of an assessment the system will display RAG ratings, calculated scores, and textual results. Furthermore, it will eliminate the unwarranted duplication of information which is currently captured, thereby freeing up time for nursing care. Nurses, doctors and allied healthcare professionals can update all patient information from the bedside on their mobile device, or large screens during board rounds. More importantly, changes can be made concurrently instead of searching for the patients notes when another clinician has taken them (which frees up time to care in itself). Staff will have full visibility of any changes to a patient's status that have occurred throughout the day or night.

Internal Development of Command & Control

The solution will provide every clinician with a consistent view of each patient, and outstanding patient based actions. Transfers of care are based on full sets of current information delivering more effective handover meetings. Efficiency and variance reporting are a vital part of the core functionality to be delivered from day 1 and not an afterthought.

Fax Decommissioning

Fax decommissioning requires digital development of standardised workflows, templates and forms derived from internal development or via third party software.

Phase 2

Electronic Document Management

An electronic document management is a system used to track, manage and store documents and reduce paper. In this context, it provides clinicians to access historical patient information and or documentation which is still paper based.

Assessments (including AKI)

Purchasing the full assessment functionality will enable the Trust to create any number of assessments and can be utilised to manage the internal referral processes and patient pathways e.g. physio, OT, nutrition without the need for

faxes or extensive time on the phone arranging staff to attend patients that are potentially ready for discharge.

Sepsis

The introduction of Sepsis into Paediatric and Maternity specialities.

Fluid Balance

This will enable the full patient observations to be recorded electronically, providing the functionality for the HCA / Nurse to record the fluid in measured units that patients can relate to e.g. cups.

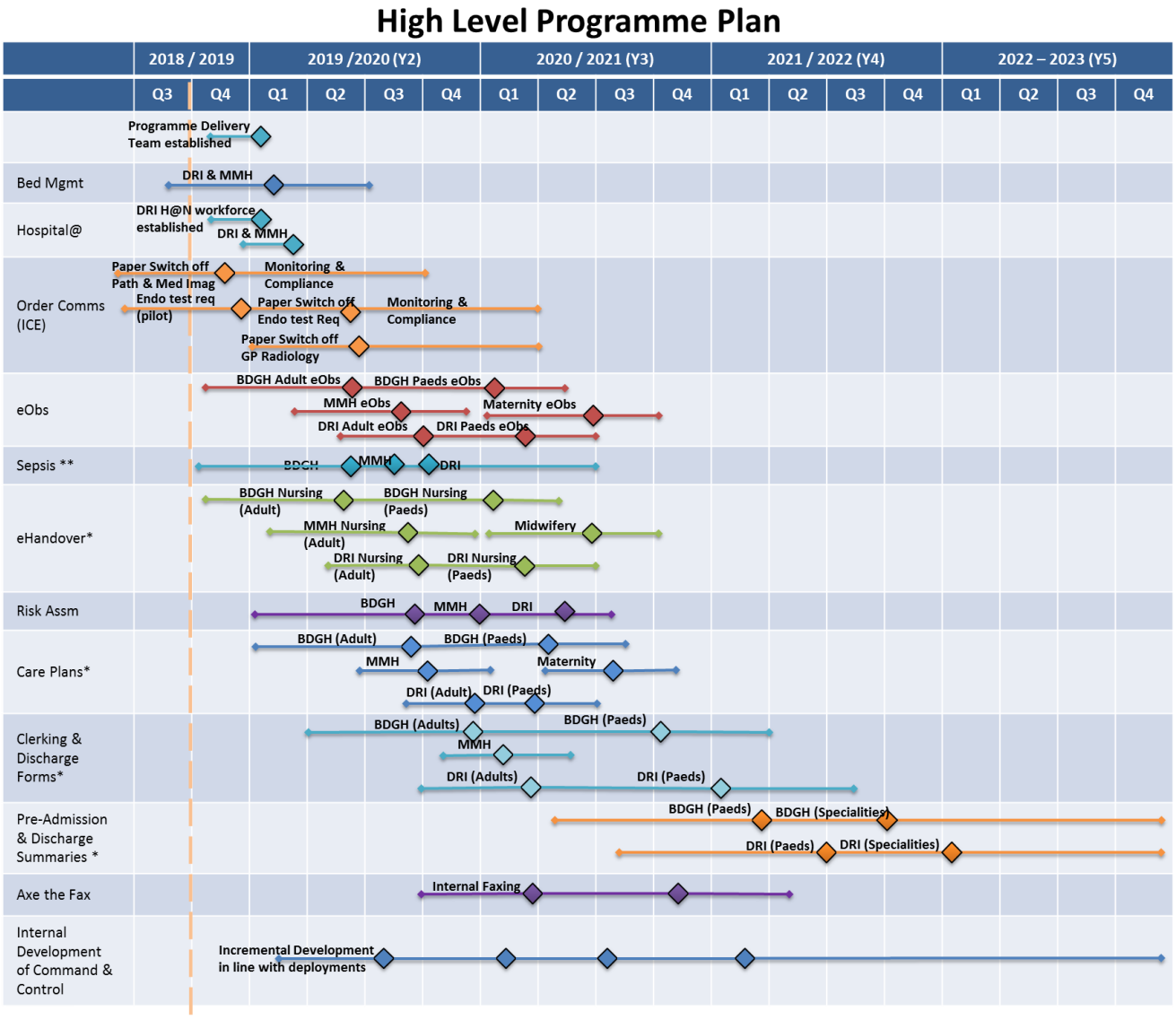
Clinical Noting (Advanced)

This will replace the daily inpatient case note documentation for clinicians and introduce electronic clinical correspondence.

Outpatient Clinical Noting

This will introduce the ability to complete electronic documentation in an outpatient setting.

Appendix 3 – High Level Programme Plan



*Clinical Noting for inpatients includes eHandover, SNOMED, Clerking and Discharge Forms, Clinical Photography, Care Plans, Pre-Admission and Discharge Summaries
**Sepsis excludes Paeds and Maternity

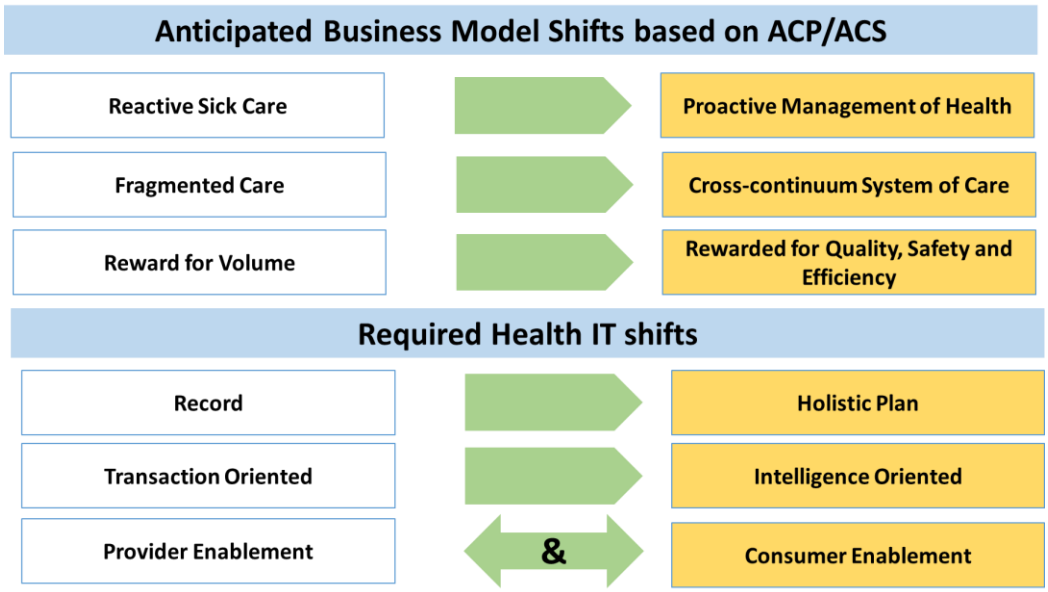
Appendix 4 - Benefits Realisation

	System	Benefit	Measure
1	Bed Management	Increased visibility of real-time bed state, giving increased patient flow.	Faster turnaround of empty beds, Decrease in boarding time in ED due to bed waits.
2	Bed Management	Reduction in need for operational meetings as will now be real time.	Release of senior nursing time into care for patients.
3	E-Obs	Earlier escalation of deteriorating patients.	Reduction in DCC admissions.
4	E-Obs	Earlier escalation of deteriorating patients.	Reduction in incidents due to lack of escalation.
5	E-Obs	Earlier escalation of deteriorating patients.	Reduction in HSMR.
6	E-Obs	Earlier escalation of deteriorating patients.	Reduction in cardiac arrest calls.
7	Sepsis alerting	Improved recognition and fast treatment of sepsis	Reduction in morbidity/mortality from sepsis.
8	Clinical noting	Up to date, correct handover information without need to copy out in handover.	Release of nursing time back to care.
9	Clinical noting	Up to date, correct handover information without need to copy out in handover.	Reduced clinical incidents due to poor handover.
10	Task Management	Easier escalation of patients.	Reduction in incidents due to patients not reviewed.
11	Task Management	System knowledge of individual clinician workload allowing balancing of tasks across the workforce out of hours.	Improved flow and ability to respond to ill patients.
12	System benefits	Overall increase in efficiency and ability to pinpoint and tackle delays in patient care from the Ops room.	Reduction in LOS.

Appendix 5 – Long term requirements for functional and hardware change in support of clinical systems within DBTH.

Strategic Alignment

This business case for £1.926m of capital with matched funding, requests initial HSLI phased capital from HSLI funding and Trust contributions, for specific aspects of the overall composite Electronic Patient Record (EPR) that **do not exist today** within DBTH and is in alignment with the Doncaster and Bassetlaw Teaching Hospitals Corporate Directorate Digital Strategy 2017-2022 published in November 2017. It fully supports the anticipated shifts required as a result of integrated health care, technology advancement and user expectations related to health and social care.



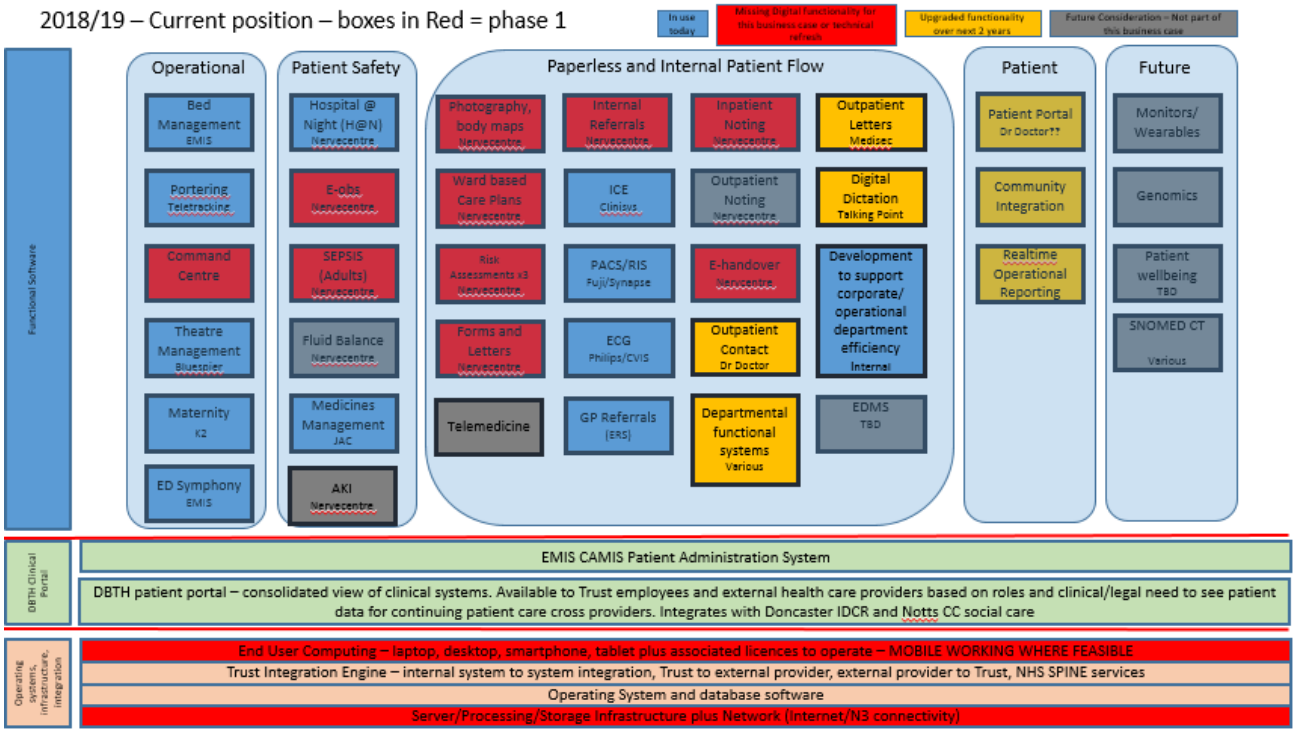
The EPR, together with the availability of relevant integrated patient data across multiple providers enables the key efficiencies detailed in Lord Carter's operational productivity review and is core to the productivity and efficiency assumptions within the 2019/20 operational planning guidance. Specifically these include

- Digitally enabled outpatient operational models
- Improved availability of mobile devices and digital service for staff

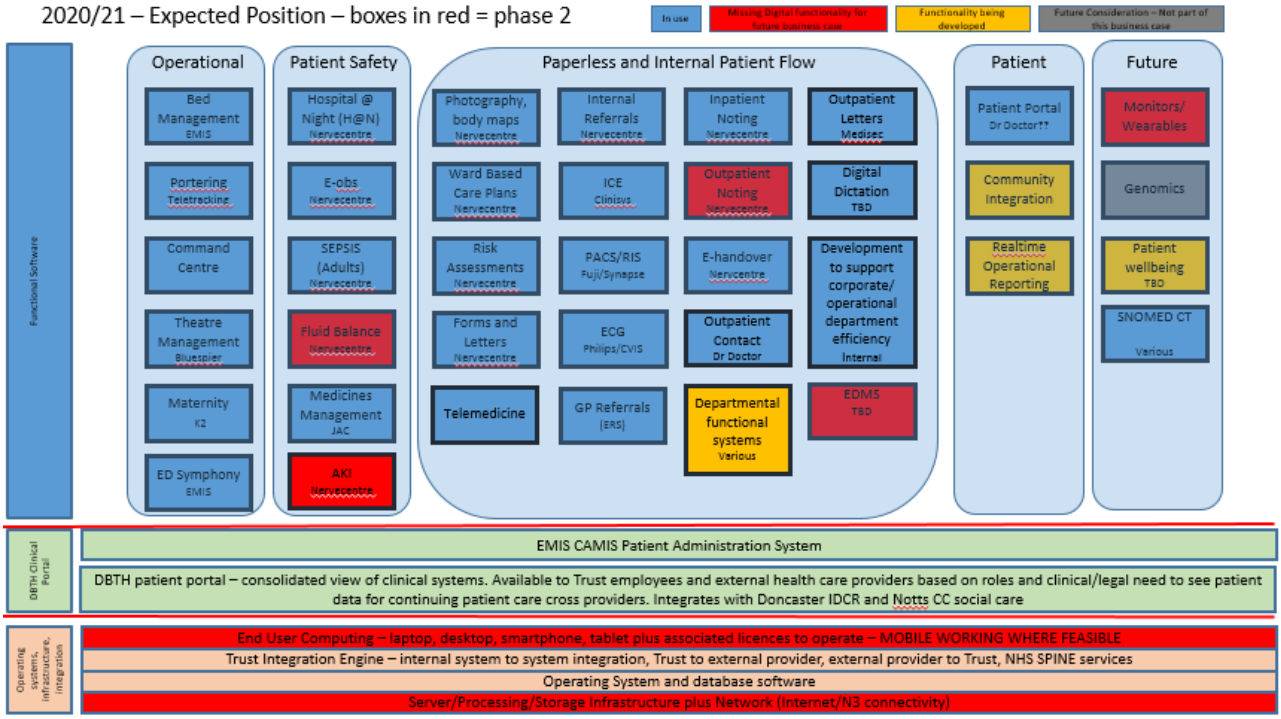
There are a large number of functional components related to systems, data and information within an acute NHS provider. Through historical procurement on a 'best of breed' basis, DBTH operates upwards of 50 separate systems across a range of administration, clinical and medical disciplines. Internal development over the last 18 months has seen these integrated into a clinical portal for use internally within the Trust and in future use externally to other NHS providers using secure infrastructure and sharing on an approved legal basis under GDPR.

The following diagram sets out the 2018/19 position for the core functional systems and underpinning technical infrastructure. The functional areas in RED are those subject to this business case and aim to infill gaps in the current digital environment and replace paper or manual process and improve patient flow. The expectation is that at the conclusion of the implementation the Trust will have a digital maturity at HIMSS Level 5. This maturity will include full integration with NHS primary and community care and to social care provided by the various councils within the DBTH operating area. There is further expectation that the

Yorkshire and Humberside Local Health Care Record Exemplar (Y&H LHCRE) will deliver patient and wider integration functionality at regional level through a separate investment route external to the Trust and managed by Y&H LHCRE (not specifically set out below).

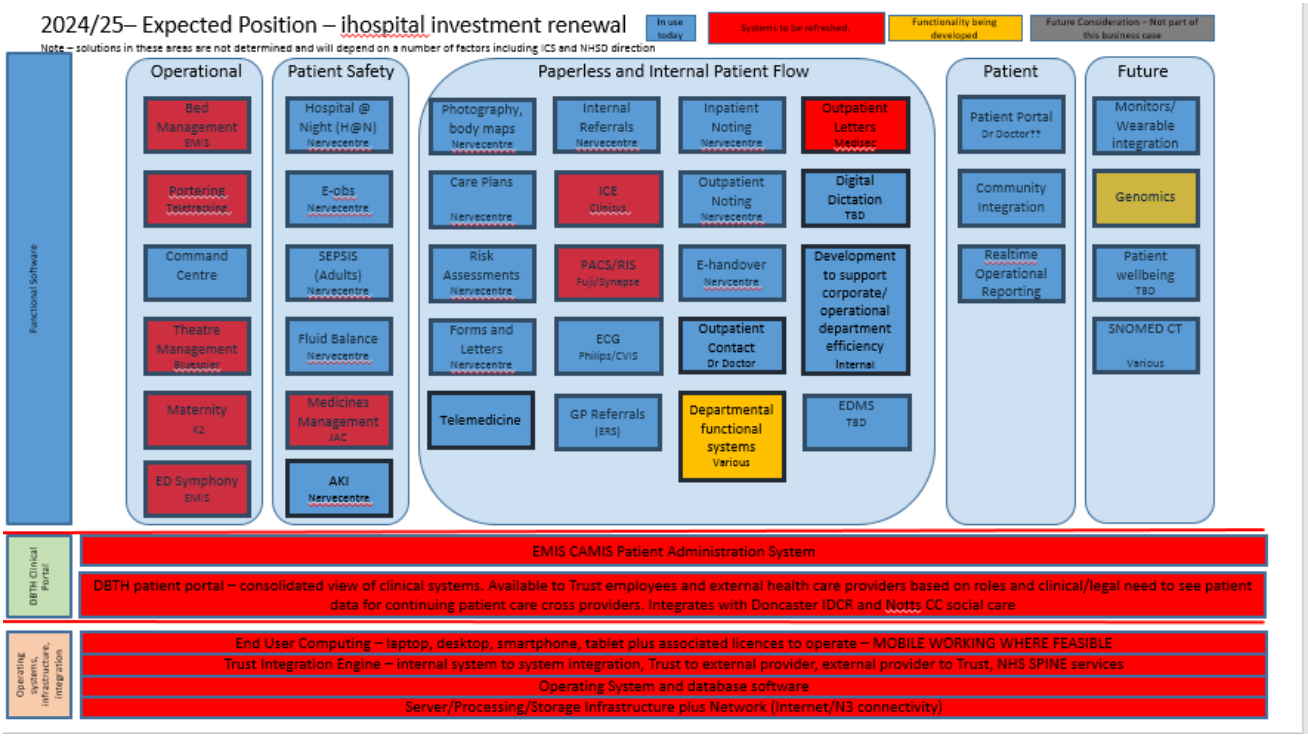


The 2020/21 position set out below results from the implementation of the functionality being procured in 2018-2021 within this business case. The expectation is that the functionality will be fully delivered and embedded within the Trust standard operating procedures. There will be a further investment required in 2021/22 to complete the functional requirements for a full EPR (outlined in RED). It is expected that requirements will evolve over time and be influenced by both ICS operational requirements, NHSE, LHCRE and other external parties as to what is required at an Acute Trust level. The Trust should budget circa £1m capital for these components in 2021-22. This is subject to functional and business requirements for the Electronic Data Management Store (EDMS) – the digitisation of existing patient paper records and new paper from other sources being fully articulated and agreed.



The Trusts iHospital programme from 2013-2015 replaced much of the core infrastructure and core PAS/ED functionality on a 10 year contract. It is expected that this will need to be either renewed or replaced in 2024-2025. Similar to the position for 2020/2021 set out above, there may be external to Trust influences on future strategic direction of systems to gain economies of scale, drive cost out from the ICS and enable a single platform. It is far too early to provide any accurate estimates as to what this will cost. However, the Trust should budget £6-8m in 2023-2025 to complete this work including business and process transformation. It should be noted that DBTH purchased the EMIS CAMIS PAS and Symphony systems on a revenue/lease model over 10 years in 2014 due to lack of capital. While this would suggest that in 2024 the recurrent revenue costs to support the capital lease and provide software support and maintenance costs should significantly reduce, EMIS, like many suppliers, have suggested they will move to a revenue only licence model as they seek to refresh there aged application stack.

The diagram below sets out an anticipated requirement for a technical refresh or wholesale replacement. Functional areas are set out in RED and include associated hardware and operating software refresh. No assumptions have been made as to supplier.



There are no trust level strategic plans for a wholesale replacement of existing functional/departmental software. This would be exceptionally capital intensive and has the potential to cause massive disruption to the operation of the Trust for little financial or patient quality benefits. Recent investments in such enterprise replacement at Huddersfield and Calderdale with Cerner are estimated to have cost circa £30m including business transformation and taken 3 years from inception to delivery. DBTH plan is to incrementally add functionality, preferably with a single supplier, on a modular basis as and when required/needed.

Functional software and associated processes are embedded within clinical and medical standard operational procedures. It is a recognised statistic that within the NHS that overall business transformational change equates to:

- 5% technical/digital
- 15% process change
- 80% people changing to new working practices and process and delivering the same or improved patient outcomes and efficiencies.

When functional software is deemed to be out of contract, expensive to own/operate compared to other Trusts, no longer suitable or fit for purpose (for changing clinical, legal, integration or other operational needs), then an investment case will be prepared. At this juncture, the Trust will seek to do one of the following options:

- Remain on the existing supplier software but use standards to improve performance and reduce costs
- Reduce total Trust operational costs by consolidating functionality to a single supplier, modular platform with the same ‘look and feel’ as other modules that reduces transformation change risk for the 95% of change that is not technical in nature
- Consolidate to a regional system used across multiple providers within the South Yorkshire and Bassetlaw ICS. This will reduce variation in clinical and administrative

process and contribute towards ICS ‘centres of excellence’ at clinical and IT support level
- Consolidate to a wider regional or national systems with proven efficacy.

Hardware, Storage and infrastructure

Many of the underpinning systems run on hardware, operating systems and other infrastructure that needs to be refreshed on a regular basis. These needs are complex, vendor dependent and underpinned by changing technical advances in hardware together with licencing arrangements that make predicting the medium to long term future (3-10 years) exceptionally difficult.

Systems run on one of the following technical environments that maintain a 24*7, 4 hour fix, resilient environment (essential for a modern digital hospital):

- On premise (at DBTH) dedicated server and storage (DSaS) hardware purchased via capital.
    - This hardware is specific to an application and is sized by the supplier to provide optimal performance depending on number of users and storage required.
        - Software is normally core, cross functional and strategic in nature and examples include CAMIS PAS and Symphony ED (from EMIS), Trust Integration Engine (TIE), PACS/RIS
    - DSaS is normally procured to include an initial 5 year support and maintenance agreement from date of installation.
    - Once this initial 5 year term expires, DBTH needs to either provide capital to replace/refresh the DSaS on latest infrastructure (with five year support and maintenance included) or procure support and maintenance on an annual recurrent revenue basis.
        - Supplier Contracts determine hardware refresh cycle and support for software when such hardware has not been refreshed
        - DSaS hardware cannot be ‘sweated’ indefinitely and manufacturers typically end support for a platform after 7-10 years. At this point refresh via capital becomes a necessary investment.
    - DSaS runs operating systems, databases (normally Microsoft products) and other system software components that require licencing on a periodic basis (and are subject to audit). These go End of Life (EOL) periodically (normally every five years. Support and maintenance is normally provided for an extended period but eventually this ceases and cyber security updates are not provided. Manufacturers licence models change periodically depending on the underlying hardware.
        - There is an intrinsic link between hardware, operating system/database software and application software. These are normally determined by the application software supplier as ‘assured environments’ that they will support. Going outside of this intrinsic coupling is problematic and not recommended.
    - Most DSaS hardware and operating system/database software was purchased as part of the iHospital Investment Programme in 2013-2015 and is due for renewal between 2018 and 2020.
    - DBTH third line infrastructure staff support the installation.

- On premise (at DBTH) virtual server and storage (VSaS) hardware purchased via capital.
    - This hardware is not specific to an application and is sized by the Trust to provide optimal performance depending on the applications, number of users and storage required.
        - Example applications are normally departmental in nature and include audiology, cancer services infoflex, CVIS Tomcat Cardiology
    - VSaS is normally procured to include an initial 5 year support and maintenance agreement from date of installation.
    - Server and Storage is added to the virtual system depending on projects (business case dependent) and capacity/performance requirements for existing applications.
    - Once this initial 5 year term expires, DBTH needs to either provide capital to replace/refresh the VSaS on latest infrastructure (with five year support and maintenance included) or procure support and maintenance on a revenue basis.
        - VSaS hardware cannot be 'sweated' indefinitely and manufacturers typically end support for a platform after 7-10 years. At this point refresh via capital becomes a necessary investment.
        - Ongoing Capacity/Performance requirements can normally be absorbed within a capital refresh programme due to manufacturer technical price/performance improvements.
    - VSaS runs operating systems, databases (normally Microsoft products) and other system software components that require licencing on a periodic basis (and are subject to audit). These go End of Life (EOL) periodically (normally every five years. Support and maintenance is normally provided for an extended period but eventually this ceases and cyber security updates are not provided. Manufacturers licence models change periodically depending on the underlying hardware.
        - Like DSaS, there is an intrinsic link between hardware, operating system/database software and application software. VSaS environments are usually more flexible and suppliers normally warrant application software under varying conditions.
    - Most VSaS hardware and operating system/database software was purchased as part of the iHospital Investment Programme in 2013-2015 and is due for renewal between 2018 and 2020.
    - DBTH third line infrastructure staff support the installation.

- Off premise cloud infrastructure (Cloud)
    - Cloud infrastructure for NHS usage is provided by one or two NHS Digital approved suppliers including Amazon Web Services (AWS) and Microsoft Azure
    - This is a recurrent revenue only investment with no capital involved. The supplier or the Trust determines the hardware, storage and other infrastructure components to provide contractual system performance.
    - Capacity can normally be flexed to deal with peak performance or the establishment of test and/or development environments.

    - The Trust requires its own internet/N3 network capacity as part of the overall solution
    - Older applications (normally core/strategic at this time) are not designed to use cloud infrastructure and performance would not be acceptable under this usage.
    - Examples applications that use Cloud include NHS Mail (supplied by NHS Digital via Accenture).

- Off premise supplied infrastructure
    - This is infrastructure supplied by a software vendor normally in their data centre as part of a national or regional service.
    - Examples include ICE OpenNet and Chemocare (cancer)
    - The Trust requires its own internet/N3 network capacity as part of the overall solution
    - Application software is provided under a contract that includes software and hardware under a single recurrent revenue payment. The software vendor is responsible for the maintenance and support of the infrastructure and application.

Health System Led Investment in Provider Digit

Instructions:

1. Complete the scheme information below and the following sheets: Costs, Financial Benefits (including cas
2. Information can be entered in all UN-FILLED (white) cells in each table.
3. Values must be input as £000s. All financial information must be input as positive values.
4. Monetary information must be input in nominal terms (i.e. including inflation).
5. Some cells have comments with guidance. These cells will have a red flag in the top right hand corner, hc
6. Key metrics will be automatically calculated at the bottom of the summary sheets.
7. Local intelligence and plans should be used to complete this template, using key financial assumptions agreed across
8. For detailed guidance on appraisal and evaluation of capital proje The Green Book: appraisal and evaluation in central

Lead organisation	**DONCASTER & BASSETLAW**
Project name	**ELECTRONIC PATIENT RECORD**
Select the base year	**2018/19**
Project life (whole years)	**10**
Project life rationale	

Contents

Sheet name	Description	Instructions
1. Economic Sum	Calculates the economic costs and benefits to society of the proposed project and the resulting Value for Money ratio. Figures in the economic summary are discounted. Discounting is a technique used to compare costs, benefits and risks that occur in different time periods. It is a separate concept from inflation. The	No input required
2. Financial Summ	Calculates the incremental financial costs and benefits to society of the proposed project, and the payback period and recurrent revenue impact.	No input required
3. Costs	Use this sheet to record information about both project costs. This information is used in the Summary sheets.	For all costs, users need to briefly explain the assumptions and methodology used to calculate the values in column B. Additional cost categories can be included by using the blank rows. The default setting is for all user-entered cost categories to apply to
4. Financial and C	Use this sheet to record the expected, monetisable incremental benefits of the proposed project. Both cash releasing and non-cash releasing benefits need to be included on this sheet. Users can enter a maximum of four cash releasing and four non-cash releasing benefits. A cash releasing benefit generally means a resource of one type or another that can be withdrawn/stood down resulting in a real cost saving e.g. a permanent reduction in total headcount, a quantity of fuel not required in a vehicle (mobile working), a permanent closure of a bed.. A non-cash releasing benefit generally means that a resource can more efficiently perform its task. For example changes to working practices may lead to savings of 20% of time for a member of	For all benefits, users need to specify what the benefit is (column B) and briefly explain the assumptions and methodology used to calculate the values (column C). For cash releasing benefits: Indicate whether or not the savings are recurrent revenue savings (column D).
5. Quality/Safety/S	Use this sheet to record the wider expected incremental benefits of the project.	Identify the specific quality/safety and wider societal benefits (e.g. reduced enviromental impact) of the proposed scheme and briefly describe how they will be generated.

6. Risks	Enter the key risks of the project and provide an initial indication of their likelihood and impact.	Record the key risks of the scheme and planned mitigations. Use the dropdown boxes to indicate the risk impact and likelihood.

ECONOMIC SUMMARY												
Costs and benefits	**Project year**	**Yr 0**	**Yr 1**	**Yr 2**	**Yr 3**	**Yr 4**	**Yr 5**	**Yr 6**	**Yr 7**	**Yr 8**	**Yr 9**	**Yr 10**
	Financial year	**2018/19**	**2019/20**	**2020/21**	**2021/22**	**2022/23**	**2023/24**	**2024/25**	**2025/26**	**2026/27**	**2027/28**	**2028/29**
(1) COSTS	**Sum of Cashflows**											
Capital	1,556	613	909	34	-	-	-	-	-	-	-	-
Recurrent revenue	4,045	-	324	466	454	441	427	413	399	386	374	362
Transitional & non-recurrent revenue	299	-	155	144	-	-	-	-	-	-	-	-
INCREMENTAL COSTS TOTAL	**5,900**	**613**	**1,387**	**644**	**454**	**441**	**427**	**413**	**399**	**386**	**374**	**362**
(2) BENEFITS												
Cash Releasing Benefits	8,732	-	442	948	926	903	989	960	931	904	877	851
Non-cash Releasing Benefits	1,505	-	-	-	207	202	196	191	185	180	175	170
INCREMENTAL BENEFITS TOTAL	**10,236**	**-**	**442**	**948**	**1,132**	**1,105**	**1,186**	**1,151**	**1,117**	**1,084**	**1,052**	**1,021**

Value for Money Ratio	**1.7**

FINANCIAL SUMMARY

	Project year	Yr 0	Yr 1	Yr 2	Yr 3	Yr 4	Yr 5	Yr 6	Yr 7	Yr 8	Yr 9	Yr 10
	Financial year	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25	2025/26	2026/27	2027/28	2028/29
(1) COSTS	Sum of Cashflows											
Capital	1,927	735	1,146	45	-	-	-	-	-	-	-	-
Recurrent revenue	7,660	-	340	850	862	865	869	872	877	881	618	626
Recurrent revenue exc PDC and depn	*5,463*	-	340	516	528	541	555	568	582	596	611	626
Transitional & non-recurrent revenue	322	-	163	159	-	-	-	-	-	-	-	-
TOTAL	**9,909**	**735**	**1,649**	**1,055**	**862**	**865**	**869**	**872**	**877**	**881**	**618**	**626**
(2) CASH RELEASING BENEFITS												
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UNDISCOUNTED TOTAL OF COSTS AND BENEFITS CHANGES		- 735	- 1,185	- 6	217	244	418	449	481	513	815	846
RECURRENT REVENUE IMPACT		-	125	533	550	568	732	753	775	798	822	846
Costs		- 735	- 1,649	- 1,055	- 862	- 865	- 869	- 872	- 877	- 881	- 618	- 626
Savings		-	465	1,049	1,078	1,109	1,286	1,321	1,357	1,394	1,433	1,472
Cumulative net impact		- 735	- 1,920	- 1,926	- 1,709	- 1,465	- 1,048	- 599	- 118	395	1,209	2,055

	2021/22	2022/23	2023/24	2024/25	2025/26
Revenue savings	1,078	1,109	1,286	1,321	1,357
Initial Capex	1,927				
Average annual revenue saving 21/22 - 25/26 (next Spending Review period)	1,230				
Revenue savings as a proportion of initial capex	**64%**				

Payback period	**9**

COSTS ANALYSIS - NOMINAL VALUES			
PROJECT COSTS			
(1) CAPITAL COSTS	**Brief description of methodology and assumptions used to calculate costs**	**Inc in Ec**	**Inc in Fin**
Capital costs (inc VAT), sourced by:			
HSLI		Y	Y
Other		Y	Y
TOTAL: CAPITAL COSTS (NOMINAL)			
VAT on ALL capital cost components above		Y	N
(2) RECURRENT REVENUE COSTS			
Staff costs (inc VAT)		Y	Y
Public Dividend Capital		N	Y
Depreciation		N	Y
Non-staff costs (inc VAT) [Specify in this cell if appropriate]	Other Non Pay - Annual license fees and replacement programme for devices	Y	Y
Non-staff costs (inc VAT) [Specify in this cell if appropriate]	Other Non Pay - Ongoing Support and Maintenance Costs	Y	Y
Non-staff costs (inc VAT) [Specify in this cell if appropriate]		Y	Y
TOTAL: RECURRENT REVENUE COSTS (NOMINAL)			
VAT on ALL recurrent revenue cost components above		Y	N
(3) TRANSITIONAL & NON-RECURRENT REVENUE COSTS			
Staff costs (inc VAT)		Y	Y
Non-staff costs (inc VAT) [Specify in this cell if appropriate]		Y	Y
Non-staff costs (inc VAT) [Specify in this cell if appropriate]		Y	Y
TOTAL: TRANSITIONAL & NON-RECURRENT REVENUE COSTS (NOMINAL)			
VAT on ALL non-recurrent revenue cost components above		Y	N
TOTAL: COSTS (UNDISCOUNTED)			

ECONOMIC ANALYSIS			
	Discount rate		
	Non-QALY Discount Factors @ 3.5% / 3.0%		
	Inflation rates (to deflate nominal values to real values for economic analysis)		
	GDP deflator		
	(1) CAPITAL COSTS		
	Capital costs (inc VAT), sourced by:		
	HSLI	Y	
	Other	Y	
	VAT on ALL capital cost components above	Y	
	TOTAL: CAPITAL COSTS (REAL, DISCOUNTED)		
	(2) RECURRENT REVENUE COSTS		
	Staff costs (inc VAT)	Y	
	Public Dividend Capital	N	
	Depreciation	N	
	Non-staff costs (inc VAT) [Specify in this cell if appropriate]	Y	
	Non-staff costs (inc VAT) [Specify in this cell if appropriate]	Y	
	Non-staff costs (inc VAT) [Specify in this cell if appropriate]	Y	
	VAT on ALL recurrent revenue cost components above	Y	
	TOTAL: REVENUE COSTS (REAL, DISCOUNTED)		
	(3) TRANSITIONAL & NON-RECURRENT REVENUE COSTS		
	Staff costs (inc VAT)	Y	
	Non-staff costs (inc VAT) [Specify in this cell if appropriate]	Y	
	Non-staff costs (inc VAT) [Specify in this cell if appropriate]	Y	
	VAT on ALL non-recurrent revenue cost components above	Y	
	TOTAL: NON-RECURRENT REVENUE COSTS (REAL, DISCOUNTED)		
	TOTAL: COSTS (DISCOUNTED)		

FINANCIAL ANALYSIS			
	(1) CAPITAL COSTS		
	Capital costs (inc VAT), sourced by:		
	HSLI		Y

Other			Y
VAT on ALL capital cost components above			N
TOTAL: CAPITAL COSTS (NOMINAL, UNDISCOUNTED)			
(2) RECURRENT REVENUE COSTS			
Staff costs (inc VAT)			Y
Public Dividend Capital			Y
Depreciation			Y
Non-staff costs (inc VAT) [Specify in this cell if appropriate]			Y
Non-staff costs (inc VAT) [Specify in this cell if appropriate]			Y
Non-staff costs (inc VAT) [Specify in this cell if appropriate]			Y
VAT on ALL recurrent revenue cost components above			N
TOTAL: RECURRENT REVENUE COSTS (NOMINAL UNDISCOUNTED)			
TOTAL: RECURRENT REVENUE COSTS EXC PDC AND DEPRECIATION (NOMINAL, UNDISCOUNTED)			
(3) TRANSITIONAL & NON-RECURRENT REVENUE COSTS			
Staff costs (inc VAT)			Y
Non-staff costs (inc VAT) [Specify in this cell if appropriate]			Y
Non-staff costs (inc VAT) [Specify in this cell if appropriate]			Y
VAT on ALL non-recurrent revenue cost components above			N
TOTAL: NON-RECURRENT REVENUE COSTS (NOMINAL, UNDISCOUNTED)			
TOTAL: COSTS (NOMINAL, UNDISCOUNTED)			

Project year	Yr 0	Yr 1	Yr 2	Yr 3	Yr 4	Yr 5	Yr 6	Yr 7	Yr 8	Yr 9	Yr 10
Sum of Cashflows	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25	2025/26	2026/27	2027/28	2028/29
1,927	735	1,146	45								
-											
1,927	735	1,146	45	-	-	-	-	-	-	-	-
321	123	191	8								
Sum of Cashflows											
2,814	-	247	254	261	269	277	285	293	301	310	319
270	-	-	66	58	48	39	29	19	10	0	-
1,927	-	-	269	275	275	275	275	275	275	6	-
1,145	-	94	108	110	112	114	117	119	121	124	126
1,504	-	-	154	157	160	164	167	170	174	177	181
-											
7,660	-	340	850	862	865	869	872	877	881	618	626
-											
Sum of Cashflows											
322		163	159								
-											
-											
322	-	163	159	-	-	-	-	-	-	-	-
-		-									
9,909	**735**	**1,649**	**1,055**	**862**	**865**	**869**	**872**	**877**	**881**	**618**	**626**

	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25	2025/26	2026/27	2027/28	2028/29
	1.000	0.966	0.934	0.902	0.871	0.842	0.814	0.786	0.759	0.734	0.709

	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25	2025/26	2026/27	2027/28	2028/29
	1.00	0.98	0.97	0.95	0.93	0.91	0.89	0.87	0.85	0.83	0.82

	Yr 0	Yr 1	Yr 2	Yr 3	Yr 4	Yr 5	Yr 6	Yr 7	Yr 8	Yr 9	Yr 10
Sum of Discounted Cashflows											
£1,867	£735	£1,090	£41	£0	£0	£0	£0	£0	£0	£0	£0
£1,867	£735	£1,090	£41	£0	£0	£0	£0	£0	£0	£0	£0
£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0
£311	£123	£182	£7	£0	£0	£0	£0	£0	£0	£0	£0
	£613	£909	£34	£0	£0	£0	£0	£0	£0	£0	£0
Sum of Discounted Cashflows											
£2,097	£0	£235	£229	£224	£219	£213	£207	£201	£195	£190	£184
£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0
£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0
£854	£0	£89	£97	£94	£91	£88	£85	£82	£79	£76	£73
£1,095	£0	£0	£139	£135	£131	£126	£121	£117	£113	£108	£104
£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0
£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0
£4,045	£0	£324	£466	£454	£441	£427	£413	£399	£386	£374	£362
£299	£0	£155	£144	£0	£0	£0	£0	£0	£0	£0	£0
£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0
£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0
£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0
£299	£0	£155	£144	£0	£0	£0	£0	£0	£0	£0	£0
£5,900	**£613**	**£1,387**	**£644**	**£454**	**£441**	**£427**	**£413**	**£399**	**£386**	**£374**	**£362**

	Yr 0	Yr 1	Yr 2	Yr 3	Yr 4	Yr 5	Yr 6	Yr 7	Yr 8	Yr 9	Yr 10
Sum of Cashflows											
£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0
£1,927	£735	£1,146	£45	£0	£0	£0	£0	£0	£0	£0	£0

£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0
£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0
£1,927	£735	£1,146	£45	£0	£0	£0	£0	£0	£0	£0	£0
Sum of Cashflows											
£2,814	£0	£247	£254	£261	£269	£277	£285	£293	£301	£310	£319
£270	£0	£0	£66	£58	£48	£39	£29	£19	£10	£0	£0
£1,927	£0	£0	£269	£275	£275	£275	£275	£275	£275	£6	£0
£1,145	£0	£94	£108	£110	£112	£114	£117	£119	£121	£124	£126
£1,504	£0	£0	£154	£157	£160	£164	£167	£170	£174	£177	£181
£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0
£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0
£7,660	£0	£340	£850	£862	£865	£869	£872	£877	£881	£618	£626
£5,463	£0	£340	£516	£528	£541	£555	£568	£582	£596	£611	£626
Sum of Cashflows											
£322	£0	£163	£159	£0	£0	£0	£0	£0	£0	£0	£0
£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0
£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0
£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0
£322	£0	£163	£159	£0	£0	£0	£0	£0	£0	£0	£0
£9,909	£735	£1,649	£1,055	£862	£865	£869	£872	£877	£881	£618	£626

MONETISED BENEFITS

Benefits Analysis

Ref	Benefit Name	Brief description of methodology and assumptions used to calculate benefit	Recurrent revenue saving?	Discounted Benefits	Total	Yr 0 2018/19	Yr 1 2019/20	Yr 2 2020/21	Yr 3 2021/22
(1) CASH RELEASING BENEFITS									
CRB1	Reduction in LOS	Based on closing 8 beds in year 2 and a further 8 bed in year 3	Y	7,461	10,142	-	465	956	984
CRB2	Reduction in CNST	2% saving on CNST premiums from reduced claims (Excl. Maternity)	Y	615	921	-	-	-	-
CRB3	Reduction in Paper	Reduction in printing of paperwork	Y	655	901	-	-	92	94
CRB4			[Please select]	-	-				
TOTAL: CASH RELEASING BENEFITS (NOMINAL)				8,732	11,964	-	465	1,049	1,078
(2) NON-CASH RELEASING BENEFITS									
NCRB1	Release of Senior Clinical Time	Senior clinical time saved due to efficiencies		669	947	-	-	-	107
NCRB2	Release of Nursing Time	Nursing time saved on admissions		836	1,185	-	-	-	134
NCRB3				-	-				
NCRB4				-	-				
TOTAL: NON-CASH RELEASING BENEFITS (NOMINAL)				1,505	2,133	-	-	-	241
TOTAL INCREMENTAL BENEFITS				10,236	14,097	-	465	1,049	1,319
TOTAL RECURRENT REVENUE BENEFITS					11,964	-	465	1,049	1,078

Discount rates		2018/19	2019/20	2020/21	2021/22
Non-QALY Discount Factors @ 3.5% / 3.0%		1.00	0.97	0.93	0.90

Inflation rates (to deflate nominal values to real values for economic anal		2018/19	2019/20	2020/21	2021/22
GDP deflator		1.00	0.98	0.97	0.95

Reference	Discounted Benefits	Total	Yr 0 2018/19	Yr 1 2019/20	Yr 2 2020/21	Yr 3 2021/22
Discounted benefits (incremental)						
CRB1	£7,461	Real terms	£0.0	£457.6	£926.3	£936.9
		Discounted	£0.0	£442.1	£864.7	£845.0
CRB2	£615	Real terms	£0.0	£0.0	£0.0	£0.0
		Discounted	£0.0	£0.0	£0.0	£0.0
CRB3	£655	Real terms	£0.0	£0.0	£89.4	£89.7
		Discounted	£0.0	£0.0	£83.5	£80.9
CRB4	£0	Real terms	£0.0	£0.0	£0.0	£0.0
		Discounted	£0.0	£0.0	£0.0	£0.0
TOTAL: CRBS (REAL)		**£10,662**	£0.0	£457.6	£1,015.7	£1,026.5
TOTAL: DISCOUNTED CRBS		**£8,732**	£0.0	£442.1	£948.2	£925.8
TOTAL: REAL, RECURRENT REVENUE SAVIN		**£10,662**	£0.0	£457.6	£1,015.7	£1,026.5
NCRB1	£669	Real terms	£0.0	£0.0	£0.0	£101.8
		Discounted	£0.0	£0.0	£0.0	£91.8
NCRB2	£836	Real terms	£0.0	£0.0	£0.0	£127.3
		Discounted	£0.0	£0.0	£0.0	£114.8
NCRB3	£0	Real terms	£0.0	£0.0	£0.0	£0.0
		Discounted	£0.0	£0.0	£0.0	£0.0
NCRB4	£0	Real terms	£0.0	£0.0	£0.0	£0.0
		Discounted	£0.0	£0.0	£0.0	£0.0
TOTAL: NON-CASH RELEASING BENEFITS (R		**£1,505**	£0.0	£0.0	£0.0	£206.6
TOTAL INCREMENTAL BENEFITS		**£10,236**	**£0.0**	**£442.1**	**£948.2**	**£1,132.4**

Yr 4	Yr 5	Yr 6	Yr 7	Yr 8	Yr 9	Yr 10
2022/23	2023/24	2024/25	2025/26	2026/27	2027/28	2028/29
1,013	1,042	1,072	1,103	1,135	1,168	1,202
-	146	149	152	155	158	161
96	98	100	102	104	106	108
1,109	1,286	1,321	1,357	1,394	1,433	1,472
110	113	116	120	123	127	131
138	142	146	150	154	159	163
248	255	262	270	278	286	294
1,356	1,541	1,583	1,627	1,672	1,718	1,766
1,109	1,286	1,321	1,357	1,394	1,433	1,472

2022/23	2023/24	2024/25	2025/26	2026/27	2027/28	2028/29
0.87	0.84	0.81	0.79	0.76	0.73	0.71

2022/23	2023/24	2024/25	2025/26	2026/27	2027/28	2028/29
0.93	0.91	0.89	0.87	0.85	0.83	0.82

Yr 4	Yr 5	Yr 6	Yr 7	Yr 8	Yr 9	Yr 10
2022/23	2023/24	2024/25	2025/26	2026/27	2027/28	2028/29
£946.6	£952.2	£957.8	£963.4	£969.0	£974.7	£980.4
£824.9	£801.7	£779.1	£757.2	£735.9	£715.1	£695.0
£0.0	£133.4	£133.1	£132.7	£132.3	£131.9	£131.5
£0.0	£112.4	£108.2	£104.3	£100.4	£96.8	£93.2
£89.8	£89.5	£89.3	£89.0	£88.8	£88.5	£88.2
£78.3	£75.4	£72.6	£70.0	£67.4	£64.9	£62.6
£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0
£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0
£1,036.4	£1,175.2	£1,180.1	£1,185.1	£1,190.1	£1,195.1	£1,200.2
£903.1	£989.5	£960.0	£931.5	£903.7	£876.8	£850.8
£1,036.4	£1,175.2	£1,180.1	£1,185.1	£1,190.1	£1,195.1	£1,200.2
£102.8	£103.4	£104.1	£104.7	£105.3	£105.9	£106.5
£89.6	£87.1	£84.6	£82.3	£79.9	£77.7	£75.5
£128.6	£129.4	£130.2	£130.9	£131.7	£132.5	£133.2
£112.1	£108.9	£105.9	£102.9	£100.0	£97.2	£94.4
£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0
£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0
£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0
£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0
£201.7	£196.1	£190.5	£185.2	£179.9	£174.9	£170.0
£1,104.9	**£1,185.5**	**£1,150.5**	**£1,116.6**	**£1,083.7**	**£1,051.7**	**£1,020.8**

QUALITY SAFETY SOCIETAL BENEFITS

Number	Benefit Name	Benefit Description
Example	Improved staff morale	Staff morale in the A&E department is likely to increase due to improved working conditions and more manageable workloads.
Clinical outcomes		
1	Reduction in preventable admissions to DCC from another inpatient location	Direct alerts generated by an electronic CDS tool direct to the Senior Clinicians mobile device will result in transformation changes for clinical interventions to ill patients providing early escallation and intervention ensuring patient do not deteriorate further requiring DCC admission.
2	Reduction in cardiac arrest calls	The improved analysis of cardiac patient observation will provide the ability to rescue unwell patients prior to a need for escalation and maximising opportunities to enhance patient care prior to the cardiac event.
3	Improved Sepsis Alerting	A marked improvement in the identification and treatment of patients with sepsis will reduce the morbidity and mortality rates for sepsis related incidents.
4	Prioritisation of acutely ill patients	Real time electronic documentation will enhanced decision-making through electonic CDS tools driven by clinically defined processes providing the capability to improve patient escalation through greater clinical engagement and proritisation of acutely ill patients.
5		
Patient safety		
6	Improved flow and ability to respond to ill patients	The mobilisation of clinical staff (ACPs) out of hours will increase the number of ill patients seen, with priority given to the patients with the greatest clinical need.
7	Reduction in HSMR	By reducing avoidable delays and accelerating the appropriate escalation of care which significantly enhances patient safety. The system reduces risks of avoidable delays in care.
8	Reduction in incidents by escalating issues earlier - eobs	Eliminates the need for paper-based recording allowing the trust to maintain an accurate audit and ensures early identification of deteriorating patients.
9	Reduction in incidents through eHandover	Handover is the glue that connects the multidisciplinary team improving real-time accurate information for the trust transforming the shift handover process.
10		
Patient experience		
11	Reduction in A&E waiting time	Reduction in A&E maximum waiting time for 4 hour from arrival to admission
12	Release of nursing time back to care	Mobile technology will undoubtedly play a major role in reinforcing time spent nursing patients
13		
14		
15		
Other		
16	Increased efficiencies in business processes	Real time data capture, escalation and electronic prioritisation based on patients clinical needs will be a major step forward in enhancing business processes and efficencies.
17	Reduction in the need for operational meetings	Accurate real-time patient recording allows for collaborative engagement to be proficient
18	Increased staff morale	Through revolutionising ways of working to streamline business process staff will feel less work related pressure, increasing retention and recruitment of patient facing clinical staff.
19	Reduction in waste through the removal of duplication	Through the removal of 'unwarranted variation' in existing process through embedding new ways of working that utilises technology at the point of interaction will remove duplication of data across IT systems and paper based systems.
20		

Calculations/assumptions made
Estimate that staff survey scores for job satisfaction and motivation will revert to Trust-wide average of 80% and 70% respectively.
Early identification of acutely ill patients from the recognition of trends in e-observations will allow more timely interventions, thus preventing further deterioration and subsequent DCC admissions. These unexpected admissions would be reduced by 50%
Downward trends in e-observations, visible at a macro ‘trust’ level will allow prioritisation of input to these patients before deterioration has set in enabling ceilings of care and appopriate resuscitation decisions. By doing this we could easily reduce cardiac arrest calls by 50-80%
The sepsis bundle and IPOC is built into the e - observations package, so early recognition of it, or the possibility of sepsis will allow focused aggressive treatment into these patients thereby reducing the mortality and morbidity associated. Reduction in mortality from sepsis will be reduced by 30-50%.
Realtime trust wide recognition of these patients will mean their care will be the priority, not buried amongst all the other day to day ward tasks.
As per the above benefits
HSMR will reduce - I don’t know by how many points. We’re already pretty good. 1 max
Reduction in DATIXs of missed escalation, reduction in coroners cases, reduction in ensuing litigation costs
Everyone will be aware of problems at the click of a button. Communication becomes instantaneous and auditable. The central coordinator will ensure tasks are not missed or forgotten.
Assuming 30-40% of nursing time is spent documenting and writing, we will cut this by half, freeing up 20% more nursing time nerf nurse on shift.
Business intelligence will highlight limitations to patient flow on each ward and department allowing focused input to specific areas. This will lead to better processes and improve efficiency.
Matrons and ward managers will have 50% more time for direct patient care
Estimate that the staff survey for patient facing clinical staff groups will show an increase in job satisfaction and motivation.
Removal of the manual bed state paper processes.

UNMONETISABLE RISK ANALYSIS

Number	Risk description	Mitigation of risk	Risk likelihood after mitigation	Risk impact after mitigation
Example	Incorrect cost and time estimates for decanting from existing buildings	Detailed decant plans drawn up in consultation with clinicians and contractors. Estimates of decant cost and time are based on similar, recent decants within the Trust and the wider NHS.	Medium	Medium
1	Interface development could delay the project or disrupt data flows.	Detailed specifications utilising HL7 and FHIR standardisations to transfer data th	Low	Medium
2	Clinical staff may not be released from clinical duties to attend the required	Ensure that training is added into mandatory training matrix for all relevent staffin	Low	Medium
3			[Please select]	[Please select]
4			[Please select]	[Please select]
5			[Please select]	[Please select]
6			[Please select]	[Please select]
7			[Please select]	[Please select]
8			[Please select]	[Please select]
9			[Please select]	[Please select]
10			[Please select]	[Please select]

INFLATION ASSUMPTIONS

GDP Deflator

Year	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25	2025/26	2026/27	2027/28	2028/29
%	-	1.57%	1.66%	1.74%	1.84%	2.30%	2.30%	2.30%	2.30%	2.30%	2.30%

Year	% change on previous year	
2019/20	1.57%	
2020/21	1.66%	https://www.gov.uk/government/statistics/gdp-deflators-at-market-prices-and-money-gdp-march-2018-quarterly-national-accounts
2021/22	1.74%	
2022/23	1.84%	
2023/24+	2.30%	http://cdn.obr.uk/FSR_Jan17.pdf

Project year	0	1	2	3	4	5	6	7	8	9	10
Category	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25	2025/26	2026/27	2027/28	2028/29
GDP deflator	-	1.57%	1.66%	1.74%	1.84%	2.30%	2.30%	2.30%	2.30%	2.30%	2.30%
Cumulative	100.00%	101.57%	103.26%	105.05%	106.98%	109.44%	111.96%	114.54%	117.17%	119.87%	122.62%
Inflation rates	1	0.98	0.97	0.95	0.93	0.91	0.89	0.87	0.85	0.83	0.82

Cost Input Inflation
Source: LTFM Assumptions

Project year	0	1	2	3	4	5	6	7	8	9	10
Category	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25	2025/26	2026/27	2027/28	2028/29
Capex Inflation	1.90%	2.00%	2.00%	2.00%	2.00%	2.00%	2.00%	2.00%	2.00%	2.00%	2.00%
Cumulative	100.00%	102.00%	104.04%	106.12%	108.24%	110.41%	112.62%	114.87%	117.17%	119.51%	121.90%
Staff Inflation	1.60%	2.90%	2.90%	2.90%	2.90%	2.90%	2.90%	2.90%	2.90%	2.90%	2.90%
Cumulative	100.00%	102.90%	105.88%	108.95%	112.11%	115.37%	118.71%	122.15%	125.70%	129.34%	133.09%
Drugs Inflation	4.10%	4.10%	4.10%	4.10%	4.10%	4.10%	4.10%	4.10%	4.10%	4.10%	4.10%
Cumulative	100.00%	104.10%	108.37%	112.81%	117.44%	122.25%	127.26%	132.48%	137.91%	143.57%	149.45%
CSS Inflation	1.90%	2.00%	2.00%	2.00%	2.00%	2.00%	2.00%	2.00%	2.00%	2.00%	2.00%
Cumulative	100.00%	102.00%	104.04%	106.12%	108.24%	110.41%	112.62%	114.87%	117.17%	119.51%	121.90%
Income Inflation	0.90%	0.90%	0.90%	0.90%	0.90%	0.90%	0.90%	0.90%	0.90%	0.90%	0.90%
Cumulative	100.00%	100.90%	101.81%	102.72%	103.65%	104.58%	105.52%	106.47%	107.43%	108.40%	109.37%
Activity Growth					1.86%	1.86%	1.86%	1.86%	1.86%	1.86%	1.86%
Cumulative				100%	101.86%	103.75%	105.67%	107.63%	109.63%	111.67%	113.74%

Section 1 - Capital

Project Element	Description of purchase or service	WTE	Phase	"Go-live" date	Phase 1a	Phase 1b	18/19 Cost Year 1 (£)	19/20 Cost Year 2 (£)	20/21 Cost Year 3 (£)	21/22 Cost Year 4 (£)	22/23 Cost Year 5 (£)	23/24 Cost Year 6 (£)	24/25 Cost Year 7 (£)	25/26 Cost Year 8 (£)	26/27 Cost Year 9 (£)	27/28 Cost Year 10 (£)	Total (£)	Comments
Phase 1a																		
E Ob's and Clinical Noting	Software Purchase (Nerve centre) - E-Obs		1a	Mar-19	538,815		538,815										538,815	Assumed 50% in Year 1 (18/19) and 50% year 2 (19/20) - Further breakdown to be provided - Includes 1st year support and maintenance in year 2.
E Ob's and Clinical Noting	Device Purchase inc licences (circa 1,100 Samsung J5 plus chargers). 54 wards, 5 per ward, £374 inc Airwatch licence plus VAT - launch e-obs across Trust		1a	Mar-19	121,176		121,176										121,176	Assumed 50% in Year 1 (18/19) and 50% year 2 (19/20)
E Ob's and Clinical Noting	Band 5 IT Technician	1.00	1a	Mar-19	45,986		9,197	36,789									45,986	
E Ob's and Clinical Noting	Band 4 Digital Trainer	1.00	1a	Mar-19	35,981		7,196	28,785										
E Ob's and Clinical Noting	Band 7 Project Manager (Internal Staff)	1.00	1a	Mar-19	67,509		13,502	54,007										
E Ob's and Clinical Noting	Qii Lead (Internal Staff)	1.00	1a	Mar-19	67,509		13,502	54,007										
Hospital@DRI	Devices (54) @ £374 for DRI and MMH		1a	Mar-19	24,235		24,235										24,235	
Hospital@DRI	Project Manager - Band 7		1a	Mar-19	7,605		7,605										7,605	40 days at 8hrs per day
Bed Management	Screens (including installation and estates work) - DRI (33), MMH (2) and BDGH (2)		1a	Apr-20	125,000			125,000									125,000	
Trust Co-ord Centre	Screens (including installation) (6 inc PC and fitting)		1a	Apr-20	12,000			12,000									12,000	
Trust Co-ord Centre	Video conference and telephony - To be absorbed by IT		1a	Apr-20	-			-									-	
	Contingency		1a	Apr-20		88,868		88,868										
Phase 1b																		
E Ob's and Clinical Noting	Software Purchase (Nerve centre) - Clinical Noting, Clinical Assessment, Sepsis		1b	Apr-20		538,815		538,815									538,815	Assumed 50% in Year 1 (18/19) and 50% year 2 (19/20) - Further breakdown to be provided - Includes 1st year support and maintenance in year 2.
E Ob's and Clinical Noting	Device Purchase inc licences (circa 1,100 Samsung J5 plus chargers). 54 wards, 5 per ward, £374 inc Airwatch licence plus VAT - launch noting across trust		1b	Apr-20		121,176		121,176									121,176	
E Ob's and Clinical Noting	Band 5 IT Technician	1.00	1a	Apr-20		18,395		18,395									18,395	
E Ob's and Clinical Noting	Band 4 Digital Trainer	1.00	1a	Apr-20		14,392		14,392										
E Ob's and Clinical Noting	Band 7 Project Manager (Internal Staff)	1.00	1a	Apr-20		27,004		27,004										
E Ob's and Clinical Noting	Qii Lead (Internal Staff)	1.00	1a	Apr-20		27,004		27,004										
Fax Decommission	Disposal		1b	Apr-21		2,000			2,000								2,000	
Fax Decommission	Non-recurrent BS IT support (6 months)	1.00	1b	Apr-21		18,395			18,395								18,395	Based on top of scale 5
Fax Decommission	Professional services to support forms development		1b	Apr-21		25,000			25,000								25,000	
																	-	
Total Capital Expenditure		**9.00**		**1,926,864**	**1,045,816**	**881,048**	**735,228**	**1,146,241**	**45,395**	-	-	-	-	-	-	-	**1,598,597**	

Section 2 - Revenue

Project Element	Description of purchase or service	WTE					18/19 Cost Year 1 (£)	19/20 Cost Year 2 (£)	20/21 Cost Year 3 (£)	21/22 Cost Year 4 (£)	22/23 Cost Year 5 (£)	23/24 Cost Year 6 (£)	24/25 Cost Year 7 (£)	25/26 Cost Year 8 (£)	26/27 Cost Year 9 (£)	27/28 Cost Year 10 (£)	Total (£)	Comments
Pay																		
E Ob's and Clinical Noting	Band 7 Digital Matron	0.40						21,603	21,603								43,206	Assumed start date April-19 - Band 7 - 2 year FT
E Ob's and Clinical Noting	Band 7 Digital Midwifery (Internal staff)	1.00															-	Band 7 - Post exists and is funded within current workforce
E Ob's and Clinical Noting	Band 6 Digital Nurse	1.00						45,807	45,807								91,615	Assumed start date April-19 - Band 6 - 2 year FT
E Ob's and Clinical Noting	Band 4 Digital HCA	1.00						28,785	28,785								57,569	Assumed start date April-19 - Band 4 - 2 year FT
E Ob's and Clinical Noting	Band 7 Clinical Lead	1.00						54,007	54,007								108,014	Assumed start date April-19 - Band 7 - 2 year FT
E Ob's and Clinical Noting	Band 6 Clinical Systems Manager	1.00	BAU					45,807	45,807	45,807	45,807	45,807	45,807	45,807	45,807	45,807	412,266	Assumed start date April-19 - Band 6 - 2 year FT
Hospital@DRI	Non Recurrent - Deployment IT - Band 6		1a					792									792	5 days at 8hrs per day
Hospital@DRI	Non Recurrent - Digital Trainer - Band 4		1a					7,364									7,364	60 days at 8hrs per day
Hospital@DRI	Co-Ordinator - Band 6	2.16	BAU					104,092	104,092	104,092	104,092	104,092	104,092	104,092	104,092	104,092	936,828	Assumed start date April 19
Hospital@DRI	Flow Co-Ordinator - Band 3	2.83	BAU					89,777	89,777	89,777	89,777	89,777	89,777	89,777	89,777	89,777	807,997	Assumed start date April 19
Total Pay		**10.39**					**-**	**398,035**	**389,879**	**239,677**	**239,677**	**239,677**	**239,677**	**239,677**	**239,677**	**239,677**	**2,465,652**	
Non Pay																		
E Ob's and Clinical Noting	Software Support and Maintenance (Nerve Centre)								148,229	148,229	148,229	148,229	148,229	148,229	148,229	148,229	1,185,830	Quote provided by Nervecentre for 5 years
E Ob's and Clinical Noting	Device Licenses (Support and maint) plus 40% replacement costs							76,205	76,205	76,205	76,205	76,205	76,205	76,205	76,205	76,205	685,843	20% replacement cost plus 20% support and maint on air watch licences
E Ob's and Clinical Noting	Software Support and Maintenance (Airwatch licence)							7,031	14,062	14,062	14,062	14,062	14,062	14,062	14,062	14,062	119,524	£21.70 per year per licence
Hospital@DRI	Annual Replacement of Devices								4,847	4,896	4,944	4,994	5,044	5,094	5,145	5,197	40,161	Ongoing replacement programme commencing April 2020
Hospital@DRI	Airwatch Licenses for 54 devices							8,262	8,262	8,262	8,262	8,262	8,262	8,262	8,262	8,262	74,358	Assumed purchase date 1st Apr-19
Hospital@DRI	Mobile Phone Contract for 54 devices							194	194	194	194	194	194	194	194	194	1,746	Assumed purchase date 1st Apr-19
Total Non pay							**-**	**91,692**	**251,798**	**251,847**	**251,896**	**251,945**	**251,995**	**252,045**	**252,096**	**252,148**	**2,107,462**	
Total Pay & Non Pay							**-**	**489,727**	**641,677**	**491,524**	**491,572**	**491,622**	**491,672**	**491,722**	**491,773**	**491,825**	**4,573,114**	
Overheads																		
E Ob's and Clinical Noting	Capital Charges								30,694	26,309	21,924	17,540	13,155	8,770	4,385	-	122,777	At 3.5% of net book value
E Ob's and Clinical Noting	Depreciation								125,282	125,282	125,282	125,282	125,282	125,282	125,282	-	876,976	Depreciated over 7 years. Assumed from year 3 once implementation is co
Hospital@DRI	Capital Charges								1,114	955	796	637	478	318	159	-	4,458	At 3.5% of net book value
Hospital@DRI	Depreciation								4,549	4,549	4,549	4,549	4,549	4,549	4,549	-	31,840	Depreciated over 7 years. Assumed from year 3 once implementation is co
Bed Management	Capital Charges								4,375	3,750	3,125	2,500	1,875	1,250	625	0	17,500	At 3.5% of net book value
Bed Management	Depreciation								17,857	17,857	17,857	17,857	17,857	17,857	17,857	-	125,000	Depreciated over 7 years. Assumed from year 3 once implementation is co
Trust Co-ord Centre & Contingen	Capital Charges								3,530	3,026	2,522	2,017	1,513	1,009	504	0	14,122	At 3.5% of net book value
Trust Co-ord Centre & Contingen	Depreciation								14,410	14,410	14,410	14,410	14,410	14,410	14,410	-	100,868	Depreciated over 7 years. Assumed from year 3 once implementation is co
E Ob's and Clinical Noting	Capital Charges								26,137	22,404	18,670	14,936	11,202	7,468	3,734	0	104,550	At 3.5% of net book value
E Ob's and Clinical Noting	Depreciation								106,684	106,684	106,684	106,684	106,684	106,684	106,684	-	746,785	Depreciated over 7 years. Assumed from year 3 once implementation is co
Fax Decommission	Capital Charges									1,589	1,362	1,135	908	681	454	227	6,355	At 3.5% of net book value
Fax Decommission	Depreciation									6,485	6,485	6,485	6,485	6,485	6,485	6,485	45,395	Depreciated over 7 years. Assumed from year 4 once implementation is co
																	-	
																	-	
Total Overheads							**-**	**-**	**334,633**	**333,299**	**323,665**	**314,030**	**304,396**	**294,762**	**285,128**	**6,712**	**2,196,625**	
Total Revenue Expenditure							**-**	**489,727**	**976,310**	**824,823**	**815,237**	**805,652**	**796,068**	**786,484**	**776,901**	**498,537**	**6,769,739**	

Section 3 - Benefits

	Description of benefit	WTE		Realisation date			18/19 Benefit Year 1 (£)	19/20 Benefit Year 2 (£)	20/21 Benefit Year 3 (£)	21/22 Benefit Year 4 (£)	22/23 Benefit Year 5 (£)	23/24 Benefit Year 6 (£)	24/25 Benefit Year 7 (£)	25/26 Benefit Year 8 (£)	26/27 Benefit Year 9 (£)	27/28 Benefit Year 10 (£)	Total (£)	Comments
Cash Releasing																		
	Reduction in length of stay			Apr-19				451,649	903,298	903,298	903,298	903,298	903,298	903,298	903,298	903,298	7,678,029	Based on closing 8 beds from year 2, and a further 8 beds from year 3. Assumes reduction in length of stay or an increase in through put.
	2% saving on CNST premiums from reduced claims			Apr-23								132,278	132,278	132,278	132,278	132,278	661,388	Based on 2% reduction against 18/19 premium (less £10m associated with Maternity) Maternity figure to be confirmed
	Reduction in printing of paperwork			Apr-20					88,760	88,760	88,760	88,760	88,760	88,760	88,760	88,760	710,080	£317k forecast annual spend - asume 40% reduction (£126.8k). Assume 30% reduction in cost since moving to grey paper.
		0.00					**-**	**451,649**	**992,058**	**992,058**	**992,058**	**1,124,335**	**1,124,335**	**1,124,335**	**1,124,335**	**1,124,335**	**9,049,497**	
Non-Cash Releasing							-	-	-	123	123	123	123	123	123	123		
	Senior clinical time saved due to efficiencies	0.77		Apr-21						98,137	98,137	98,137	98,137	98,137	98,137	98,137	686,956	1600 hours per annum (20% of Northumbria's Trust savings). Based on average 18-19 budget for Consultant/Registrar
	Nursing time saved on admissions	3.08		Apr-21						122,752	122,752	122,752	122,752	122,752	122,752	122,752	859,264	6000 hours per annum. Based on average 18-19 budget for Band 5 nurses
		3.85					**-**	**-**	**-**	**220,889**	**220,889**	**220,889**	**220,889**	**220,889**	**220,889**	**220,889**	**1,546,220**	
Total Benefits		**3.85**					**-**	**451,649**	**992,058**	**1,212,946**	**1,212,946**	**1,345,224**	**1,345,224**	**1,345,224**	**1,345,224**	**1,345,224**	**10,595,717**	

Cash flow - costs							**- 735,228**	**- 1,635,968**	**- 687,072**	**- 491,524**	**- 491,572**	**- 491,622**	**- 491,672**	**- 491,722**	**- 491,773**	**- 491,825**		
Cash flow - savings							**-**	**451,649**	**992,058**	**992,058**	**992,058**	**1,124,335**	**1,124,335**	**1,124,335**	**1,124,335**	**1,124,335**		
Cumulative cash flow							**- 735,228**	**- 1,919,547**	**- 1,614,561**	**- 1,114,027**	**- 613,542**	**19,171**	**651,834**	**1,284,447**	**1,917,009**	**2,549,519**		
Total Costs (Capital + Pay & Non-Pay)							**735,228**	**1,635,968**	**1,021,704**	**824,823**	**815,237**	**805,652**	**796,068**	**786,484**	**776,901**	**498,537**	**8,696,602**	
Discounted Total Costs (Capital + Pay & Non-Pay)							**735,228**	**1,580,645**	**953,772**	**743,943**	**710,432**	**678,338**	**647,602**	**618,169**	**589,987**	**365,792**	**7,623,909**	
Total Cash Releasing Benefits							**-**	**451,649**	**992,058**	**992,058**	**992,058**	**1,124,335**	**1,124,335**	**1,124,335**	**1,124,335**	**1,124,335**	**9,049,497**	
Discounted Total Cash Releasing Benefits							**-**	**436,376**	**926,096**	**894,779**	**864,521**	**946,660**	**914,647**	**883,717**	**853,833**	**824,960**	**7,545,589**	

Undiscounted costs	**£**	**8,696,602**
Discounted costs	**£**	**7,623,909**
Undiscounted savings (financial)	**£**	**9,049,497**
Discounted benefits (VFM)	**£**	**7,545,589**

Value for Money - discounted cost/benefit ratio	**0.99**
Return on Investment	**4%**
Payback period (Includes Depreciation)	**6**

Section 1 - Capital

Project Element	Description of purchase or service	WTE	Phase	Procurement or start date	VAT ELEMENT CHECKED	Phase 1	Phase 2	18/19 Cost Year 1 (£)	19/20 Cost Year 2 (£)	20/21 Cost Year 3 (£)	21/22 Cost Year 4 (£)	22/23 Cost Year 5 (£)	23/24 Cost Year 6 (£)	24/25 Cost Year 7 (£)	25/26 Cost Year 8 (£)	26/27 Cost Year 9 (£)	27/28 Cost Year 10 (£)	Total (£)	Comments
				1,926,863		986,845	940,019												
Phase 1								**731,289**	**255,556**	-									
E Ob's and Clinical Noting	Software Purchase (Nerve centre) - E-Obs		1	Mar-19		586,800		586,800										586,800	Assumed 50% in Year 1 (18/19) and 50% year 2 (19/20) - Further breakdown to be provided - Includes 1st year support and maintenance in year 2.
E Ob's and Clinical Noting	Device Purchase inc licences (circa 270 Samsung J5 plus chargers). 54 wards, 5 per ward, £374 inc Airwatch licence plus VAT - launch e-obs across Trust (note device itself is £147 plus VAT)		1	Mar-19		121,176		121,176										121,176	Assumed 50% in Year 1 (18/19) and 50% year 2 (19/20)
E Ob's and Clinical Noting	Implementation Team (Incl. PM for year 1)	3.00	1	Apr-19		99,496			99,496									99,496	Detail on tab 01 - Implementation Team
Hospital@DRI	Devices (35) @ £374 for DRI and MMH		1	Mar-19		15,708		15,708										15,708	Cost Incl. VAT - Funded in capital plan 2018/19
Hospital@DRI	Project Manager - Band 7		1	Apr-19		7,605		7,605										7,605	40 days at 8hrs per day - Funded in capital plan 2018/19
Bed Management	Screens (including installation and estates work) - DRI (33), MMH (2) and BDGH (2)		1	Apr-19		125,000			125,000									125,000	
Bed Management	Non-recurrent matron, clinical lead 15 hrs pw x 16	0.40	1	Apr-19		7,740			7,740									7,740	Based on top of scale 8A
Bed Management	Non- recurrent nurse, training on wards full-time x 16	1.00	1	Apr-19		11,320			11,320									11,320	Based on top of scale 5
Trust Co-ord Centre	Screens (including installation) (6 inc PC and fitting)		1	Apr-19		12,000			12,000									12,000	
Trust Co-ord Centre	Video conference and telephony - To be absorbed by IT		1			-			-									-	
Phase 2								-	894,624	45,395									
Fax Decommission	Professional services to support forms development (core to replacing fax with digital forms)		2	Sep-19			25,000			25,000								25,000	
E Ob's and Clinical Noting - E-Obs	Software Purchase (Nerve centre) - Clinical Noting		2	Dec-19			773,448		773,448									773,448	
E Ob's and Clinical Noting	Device Purchase inc licences (circa 270 Samsung J5 plus chargers). 54 wards, 5 per ward, £374 inc Airwatch licence plus VAT - launch noting across trust		2	Dec-19			121,176		121,176									121,176	
Fax Decommission	Disposal		2	Apr-20			2,000			2,000								2,000	
Fax Decommission	Non-recurrent B5 IT support (6 months)	1.00	2	Apr-20			18,395			18,395								18,395	Based on top of scale 5
Total Capital Expenditure		**5.40**				**986,845**	**940,019**	**731,289**	**1,150,180**	**45,395**	-	-	-	-	-	-	-	**1,926,863**	

Section 2 - Revenue

Project Element	Description of purchase or service - NOTE - this is mainly the annual recurring cost once project handed over from implementation to support	WTE	Phase	Procurement or start date	VAT ELEMENT CHECKED	Phase 1	Phase 2	18/19 Cost Year 1 (£)	19/20 Cost Year 2 (£)	20/21 Cost Year 3 (£)	21/22 Cost Year 4 (£)	22/23 Cost Year 5 (£)	23/24 Cost Year 6 (£)	24/25 Cost Year 7 (£)	25/26 Cost Year 8 (£)	26/27 Cost Year 9 (£)	27/28 Cost Year 10 (£)	Total (£)	Comments
Pay																			
E Ob's and Clinical Noting	Band 6 System Manager (IT)	1.00	BAU							40,074	40,074	40,074	40,074	40,074	40,074	40,074	40,074	320,592	
E Ob's and Clinical Noting	Staff Training (Internal Staff)	4.00	1						118,350									118,350	Band 7 - for year 2 FT
E Ob's and Clinical Noting	Ongoing clinical system support (B7)	1.00	BAU							46,471	46,471	46,471	46,471	46,471	46,471	46,471	46,471	371,768	Band 7 nurse support recurrently
Hospital@DRI	Non Recurrent - Deployment IT - Band 6		1					792										792	5 days at 8hrs per day
Hospital@DRI	Non Recurrent - Digital Trainer - Band 4		1					7,364										7,364	60 days at 8hrs per day
Hospital@DRI	System Manager - Band 6	0.27	BAU					2,582	10,327	10,327	10,327	10,327	10,327	10,327	10,327	10,327	10,327	95,529	Assumed start date 1st Jan-19
Hospital@DRI	Flow Co-Ordinator - Band 3	2.83	BAU					22,444	89,777	89,777	89,777	89,777	89,777	89,777	89,777	89,777	89,777	830,442	Assumed start date 1st Jan-19
Bed Management	*No revenue costs identified*																	-	
Trust Co-ord Centre	*No revenue costs identified*																	-	
Fax Decommission	*No revenue costs identified*																	-	
Total Pay		**9.10**						**33,183**	**218,455**	**186,650**	**186,650**	**186,650**	**186,650**	**186,650**	**186,650**	**186,650**	**186,650**	**1,744,837**	
Non Pay																			
E Ob's and Clinical Noting	Software Support and Maintenance (Nerve Centre)		BAU							184,800	184,800	184,800	184,800	184,800	184,800	184,800	184,800	1,478,400	
E Ob's and Clinical Noting	Airwatch Device Licenses (Support and maint) (£18.6k) plus 20% (540*0.2 = 108) device replacement costs (£19k) based on loss or damage (inc VAT)								37,600	37,600	37,600	37,600	37,600	37,600	37,600	37,600	37,600	338,400	20% replacement cost plus 20% support and maint on air watch licences
Hospital@DRI	Airwatch Licenses for 35 devices (19.31+£9.41+VAT = £34 pa)							1,190	1,190	1,190	1,190	1,190	1,190	1,190	1,190	1,190	1,190	11,900	Assumed purchase date 1st Jan-19
Hospital@DRI	Mobile Phone Contract for 35 devices							32	126	126	126	126	126	126	126	126	126	1,166	Assumed purchase date 1st Jan-19
Bed Management	*No revenue costs identified*																	-	
Trust Co-ord Centre	*No revenue costs identified*																	-	
Fax Decommission	*No revenue costs identified*																	-	
Total Non pay								**1,222**	**38,916**	**223,716**	**223,716**	**223,716**	**223,716**	**223,716**	**223,716**	**223,716**	**223,716**	**1,829,866**	
Total Pay & Non Pay								**34,404**	**257,371**	**410,366**	**410,366**	**410,366**	**410,366**	**410,366**	**410,366**	**410,366**	**410,366**	**3,574,703**	

Section 3 - Benefits

	Description of benefit	WTE		Realisation date				18/19 Benefit Year 1 (£)	19/20 Benefit Year 2 (£)	20/21 Benefit Year 3 (£)	21/22 Benefit Year 4 (£)	22/23 Benefit Year 5 (£)	23/24 Benefit Year 6 (£)	24/25 Benefit Year 7 (£)	25/26 Benefit Year 8 (£)	26/27 Benefit Year 9 (£)	27/28 Benefit Year 10 (£)	Total (£)	Comments
Cash Releasing																			
	Reduction in length of stay			Apr-20						451,649	451,649	451,649	451,649	451,649	451,649	451,649	451,649	3,613,190	Based on either closing 8 or 16 escalation beds
	Reduction in clinical coding time spent looking for missing admissions. Band 4 - 10 hours pw	0.27		Apr-21						7,676	7,676	7,676	7,676	7,676	7,676	7,676	7,676	61,408	Based on top band 4 as majority staff top of scale
	2% saving on CNST premiums from reduced claims			Apr-23									332,278	332,278	332,278	332,278	332,278	1,661,388	Based on 2% reduction against 18/19 premium
	Reduction in printing of paperwork			Apr-20						37,942	37,942	37,942	37,942	37,942	37,942	37,942	37,942	303,536	
	50% reduction in remaining medical records staff	24.41		Apr-23									517,874	517,874	517,874	517,874	517,874	2,589,370	50% reduction on Patient Admin Support Services staff (based on mid-point band 2)
																		-	
		24.67						-	-	**497,267**	**497,267**	**497,267**	**1,347,419**	**1,347,419**	**1,347,419**	**1,347,419**	**1,347,419**	**8,228,893**	
Non-Cash Releasing																			
	Senior clinical time saved due to efficiencies	0.77		Apr-21							98,137	98,137	98,137	98,137	98,137	98,137	98,137	686,956	1600 hours per annum (20% of Northumbria's Trust savings). Based on average 18-19 budget for Consultant/Registrar
	Nursing time saved on admissions	3.08		Apr-21							122,752	122,752	122,752	122,752	122,752	122,752	122,752	859,264	6000 hours per annum. Based on average 18-19 budget for Band 5 nurses
		3.85						-	-	-	**220,889**	**220,889**	**220,889**	**220,889**	**220,889**	**220,889**	**220,889**	**1,546,220**	
Total Benefits		**28.52**						-	-	**497,267**	**718,155**	**718,155**	**1,568,307**	**1,568,307**	**1,568,307**	**1,568,307**	**1,568,307**	**9,775,113**	

Cash flow - costs								- **765,693**	- **1,407,551**	- **455,760**	- **410,366**	- **410,366**	- **410,366**	- **410,366**	- **410,366**	- **410,366**	- **410,366**		
Cash flow - savings								-	-	**497,267**	**497,267**	**497,267**	**1,347,419**	**1,347,419**	**1,347,419**	**1,347,419**	**1,347,419**		
Cumulative cash flow								- **765,693**	- **2,173,244**	- **2,131,738**	- **2,044,837**	- **1,957,936**	- **1,020,883**	- **83,831**	**853,222**	**1,790,274**	**2,727,327**		

Total Costs (Capital + Pay & Non-Pay)								**765,693**	**1,407,551**	**455,760**	**410,366**	**410,366**	**410,366**	**410,366**	**410,366**	**410,366**	**410,366**	**5,501,566**	
Discounted Total Costs (Capital + Pay & Non-Pay)								**765,693**	**1,359,952**	**425,457**	**370,127**	**357,610**	**345,517**	**333,833**	**322,544**	**311,637**	**301,098**	**4,893,468**	
Total Cash Releasing Benefits								-	-	**497,267**	**497,267**	**497,267**	**1,347,419**	**1,347,419**	**1,347,419**	**1,347,419**	**1,347,419**	**8,228,893**	
Discounted Total Cash Releasing Benefits								-	-	**464,204**	**448,506**	**433,339**	**1,134,490**	**1,096,126**	**1,059,059**	**1,023,245**	**988,643**	**6,647,612**	

Undiscounted costs	**£ 5,501,566**
Discounted costs	**£ 4,893,468**
Undiscounted savings (financial)	**£ 8,228,893**
Discounted benefits (VFM)	**£ 6,647,612**

Value for Money - discounted cost/benefit ratio	**1.36**
Return on Investment	**50%**
Payback period	**8**

Nervecentre Quote

	Quantity	Price	VAT	Total (Incl. VAT)
E-Obs				
Client Licences for connection of one iOS or Android client to Nervecentre, per concurrent device. One licence is required per concurrently connected device.	295	£ 234,525	£ 46,905	£ 281,430
Feature licence for Observations.	1	£ 75,000	£ 15,000	£ 90,000
Feature licence for base observations models for adult inpatient areas only. Models: NEWS or equivalent; End of life special circumstance; Ward Based Care special circumstance; Blood transfusion special circumstance; COPD special circumstance. Does not include ED, ITU, Maternity or Paediatrics. Also includes additional Charts for interim observations: Adult models: Bowels assessment; Pain assessment; Peripheral perfusion assessment; Additional BP; Urinalysis; Interim obs (core model values recorded ad hoc); GCS; GCS with trache.	1	£ -	£ -	£ -
Feature licence for base observations models for paediatric inpatient areas only. Paediatrics models for up to 5 age ranges: End of Life; Blood transfusion; Low sats Also includes additional Charts for interim observations:	1	£ -	£ -	£ -
Feature licence for base observations models for maternity inpatient areas only. Base maternity models: Ante natal; Post Natal Also includes additional Charts for interim observations:	1	£ -	£ -	£ -
Observations models for ED patient areas only. Models for adults: NEWS or equivalent; Minor Injuries special circumstance; End of life special circumstance; COPD special circumstance. Resus base model for resus area. Models for children: PEWS or equivalent for up to 5 age ranges; Minor Injuries special circumstance. Excludes escalations. Requires ED to use the same PAS as the rest of the hospital, or else may require additional integration costs.	1	£ -	£ -	£ -
Professional Services to deploy observations base adult models (NC-FObs). Includes: Requirements capture and documentation, model creation, inhouse testing, delivery to customer test system, minor changes required following customer UAT, data warehouse extract, project management.	1	£ 10,000	£ 2,000	£ 12,000
Professional Services for the creation/adaptation of maternity models Includes: Requirements capture and documentation, model creation, inhouse testing, delivery to customer test system, minor changes required following customer UAT, project management.	1	£ 10,000	£ 2,000	£ 12,000

Professional Services for the creation/adaptation of paediatrics models Includes: Requirements capture and documentation, model creation, inhouse testing, delivery to customer test system, minor changes required following customer UAT, project management.	1	£ 10,000	£ 2,000	£ 12,000
Professional Services for the creation/adaptation of inpatient models for use in ED. Includes: Requirements capture and documentation, model creation, inhouse testing, delivery to customer test system, minor changes required following customer UAT, project management. Requires inpatient observations licences and PS to have also been procured, as ED models are adaptations on inpatient models but with no escalations.	1	£ 20,000	£ 4,000	£ 24,000
Total E-Obs		**£ 359,525**	**£ 71,905**	**£ 431,430**
Clincal Noting				
Clinical Noting for EPR for Inpatients Includes: Full Clinical Noting (unlimited notes and profiles), Snomed, photography, clerking and discharge forms, care plans, pre-admissions, discharge summaries of clinical notes.	1	£ 335,000	£ 67,000	£ 402,000
Initial Professional Services for Clinical Noting for EPR for Inpatients Includes: Requirements capture and documentation, configuration, inhouse testing, delivery to customer test system, minor changes required following customer UAT, project management.	1	£ 55,000	£ 11,000	£ 66,000
Total Clinical Noting		**£ 390,000**	**£ 78,000**	**£ 468,000**
Clinical Assessment				
Base licence for Clinical Assessments	1	£ -	£ -	£ -
Standard out of the box clinical assessment. One of: VTE, MUST, Dementia, Falls Risk, Waterlow	3	£ 22,500	£ 4,500	£ 27,000
Initial Services to deploy Clinical Assessments Services to deploy NC-F-CA or NC-F-CA-Unlimited.	1	£ 1,000	£ 200	£ 1,200
Total Clinical Assessment		**£ 23,500**	**£ 4,700**	**£ 28,200**
Sepsis				
Sepsis screening, alerting and workflow module base licence Required in order to provide sepsis screening, alerting and workflow in any patient area. This is a standard Sepsis screening tool based on NICE guidelines for red flag sepsis excluding a pathology feed. Screening: Identification of possible sepsis using clinical rules. Alerts: Escalation to individuals using task management. Workflow: Staff action tracking and creation of onward tasks based on staff response.	1	£ 75,000	£ 15,000	£ 90,000
Sepsis screening, alerting and workflow for adult wards	1	£ 30,000	£ 6,000	£ 36,000

Professional Services to implement Sepsis screening, alerting and workflow for adult wards	1	£	20,000	£	4,000	£	24,000
Total Sepsis		**£**	**125,000**	**£**	**25,000**	**£**	**150,000**
		£	898,025	£	179,605	£	1,077,630
Annual Support, Maintenance & Software Assurance		£	123,524	£	24,705	£	148,229

EPR Benefits Realisation and Governance

Following feedback from the Board's Non-Executive Directors this short paper provides additional information relating to:

a) Tangible benefits as a result of introducing bed management and task management (Hospital@) at Bassetlaw.
b) The action planned to record benefits realisation over the duration of the transition and beyond to ensure the benefits identified are fully realised
c) The governance arrangements that will be deployed to manage the programme over the next 18-24 months

Bed management

The 'go-live' date for bed management at Bassetlaw was 10 October 2018. From a deployment perspective, the process was relatively straightforward as the application is relatively intuitive. However, a considerable amount of time and effort was spent on communications and training in advance of the 'go-live'.

A month after 'go-live' the following benefits were identified:

- Patient admissions are being recorded on to the PAS system approximately 24% faster. On a monthly basis, this equates to a time saving of 175 weeks (based on 37.5 hours per week) of non-cash releasing time which has been put back into patient related clinical and administrative duties.
- The overall business processes have been considerably streamlined and the resulting new ways of working is releasing time back into nursing care
- Operational flow meetings are now focused around complete and accurate real-time operational data. Since 'go-live' no escalation beds have been opened at Bassetlaw.
- There is clear identification of those patients that require a senior review. Previously patients may have been missed or had duplicate senior reviews

Anecdotal feedback from ward personnel has been positive:

> *The bed management system makes my job easier, as real time information is easily accessible. The process for getting D numbers is simplified alongside locating past and present patients.* **Ward Clerk**

> *This system supports me in the Op Flow meetings by providing evidence in real time of what is happening on the ward. Communications between wards has improved considerably. I am able to track the patient's length of stay, assists the facilitation of the patient pathway. The system is easy to use and it's brilliant.* ***Senior Sister***

> *The Bed Management system is fantastic and I have nothing but praise. There are no missing admissions, everyone is accounted for and we can easily keep track of locations. It's been a massive help to us on the ward and I'm sure that it will be even better as it evolves in the future.* ***Ward Clerk***

Task Management (Hospital@)

The ‘go-live’ date for task management at Bassetlaw was 4 July 2018. Once again, the deployment process was quite straightforward as the application is very intuitive. We had given considerable consideration to the amount of training required in advance of ‘go-live’. In practice, the majority of personnel were up and running within 10 minutes following a ward based demonstration. From ‘go-live’ to-date (21/01/2019) some 11,600 tasks have been actioned and closed via Hospital@. Expectations, consistent with the experience of Nottingham University Hospital (NUH), are this will be having a positive impact in the reduction of clinical incidents. Further analysis is required at Bassetlaw to justify this statement.

We are still in the process of capturing quantifiable benefits. From a qualitative perspective, there has been a significant improvement in the out-of-hours operation. Every request is now being managed and allocated to the most appropriate person within the team, according to the complexity / priority of the request and appropriate role. The experience from NUH is that some 8,000 hours per annum of senior clinical time is being released back into patient care.

Benefits Realisation

Benefits realisation will be managed as a discreet strand of work within the EPR Programme. A benefits management approach and plan will clearly define and track the actions that will be put in place to ensure the Programme’s outcomes are achieved. The benefits management approach will be updated at each phase of the Programme with actual benefits achieved and any updates for benefits management activities or benefits reviews (whether within or beyond the life of the Programme). In practical terms, a benefits report (which will include a full financial analysis) will be provided to the monthly Programme Board. Post Programme benefits measurement activities will be transferred to the Executive Team lead responsible for the operational area(s) when the Programme closes (as the on-going reviews will need to be resourced).

Governance arrangements

The Programme will be delivered via best practice in programme and project management (i.e. Managing Successful Programmes (MSP) and PRINCE2). A detail breakdown of the Programme governance structure is outlined in the diagram below.

The Director of Nursing Midwifery and Allied Health Professionals (‘executive’) will act as Chair of the Programme Board and report on progress to the Management Board.

Other Board members will include:

The Clinical Chief Information Officer (CCIO) Mike Whiteside will act as the ‘senior user’ and be responsible for specifying the needs of those who will use the respective applications.

The Chief Information Officer (CIO) Simon Marsh will act as the ‘senior supplier’ and be responsible for the technical integrity of the Programme.

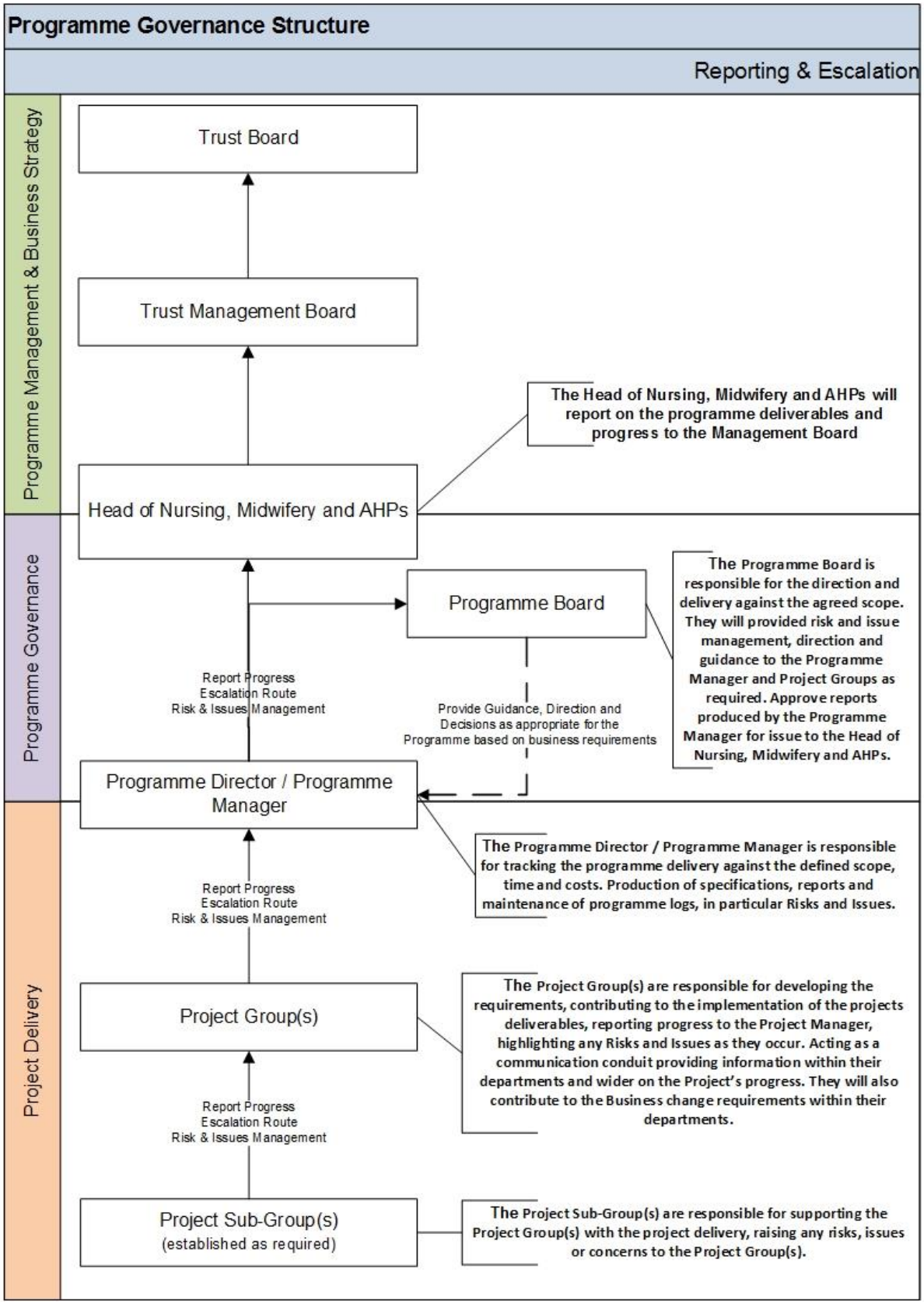
A Non-Executive Member of the Trust Board will be invited to provide additional independent assurance, particularly in relation to Programme benefits realisation.

The Head of IT Programmes and Development Ken Anderson will lead as Programme Director and Jo Hutchinson will lead as Programme Manager. Ken and Jo, who are both qualified PRINCE2 Practitioners, will be responsible for running the Programme on a day-to-day basis, within the constraints provided to them by the Programme Board.

The Acting Head of Projects, Planning and Costing Justin Fowler will provide financial assurance activities and advise on benefits realisation.

The Data Protection Officer Roy Underwood will provide data / information assurance matters and advise on statutory / regulatory implications under GDPR.

Regular highlight reports, as least bi-monthly, will be will be provided to the Management Board with a summary of progress within the reporting period and key issues and risks.


Programme Governance Structure
Reporting & Escalation
Programme Management & Business Strategy
Programme Governance
Project Delivery
Trust Board
Trust Management Board
Head of Nursing, Midwifery and AHPs
The Head of Nursing, Midwifery and AHPs will report on the programme deliverables and progress to the Management Board
Programme Board
The Programme Board is responsible for the direction and delivery against the agreed scope. They will provided risk and issue management, direction and guidance to the Programme Manager and Project Groups as required. Approve reports produced by the Programme Manager for issue to the Head of Nursing, Midwifery and AHPs.
Report Progress
Escalation Route
Risk & Issues Management
Provide Guidance, Direction and Decisions as appropriate for the Programme based on business requirements
Programme Director / Programme Manager
The Programme Director / Programme Manager is responsible for tracking the programme delivery against the defined scope, time and costs. Production of specifications, reports and maintenance of programme logs, in particular Risks and Issues.
Report Progress
Escalation Route
Risk & Issues Management
Project Group(s)
The Project Group(s) are responsible for developing the requirements, contributing to the implementation of the projects deliverables, reporting progress to the Project Manager, highlighting any Risks and Issues as they occur. Acting as a communication conduit providing information within their departments and wider on the Project's progress. They will also contribute to the Business change requirements within their departments.
Report Progress
Escalation Route
Risk & Issues Management
Project Sub-Group(s)
(established as required)
The Project Sub-Group(s) are responsible for supporting the Project Group(s) with the project delivery, raising any risks, issues or concerns to the Project Group(s).

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Title	**Financial Performance – Month 9 - December 2018**		
Report to	**Trust Board**	**Date**	**29th January 2019**
Author	**Jon Sargeant - Director of Finance** **Alex Crickmar – Deputy Director of Finance**		
Purpose			Tick one as appropriate
	Decision		
	Assurance		
	Information		X

Executive summary containing key messages and issues
The Trust's surplus for month 9 (December 2018) was £59k, which is a favourable variance against plan of £1,512k and a favourable variance against forecast of £233k in month. The cumulative position to the end of month 9 is an £11.5m deficit, which is £35k favourable to plan and £844k favourable against forecast YTD. The Trust needs to achieve a £6.6m deficit to deliver the year end control total, and therefore needs to achieve a better than break even position for the rest of the year. At the previous F&P Committee and Board a range of forecast scenarios were presented to, which showed a £7.1m gap to the control total (before PSF) as the realistic case. The Committee and Board agreed that if no further mitigations could be identified then a change in forecast of £7.1m would be submitted to NHSi at Month 9. Since the last Board meeting requests for additional funding from the CCG and ICS have been made to support the gap. Whilst discussions are ongoing regarding these (an update will be provided at the Board meeting), in the Month 9 forecast submitted to NHSi the Trust has assumed these funds are received based on the progress of these discussions and offers received. Thereby the year end forecast in the NHSi return submitted at Month 9 showed a forecast position of a £3.72m gap to the control total before PSF impact (£9.4m gap including impact of not achieving Q4 PSF).
Key questions posed by the report
Is the Trust 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
This report relates to strategic aims 2 and 4 and the following areas as identified in the Trust's BAF and CRR.

- F&P 1 - Failure to achieve compliance with financial performance and achieve financial plan and subsequent cash implications
- F&P 3 - Failure to deliver Cost Improvement Plans in this financial year
- F&P 19 - Failure to achieve income targets arising from issues with activity
- F&P 13 - Inability to meet Trust's needs for capital investment

How this report impacts on current risks or highlights new risks

Update on risk relating to delivery of 2018/19 financial plan.

Recommendation(s) and next steps

The Board is asked to note:

- The Trust's surplus for month 9 (December 2018) was £59k, which is a favourable variance against plan in month of £1,512k. The cumulative position to the end of month 9 is a £11.5m deficit, which is £35k favourable to plan and £844k favourable to forecast.
- The progress in closing the gap on the Cost Improvement Programme.
- The forecast presented and reported to NHSi, of a £3.72m gap from delivering the control total before PSF (£9.4m gap including impact of not achieving Q4 PSF) and the assumptions contained within this.
- The risks set out in this paper.

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

FINANCIAL PERFORMANCE

P9 December 2018

DONCASTER AND BASSETLAW TEACHING HOSPITALS NHS FOUNDATION TRUST

P9 December 2018

1. Income and Expenditure vs. Plan

Performance Indicator	Monthly Performance			YTD Performance			Annual
	Actual £'000	Variance to budget £'000	Variance to Forecast £'000	Actual £'000	Variance to budget £'000	Variance to Forecast £'000	Plan £'000
I&E Perf Exc Impairments	(36)	(1,513) F	(231) F	11,730	(59) F	(850) F	6,900
Income	(33,273)	(3,342) F	(101) F	(282,952)	(1,206) F	(924) F	(375,793)
PSF (previously STF)	(1,624)	0	0 A	(10,555)	0	0 A	(16,238)
Donated Asset Income	(23)	1 A	(1) F	(190)	24 A	6 A	(285)
Operating Expenditure	33,734	1,838 A	(77) F	295,096	1,217 A	198 A	385,315
Pay	22,015	351 A	(402) F	197,376	3,099 A	(333) F	259,658
Non Pay & Reserves	11,719	1,487 A	325 A	97,720	(1,882) F	531 A	125,657
Financing costs	1,127	(9) F	(54) F	10,141	(70) F	(123) F	
I&E Perf Exc 16/17 STF & Donated Asset Income	**(59)**	**(1,512) F**	**(233) F**	**11,540**	**(35) F**	**(844) F**	**6,615**

F = Favourable A = Adverse

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

2. CIPs

Performance Indicator	Monthly Performance			YTD Performance			Annual
	Actual £'000	Variance to budget £'000	Variance to Forecast £'000	Actual £'000	Variance to budget £'000	Variance to Forecast £'000	Plan £'000
Employee Expenses	260	315 A	74 A	1,766	1,304 A	(32) F	4841
Drugs	43	15 A	15 A	537	(12) F	11 A	700
Clinical Supplies	55	15 A	35 A	316	63 A	233 A	584
Non Clinical Supplies	0	0 A	0 A	0	0 A	0 A	0
Non Pay Operating Expenses	51	658 A	66 A	2,186	741 A	6 A	9787
Income	707	(482) F	(528) F	1,689	(452) F	(399) F	1913
Total	**1,116**	**522 A**	**(337) F**	6,494	**1,645 A**	**(181) F**	**17,825**

3. Statement of Financial Position

All figures £m	Opening Balance	Current Balance	Movement in year
Non Current Assets	**209,108**	**205,105**	**4,003**
Current Assets	49,291	42,461	6,830
Current Liabilities	-54,834	-53,708	-1,126
Non Current liabilities	-81,105	-83,755	2,650
Total Assets Employed	**122,460**	**110,920**	**11,540**
Total Tax Payers Equity	**-122,460**	**-110,920**	**-11,540**

4. Other

Performance Indicator	Monthly Performance		YTD Performance		Annual
	Plan £'000	Actual £'000	Plan £'000	Actual £'000	Plan £'000
Cash Balance	4,265	6,055	4,265	6,055	1,900
Capital Expenditure	1604	592	9211	3348	13,911

5. Workforce

	Funded WTE	Actual WTE	Bank WTE	Agency WTE	Total in Post WTE
Current Month	5914.14	5496.06	380.04	201.36	6077.46
Previous Month	5909.71	5527.53	198.37	100.20	5826.10
Movement	-4.43	31.47	-181.67	-101.16	-251.36

Key

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

1. Executive Summary

The Trust's surplus for month 9 (December 2018) was £59k, which is a favourable variance against plan of £1,512k and a favourable variance against forecast of £233k in month. The cumulative position to the end of month 9 is an £11.5m deficit, which is £35k favourable to plan and £844k favourable against forecast YTD. The Trust needs to achieve a £6.6m deficit to deliver the year end control total, and therefore needs to achieve a better than break even position for the rest of the year.

The YTD income position at the end of month 9 is (£1,206k) favourable to plan. The month 9 position was £3,342k and £102k favourable to plan and forecast respectively. In month 9, NHS Clinical Income (including Non-PbR drugs) was £2,356k ahead of plan and £25k adverse to forecast (£948k adverse YTD to plan, £624k favourable YTD to forecast). In Month 9 the income position includes c.£2.8m of additional non-recurrent funding from Doncaster CCG, which represents 9 months of the additional £3.7m funding agreed with the CCG (as per the forecast, as previously reported to the Committee). Excluding the impact of the non-recurrent funding Doncaster CCG has an adverse YTD variance against the Trust's plan of £870k (favorable variance against contract of £2,115k) and Bassetlaw CCG has a favorable income variance of (£1,558k) against the Trust's plan (£2,378k favorable against contract), excluding the impact of Non PbR drugs. Non NHS Clinical Income and Other Income is £986k and £127k ahead of plan and forecast in month 9 and YTD £2,154k and £300k favorable to plan and forecast. PSF is assumed at 100% in the position and CQUIN achievement at 90%.

Income Group	Annual Budget	In Month Budget	In Month Actual	In Month Variance	YTD Budget	YTD Actual	YTD Variance
Commissioner Income	-312,532	-24,890	-27,170	-2,280 F	-234,133	-235,392	-1,259 F
Drugs	-24,089	-1,771	-1,847	-76 F	-18,262	-16,055	2,207 A
STF	-16,238	-1,624	-1,624	0 F	-10,555	-10,555	0 F
Trading Income	-39,172	-3,270	-4,256	-986 F	-29,350	-31,505	-2,154 F
Grand Total	**-392,031**	**-31,555**	**-34,897**	**-3,342 F**	**-292,301**	**-293,508**	**-1,206 F**
Pay Award Adjustment	4,224	444	444	0 F	3,260	3,260	0 F
	-387,807	**-31,111**	**-34,453**	**-3,342 F**	**-289,041**	**-290,248**	**-1,206 F**

Income Group	In Month Actual	In Month Forecast	In Month Variance	YTD Actual	YTD Forecast	YTD Variance
Commissioner Income	-27,170	-27,238	68 A	-235,392	-234,583	-809 F
Drugs	-1,847	-1,804	-43 F	-16,055	-16,240	185 A
STF	-1,624	-1,624	0 F	-10,555	-10,555	0 F
Trading Income	-4,256	-4,129	-127 F	-31,505	-31,205	-300 F
Grand Total	**-34,897**	**-34,795**	**-102 F**	**-293,508**	**-292,584**	**-924 F**
Pay Award Adjustment	444	352	92 F	3,260	3,168	92 F
	-34,453	**-34,443**	**-10 F**	**-290,248**	**-289,416**	**-832 F**

In month the expenditure position was £77k favourable to forecast, of which pay was £402k favourable to forecast and non-pay £325k adverse to forecast. The YTD expenditure position at the end of Month 9 is £1.2m adverse to plan, £198k adverse to forecast (with pay £333k favourable to forecast and non-pay £531k adverse to forecast). Non-PbR drugs were significantly lower than planned levels (c.£2.2m which is offset by underperformance on income).

Subjective Code	In Month Budget	In Month Actual	In Month Variance		In Month Forecast	In Month Variance to forecast		YTD Budget	YTD Actual	YTD Variance		YTD Forecast	YTD Variance to forecast		Annual Budget	Forecast
1. Pay	21,664	22,015	351	A	22,417	-402	F	194,277	197,376	3,099	A	197,709	-333	F	259,658	259,896
2. Non-Pay	9,984	10,808	824	A	10,483	325	A	93,563	95,851	2,288	A	95,320	531	A	123,366	118,466
3. Reserves	249	911	663	A	911		A	6,039	1,869	-4,170	F	1,869		A	2,291	10,640
Total Expenditure Position	**31,896**	**33,734**	**1,838**	A	**33,811**	**-77**	F	**293,880**	**295,096**	**1,217**	A	**294,898**	**198**	A	**385,315**	**389,002**

Capital expenditure YTD is £3,348k against the YTD plan of £9,211k, £5,863k behind plan (£3,430k behind plan excluding CT/HASU). YTD actuals against the revised plan are £5,802k behind plan (£3,369k behind plan excluding CT/HASU). The main reason for the slippage relates to estate schemes being behind plan by c.£3m including; Fire Enforcement, Electrical Infrastructure, Other Minor Estates Work, Medical Equipment (including Medical Imaging).

The cash balance at the end of December was £6.1m against a plan of £4.3m. The main movements include; the receipt of Q4 STF funds (£2m more than anticipated), delayed capital expenditure (£5.9m), which is in part offset by PDC Dividend not received (£2.6m), and movement in trade receivables/reduction in payables (£3.5m). The Trust's financial plan assumed borrowing in 2018/19 of £6.6m and in December, the remaining amount of loan (£4m) was drawn down in December.

In December 2018, CIP savings of £1,116k (last month £737k) are reported, against a forecast of £778k, therefore an over achievement of £337k in month.

At the previous F&P Committee and Board a range of forecast scenarios were presented to, which showed a £7.1m gap to the control total (before PSF) as the realistic case. The Committee and Board agreed that if no further mitigations could be identified then a change in forecast of £7.1m would be submitted to NHSi at Month 9. Since the last Board meeting requests for additional funding from the CCG and ICS have been made to support the gap. Whilst discussions are ongoing regarding these (an update will be provided at the Board meeting), in the Month 9 forecast submitted to NHSi the Trust has assumed these funds are received based on the progress of these discussions and offers received. Thereby the year end forecast in the NHSi return submitted at Month 9 showed a forecast position of a £3.72m gap to the control total before PSF impact (£9.4m gap including impact of not achieving Q4 PSF).

2. Conclusion

The Trust's surplus for month 9 (December 2018) was £59k, which is a favourable variance against plan of £1,512k and a favourable variance against forecast of £223k in month. The cumulative position to the end of month 9 is an £11.5m deficit, which is £35k favourable to plan and £844k favourable against forecast.

In Month 9 the income position includes c.£2.8m of additional non-recurrent funding from Doncaster CCG, which represents 9 months of the additional £3.7m funding agreed with CCGs (as per the forecast as previously reported to the Board).

The Board asked to note the forecast position and the recovery plan to close the gap to the control total. This currently shows that the Trust's financial position would be a £3.72m gap to delivering its control total before PSF (£9.4m gap including impact of losing Q4 PSF).

The Board is asked to note that within this forecast position this assumes that the requests for additional funding from the ICS and CCGs are agreed and any actions required within these offers are delivered (e.g. waiting list position). In order to deliver the remaining control total gap of £3.72m the Trust's DoF is waiting for NHSi to confirm if this will be covered by a change to control total or additional income.

3. Recommendations

The Board is asked to note:

- The Trust's surplus for month 9 (December 2018) was £59k, which is a favourable variance against plan in month of £1,512k. The cumulative position to the end of month 9 is a £11.5m deficit, which is £35k favourable to plan and £844k favourable to forecast.
- The progress in closing the gap on the Cost Improvement Programme.
- The forecast presented and reported to NHSi, of a £3.72m gap from delivering the control total before PSF (£9.4m gap including impact of not achieving Q4 PSF) and the assumptions contained within this.
- The risks set out in this paper.

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Title	**b) Annual Planning – Control Total**		
Report to	**Board of Directors**	**Date**	**29 January 2019**
Author	**Jon Sargeant - Director of Finance**		
Purpose			Tick one as appropriate
	Decision		
	Assurance		
	Information		X

Executive summary containing key messages and issues
The Board is asked to note the Control Total for 2019/20 as notified by NHS Improvement. This sets out that the Control Total for the Trust in 2019/20 is a £15.296m deficit before PSF, FRF and MRET adjustments; and a breakeven control total when including MRET, PSF and FRF allocations. The attached letter from NHS Improvement sets out the different aspects of the control total which will be discussed at the Committee in further detail.
Key questions posed by the report
N/A
How this report contributes to the delivery of the strategic objectives
This report relates to strategic aims 2 and 4 and the following areas as identified in the Trust's BAF and CRR. • F&P 1 - Failure to achieve compliance with financial performance and achieve financial plan and subsequent cash implications • F&P 3 - Failure to deliver Cost Improvement Plans in this financial year • F&P 19 - Failure to achieve income targets arising from issues with activity
How this report impacts on current risks or highlights new risks
Update on risk relating to delivery of 2019/20 financial plan.
Recommendation(s) and next steps
The Board is asked to note the Control Total for 2019/20 as notified by NHS Improvement.

Our Ref: Y54/RP5/L1

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15 January 2019

Sent via Email

Richard Parker
Chief Executive

Jonathan Sargeant
Finance Director

Financial Control Total for 2019/20

Doncaster & Bassetlaw Hospitals NHS Foundation Trust

'NHS Operational Planning and Contracting Guidance 2019/20' sets out the approach to developing operational plans for the coming financial year. 2019/20 will be the foundation year for laying the groundwork for delivering the commitments in the recently published Long Term Plan.

The long-term financial settlement helps put the NHS on a sustainable footing and the significant changes to the financial architecture move us away from a system where provider deficits are the norm. This commitment is backed by allocating additional resources to the provider sector at the start of year, supported by a simplified financial framework.

The additional resource enables 2019/20 to be a transitional year, with one year rebased control totals. Control totals have been set so they are stretching, deliverable and reflect the distributional impact of the changes that have been made to the financial architecture of the NHS.

By allocating the extra funds up-front it is critical that each organisation delivers their part in this financial reset opportunity through the development of realistic, integrated delivery plans that commit to the control total contained in Appendix 1 of this letter.

The plans developed for 2019/20 should be based on assumptions that are aligned across your local system and are internally consistent between activity, workforce and finance. There are no national financial reserves in place for 2019/20, making the identification and management of risk a key component of organisation and system planning.

Each provider will be allocated non-recurring funding from the remaining £1.25bn Provider Sustainability Fund (PSF) as outlined in Appendix 1. In 2019/20 all providers will continue to receive a share of the PSF linked to acceptance and delivery of a control total, with cash payments made quarterly in arrears dependent on year to date financial performance compared to plan. There are no performance, or any other requirements linked to the ability to earn PSF in year.

In addition, we have created a new £1.05bn Financial Recovery Fund (FRF) in 2019/20 to support the sustainability of essential services. Our expectation is that we will move away from the current control total regime and associated PSF from 2020/21 and the remaining non recurrent PSF funds will be transferred to increase the value of the FRF.

The marginal rate emergency tariff (MRET) will be abolished as a national rule for 2019/20. Where providers and commissioner confirmed an MRET value in the Autumn 2018 exercise, a provider will be eligible to receive additional income equal to this value. This payment will be centrally funded and paid quarterly in advance. There are no in year financial or other performance requirements linked to the receipt of MRET funding. As part of the changes to the financial architecture associated with the end of control totals in 2020/21, MRET funding will transfer into baseline resources and be available as a recurrent source of funds.

Where a provider remains in deficit after the control total has been rebased and adjusted for the distribution impact of key changes (i.e. policy changes, MRET and PSF), the provider will be eligible to access additional resources on a non-recurring basis from the FRF. The FRF has been allocated at a maximum financial value to each provider in deficit and capped at a breakeven position. Access to the FRF allocation is conditional on the provider signing up to the control total, with payments made quarterly in arrears dependent on year to date financial performance compared to plan. There are no performance, or any other requirements linked to the receipt of FRF funding.

Subject to the current NHS Standard Contract consultation process, providers who sign up to their control totals and are therefore eligible to earn PSF, will have the financial sanctions set out in Schedules 4A and 4B of the Particulars of the Contract suspended. The only standards in those Schedules for which sanctions remain active for providers within scope of PSF in 2019/20 are those covering mixed sex accommodation, cancelled operations, Healthcare Associated Infections (MRSA and C difficile), the duty of candour and 52-week wait breaches. Where a commissioner applies contract sanctions, the use of the resultant funding will be subject to sign off by the joint NHS Improvement and NHS England regional teams.

Financial planning assumptions

Treatment of asset disposals

The treatment of gains on disposal of assets has been amended in 2019/20. Providers will not be able to use any of these gains to deliver their original 2019/20 control total notified in Appendix 1 to this letter.

CNST

As previously confirmed, the figures included for CNST in the 2017/19 National Tariff for 2018/19 (2-year tariff set in 2016/17) overestimated the actual amount of CNST contributions collected by £330 million. The 2019/20 national tariff prices have been reduced to more accurately reflect the level of contributions made. We have reflected this reduction in income and the increase or decrease in contribution levels between 2018/19 and 2019/20 in the 2019/20 controls. The net impact of these changes is identified separately in the table in Appendix 1.

Pay inflation

The split of the cost base of each provider between pay and non-pay combined with the differing impact by grade of the agenda for change pay award, has resulted in a differential impact of pay cost increases compared to associated pay uplifts in the national tariff. These differential impacts have been reflected in the control totals included in Appendix 1 for all providers, with the exception of ambulance trusts. The agenda for change grade mix and the impact of unsocial hours costs in ambulance trusts results in material additional costs above the pay increase included in the tariff uplift which has not been reflected in control totals. In line with '2019/20 planning prices: an explanatory note' published on 21 December 2018 CCGs are expected to fund ambulance trusts for these costs.

The additional costs associated with changes to the pension scheme are not included in the pay uplift in the tariff and will be resourced separately from additional central funding.

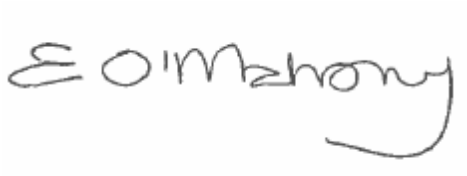
Next steps

In the context of the planning guidance and the details contained in Appendix 1 of this letter, your Board should consider signing up to your 2019/20 control total and confirm acceptance in the financial planning template.

It is important that there must be no ambiguity as to whether a control total has been accepted. We will therefore use the financial planning template to capture the board approved decision.

We have actively engaged in discussions on the key changes to the financial architecture and price relativities for 2019/20, but these changes are complex at a provider level and should be worked through in detail to enable the control total to be considered by the Board.

Yours sincerely



Elizabeth O'Mahony
Chief Financial Officer

Copy to:
Ian Dalton, Chief Executive, NHS Improvement
Lyn Simpson, Executive Regional Managing Director (North), NHS Improvement
Jonathan Stephens, Regional Director of Finance (North), NHS Improvement

NHS Improvement

Appendix 1

Financial control total and PSF, FRF and MRET funding for 2019/20

Financial control total	**£ million**
Rebased baseline position excluding PSF	**-22.966 Deficit**
£1bn PSF transferred into urgent and emergency care prices	7.542
CNST net change in tariff income and contribution[1]	-0.973
Other changes[2]	-0.751
Subtotal before efficiency	**-17.148 Deficit**
Additional efficiency requirement up to 0.5%	1.852
2019/20 control total (excluding PSF, FRF and MRET funding)	**-15.296 Deficit**
MRET central funding	2.069
Subtotal before PSF and FRF allocations	**-13.227 Deficit**
Non recurring PSF allocation	7.577
Subtotal before FRF allocation	**-5.650 Deficit**
Non recurring FRF allocation	5.650
2019/20 control total (including PSF, FRF and MRET funding)	**0.000 Breakeven**

CNST net change in tariff income and contribution[1]

- changes to tariff income as set out in '2019/20 planning prices: an explanatory note' and to changes in CNST contribution levels between 2018/19 and 2019/20

Other changes[2] include the impact of:

- Pricing changes in the national tariff - including changes to MFF, top ups and other price relativities
- Distributional impact of Agenda for Change cost increases relative to tariff income increase
- Impact of changes to MFF for Health Education England (HEE) tariffs
- Other changes include increases in overseas patient income, commercial income and inflationary impacts.

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Title	**Business Intelligence Report**		
Report to	**Board of Directors**	**Date**	**29th January 2019**
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 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 key tests
Infection control measures, C Diff and MRSA Bacteraemia

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

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

The performance report contains a deep dive into December activity in ED
Key questions posed by the report
Is the Trust maintaining performance against agreed trajectories with CCG? Is the Trust providing a quality service for the patients? Are NEDs assured that the actions being undertaken to address underperformance and maintain current standards are robust and deliver the agreed improvements?
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
F&P6 Failure to achieve compliance with performance and delivery aspects of the Single Oversight Framework, CQC and other regulatory standards F&P15 Commissioner plans do not come to fruition and do not achieve the required levels of acute service reduction F&P5 Failing to address the effects of the agency cap
Recommendation(s) and next steps
That the report be noted.

Performance Executive Summary Board of Directors January 2019

The performance report is against operational delivery in October, November and December 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.

The Trust position remains below the target at 86.6, which is a decrease of 0.3% on the November position.

The total number of Incomplete Pathways has decreased by 933 between November and December, however the number of incomplete pathways over 18 weeks increased by 310 hence the performance has fallen. The total number of Incomplete Pathways with a decision to admit for treatment has increased between November and December 2018.

The waiting list total size fell in December to 955 above the March 31st position, which is a significant improvement from the end of November.

Trajectory targets are set for all specialities to achieve contract targets for the RTT position to improve and the waiting list to be 1 less than at the end of March 2018.

At the end of December 2018 there were 4 Incomplete Pathway over 52 Weeks (General Surgery – NHS England, Ophthalmology – Rotherham CCG, 2 x T&O – Doncaster CCG). These have all been validated. NHS England and the Trust have agreed the new process for reviewing potential 52 week breaches. 3 of these pathways have stopped.

The joint Access Policy is due to be launched and ensuring compliance with the policy is part of the training programme for the administrative and clinical teams.

Diagnostics

The target has been achieved for December, with **99.3%** performance at Trust level (**99.3%** at NHS Doncaster and **99.2%** at NHS Bassetlaw).

There were 65 trust level breaches due to slot capacity, the majority of these were Nerve Waiters(15), Audiology (13) and Urodynamics (12).

Missed Targets:

The 99% target was missed in:

- DEXA – 95.5% - 6 breaches out of 134 waiters
- Audiology – 93.9% - 13 breaches out of 212 waiters
- Echo – 98.2% - 5 breaches out of 284 waiters
- Nerve Conduction – 90.3% - 15 breaches out of 154 waiters
- Urodynamics – 77.4% - 12 breaches out of 54 waiters

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.

December Performance

Trust 91.3%

Quarter 3 92.12%, PSF target for Q3 90.9%, achieved

Year to date 92.9%

The Trust managed 14376 ED attendances during December this year, 508 more than in December 2017. 1252 patients failed to be treated in 4hrs; with the key issues being Waits to see ED doctor, ED doctor reviews.

The new streaming pathways were embedded at DRI, with 14.4% of patients streamed.

Summary of Emergency Activity at Doncaster in December

DRI activity saw a statistically high number of attendances (9042). This is the second highest number of attendances in the last 21 months with only July 18 being higher (9254). When compared to December 17 we saw 334 (3.8%) more patients this December.

From an acuity point of view there was a statistically high number of Resus patients this December (478), the number of major patients was also statistically high in December 18 (2603).

Ambulance Arrivals were statistically high with DRI receiving 2809 patients via Ambulance, the highest number over the last 21 months.

Montagu saw a significant drop in the number of patients seen with December 18 only having 1198 recorded arrivals, this is a statistically low number of attendances and also the lowest over the last 21 months.

The high activity at DRI seems to be down to the fact that when in previous years the number of Minor cases has dropped over the winter period it has not done so this time. Coupled with statistically high activity in Resus and Majors it has meant we have seen a high level of activity at DRI.

Additional Reporting

18.2% of all of DRI discharges take place at a weekend and 15.3% at BDGH

If the rest of the week was at the same level as Mondays then we would see an extra 168 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 16.0% at BDGH

Non Elective Admissions on a weekday that GP admissions account for is 20.5% of all Emergency Admissions on a weekday at DRI but only 7.8% at BDGH.

When we move into the weekend this drops to 11.1% at DRI and 2.3% at BDGH

Cancer Performance

November 2018

62 day 86.9%

The 62 day standard was achieved by the Trust in November.
The key issues remain around complex pathways and shared breaches.
Local performance improved in November across all specialties.
The outcomes from the One Stop Prostate Clinic have been positive with an average of 11 days being removed from the pathway.
The local gynaecology breaches have improved and the one stop post-menopausal clinic is due to commence in January.

Two Week Wait Performance 91.9%

This position is a deterioration from October and is a result of capacity issues within the skin pathway due to consultant availability and in lower GI due to consultant sickness.
The 2 week action plan has been reviewed at the local Cancer Forum to ensure delivery against the plan.

Stroke Performance

October stroke discharges 56

Direct admission 57.1%

CT within 1 hour 55.4%

Of note this month, there was an unusually high number of Bassetlaw patients in this cohort (17) and the delays involved in the transfers from Bassetlaw A&E to DRI. The NHS Bassetlaw percentage for 4 Hour Admissions was therefore very low at 29.4% (5 out of the 17 patients).

Delays in A&E were reported, with 3 instances where the SNP was reviewing other patients and therefore unable to assess within 4hrs.

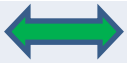
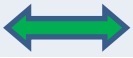
David Purdue Chief Operating Officer January 2019

DBTH PERFORMANCE REPORT – December 2018

Cancer Performance

The following information relates to Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust performance in December. The action plan to improve 62 day and 2 week wait performance is now underway with expectations of improving performance over time.

November Performance

Standard	Local Performance %	Position from Previous Month
TWW	91.9%	
31 day	99.4%	
62 day	86.9 %	
31 day Sub – Surgery	100%	
31 day Sub – Drugs	100%	
31 day Sub – Other	100%	
62 day Screening	94.4%	
62 day Con Upgrades	88.5%	
Breast Symptomatic	87.4%	

62 day Cancer performance

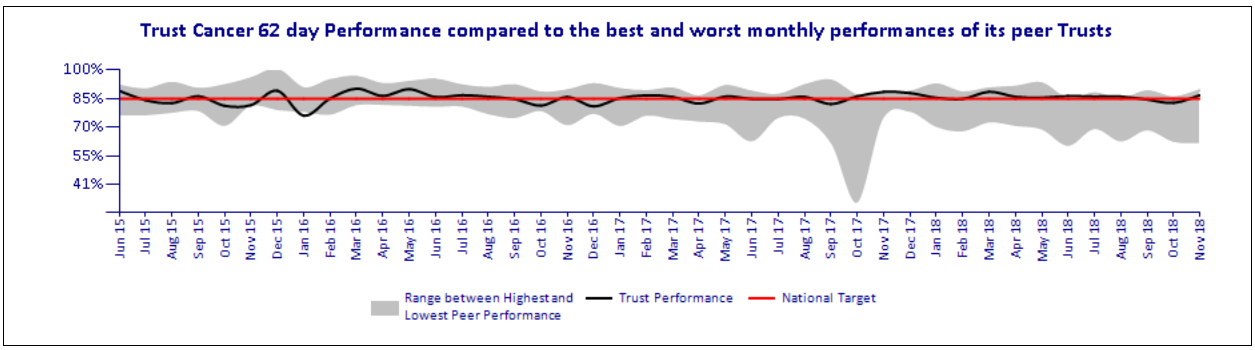
The 62 day standard was achieved by the Trust in December; rising to 86.9%.

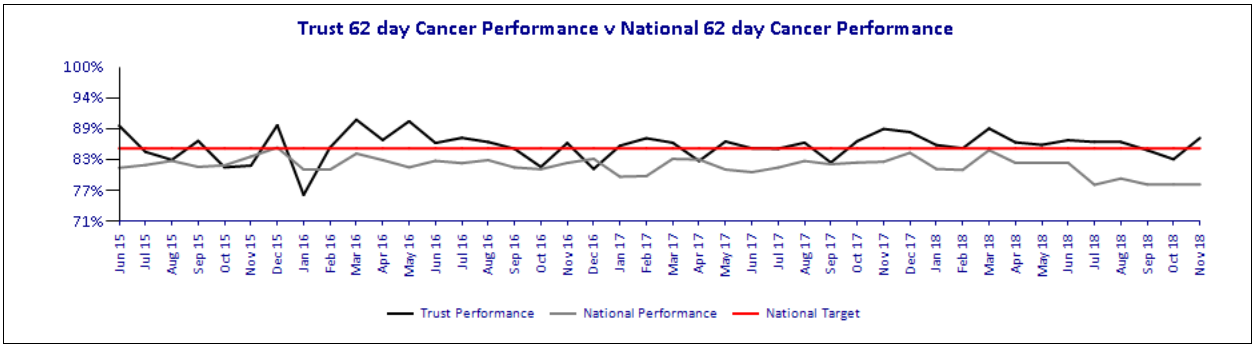
The key issues remain around complex pathways and shared breaches.
The system Cancer performance was reviewed by NHSE; key pathways were identified as requiring additional support. These included the prostate pathway, gynae and OMFS.

To improve gynaecology local performance, the Trust has started a pilot of a one stop post-menopausal bleed clinic. The Trust has met with colleagues from STH to review the current arrangements for OMFS to improve the local offer for patients.

DBTH PERFORMANCE REPORT – December 2018

The graphs below compare 62 day performance up to , at Doncaster and Bassetlaw compared with National performance.





<u>Two Week Wait Performance</u>

The November position for two week wait has deteriorated slightly in month to 91.9%.

Work with the Capacity and Demand tool continues. Care groups are continuing to use the tool proactively in order to plan two week wait capacity.

Skin – down to some clinic cancellation and no consultants – creating ASI's
Upper GI – drop in performance due to consultant sickness

Gynae; continued improved performance for Gynae TWW. Post -Menopausal Bleed clinic started at the end of November. Also improved 62 day for December to 88.9%

LGI – also achieved above 93% for December.

Weekly PTL meetings with each specialty continue; to jointly track patient booking, pathways and to review breaches. These meetings focus on both 2ww and 62 day breaches, with presentations for each service, to support key issues and achievements.

DBTH PERFORMANCE REPORT – December 2018

TWW Performance by specialty for December

	2ww	Non 2ww Symptomatic Breast Referrals	31 Day - Classic	31 Day Sub - Surgery	31 Day Sub - Drugs	31 Day Sub - Palliative	62 Day - Classic	62 Day Screening	62 Day Consultant Upgrades
Operational Standard	93%	93%	96%	94%	98%	94%	85%	90%	TBA
Breast	97.5%	87.4%	100%	100%	100%		93.9%	94.4%	
Gynaecology	97.6%		100%				68.4%		
Haematology	100%		100%		100%	100%	100%		
Head & Neck	94.7%		100%				50%		0%
Lower GI	92.1%		100%				80%		100%
Lung	96.7%		100%				100%		100%
Sarcoma									
Skin	78.6%		92.3%				83.3%		
Upper GI	87%		100%				90.9%		0%
Urological	91.3%		100%	100%	100%	100%	90.9%		83.3%

EXCEPTIONS

62 DAY

Breast, Haematology, Lung, Upper GI and Urology were compliant with the standard in December. The reasons for the breaches across all services were 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 December. This remains a challenge; mostly due to patient choice, clinic cancellation and admin delays in booking.

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

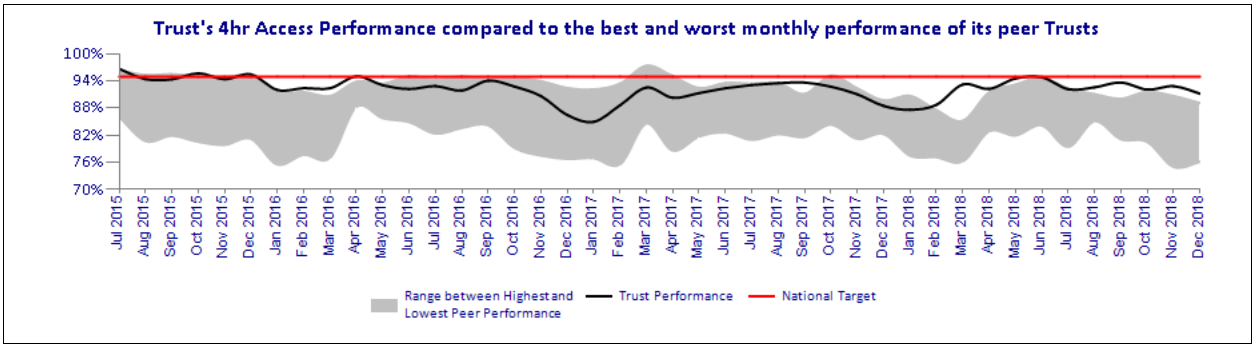
DBTH PERFORMANCE REPORT – December 2018

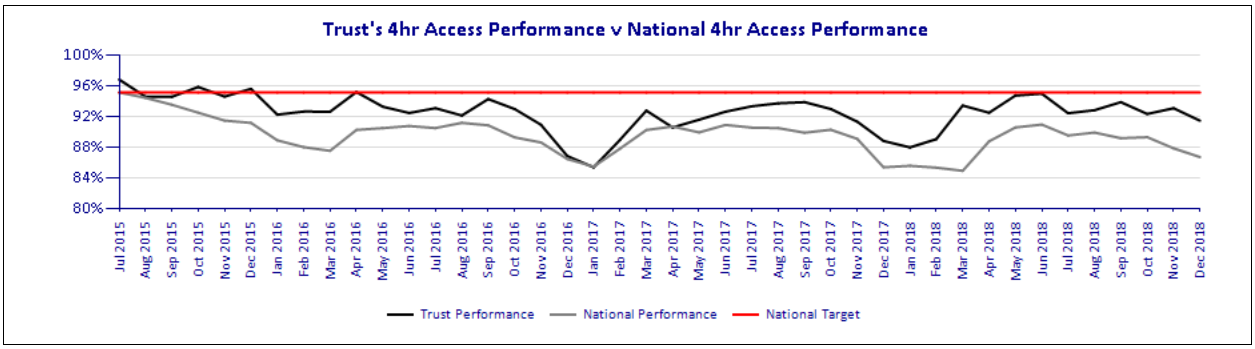
Cancer Waiting Time Standard (CWT)	Tumour Group	Performance against CWT standard	High Level View
Two Week Wait (93%)	Gynae	**92.1%**	18 Patients – 15 patient choice, 1 administrative delay - unable to contact patient , 1 capacity
	H&N	**78.6%**	42 Patients – 9 patient choice, 6 capacity, 1 hospital cancellation, 26 admin delays.
	Lower GI	**87%**	15 Patients– 4 patient choice, 11 capacity/administrative delays
	Skin	**91.3%**	19 Patients– 6 patient choice, 4 capacity/administrative delays , 7 administrative delay unable to contact patient, 2 hospital cancellations
	Urology	**92.3%**	1 patient – local pathway – elective capacity
62 day (85%)	Gynae	**68.4%**	5 patients – 1 local and 4 shared care - Local - delays for medical reason. Shared Care – all pathway delays around diagnostics
	H&N	**50%**	2 patients – both shared care - 1 complex diagnostic pathway, 1 pathway delays
	Lower GI	**80%**	2 patients – 1 local - complex diagnostic pathway, 1 shared care – Complex planning for treatment
	Lung	**83.39%**	4 patients – 1 local and 3 shared care. Local – elective capacity. 3 shared care – 1 Complex diagnostic pathway. 2 delays to biopsy
	Sarcoma	**0%**	1 patient – shared care – Patient choice
	Upper GI	**0%**	1 patient – shared care – complex planning for treatment
	Urology	**83.3%**	1 patient – shared care – capacity issues @ STH
62 day Screening	Lower GI	**92.1%**	18 Patients – 15 patient choice, 1 administrative delay - unable to contact patient , 1 capacity
62 day Con Upgrade	Gynae	**78.6%**	42 Patients – 9 patient choice, 6 capacity, 1 hospital cancellation, 26 admin delays.
	Lung	**87%**	15 Patients– 4 patient choice, 11 capacity/administrative delays
	Urology	**88.3 %**	19 Patients– 6 patient choice, 4 capacity/administrative delays 7 administrative delays; unable to contact patient, 2 hospital cancellations

4hr Access Target

In December 2018 the Trust achieved a performance 91.3 % against the 4hr access standard of 95%. In quarter 3 this means a 92.1% A&E performance was achieved. (q3 last year = 90.86%)

The graphs below compare 4 hour access performance at Doncaster and Bassetlaw with National performanceup to December.





The Trust managed 14376 ED attendances across sites and streams, during December. This is 509 more patients than in Dec 2017.

The acuity of patients has impacted on the flow and admission of patients with winter impacting on bed demand and staffing. Post Christmas /New Year week saw a rise in attendance in ED and admissions.

Streaming December 2018

DRI to FDASS

Total Attendances Arriving at DRI FDASS	**9043**	
Total Streamed from FDASS	**1324**	**14.6%**
Total Returned from FCMS UCC	**24**	**0.3%**
Net Streamed from FDASS	**1300**	**14.4%**
Total Streamed to the DRI Emergency Centre	**7743**	**85.6%**

Ongoing weekly meetings between DBTH and FCMS, with clinicians from both organisations, discuss all returns on an individual basis. This supports development of improved and new pathways and better joint working.

EXCEPTIONS

In December, there were a total of 1252 breaches. (vs Dec 2017 breaches = 1585). Key issues impacting on service delivery are; delays to see or be reviewed by Doctors, deterioration in patients' condition and number of patients requiring resuscitation and by bed availability.

Weekly pathway meetings continue to occur to analyse the Emergency pathway and how we collaborate to support the 4 hour target.

The patient attendance for December has risen as anticipated, with Flu and complexity and acuity of patients continuing to be high.

Streaming pathways continue to be reviewed at BDGH jointly with Nott's Health Care FT and a proposal developed for commissioners to review to improve front-door streaming alternative pathways.

Referral to Treatment (RTT)

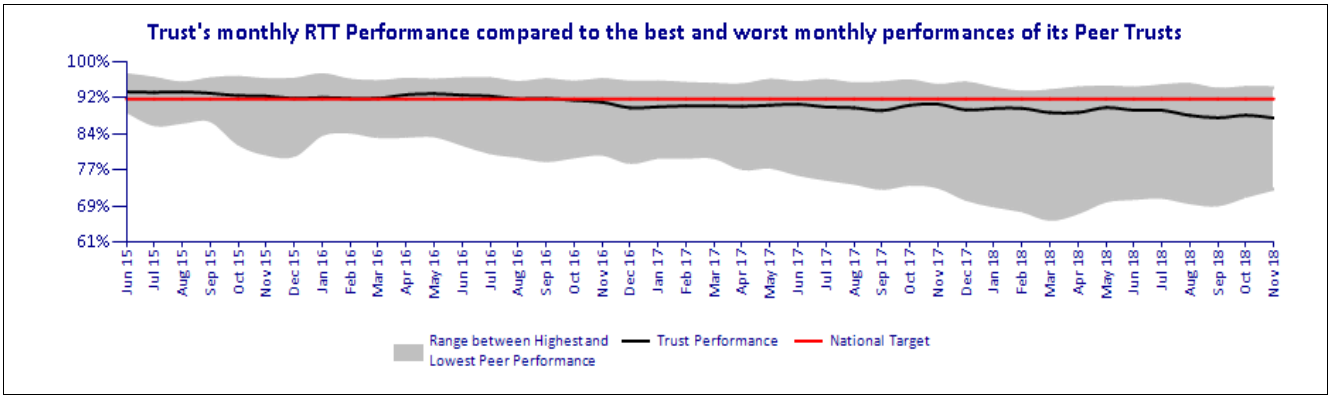
The Referral to Treatment Target, for active waiters below 18 weeks is set at 92%.

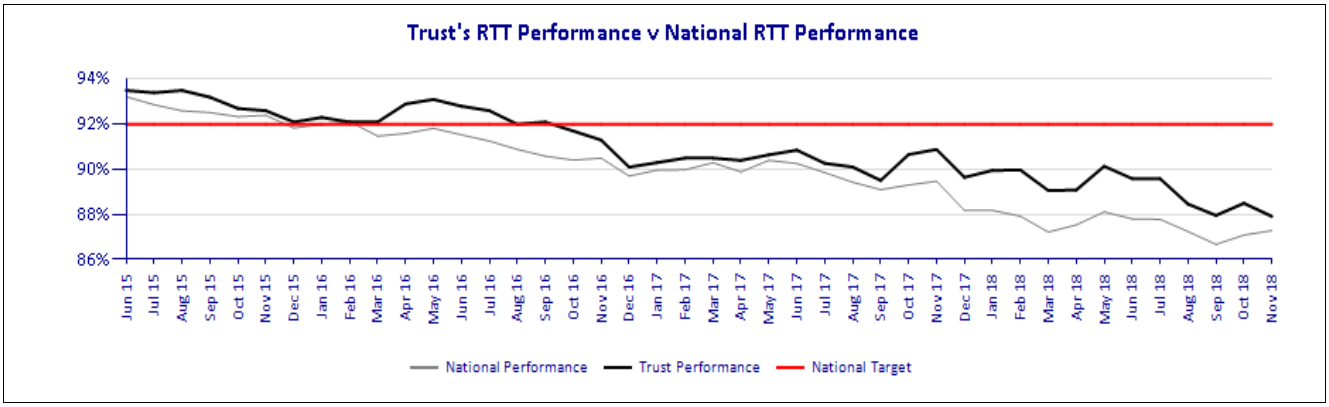
DBTH contract for 2018/19 anticipates the Trust will maintain the March 2018 position of 89.1% and the waiting list size will reduce from what it was at the end of March 2018.

DBTH PERFORMANCE REPORT – December 2018

The Trust position was 86.6% in December, a slight decrease from November at 87.9%

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





The total number of Incomplete Pathways has decreased by 933 between November and December, however the number of incomplete pathways over 18 weeks increased by 310 hence the performance has fallen.
The total number of Incomplete Pathways with a decision to admit for treatment has increased between November and December 2018.
The number of new RTT periods in December was 2822 fewer than in November meaning the proportion of short waiters in the month will also have also gone down. There were 1771 fewer Non Admitted and 460 fewer Admitted clock stops in December than in November.

The specialty groups with the largest increase in the number of waiters over 18 weeks are:

- T&O – increase of 92 over 18 weeks
- Dermatology – increase of 56 over 18 weeks
- General Medicine – increase of 45 over 18 weeks
- Oral Surgery – increase of 40 over 18 weeks
- Rheumatology – increase of 31 over 18 weeks
- Cardiology – increase of 31 over 18 weeks

At the end of December 2018 there were 4 Incomplete Pathway over 52 Weeks (General Surgery – NHS England, Ophthalmology – Rotherham CCG, 2 x T&O – Doncaster CCG). These have all been validated.

Decembers Specialty level RTT performance, against a target of 92%, can be found below:

Specialty Group	Under 18 Weeks	18 Weeks & Over	Total	Percentage
General Surgery	2683	522	3205	83.7%
Urology	1299	199	1498	86.7%
T&O	5070	970	6040	83.9%
ENT	2598	600	3198	81.2%
Ophthalmology	2505	259	2764	90.6%
Oral Surgery	1641	184	1825	89.9%
General Medicine	1763	338	2101	83.9%
Cardiology	1729	253	1982	87.2%
Dermatology	1920	191	2111	91.0%
Thoracic Medicine	805	60	865	93.1%
Rheumatology	741	225	966	76.7%
Geriatric Medicine	188	29	217	86.6%
Gynaecology	1266	90	1356	93.4%
Others	3721	400	4121	90.3%
Trust Total	**27929**	**4320**	**32249**	**86.6%**

Diagnostics

In December the Trust achieved 99.28% against the 6ww Diagnostic Performance standard of 99%.

There were 65 patient breaches in month, out of a total 8984 patients.
These were a result of insufficient slot capacity; the majority of these were Nerve Waiters(15), Audiology (13) and Urodynamics (12).

DBTH PERFORMANCE REPORT – December 2018

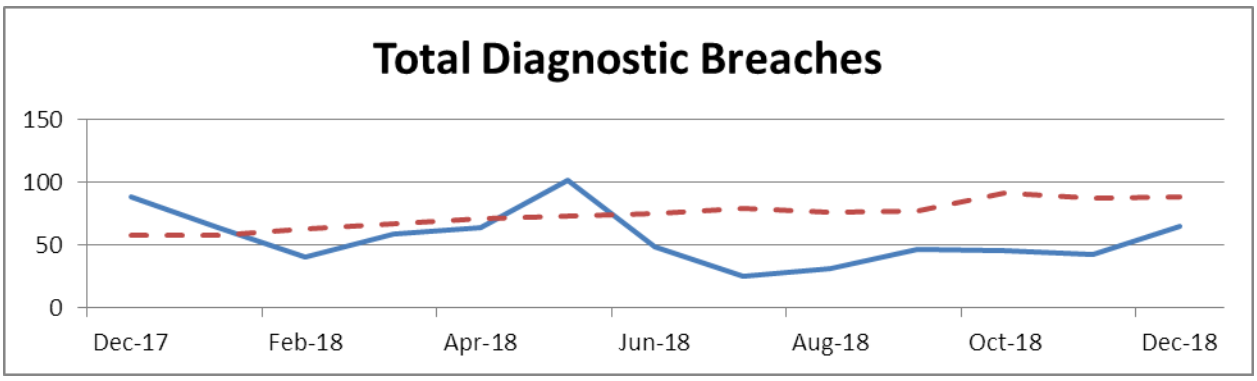
	Waiters <6W	Waiters >=6W	Total	Performance
Trust	8912	65	8977	99.28%
NHS Doncaster	5934	43	5977	99.28%
NHS Bassetlaw	2089	17	2106	99.19%

Most exam types continue to achieve the target in December, with 8 of the 13 diagnostic areas again achieving more than 99% and 4 of these 8 achieving 100%.

EXCEPTIONS:

The 99% target was missed in 5 areas:

- DEXA – 95.5% - 6 breaches out of 134 waiters
- Audiology – 93.9% - 13 breaches out of 212 waiters
- Echo – 98.2% - 5 breaches out of 284 waiters
- Nerve Conduction – 90.3% - 15 breaches out of 154 waiters
- Urodynamics – 77.4% - 12 breaches out of 54 waiters



Stroke

Performance in October

The Trust level percentage for Direct Admission to the Stroke Unit was 57.1% against a 90% target.

Against a target of 48%, performance in October was compliant with the 1 Hour to scan standard at 55.4%

DBTH PERFORMANCE REPORT – December 2018

EXCEPTIONS (for October)

Of note this month; there was an unusually high number of Bassetlaw patients in this cohort (17) and the usual delays involved in the transfers from Bassetlaw A&E to DRI were apparent.

The NHS Bassetlaw percentage for 4 hour admissions was therefore low at 29.4% (only 5 out of the 17 patients).

There were other delays in A&E reported, with 3 instances where the SNP was busy with other patients and therefore unable to chase up.

Direct Admission Target =90%

	CCG			
Direct Admission within 4 Hours	Bassetlaw	Doncaster	Other	**Total**
Yes	5	24	3	**32**
No	12	11	1	**24**
Grand Total	**17**	**35**	**4**	**56**
Performance	29.4%	68.6%	75.0%	**57.1%**

Direct Admission

Category	Sub Category	Total
Organisational	Beds	1
	Pathway	16
	Staff Availability	3
Clinical	Patient Presentation	3
	Patient Needs	1
Patient Choice	Declined	1
Awaiting further validation		

Scan within 1 Hour Target = 48%

	CCG			
Scan 1 hr	Bassetlaw	Doncaster	Other	**Total**
Yes	9	20	2	**31**
No	8	15	2	**25**
Grand Total	**17**	**35**	**4**	**56**
Performance	52.9%	57.1%	50.0%	**55.4%**

Scan within 1 Hour

Category	Sub Category	Total
Organisational	Scanner	
	Pathway	22
	Staff Availability	
Clinical	Criteria	
	Patient Needs	
	Patient Presentation	3
Patient Choice	Declined	
Awaiting further validation		

Community paediatric GDA and AHD

Community Paediatrics Waiting Times Report 2017/18-2018/19 - Doncaster
Longest Waits for GDA are shown in weeks

Doncaster	April	May	June	July	August	September	October	November	December	January	February
Longest Wait Of First GDA Attendances 2017-18	40	31	29	18	12	4	4	6	8	8	9
Longest Wait Of First GDA Attendances 2018-19	14	14	15	14	14	9	6	6			

Longest Waits ASD are shown in Days

Doncaster	April	May	June	July	August	September	October	November	December	January	February
Longest wait of those children waiting for their first consultation/contact <5 ASD 2017-18	367	398	428	431	449	387	488	308	276	307	279
Longest wait of those children waiting for their first consultation/contact <5 ASD 2018-19	308	301	275	292	274	304	314	309			

Doncaster	April	May	June	July	August	September	October	November	December	January	February
Longest wait of those children waiting for their first consultation/contact => ASD 2017-18	656	681	662	630	661	600	589	566	531	530	457
Longest wait of those children waiting for their first consultation/contact =>5 ASD 2018-19	497	470	402	433	464	438	468	470			

Community Paediatrics Waiting Times Report 2017/18-2018/19 -

DBTH PERFORMANCE REPORT – December 2018

Bassetlaw
Longest Waits for GDA are shown in weeks

Bassetlaw	April	May	June	July	August	September	October	November	December	January	February	March
Longest Wait Of First GDA Attendances 2017-18	8	4	6	6	6	6	6	4	6	8	8	8
Longest Wait Of First GDA Attendances 2018-19	8	8	8	10	10	14	10	10				

Longest Waits for ASD & ADHD are shown in Months

Bassetlaw	April	May	June	July	August	September	October	November	December	January	February	March
Longest Wait Of First ASD Attendances 2017-18	6	8	8	10	10	10	8	6	6	6	8	8
Longest Wait Of First ASD Attendances 2018-19	8	8	8	8	8	8	8	10				

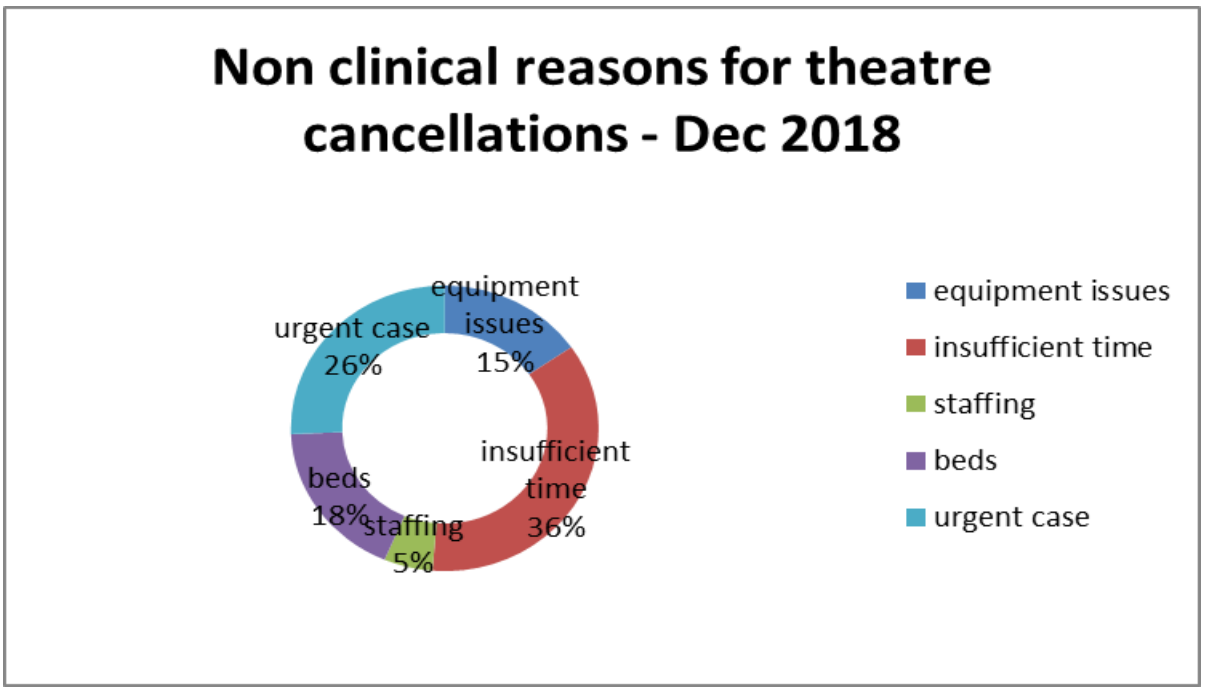
Bassetlaw	April	May	June	July	August	September	October	November	December	January	February	March
Longest Wait Of First ADHD Attendances 2017-18	6	8	8	10	10	10	8	6	6	6	8	8

Cancelled Operations

In December 1.18% of Trust operations were cancelled; this is in line with the range of performance %. 39 operations were theatre cancellations for clinical reasons and 13 for non-theatre reasons.

Indicator	Standard	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18
Cancelled Operations (Total)	1.0%	1.67%	1.14%	1.13%	1.00%	1.18%

Of which Theatre Cancellations	-	*1.50%*	*0.97%*	*0.88%*	*0.63%*	*0.89%*
Of which Non-Theatre Cancellations	-	*0.17%*	*0.17%*	*0.24%*	*0.37%*	*0.30%*
Cancelled Operations – 28 day standard	*0*	*1*	*1*	*1*	*1*	*1*



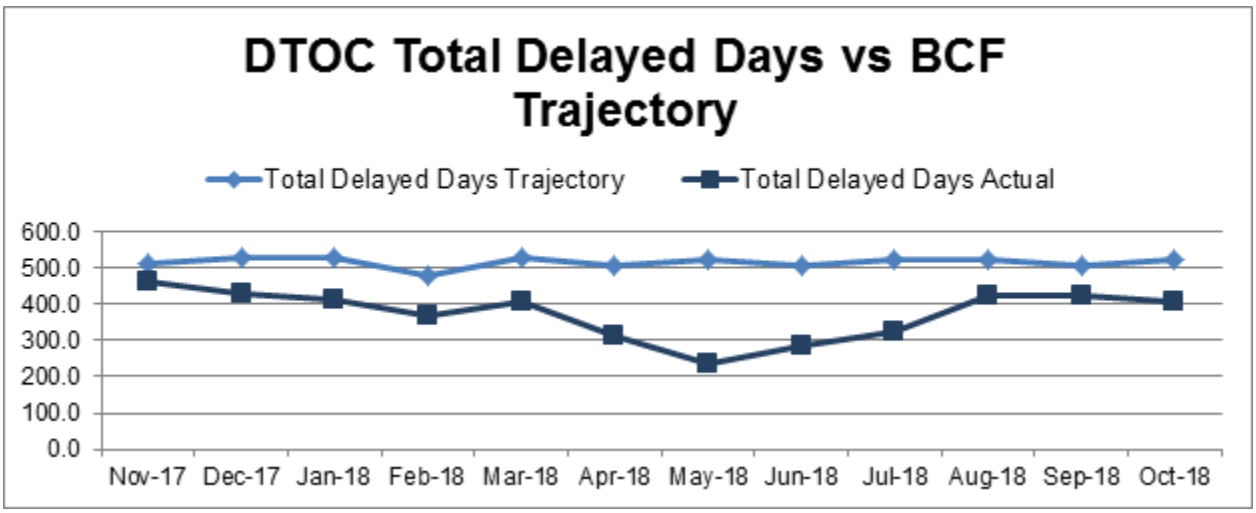
DNA and CNA Rates

Indicator	Dec
Outpatients: DNA Rate Total	8.83%
Outpatients: Hospital cancellation Rate	5.20%

In December the overall DNA rate across the Trust reduced slightly to 8.83%
The hospital cancellation rate was 5.20%.

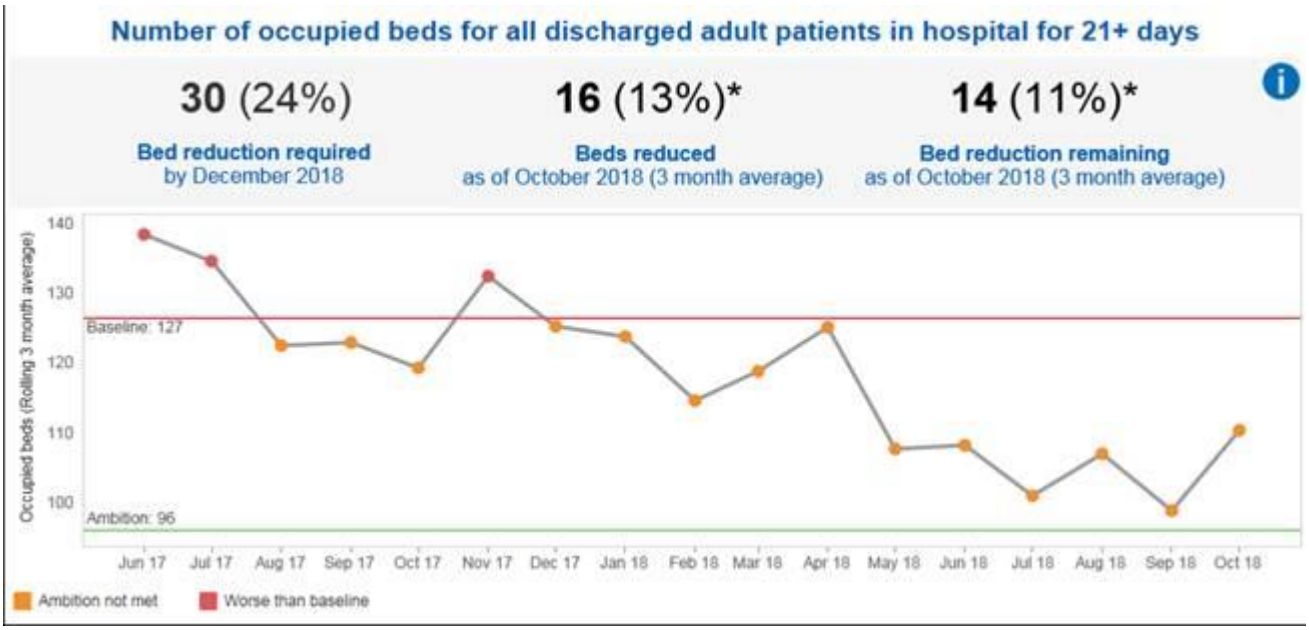
Delayed Transfers of Care

The new National DTOC guidance has been shared and current reporting for Doncaster and Bassetlaw is being reviewed in light of the changes.



The number of patients with a LOS greater than 21 days did increase in October 2018. The most common diagnoses with a long length of stay are: stroke, pneumonia and fractured femur. In addition, there are ongoing challenges with housing, and with patients from out of area.

Monthly LOS meetings are ongoing and the care of every patient with a length of stay greater than 7 days is discussed with clinical teams. The details of all patients with a LOS over 21 days are documented and discussed with partners. Weekly MDT visits to wards have also commenced, in order to support teams in the management and discharge of patients with an extended length of stay.


Number of occupied beds for all discharged adult patients in hospital for 21+ days
30 (24%)
Bed reduction required
by December 2018
16 (13%)*
Beds reduced
as of October 2018 (3 month average)
14 (11%)*
Bed reduction remaining
as of October 2018 (3 month average)
Occupied beds (Rolling 3 month average)
140
130
120
110
100
Baseline: 127
Ambition: 96
Jun 17
Jul 17
Aug 17
Sep 17
Oct 17
Nov 17
Dec 17
Jan 18
Feb 18
Mar 18
Apr 18
May 18
Jun 18
Jul 18
Aug 18
Sep 18
Oct 18
Ambition not met
Worse than baseline

At a Glance December 2018 (Month 9)

Doncaster & Bassetlaw Teaching Hospital NHS Foundation Trust

	Indicator	Standard	Current Month	Month Actual	Direction of travel compared to previous Month	NHS England Benchmarking: NHS England %	NHS England Benchmarking: DBTHFT	NHS England Benchmarking: Month	Peer Group Benchmarking: Peer Groups %	Peer Group Benchmarking: DBTHFT	Peer Group Benchmarking: Month
Monitor Compliance Framework	31 day wait for second or subsequent treatment: surgery	94.00%	November	100.00%	↔	93.00%	100.00%	November	92.20%	100.00%	November
	31 day wait for second or subsequent treatment: anti cancer drug treatments	98.00%		100.00%	↔	99.40%	100.00%		99.50%	100.00%	
	31 day wait for second or subsequent treatment: radiotherapy	94.00%		100.00%	↔	97.30%	100.00%		Not Available	100.00%	
	62 day wait for first treatment from urgent GP referral to treatment	85.00%		86.90%	↗	79.20%	86.90%		77.00%	86.90%	
	62 day wait for first treatment from consultant screening service referral	90.00%		94.40%	↗	88.50%	94.40%		79.40%	94.40%	
	31 day wait for diagnosis to first treatment- all cancers	96.00%		99.40%	↔	96.60%	99.40%		96.10%	99.40%	
	Two week wait from referral to date first seen: all urgent cancer referrals (cancer suspected)	93.00%		91.90%	↘	92.50%	91.90%		96.60%	91.90%	
	Two week wait from referral to date first seen: symptomatic breast patients (cancer not initially suspected)	93.00%		87.40%	↘	88.10%	87.40%		94.20%	87.40%	
	A&E: Maximum waiting time of four hours from arrival / admission / transfer / discharge (Trust)	95.00%	December	91.30%	↘	87.60%	91.30%	December	83.93%	91.30%	December
	Maximum time of 18 weeks from point of referral to treatment- incomplete pathway	92.00%	Decemer	86.60%	↘	87.73%	87.90%	November	84.76%	87.90%	November
	% of Patients waiting less than 6 weeks from referral for a diagnostics test	99.00%	December	99.28%	↘	97.60%	99.51%	November	98.60%	99.51%	November
Ambulance Handover Times	Ambulance Handovers Breaches -Number waited over 15 & Under 30 Minutes		November	792	↗	UCL: 796 & LCL: 659					
	Ambulance Handovers Breaches-Number waited over 30 & under 60 Minutes			26	↗	UCL: 122 & LCL: 56					
	Ambulance Handovers Breaches -Number waited over 60 Minutes			1	↗	UCL: 29 & LCL: 2					
Stroke	Proportion of patients scanned within 1 hour of clock start (Trust)	48.00%	October	55.40%	↗	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%		57.10%	↗						
	Percentage of eligible patients (according to the RCP guideline minimum threshold) given thrombolysis (Trust)	20.00%		10.70%	↗						
	Percentage of patients treated by a stroke skilled Early Supported Discharge team (Trust)	40.00%		77.60%	↗						
	Percentage of those patients who are discharged alive who are given a named person to contact after discharge (Trust)	95.00%		87.80%	↗						
	Implementation of Stroke Strategy - TIA Patients Assessed and Treated within 24 Hours	60.00%	December	53.30%	↓						
Theatres & Outpatients	Cancelled Operations	0.80%	December	1.18%	↘	No Benchmarking available					
	Cancelled Operations-28 Day Standard	0		1	↔						
	Out Patients: DNA Rate			9.80%	↘	7.71%	9.95%	September	6.96%	9.95%	September
	Out Patients: Hospital Cancellation Rate			4.93%	↘	No Benchmarking available - data not submitted to Secondary Uses Service by all Trusts					
Effective	Emergency Readmissions within 30 days (PbR Methodology)		November	6.20%	↗	7.56%	6.50%	August	8.10%	6.50%	August

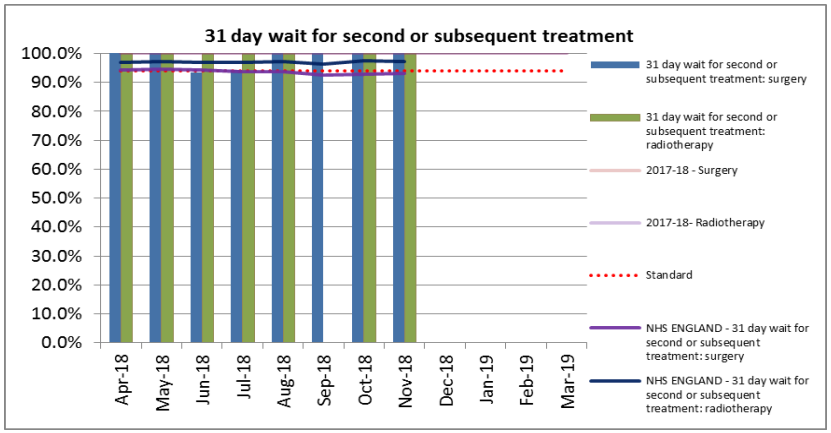
	Indicator	Current Month	Month Actual (TRUST)	Month Actual (DRI)	Month Actual (BDGH)	Data Quality RAG Rating
Fractured Neck of Femur	% of patients achieving Best Practice Tariff Criteria	Dec-18	41.70%	42.10%	40.00%	
	Best Practice Criteria					
	36 hours to surgery Performance	Dec-18	50.00%	47.37%	60.00%	
	72 hours to geriatrician assessment Performance		81.25%	81.58%	80.00%	
	% of patients who underwent a falls assessment		98.00%	97.00%	100.00%	
	% of patients receiving a bone protection medication assessment		96.00%	97.00%	90.00%	
	Mortality-Deaths within 30 days of procedure		2.00%	2.60%	0.00%	

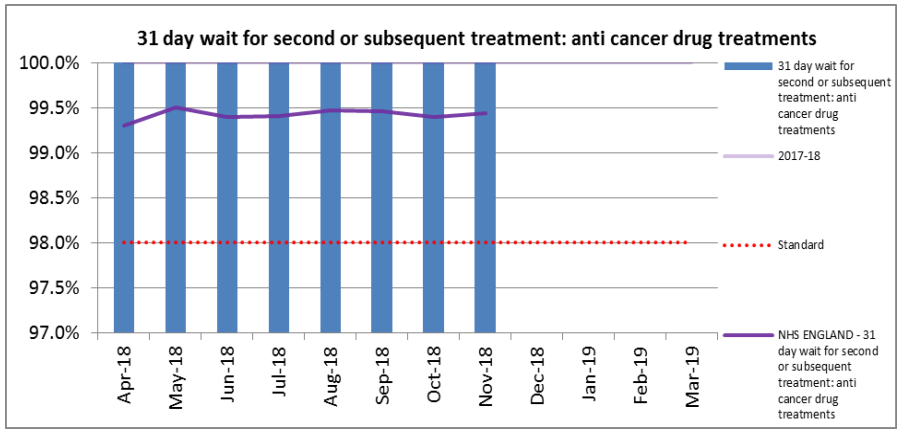
	Indicator	Standard (Local, National Or Monitor)		Current Month	Month Actual	Data Quality RAG Rating
Safe	Infection Control C.Diff	4 Per Month - 45 full year	M	Dec-18	2	
	Infection Control MRSA	0	L		0	
	HSMR (rolling 12 Months)	100	N	Oct-18	93.43	
	Never Events	0	L	Dec-18	0	
	VTE	95.0%	N	Nov-18	95.0%	
	Avoidable Pressure Ulcers Cat 3&4	21 Full Year	L	Dec-18	1	
	Falls that result in a serious Fracture	2 Per Month 23 full Year	L	Dec	1	
	Catheter UTI	Snap shot audit			0.57%	

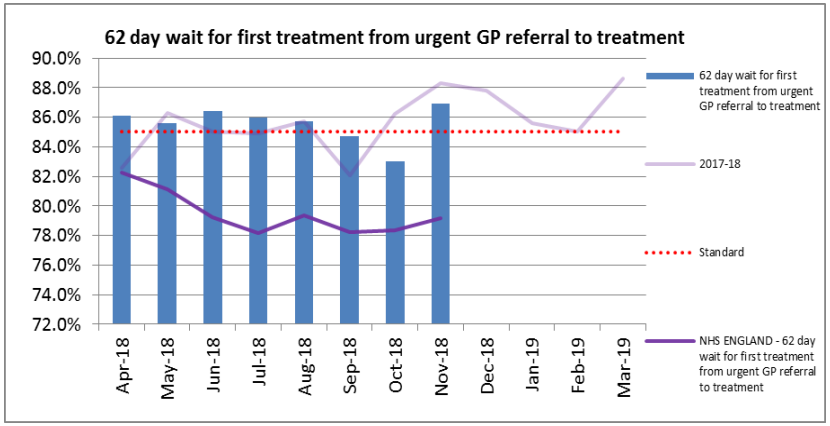
	Indicator	Current Month	Month Actual	Data Quality RAG Rating
Complaints & Claims	Complaints received (12 Month Rolling)	Dec-18	406	
	Concerns Received (12 Month Rolling)		695	
	Complaints Performance		94.0%	
	Clinical Negligence Scheme for Trusts (CNST)		4	
	Liabilities to Third Parties Scheme (LTPS)		2	
	Claims per 1000 occupied bed days		0.17	

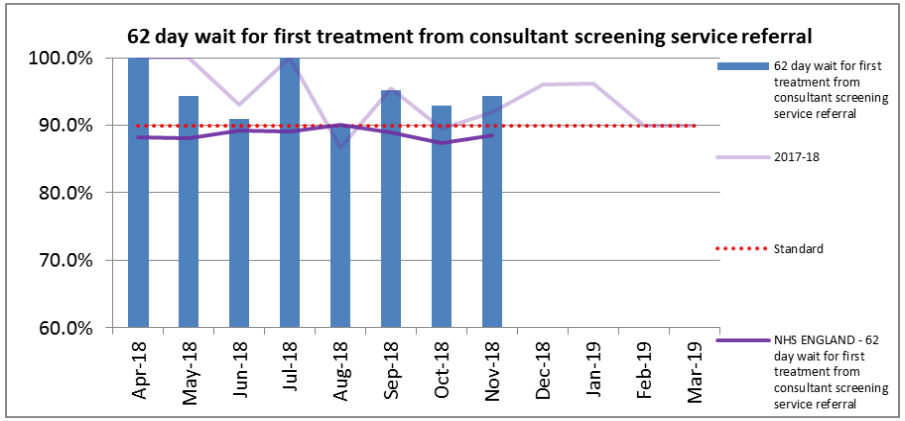
	Indicator	Current Month	YTD (Cumulative)	Data Quality RAG Rating
Workforce	Appraisals	December	78.85%	
	SET Training		81.78%	

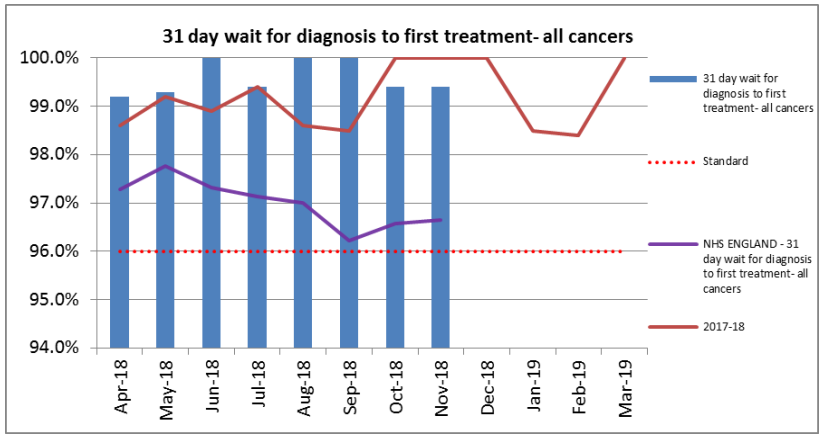
Monitor Compliance Framework: Cancer - Graphs - November 2018 (Month 8)

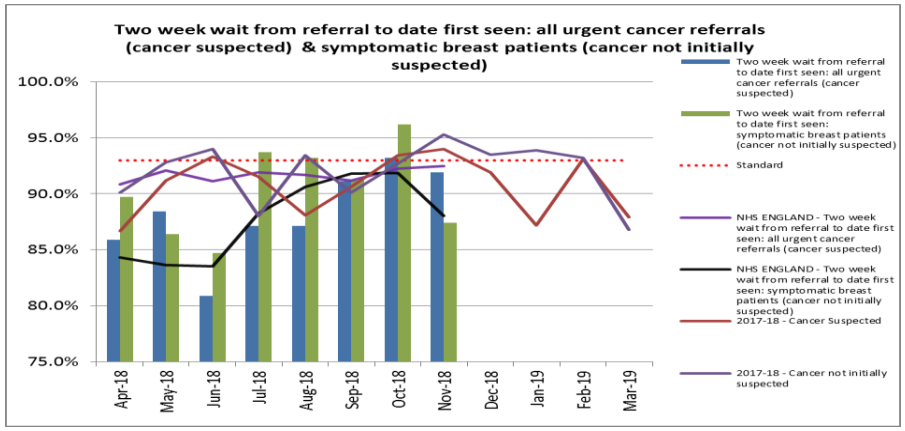




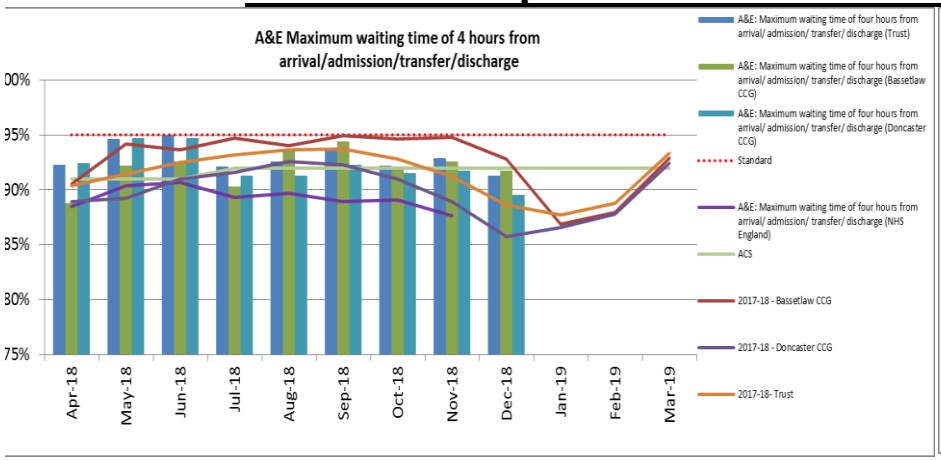


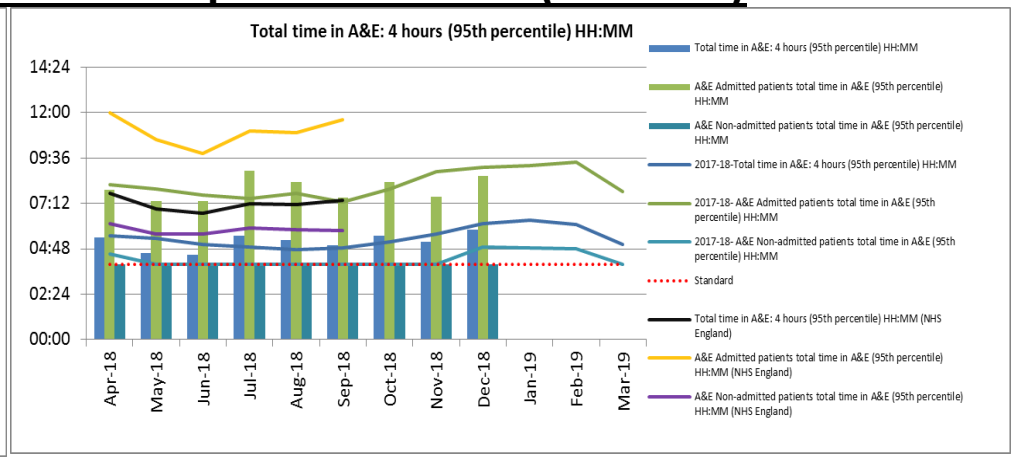


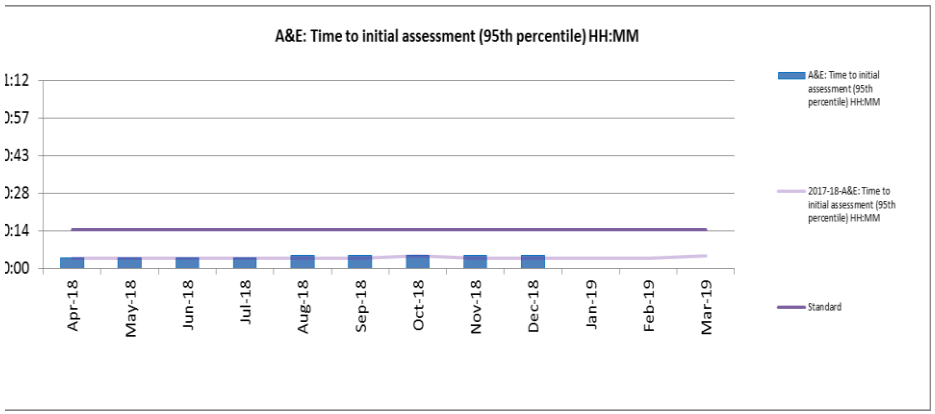


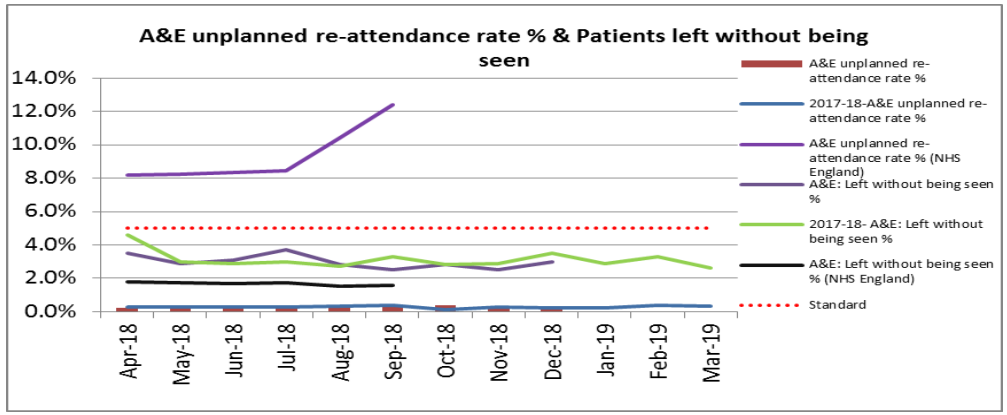


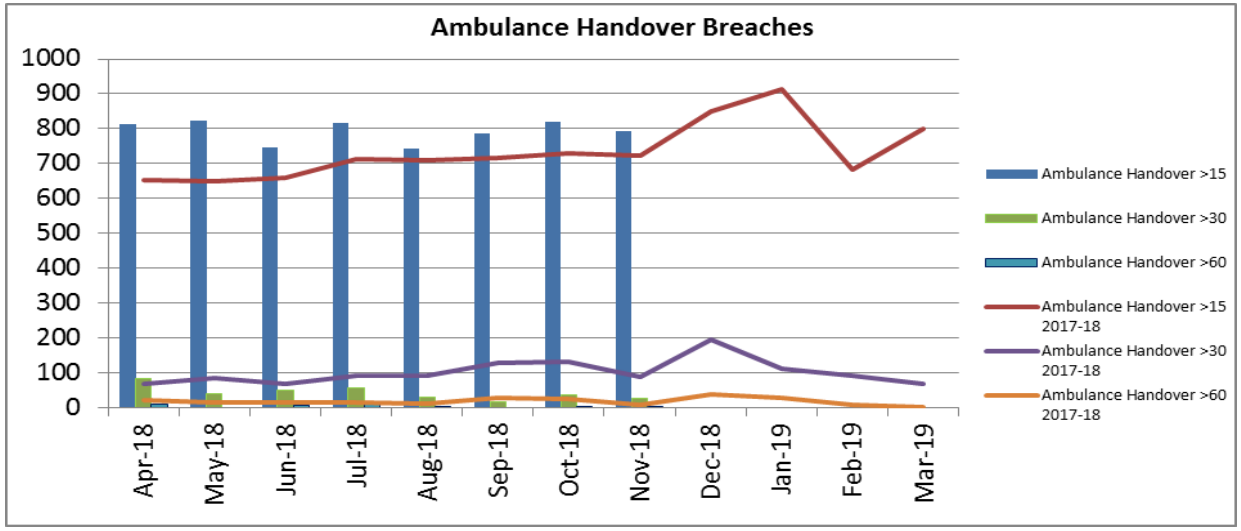
Monitor Compliance Framework: A&E - Graphs - December (Month 9)



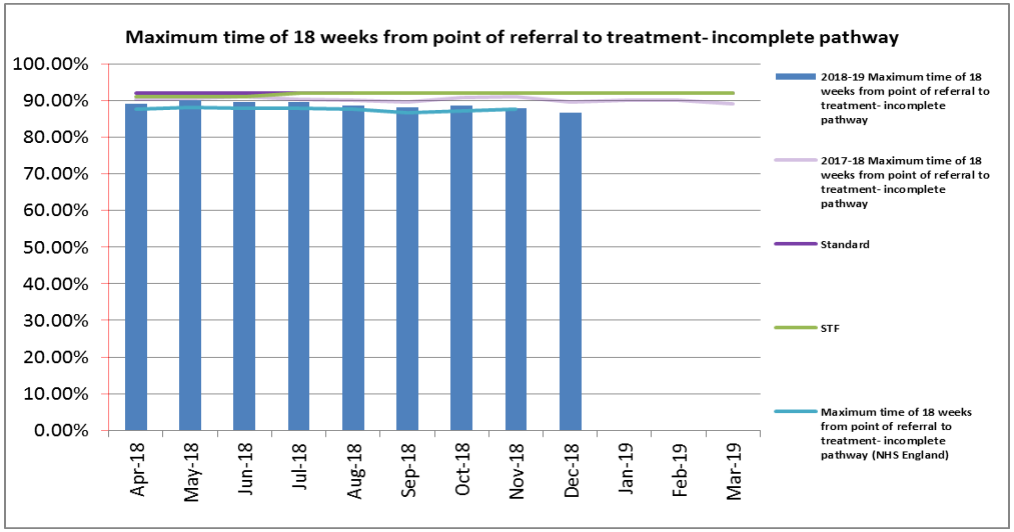


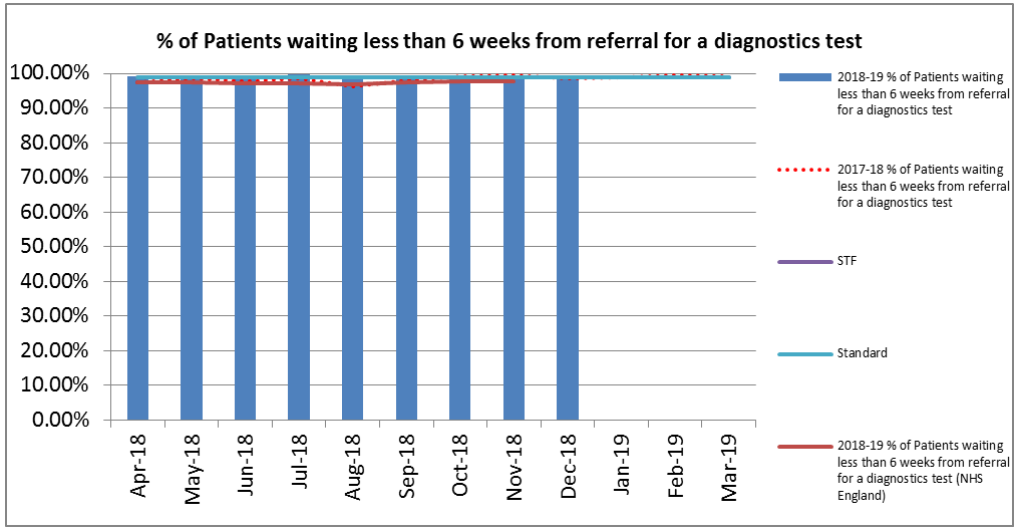


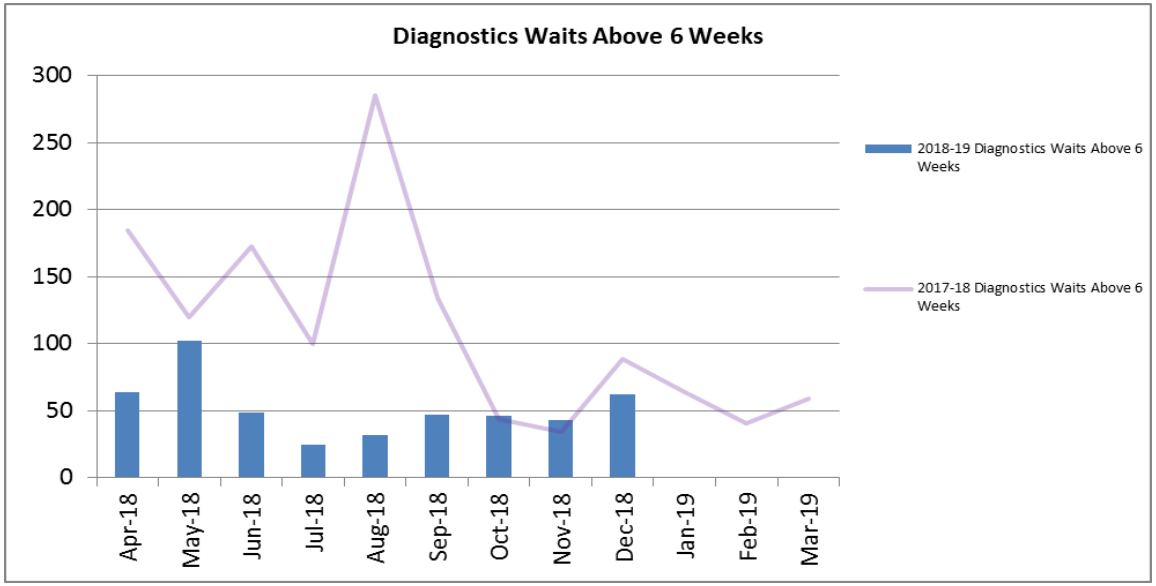




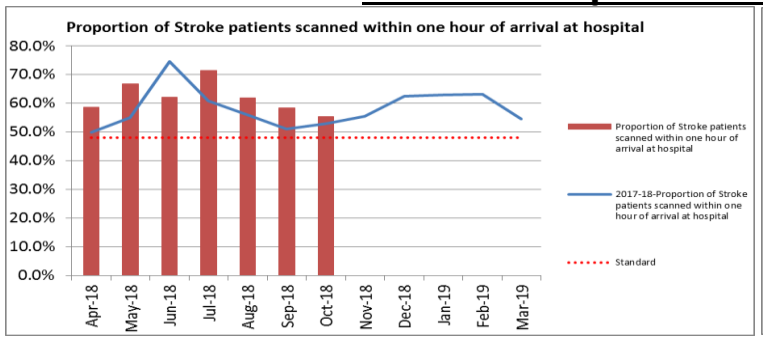
Monitor Compliance Framework: 18 Weeks & December -October (Month 9)

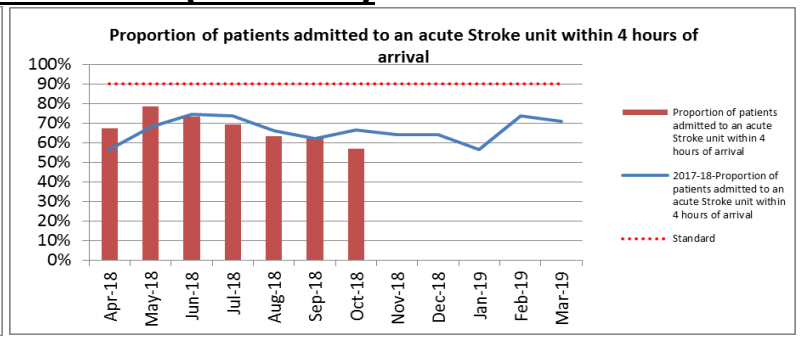


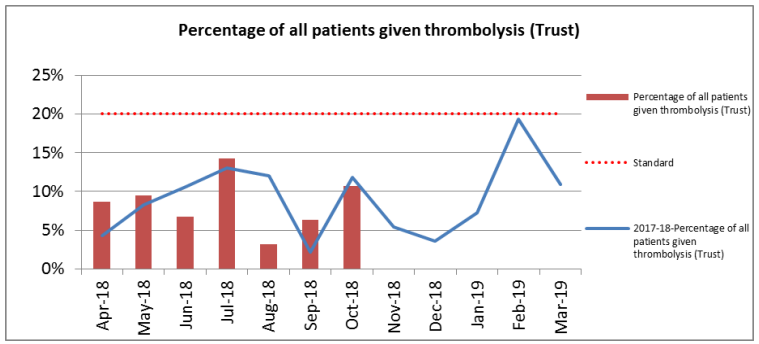


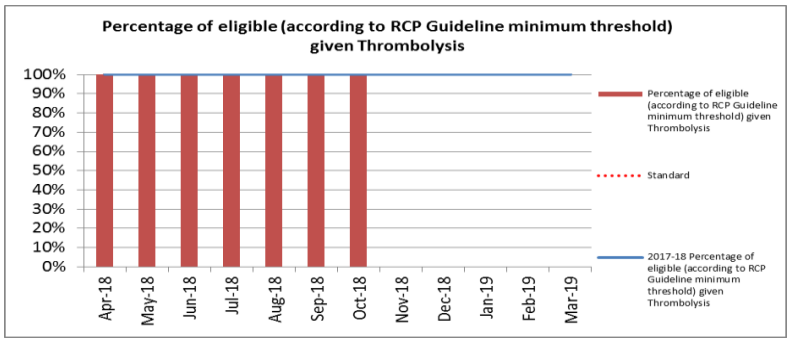


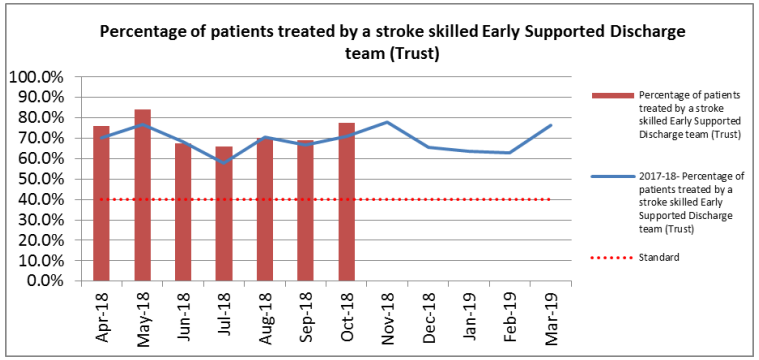
Stroke - Graphs October 2018 (Month 7)

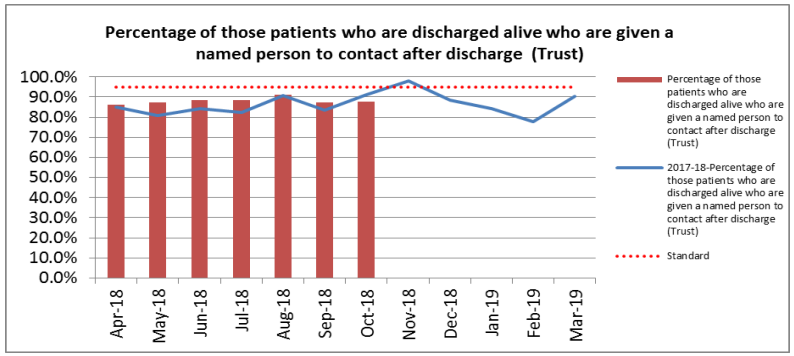


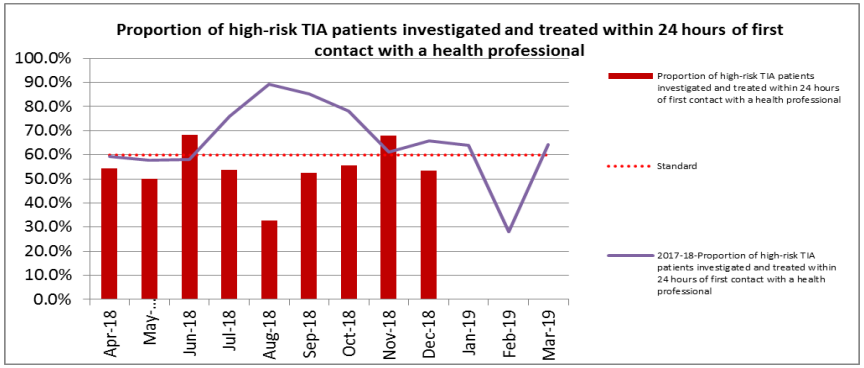












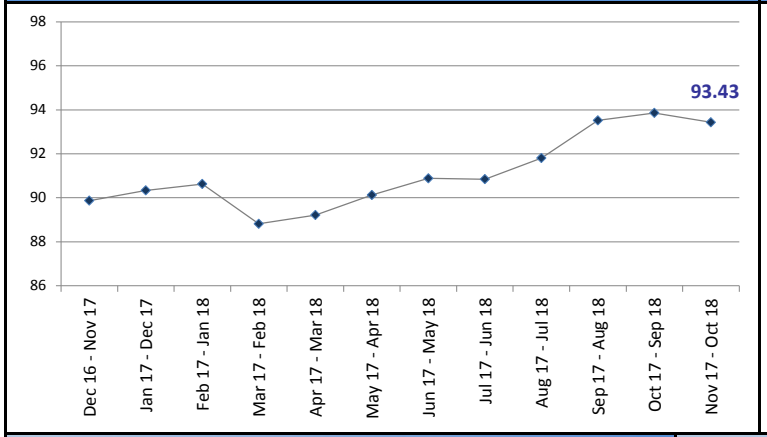
Executive Summary - Safety & Quality - December 2018 (Month 9)

HSMR:	HSMR for the month of October 93.40 with a rolling 12 month HSMR of 93.43 which remains lower than expected.
Fractured Neck of Femur:	Although relative mortality risk reamins low, achievement of BPT deteriorated in month due to theatre capacity. The QI initiative is in train and will help address this.
Serious Incidents:	There were 3 SI's reported in month - fall resulting in fracture, a delay in diagnosis and a HAPU.
Executive Lead:	**Mr S Singh**

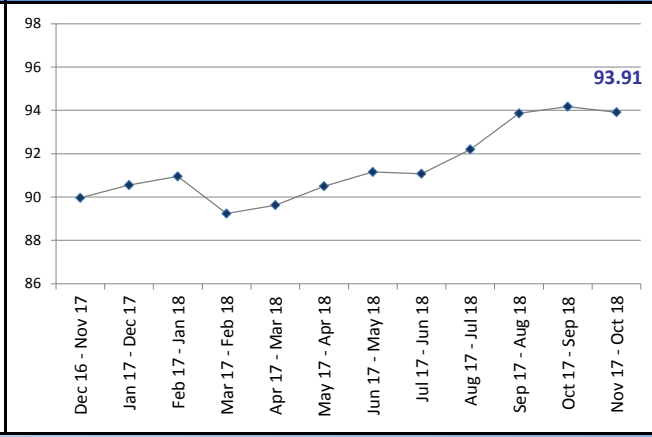
C-Diff	The rate is above that of the same period last year and lower than the year to date position and national trajectory
Fall resulting in significan harm:	The rate is the same as in December 2017 and higher than the YTD position
Hospital Acquired Pressure Ulcers:	The rate for December is the same as in December 2017 and higher than the YTD position.
Complaints and Concerns	The number of complaints and concerns has dropped although remains within normal variation. Complaints response times with in timescale has improved slightly to 94%.
Friends & Family Test:	The response rates for both Inpatients and ED remains below national average with positivity of responses continuing to be better than the national average again for both inpatients and ED.
Executive Lead:	**Mrs M Hardy**

Hospital Standardised Mortality Ratio (HSMR) - Oct 2018 (Month 7)

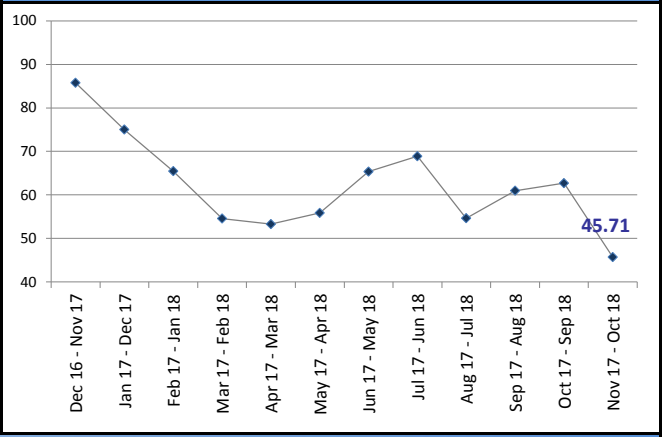
Overall HSMR (Rolling 12 months)



HSMR - Non-elective Admission (Rolling 12 months)



HSMR - Elective Admission (Rolling 12 months)

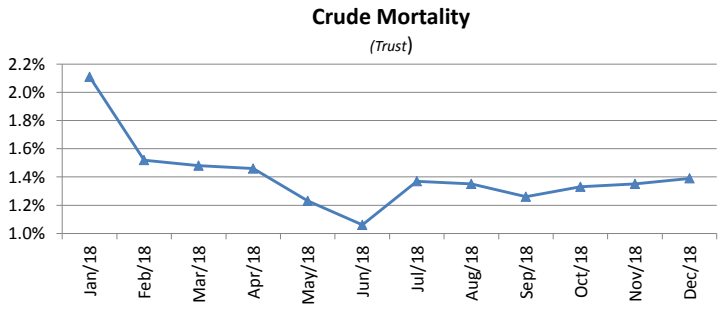


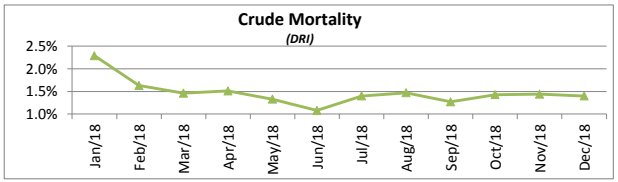
HSMR Trend (monthly)

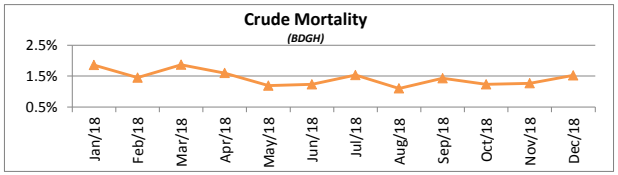
	2015	2016	2017	2018
January	116.80	99.21	94.86	93.92
February	99.94	97.73	105.44	84.21
March	90.54	97.37	82.66	87.34
April	105.91	88.50	85.36	97.21
May	101.15	96.60	82.88	92.23
June	80.27	93.67	89.99	89.54
July	92.56	97.73	96.09	111.06
August	100.27	87.52	73.78	96.61
September	90.26	95.34	87.30	91.16
October	90.29	88.66	98.57	93.40
November	88.98	82.30	88.02	
December	82.30	93.52	99.02	

Crude Mortality (monthly) - Dec 2018 (Month 9)

(number of deaths/number of patient discharged)



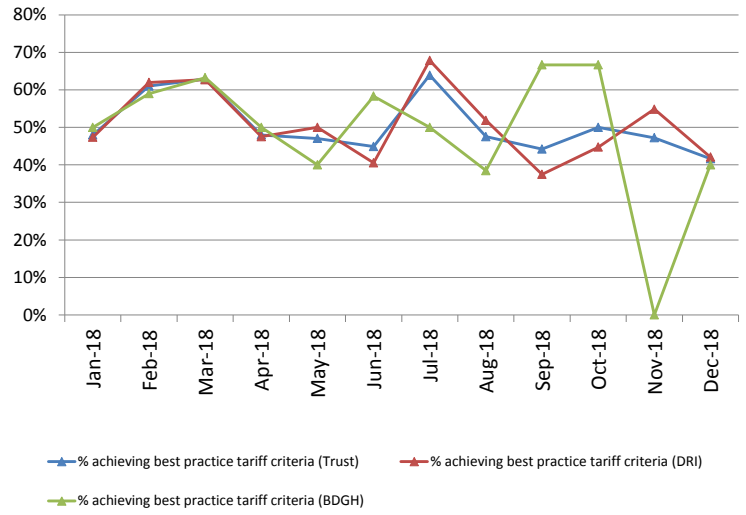




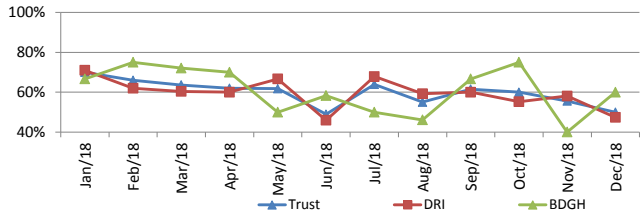
	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18
Trust	2.11%	1.52%	1.48%	1.46%	1.23%	1.06%	1.37%	1.35%	1.26%	1.33%	1.35%	1.36%
Donc	2.29%	1.63%	1.46%	1.51%	1.33%	1.08%	1.40%	1.47%	1.27%	1.43%	1.44%	1.45%
Bass	1.86%	1.45%	1.87%	1.60%	1.19%	1.23%	1.53%	1.10%	1.43%	1.23%	1.27%	1.26%

NHFD Best Practice Pathway Performance -Dec 2018 (Month 9)

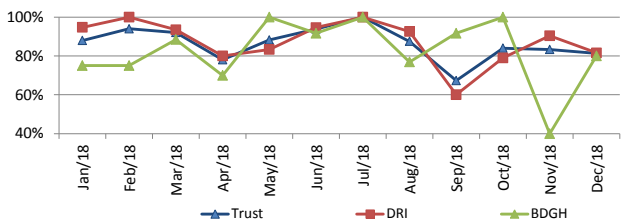
Best Practice Criteria Performance



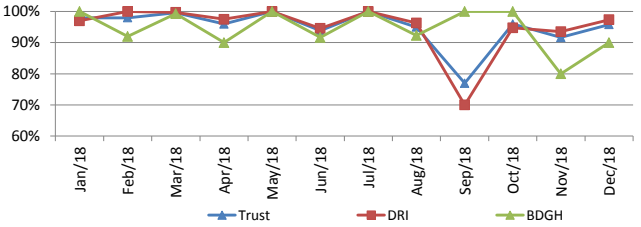
36 Hours to Surgery Performance



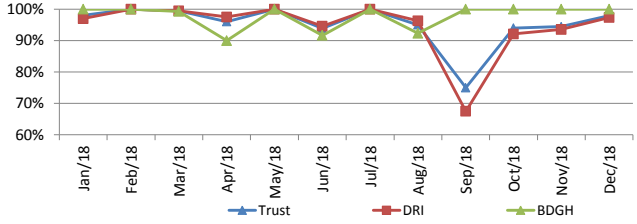
72 hours to Geriatrician Assessment Performance



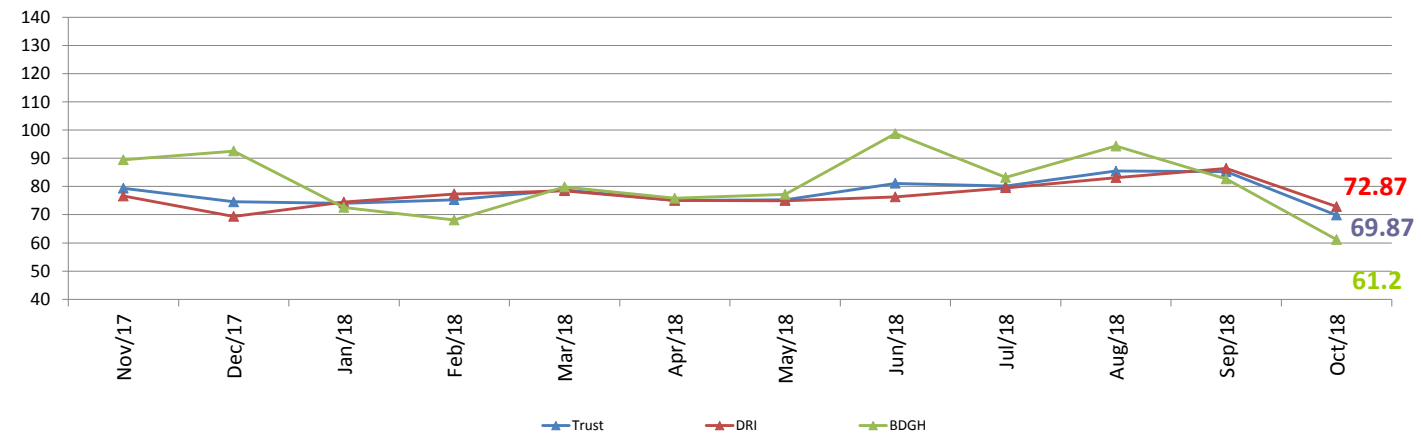
Bone Protection Medication Assessment



Falls Assessment Performance



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



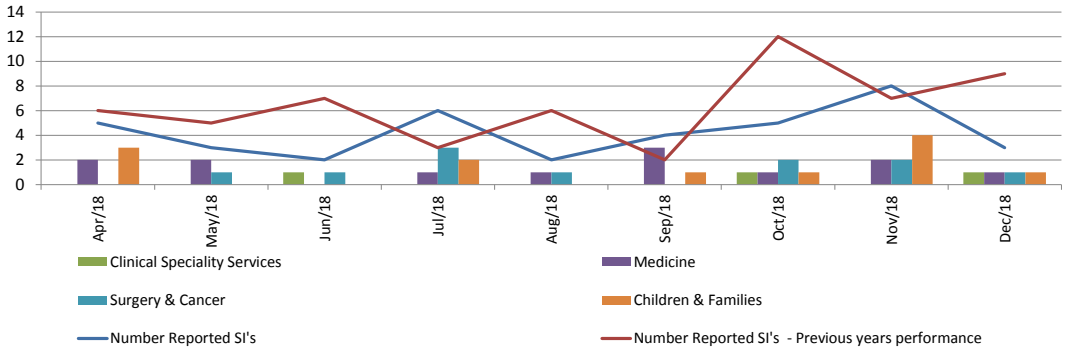
Serious Incidents - Dec 2018 (Month 9)

(Data accurate as at 11/01/2019)

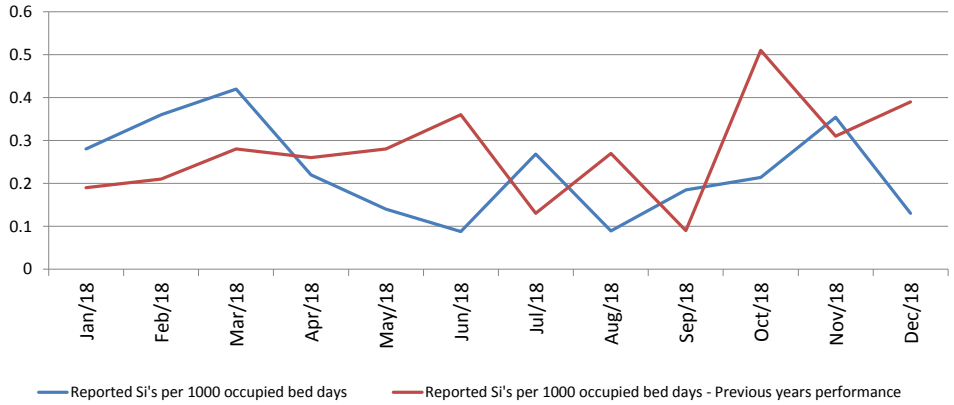
Please note: At the time of producing this report the number of serious incidents reported are prior to the RCA process being completed.

Overall Serious Incidents

Number Serious Incidents Reported
(Trust & Care Group)



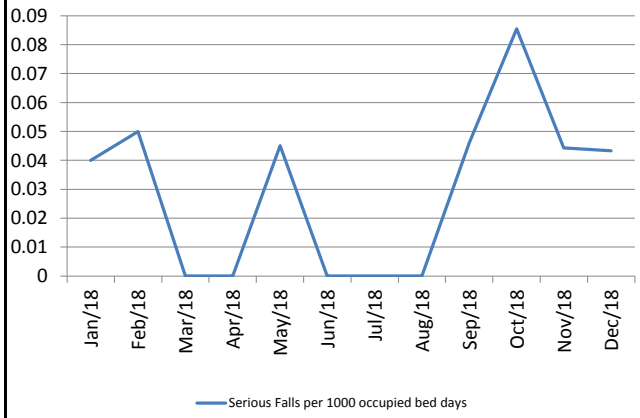
Serious Incidents per 1000 occupied bed days



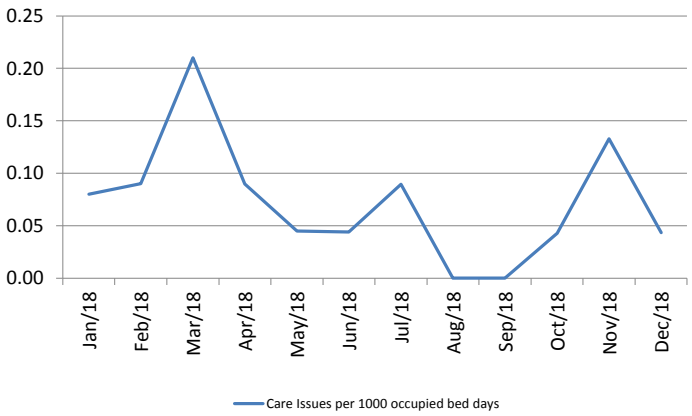
Current YTD reported SI's (April-Dec 18)	38	Number reported SI's (Apr-Dec 17)	57
Current YTD delogged SI's (April-Dec 18)	1	Number delogged SI's (Apr-Dec 17)	29

Themes

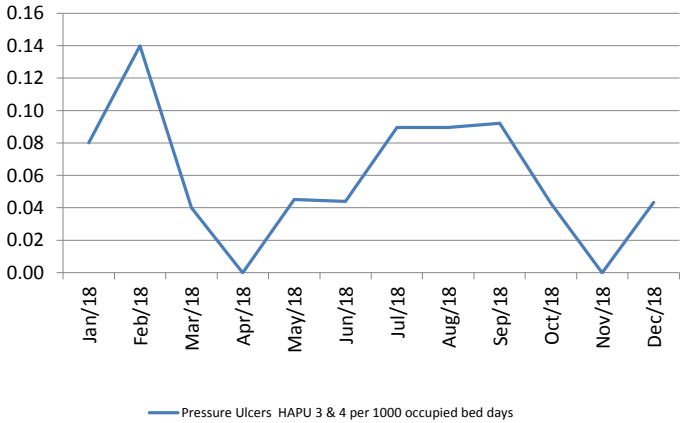
Serious Falls



Care Issues

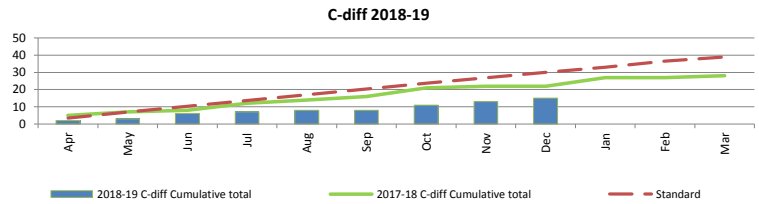


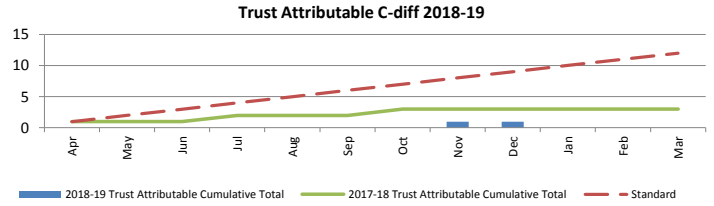
Pressure Ulcers - Category 3 & 4 (HAPU)



Monitor Compliance Framework: Infection Control C.Diff - Dec 2018 (Month 9)
(Data accurate as at 14/01/2019)

	Standard	Q1	Q2	Oct	Nov	Dec	YTD
2018-19 Infection Control - C-diff	39 Full Year	6	2	3	2	2	15
2017-18 Infection Control - C-diff	40 Full Year	8	8	5	1	0	22
2018-19 Trust Attributable	12	0	0	0	1	0	1
2017-18 Trust Attributable	12	1	1	1	0	0	3

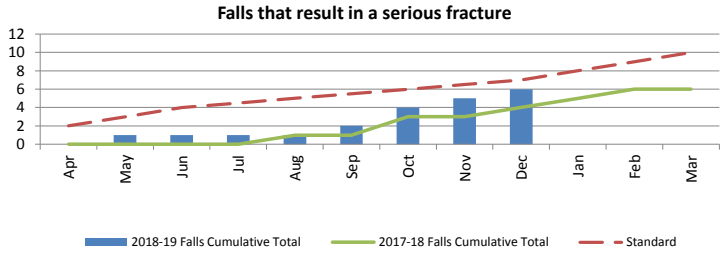




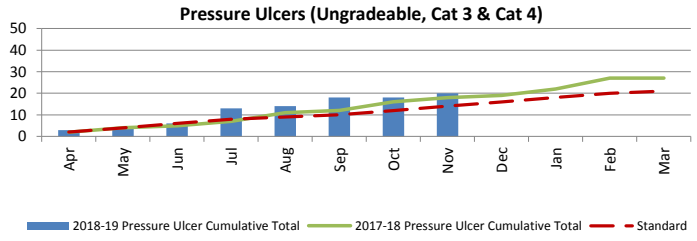
Pressure Ulcers & Falls that result in a serious fracture - Nov 2018 (Month 8)
(Data accurate as at 06/12/2018)

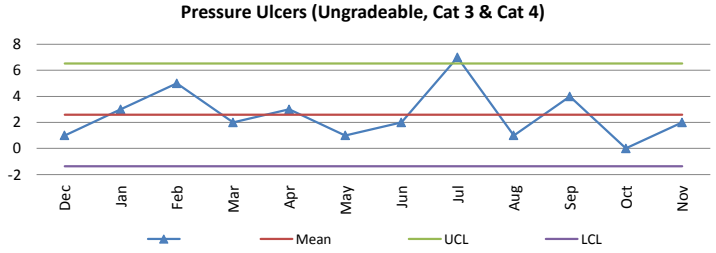
	Standard	Q1	Q2	Oct	Nov	Dec	YTD
2018-19 Serious Falls	10 Full Year	1	1	2	1	1	6
2017-18 Serious Falls	6 Full Year	0	1	2	0	1	4

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



	Standard	Q1	Q2	Oct	Nov	YTD
2018-19 Pressure Ulcers	21 Full Year	6	12	0	2	20
2017-18 Pressure Ulcers	27 Full Year	5	7	4	2	18





Hard Truths - Dec 2018 (Month 9)

(Data accurate as at 14/01/2019)

				Planned v Actual		Safe	Effective	Caring	Responsive	Well Led	Profile	
Division	Matron	Ward	No of Funded Beds	CHPPD	Variance	Total score	Total score	Total score	Total score	QM total score	Work-force	Quality
Surgery & Cancer		B5	30.7	6.6	94%	0.0	1.5	1.0	2.0	4.5		
		B6	16	7.3	98%	3.5	0.0	2.0	2.0	7.5		
	AH	St Leger	35	6.6	97%	1.0	0.5	1.0	2.0	4.5		
	AH	1&3	23	8.4	95%	1.0	0.0	0.5	2.0	3.5		
		20	27	5.2	100%	3.0	0.5	2.5	1.0	7.0		
		21	27	5.0	98%	2.5	0.5	1.0	2.0	6.0		
		S10	20	5.6	99%	1.5	0.5	1.0	2.0	5.0		
		S11	19	6.2	98%	0.5	0.5	0.0	1.0	2.0		
		S12	20	5.5	98%	1.0	0.5	1.0	1.5	4.0		
		SAW	21	8.4	97%	1.5	0.0	2.0	1.5	5.0		
					98%							
Medicine	JC	A4	24	6.4	104%	0.0	1.5	3.0	1.5	6.0		
	JC	C1	16	5.7	92%	0.0	2.5	0.5	2.0	5.0		
	JC	CCU/C2	18	6.6	100%	1.5	0.5	1.0	2.5	5.5		
	JC	ATC	21	7.9	101%	1.5	1.0	0.5	2.0	5.0		
	SS	AMU	40	8.4	109%	3.5	2.5	1.0	1.5	8.5		
	MT	FAU	16	8.1	98%	1.5	1.0	1.0	2.0	5.5		
	AW	16	24	7.9	110%	3.0	1.0	1.5	0.5	6.0		
	AW	17	24	5.7	97%	2.0	1.0	2.0	2.0	7.0		
		18 Haem	12	7.4	101%	4.0	0.0	0.0	1.5	5.5		
		18 CCU	12	7.4	95%	2.0	0.0	1.5	2.0	5.5		
		24	24	5.7	100%	0.0	1.0	2.0	1.5	4.5		
		25	16	7.7	128%	1.0	2.0	1.0	1.5	5.5		
		Respiratory unit	56	6.4	100%	2.0	1.0	2.0	0.5	5.5		
		32	18	6.2	98%	1.5	0.5	2.0	2.0	6.0		
	MT	Mallard	16	8.1	98%	2.5	0.5	2.5	2.0	7.5		
	MT	Gresley	32	5.8	99%	1.0	0.0	1.5	1.0	3.5		
	MT	Rehab 2	19	6.4	113%	2.0	0.0	2.0	2.0	6.0		
	MT	Rehab 1	29	5.2	104%	2.0	1.5	2.0	1.5	7.0		
					103%							
Clinical Speciality Services		ITU DRI	20	24.6	86%	3.0	3.0	1.0	1.0	8.0		
		ITU BDGH	6	26.5	88%	0.0	3.0	2.0	0.5	5.5		
					87%							
Children and Families	AB	SCBU	8	12.5	100%	0.0	0.0	0.0	1.5	1.5		
	AB	NNU	18	10.0	97%	0.5	0.0	0.0	1.0	1.5		
	AB	CHW	18	9.6	88%	1.5	0.0	0.0	1.0	2.5		
	AB	COU	12	14.8	96%	1.0	0.0	0.0	1.0	2.0		
	TB	G5	24	6.9	83%	2.0	2.5	1.0	1.0	6.5		
	JH	M1	26	8.7	94%	0.0	1.5	0.5	1.0	3.0		
	JH	M2	18	12.5	96%	1.0	1.5	0.0	1.0	3.5		
	SR	CDS	14	30.4	91%	1.0	1.0	1.0	1.0	4.0		
	JH	A2	18	8.5	74%	2.5	3.0	1.0	0.5	7.0		
	KC	A2L	6	28.9	97%	1.0	1.0	0.0	1.0	3.0		
					92%							

The workforce data submitted to UNIFY provides the actual hours worked in December 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 98% in December 2018; slightly higher than November 2018. There are no wards flagging as red on quality.

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

26 wards (65%) within 5% of the planned staffing level, 6 more than last month

7 wards (17.5%) between 5-10% of planned staffing levels, 3 less than last month.

2 wards (5%) <10% higher than planned staffing level, 1 less than last month.

5 wards (12.5%) >10% lower than planned staffing level, 2 less than last month.

The wards where there were deficits in excess of 10% of the planned hours are ITU at BDGH, DCC, CHW, G5 and A2. ITU at BDGH had some periods of reduced occupancy so staff were redeployed to wards and departments to optimise safe staffing needs, as did DCC, but the roster gaps were also part of a vacancy rate which has been recruited to. G5 experienced sickness, but requires a revision of the roster plan to optimise the use of staff resources, due to a change in bed base.

The wards with greater than 10% of actual staffing over planned staffing are Ward 25 and Rehab 2. Escalation beds opened due to demand on Ward 25 impacting on staffing plans, with enhanced care needs impacting also. Enhanced care also impacted on Rehab 2.

Care Hours Per Patient Day (CHPPD) - Dec 2018 (Month 9)

(Data accurate as at 14/01/2019)

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

Site Name	Registered midwives/ nurses	Care Staff	Overall
BASSETLAW HOSPITAL	4.67	3.20	7.87
DONCASTER ROYAL INFIRMARY	4.64	3.51	8.15
MONTAGU HOSPITAL	2.30	3.33	5.63
TRUST	4.50	3.43	7.94

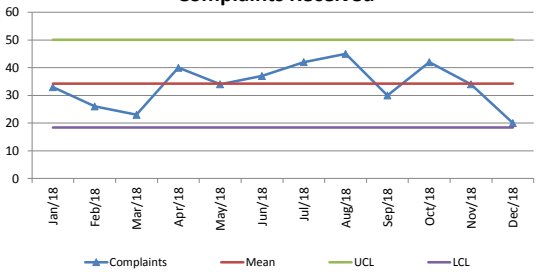
The data for December 2018 shows a similar CHPPD position to previous months overall. There is an increase in the Registered Nurse and Midwife CHPPD, which brings the Trust into closer alignment with peers.

Complaints & Claims - Dec 2018 (Month 9)

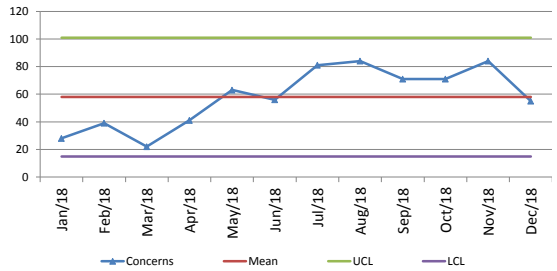
(Data accurate as at 11/01/2019

Complaints

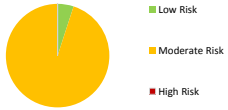
Complaints Received



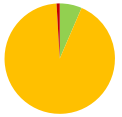
Concerns Received



Dec 2018 Complaints Received Risk Breakdown



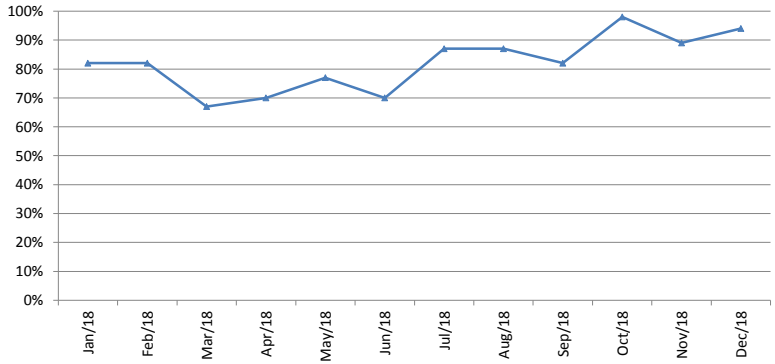
Year to Date Complaints Received Risk Breakdown



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
Dec-18	1	6

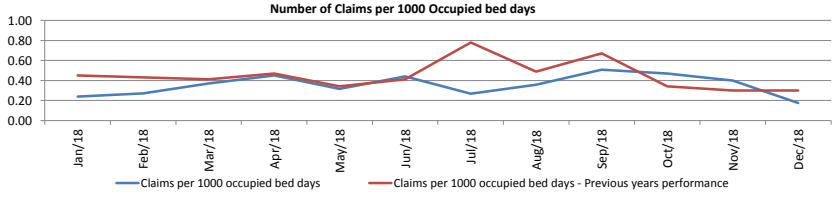
	Number referred for investigation YTD	Outcomes YTD	
2016/17	8	Outstanding	0
2017/18	7	Fully / Partially Upheld	2
		Not Upheld	1
		No further Investigation	0
		Case Withdrawn	0
		Not Investigated	3
		Outstanding	1
2018/19	8	Fully / Partially Upheld	3
		Not Upheld	0
		No further Investigation	0
		Case Withdrawn	0
		Outstanding	5

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	10	6	8	11	11	9	4				76
	2017/18	8	12	10	18	11	17	9	9	9	6	6	9	116
Liabilities to Third Parties Scheme (LTPS)	2018/19	2	6	1	1	7	0	2	0	2				21
	2017/18	2	3	1	1	2	1	1	4	1	2	4	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

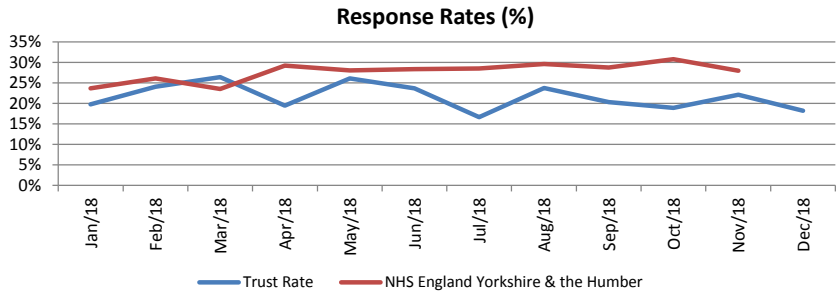


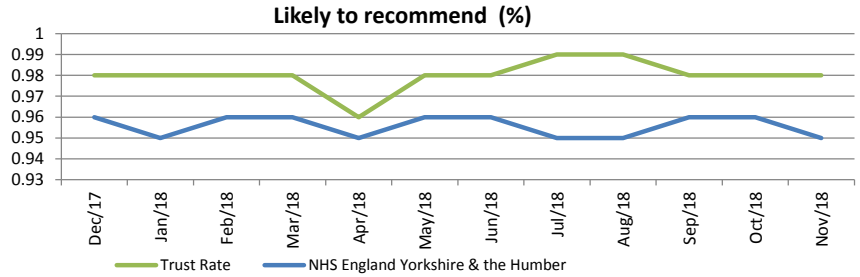
Friends & Family - Nov 2018 (Month 8)

(Data accurate as at 14/01/2019)

Inpatients

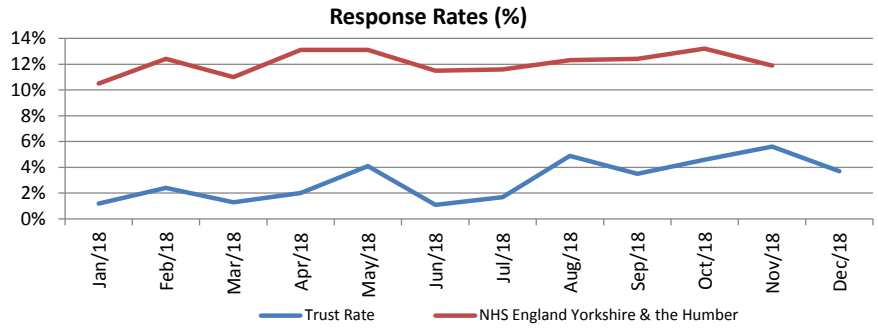
Please note: At the time of producing this report no further benchmarking data is available from NHS England.

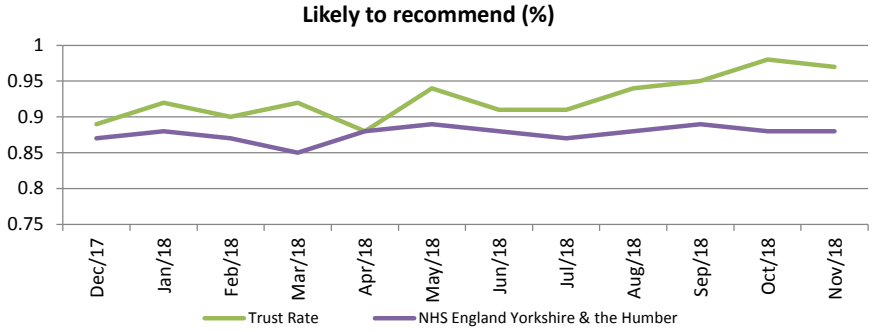




Accident & Emergency

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





Executive summary - Workforce - December 2018 (Month 9)

Sickness absence

December has seen an increase in sickness absence as typically occurs at this time of year (ref the previous year's data) with rates for December being 4.76% and the cumulative position being 4.38%. Whilst there has been a reduction in the rate for long term absences, there has been a rise in absences of between 1 and 6 months.

Appraisals

The Trusts appraisal completion rate on the attached has maintained at 78.85% as at the end of December 2018 following the end of the appraisal season.

SET

Disappointingly SET compliance has only increased slightly to 81.78% as at the end of December following the small increase last month. 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.

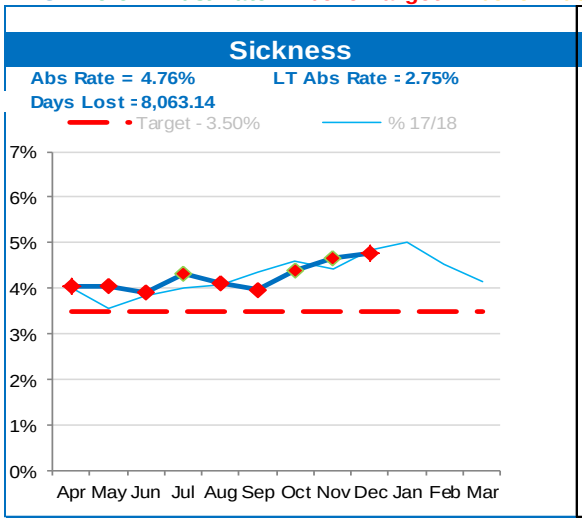
Staff in post

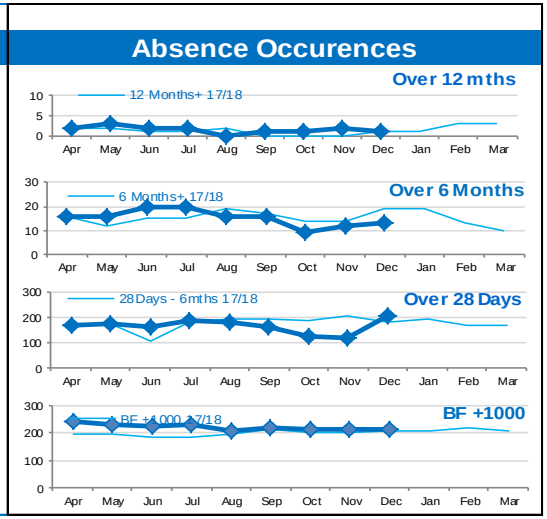
Please see attached tab covering staff in post by staff group. Vacancy rates are provided to both Finance & Performance and Quality & Effectiveness Committees.

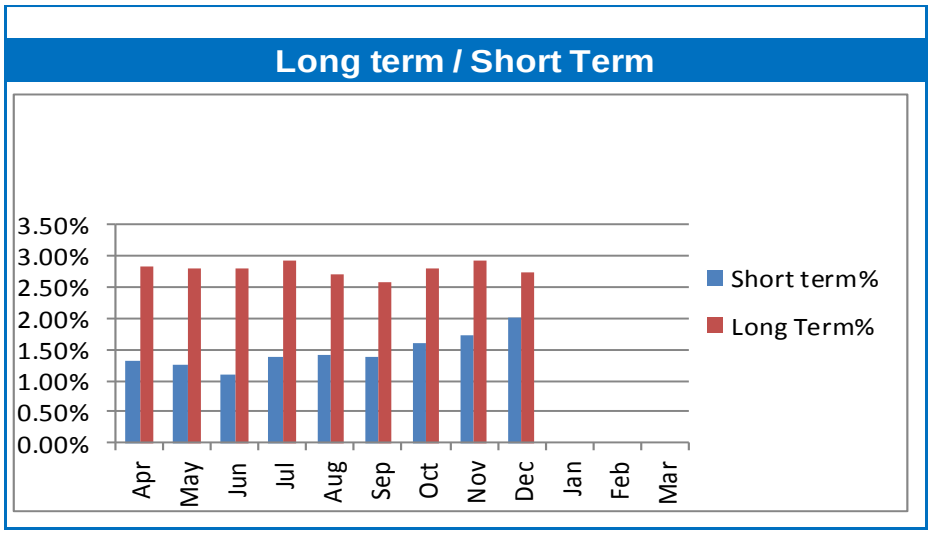
Workforce: Sickness Absence - December (Month 9)

CG & Directorate Sickness Absence - December 2018 (Q3)

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





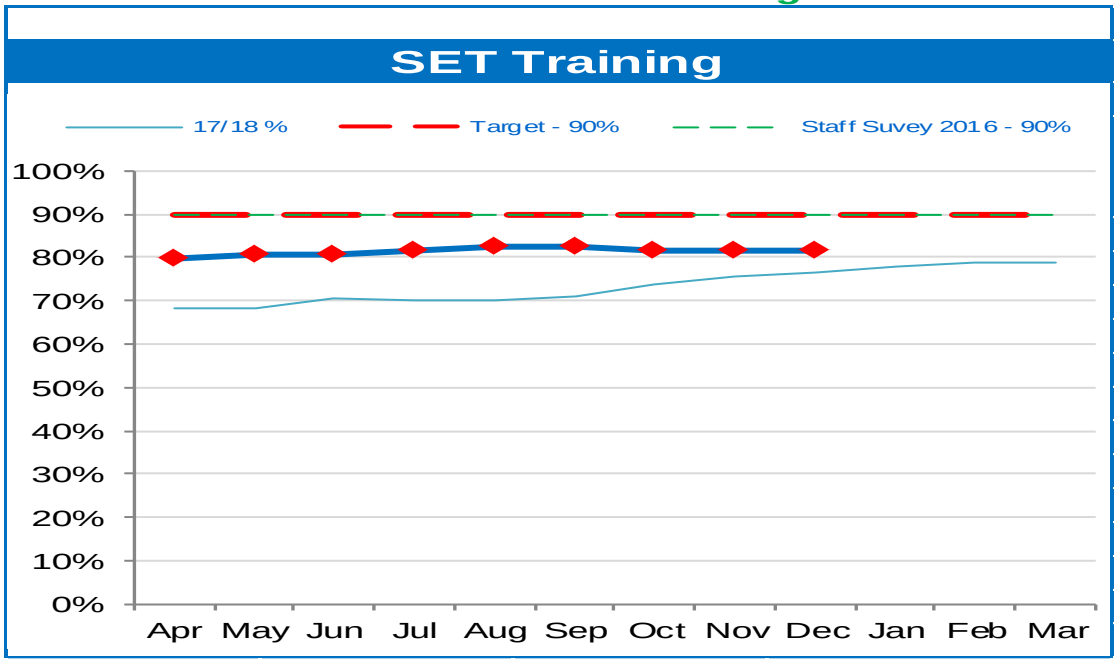


	Apr-18		May-18		Jun-18		Jul-18		Aug-18		Sep-18		Oct-18		Nov-18		Dec-18		Cumulative	
	Days Lost	% Rate	Days Lost	% Rate	Days Lost	% Rate	Days Lost	% Rate	Days Lost	% Rate	Days Lost	% Rate	Days Lost	% Rate	Days Lost	% Rate	Days Lost	% Rate	Days Lost	% Rate
Doncaster & Bassetlaw Teaching Hospitals NHS FT	**6966.07**	**4.30%**	**6852.91**	**4.09%**	**6610.26**	**4.08%**	**7244.35**	**4.34%**	**6993.67**	**4.16%**	**6462.26**	**3.96%**	**7420.23**	**4.39%**	**7621.25**	**4.66%**	**8063.14**	**4.76%**	**65,333.37**	**4.38%**
Chief Executive Directorate	14.00	2.67%	27.76	5.12%	18.80	3.58%	0.00	0.00%	2.00	0.36%	0.91	0.17%	0.00	0.00%	0.00	0.00%	0.00	0.00%	63.47	1.34%
Children & Families Division	840.01	4.65%	851.44	4.60%	608.47	3.43%	769.74	4.21%	843.46	4.62%	666.99	3.77%	867.01	4.71%	913.96	5.15%	1018.74	5.60%	7,636.36	4.69%
Clinical Specialist Division	1932.19	4.51%	1682.42	3.81%	1650.39	3.88%	2000.43	4.57%	1854.48	4.22%	1768.63	4.16%	2066.21	4.72%	2100.29	4.97%	2251.10	5.17%	17,470.91	4.50%
Directorate Of Strategy & Improvement	0.00	0.00%	2.00	1.72%	0.00	0.00%	1.00	0.80%	0.00	0.00%	0.00	0.00%	0.00	0.00%	0.00	0.00%	2.00	0.62%	5.00	0.37%
Estates & Facilities	818.11	5.76%	772.80	5.24%	745.79	5.21%	878.47	5.94%	811.97	5.57%	895.99	6.37%	939.14	6.53%	861.69	6.16%	1040.58	7.11%	7,777.10	6.00%
Executive Team Board	0.00	0.00%	1.00	0.08%	2.00	0.16%	0.00	0.00%	0.00	0.00%	0.00	0.00%	3.00	0.11%	30.60	1.13%	0.00	0.00%	36.60	0.20%
Finance & Healthcare Contracting Directorate	80.84	2.96%	42.00	1.52%	72.54	2.74%	31.07	1.16%	15.60	0.58%	12.00	0.48%	32.92	0.83%	29.48	0.76%	23.77	0.62%	573.78	1.57%
IT Information & Telecoms Directorate	71.46	2.22%	113.84	3.46%	143.69	4.46%	141.81	4.20%	125.97	3.72%	162.66	4.91%	114.08	5.68%	102.44	5.24%	47.12	2.32%	764.21	4.48%
Medical Director Directorate	3.60	0.64%	21.14	3.62%	23.40	4.22%	23.15	4.15%	23.15	4.15%	10.45	1.94%	1.00	0.18%	13.45	2.43%	46.05	8.07%	170.59	3.38%
Medicine Division	1901.44	4.53%	1967.12	4.49%	1750.43	4.14%	1832.66	4.20%	1783.53	4.07%	1655.56	3.90%	1924.36	4.28%	1994.65	4.60%	1902.06	4.24%	17,237.82	4.35%
Nursing Services Directorate	74.84	4.27%	58.53	3.27%	86.20	4.97%	87.04	4.81%	73.20	3.98%	39.60	2.27%	57.36	3.11%	107.31	5.76%	126.10	6.68%	894.18	5.50%
People & Organisational Directorate	118.60	3.97%	124.76	4.00%	112.95	3.79%	93.69	3.01%	2.65	0.09%	6.60	0.21%	50.41	1.53%	61.48	1.89%	101.43	2.98%	679.57	2.39%
Performance Directorate	236.65	4.47%	161.87	2.99%	301.99	5.79%	277.01	5.17%	200.33	3.81%	186.43	3.66%	258.43	4.93%	270.65	5.31%	295.23	5.52%	2,395.05	5.06%
Surgery & Cancer Division	874.34	3.29%	1026.23	3.72%	1093.61	4.07%	1108.29	4.01%	1257.34	4.54%	1056.45	3.93%	1106.31	4.08%	1135.25	4.31%	1208.96	4.45%	9,628.74	4.03%

Workforce: SET Training - December (Month 9)

CG & Directorate SET Training - December 2018 (Q3)

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

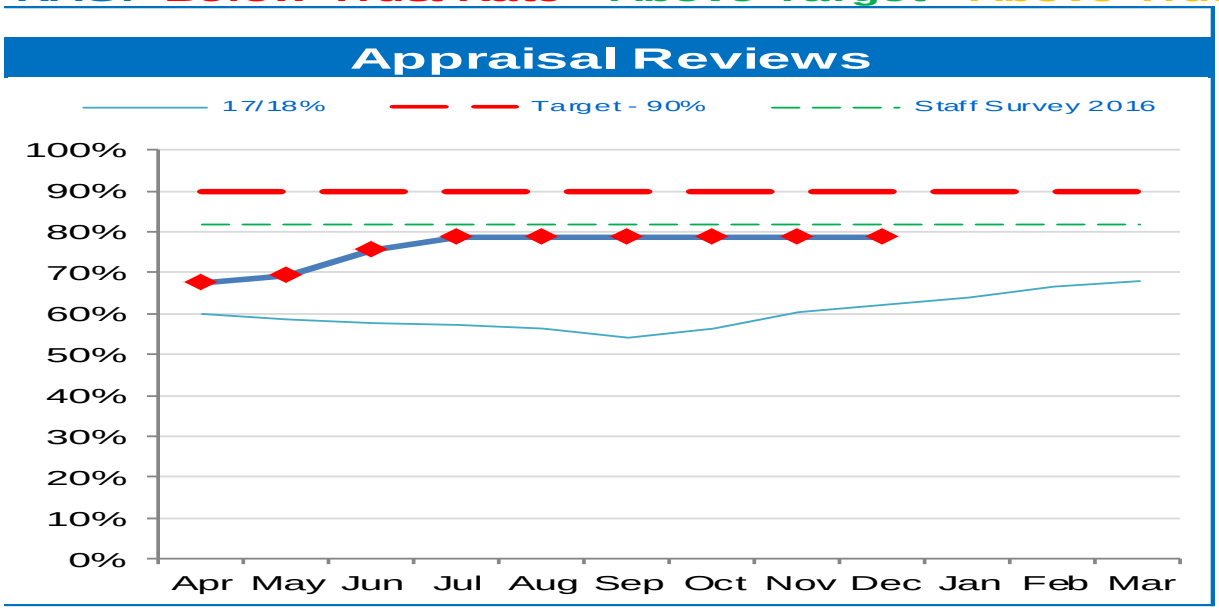


	% Compliance
Doncaster & Bassetlaw Teaching Hospitals NHS FT	**81.78%**
Chief Executive Directorate	**82.14%**
Children & Families Division	**82.80%**
Clinical Specialist Division	**85.42%**
Directorate Of Strategy & Improvement	**93.75%**
Estates & Facilities	**73.16%**
Finance & Healthcare Contracting Directorate	**97.17%**
IT Information & Telecoms Directorate	**87.21%**
Medical Director Directorate	**88.67%**
Medicine Division	**79.74%**
Nursing Services Directorate	**92.69%**
People & Organisational Directorate	**96.43%**
Performance Directorate	**81.86%**
Surgery & Cancer Division	**78.96%**

Workforce: Appraisals - December (Month 9)

CG & Directorate Appraisals - December (Q3)

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



Trust Total
AFC & M&D

	% Completed
Doncaster & Bassetlaw Teaching Hospitals NHS FT	**78.85**
Chief Executive Directorate	**100.00**
Children & Families Division	**79.34**
Clinical Specialist Division	**79.90**
Directorate Of Strategy & Improvement	**100.00**
Estates & Facilities	**94.07**
Finance & Healthcare Contracting Directorate	**98.61**
IT Information & Telecoms Directorate	**91.82**
Medical Director Directorate	**77.27**
Medicine Division	**72.72**
Nursing Services Directorate	**89.39**
People & Organisational Directorate	**95.40**
Performance Directorate	**79.48**
Surgery & Cancer Division	**70.63**

Workforce: Staff in post -December (Month 9)

	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	**Jan-18**		**Feb-18**		**Mar-18**		**Apr-18**		**May-18**		**Jun-18**		**Jul-18**		**Aug-18**		**Sep-18**		**Oct-18**		**Nov-18**		**Dec-18**	
Add Prof Scientific and Technic	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	172.07	190.00	172.89	190.00	175.49	191.00	175.23	193.00
Additional Clinical Services	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	1,179.29	1,421.00	1,164.05	1,405.00	1,165.06	1,409.00	1,166.15	1,417.00
Administrative and Clerical	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	1,045.71	1,274.00	1,033.17	1,259.00	1,033.15	1,258.00	1,048.69	1,329.00
Allied Health Professionals	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	322.84	375.00	323.24	376.00	323.81	375.00	323.76	387.00
Estates and Ancillary	492.84	701.00	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	474.36	678.00	474.06	676.00	478.66	682.00
Healthcare Scientists	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	122.78	139.00	123.72	140.00	123.72	140.00	123.03	139.00
Medical and Dental	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	551.15	633.00	559.68	642.00	561.04	639.00	559.44	591.00
Nursing and Midwifery Registered	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	1,570.41	1,835.00	1,603.36	1,868.00	1,599.93	1,863.00	1,581.97	1,873.00
Students	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	8.80	9.00	2.00	2.00	1.00	1.00	19.00	19.00
Grand Total	**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**	**5,447.40**	**6,554.00**	**5,456.17**	**6,558.00**	**5,461.86**	**6,558.00**	**5,478.83**	**6,638.00**

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Title	**Widening Participation Framework**		
Report to	**Board of Directors**	**Date**	**January 2019**
Author	**Dr Alasdair Strachan, Director of Education** **Dr Sam Debbage, Deputy Director of Education** **Kelly Turkhud, Vocational Education Manager**		

Purpose		Tick one as appropriate
	Decision	x
	Assurance	x
	Information	

Executive summary containing key messages and issues

In October 2014 Health Education England (HEE) published 'Widening Participation– It Matters'. In it, it is stated that all staff should be encouraged to engage in the concept of learning, especially those without entry level qualifications whilst supporting existing staff into Higher Education to enable organisations to 'grow their own' registered clinicians.

This framework sets out ways to enable widening participation within Doncaster & Bassetlaw Teaching Hospitals (DBTH) using our workforce and education commissioning leverage and strategic partnerships "ensuring an approach where the NHS workforce is more representative of the communities it seeks to serve" (HEE 2014) and will provide the support and guidance required for managers to grow their own workforce. The recent report Diversity The New Prescription for the NHS (Fanshawe 2018) highlights that when the diversity and mix of front line staff matches that of the surrounding population, the staff behave more civilly in total to the people they interact with because they cover the range of people 'like me'. What that does is create a culture of civility. That civility does not stop at the boundaries of staff-patient interactions but is likely to spread across other relationships as well.

The aim and objectives of the framework are:

Aim: As part of our ambition to become an outstanding organisation, DBTH wants to ensure it is recognised as an employer of choice by attracting, training and retaining staff from across society to provide sustainable workforce capable of providing safe, compassionate and effective care.

Objectives:

- To enhance the career and educational opportunities available at DBTH including maximising the use of apprenticeships
- To expand our work experience opportunities
- To increase our partnership working across training and education
- To increase our outreach work across training and education

The framework details the various pieces of work being undertaken across the Trust and includes an action plan for 2019.

In addition a memorandum of understanding is appended which the Board is asked to approve – this MOU seeks to formally recognise our partnership work with DN College, Hungerhill School (as the host for the UTC) and Hall Cross Academy across post 16 education. The MOU sets out our educational vision within the Centre of Doncaster as part of our widening participation agenda. It will add to our widening participation vision, especially in post 16 education for students who would not be able to attend Hall Cross sixth form. These students, which have a more vocational training agenda in the College (and soon to be) UTC, are key to raising aspirations and would be an important route for students to enter the start of the many career pathway ladders we are creating.

With the aim of inspiring individuals of all ages and all backgrounds, widening participation offers career opportunities not only for those that wish to pursue a career in health but also to those that have not yet considered a career in health. These opportunities are instrumental in ensuring that we have a diverse workforce that meets the diverse needs of the community and one that has the right skills, values and behaviours to deliver the safest and most effective care for our patients in the future.

Widening participation provides DBTH staff with an opportunity to share their own experiences and inspire others, whilst at the same time provides those staff with an opportunity to develop and progress. Increasing diversity through participation in education and employment opportunities will help us to begin to realise the health dividends which come through seeing, enjoying and using difference in both staff and patients to provide better care, innovate more and redesign services so that they answer the ever more complex challenges presented by our fast changing demography.

Key questions posed by the report

Does the Board feel assured on the work being undertaken by the Trust to encourage members of the local communities to join the Trust as a member of Team DBTH and to develop existing members of staff?

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 framework seeks to demonstrate how we continue to develop our staff.

How this report impacts on current risks or highlights new risks

Agency staffing and vacancy levels – this report seeks to demonstrate that the Trust is seeking ways of increasing our future workforce and to continue to develop staff once they are a member of Team DBTH.

Staff morale – the framework seeks to demonstrate that we continue to offer development for staff who are not professionally qualified.

Inability to recruit the right staff and have staff with the right skills – this framework provides details as to how the Trust continues to provide opportunities for the local community to experience the opportunities on offer across the hospitals and how we continue to develop staff once they join the organisation

Recommendation(s) and next steps

Members of the Board are asked to approve the memorandum of understanding between DN college, Hungerhill School, Hall Cross Academy and the Trust and to note the Trust's Widening Participation framework.

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Widening Participation Framework

for

Doncaster & Bassetlaw Teaching Hospitals

Introduction

In October 2014 Health Education England (HEE) published the 'Widening Participation– It Matters' document. In it, it is stated that all staff should be encouraged to engage in the concept of learning, especially those without entry level qualifications whilst supporting existing staff into Higher Education to enable organisations to 'grow their own' registered clinicians.

This framework sets out ways to enable widening participation within Doncaster & Bassetlaw Teaching Hospitals (DBTH) using our workforce and education commissioning leverage and strategic partnerships "ensuring an approach where the NHS workforce is more representative of the communities it seeks to serve" (HEE 2014) and will provide the support and guidance required for managers to grow their own workforce. The recent report Diversity The New Prescription for the NHS (Fanshawe 2018) highlights that when the diversity and mix of front line staff matches that of the surrounding population, the staff behave more civilly in total to the people they interact with because they cover the range of people 'like me'. What that does is create a culture of civility. That civility does not stop at the boundaries of staff-patient interactions but is likely to spread across other relationships as well.

Following on from the above publication, Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust (DBTH) pledged to support the widening participation agenda with a shared consensus that to improve the quality of patient care we need staff with the right skills, values and behaviours whilst promoting equal access for all. As an enabler of the widening participation agenda, DBTH have strived to include not only the current workforce but also the future workforce in all widening participation activities. This framework aims to ensure equal access for all, regardless of age, gender, sex, disability or race by providing access to some of the 350+ careers in health in a variety of ways to inspire and educate the existing workforce and local community of the opportunities that DBTH has to offer. Additionally we recognise that engaging the whole organisation in pursuing diversity means engaging the whole Trust in the idea that patient centred care can only be a reality when it uses the full range of skills and abilities, life experiences and approaches it has within in its entire staff. The framework will also support the delivery of the action plan set out in the P&OD enabling strategy (2018).

In December 2018, Health Education England published the results from its annual widening participation survey 'Preparation to Work 2017/2018' (HEE 2018). The results reflect an increase in widening participation activities throughout the National Health Service nationally, suggesting a greater recognition of the importance of widening participation in ensuring a workforce fit for the future.

What are the benefits for Doncaster & Bassetlaw Teaching Hospitals?

DBTH is one of Yorkshire's leading acute trusts, hosting three main hospital sites and serving a population of over 420,000 across South Yorkshire, North Nottinghamshire and surrounding area. One of only five Teaching Hospitals in Yorkshire, the Trust trains a quarter of all medical students in the region and 30% of other health care professional students.

It is without doubt that the rapidly changing demographics both nationally and throughout the Doncaster and Bassetlaw place will inevitably have implications on the ability of the organisation to attract, train and sustain a workforce capable of providing safe and effective patient care to an ever-growing population. By embedding the Talent for Care (HEE 2014) 'get in' principles within the organisation's workforce plans, individuals of all ages and backgrounds can be supported in starting their careers in the health sector through entry into pre-employment opportunities, pre-registration programmes and support roles with a targeted approach for previously hard to reach groups.
Identified as an 'Opportunity Area', DBTH can support the government's plans to offer work place opportunities to the local community with the aim of improving social mobility. The invitation to become a 'Cornerstone Employer' may also enable DBTH to further provide opportunities for individuals to experience the NHS. By expanding the opportunities that DBTH has to offer we will not only inspire but inevitably increase participation, diversity and career progression for all including under-represented groups achieving the widening participation objectives set about by HEE. It is acknowledged that by increasing participation in education and employment opportunities, better outcomes including improvements in health and wellbeing will be achieved for existing staff and the community.

Aim

"As part of our ambition to become an outstanding organisation, DBTH wants to ensure it is recognised as an employer of choice by attracting, training and retaining staff from across society to provide sustainable workforce capable of providing safe, compassionate and effective care."

DBTH Objectives

Over the past two years, DBTH has seen an increase in widening participation activity throughout the organisation, with all activity monitored and reported to HEE quarterly as required. DBTH's widening participation key objectives include:

1. **Enhancing the career and educational opportunities available at DBTH including maximising the use of apprenticeships**
2. **Expanding our work experience opportunities**
3. **Increasing our partnership working**
4. **Increasing our outreach work**

Supporting Widening Participation at DBTH

1. Enhancing the career and educational opportunities available at DBTH

a) School Engagement

The Training and Education Department (TED) have been working with local schools to strengthen relationships and have provided support and advice to students considering a career in health. The recent launch of the formal partnership between DBTH and Hall Cross Academy 'A Foundation School in Health' will enable the hospital and the school to work more closely together. The partnership will provide an opportunity for work related learning highlighting the skills and knowledge required in the work place, ultimately making careers more accessible to young people by providing an insight into some of the 350+ careers available within healthcare. Activities such as those identified within HEE's Preparation to Work Report (HEE 2018) will be essential for the development of the partnership. The launch of a Foundation School for Health in collaboration with Hall Cross School aims to increase social mobility providing a focused and formal commitment to work for Doncaster's diverse population. The first of its kind in the country, it is hoped that this partnership is the first of many across the Borough further developing opportunities for pupils wishing to pursue a career in health. The partnership between DBTH and Hall Cross Academy aims to test and develop best practice to work with other schools and has already gained significant interest from other partners. To sustain and develop their workforce, Doncaster's Primary Care has acknowledged within its Strategy the partnership between DBTH and Hall Cross Academy and the opportunity it will provide to promote primary care as a career of choice also. DBTH now plans to replicate the partnership with Hall Cross Academy across the Doncaster and Bassetlaw Places by working in collaboration with Retford Oaks Academy.

b) Career Pathways

Simplified career pathways will enhance visibility and support individuals with successful recruitment into entry level jobs whilst supporting progression for the existing workforce. Pathways will support managers in identifying opportunities for new and innovative roles within their establishments. The availability of vocational educational opportunities for existing staff will enable progression. Opportunities include apprenticeships, level 2 English and Maths, preparation to study and the Care Certificate. Managers will be supported in incorporating within their workforce plans opportunities for new and existing staff to 'get in', 'get on' and 'go further' to ensure that we continue to develop a workforce that is fit for the future. Managers can then support staff to progress by delivering quality appraisals with the right information to understand career progression opportunities.

DBTH will build on its partnership with local partners at place and across the ICS to develop and support the transferability of skills across health and social care with the ambition of having combined career pathways to support a sustainable, multi-skilled and flexible workforce for the future.

c) Apprenticeships

With the government's commitment to continue to improve the quality of apprenticeships, the apprenticeship levy came into effect in April 2017. The apprenticeship levy has provided new and innovative ways to develop our workforce. Whilst in the past apprenticeships in the NHS have been predominantly focused on support staff, the apprenticeship levy has provided opportunities for higher level apprenticeships including Degree and Masters levels for both new and existing staff. Apprenticeships now offer a broad range of development opportunities including health and social care, business and admin, healthcare sciences, estates and facilities, and leadership with many professional standards being developed e.g. pre-registration nursing. The rapidly changing educational landscape is now providing greater opportunities for learners to undertake an apprenticeship than ever before, allowing them to develop the skills and knowledge required whilst remaining in the workplace. The advances in apprenticeship opportunities have resulted in the introduction of innovative and new roles within the workplace including the Trainee Assistant Practitioner and the Trainee Nursing Associate roles. These new roles offer safe and effective alternatives within the workforce to bridge workforce gaps whilst offering development opportunities for existing staff. To ensure parity across the region, both roles have been commissioned collaboratively with our partners.

The Apprenticeship Operational Group is responsible for governing all apprenticeship activity throughout DBTH to ensure that the apprenticeship levy is utilised to meet the needs of the organisation. DBTH will continue to promote apprenticeship opportunities for new and existing staff by facilitating open days and sharing information with managers using a range of promotional materials. In addition to the Apprenticeship Operational Group, DBTH is an active member of the South Yorkshire Region Excellence Centre (SYREC) apprenticeship work stream. Accountable to the South Yorkshire Region Excellence Centre, the SYREC Apprenticeship work stream continues to work in collaboration to ensure that apprenticeship provision meets the needs of the Health and Social Care sector across the South Yorkshire region. Following on from

the apprenticeship reforms, DBTH has been active in several apprenticeship trailblazers with the Institute for Apprentices to ensure that the programme content meets the needs of the healthcare service. The reforms have for the first time ever enabled the programme content to be employer led, ensuring that staff have the right skills to provide safe and effective care and thus the content is fit for purpose. An Apprenticeship framework is under development for DBTH.

Key challenges include the availability of apprenticeships to reflect the organisational need, the ability to protect the minimum 20% off the job learning requirement, awareness of the availability of apprenticeships and the restrictions placed on the utilisation of the apprenticeship levy. DBTH will continue to work with partners to maximise the use of the apprenticeship levy combined. In collaboration with partners DBTH will endeavour to offer the same workforce development opportunities throughout the region by considering levy transfers to support innovative workforce solutions.

2. Expanding our work experience opportunities

a) Work Experience

Work experience is defined as the provision of opportunities for direct experience within an organisational setting, including activities such as shadowing (HEE 2018). In 2016/2017 DBTH's work experience framework was developed. To broaden the opportunities for young people, the framework now includes the provision of work experience placements in non-clinical areas for learners aged 14-16 in addition to those aged 16 and above. The framework provides a rigorous and quality assured placement provision for individuals from the Doncaster and Bassetlaw place to experience careers within the NHS. In addition to this, the framework aims

to provide managers with a process to support learners in the workplace whilst monitoring and evaluating the provision of work experience placements that we provide as a Trust. The introduction of placement cohorts has allowed work experience placements to be undertaken in blocks throughout the year. Learners are provided with an induction to the organisation including statutory and essential training. To quality assure placement provision, an evaluation session to monitor the learning experience of learners is also provided on the last day of the programme. Annual risk assessments are undertaken for any department able to accommodate work experience learners and the introduction of work experience uniforms has also increased the visibility of learners whilst on placement. Cohort placements provide greater access for learners including cadets, school students and independent learners from 14 years plus wanting to pursue a career in health. Throughout 2017/2018, DBTH saw an increase in work experience activity, 5.06 work experience placements per 100 employees were provided, higher than the mean National average of 3.39 placements per 100 employees reported in HEE's Preparation to Work Report 2018.

The role of the Work Experience Champion for aspiring medics has also been introduced to support individuals with their chosen career pathways in medicine.

Since the implementation of the work experience framework DBTH has seen a significant increase in demand for work experience placements, therefore exclusions have been applied to widen opportunities due to current capacity; these exclusions include commissioning the fair train work experience quality mark and partaking in the 'I am a medic' initiative.

3. Increasing our partnership working

a) Partnership working

The Trust employs over 6,000 people, across approximately 250 professions, and aims to be a transformational partner with other health and social care providers. It seeks to develop innovative strategies to widen participation across the range of its employment opportunities. Working closely with our partners through the South Yorkshire Region Excellence Centre, DBTH will ensure that best practice is shared and opportunities are enhanced throughout the Doncaster and Bassetlaw place. A task and finish group has recently been established with the South Yorkshire Region Excellence Centre to consider ways to inspire hard to reach groups across the region.

Innovations such as joint appointments between DBTH and local Education Providers have allowed us to enhance the standard of health and social care educational delivery both internally and externally. DBTH will continue to work in partnership with our providers to ensure that best practice is shared; this will include supporting the development of a simulation facility within DN College during 2019.

In response to the 'One Doncaster Report' and the 'Doncaster post 16 review' a formal agreement between Doncaster College, Hungerhill School (the host for the UTC), Hall Cross Academy and DBTH has been developed with the intent of working collaboratively to improve outcomes and social mobility for young people in Doncaster. This will allow us to build on our existing partnerships ensuring a central focus on our students.

DBTH work closely with the Universities and are supporting their widening participation initiatives in the Doncaster and Bassetlaw area. We are working closely with Sheffield Medical School on its widening participation aspirations within the recent expansion. We will also work alongside the Higher Education Progression Partnership South Yorkshire (HEPPSY) to widen opportunities further.

b) Enabling access to pre-registration placements

DBTH will continue to provide placements for Doncaster and Bassetlaw residents studying in and out of area to widen recruitment opportunities. Currently local residents studying pre-registration Nursing at Lincoln University have been offered placements within DBTH resulting in successful recruitment upon completion of their programme. Further discussions are ongoing with other out of area Higher Education Institutes to replicate the offer of placements. In addition an increased number of students at Sheffield Medical School can now access developments in the Doncaster area and an increase in the offer of widening participation places.

c) Existing full time Health Care Students

We have strengthened our partnership with our local Further and Higher Education Providers to ensure that learners are 'job' ready at the point of graduation. Prioritisation of work experience placements for these learners and formulating relationships with learners has enabled DBTH to share advice and expertise for individual preferred career pathways. We will continue to work

with our Education Providers to prioritise placements for students on full time programmes and who upon completion may provide a further workforce solutions.

d) Supporting the vision

DBTH is an integral member of the strategic group taking forward the development of a Doncaster University and the development of the University Technical College in Doncaster.

4. Increasing our outreach work

a) Health Careers Champions

The previous Health Ambassador launch driven by Inspiring the Futures failed to identify a given number of ambassadors. As a result, it is anticipated that the introduction of the Health Careers Champion specific to DBTH will allow vocational experts to share their experiences with local schools and colleges inspiring others to consider careers in health. The introduction of the Health Careers Champion will provide a spotlight for some of the 350+ careers in Health. Working with our partners within Social Care, we will also explore the 'I Care' Ambassador role to ensure that best practice is shared.

b) Careers Events

Careers events allow us to highlight the opportunities that DBTH has to offer both internally and externally. Increasing awareness of education and the benefits is key to highlighting the different career pathways within health. The Training and Education Department are actively engaged with

Doncaster and Bassetlaw annual careers events including the Big Bang Science Careers event and other campaigns such as those facilitated by the Department of Work and Pensions.

c) Pre-employability programmes

Improving social mobility across the local area with the aim of improving health and well-being, career opportunities and employment will inevitably have a positive impact on the local economy. We will explore and prioritise pre-employability programmes for refugees, individuals with learning disabilities and those seeking employment, including EPIC mentors (working with vulnerable individuals), Department of Works and Pensions, Project Search, Project Choice and ex-armed forces.

Summary

With the aim of inspiring individuals of all ages and all backgrounds, widening participation offers career opportunities not only for those that wish to pursue a career in health but also to those that have not yet considered a career in health. These opportunities are instrumental in ensuring that we have a diverse workforce that meets the diverse needs of the community and one that has the right skills, values and behaviours to deliver the safest and most effective care for our patients in the future.

Widening participation provides DBTH staff with an opportunity to share their own experiences and inspire others, whilst at the same time provides those staff with an opportunity to develop and progress. Increasing diversity through participation in education and employment opportunities will help us to begin to realise the health dividends which come through seeing, enjoying and using difference in both staff and patients to provide better care, innovate more and redesign services so that they answer the ever more complex challenges presented by our fast changing demography.

Further information

Work Experience enquiries at DBTH should be sent to: dbth.workexperience@nhs.net

DBTH work experience framework (2016)
P&OD enabling strategy (2018)
Widening Participation it Matters, Health Education England (2014)

Action plan for DBTH: Widening Participation - The local partnership pledge January 2019

Objective	Work streams	Actions	Responsibility	Timeline	Measure of Success
1.Enhancing the career and educational opportunities available at DBTH including maximising the use of apprenticeships	a) School Engagement	The formal partnership with Hall Cross Academy will: **Introduce** a task and finish group to enable the realisation of the 2 year plan **Facilitate** a Health Careers event on 3rd July 2019 for all Year 8 pupils across Doncaster **Develop** a careers App for students **Develop** a Careers web page **Develop** a professional learning group **Widen** work experience opportunities	TED Hall Cross Academy Communications Partners	Oct 2018 to Oct 2020	Increased number of formal partnerships with other schools across Doncaster and Bassetlaw
	b)Career Pathways	Ensuring a work force fit for the future by providing opportunities to not only 'get in', but to 'get on' and in some instances 'go further' by: **Simplifying** Career pathways **Support** staff to progress through quality appraisals	TED Recruitment Divisional Managers	Sept 2019	Simplified Career pathways to be developed and made available to staff and Managers
	c) Apprenticeships	**Support** Managers in identifying apprenticeship opportunities throughout the workforce for new and existing staff **Develop** an Apprenticeship Strategy **Facilitate** Apprenticeship Open Days **Develop** an Apprenticeship Communication Strategy **Responsibility** to remain with the	TED AOG Comms Recruitment	July 2019 August 2019	Increase in Apprenticeship Activity Trust wide – Quarterly review of progress via HEE data return Annual report to Government and DBTH

		Apprenticeship Operational Group in governing all apprenticeship activity		July 2019	
2.Expanding our work experience opportunities	a) Work experience opportunities	**Ensure** equal access for Doncaster and Bassetlaw residents aspiring to step into careers in health via the work experience framework **Review** Work Experience Framework July 2019 **Recruit** a Work Experience Champion for aspiring medics	TED	Quarterly review	Monitor activity via quarterly HEE return and annual report for DBTH
3.Increasing our partnership working	a) Partnership Working	**Joint appointments** between DBTH and local Education to enhance the standard of health and social care educational delivery **Support** the development of a simulation facility within DN Colleges **Work** in collaboration with Hungerhill School, Hall Cross Academy, Doncaster College and DBTH to improve social mobility. **Work in partnership** with the South Yorkshire Region Excellence Centre (SYREC)	TED Education Providers MCSC/TED/ Doncaster College DBTH/Hungerhill School Hall Cross Academy/ Doncaster College SYREC	November 2018 to October 2020	Monitor the number of joint appointments
	b) Enabling access to pre-registration placements for Doncaster residents studying in and out of area	**Provide** placement opportunities at DBTH for Doncaster residents studying at Lincoln University **Further** discussions are ongoing with other Higher Education Institutes. **Provision** of additional placements for students studying at Sheffield medical School	TED	ongoing	Increased placement provision for Doncaster residents studying out of area in 2019 Destination data to be monitored by the placement team on completion of studies

	c) Existing full time Health Care Students	**Prioritise** placements for existing full time students with local providers	TED/Providers	ongoing	Monitor placement capacity and activity
	d) Supporting the vision	**Participate** in the strategic development of the UTC **Support** the curriculum development for the UTC **Participate** in the development of Doncaster university	TED/Estates and Facilities TED	Ongoing Ongoing	
4.Increasing our outreach work	a) Health Career Champions	**Introduce** the role of the Health Career Champion	TED Trust staff	April 2019	Annual Report
	b) Careers Events	**Target** under-represented groups to raise aspirations **Increase** awareness of education **Highlight** the different career pathways within health. **Participate** in the Big Bang event **Participate** in the Skills Fest event **Develop** and host Your Futures in Health care	TED Speciality Leads Health Careers Champions Comms DBTH Doncaster Chambers DBTH/SHU	Ongoing Annual	Annual report
	c) Pre employability programmes	**Explore and prioritise** pre-employability programmes for refugees, individuals with learning disabilities, those seeking employment, vulnerable individuals and ex-armed forces	TED DWP Project Choice Project Search Armed Forces EPIC		Review July 2019

Would need to add DBTH logo

MEMORANDUM OF UNDERSTANDING

This Memorandum of Understanding signifies a statement of intent to work collaboratively in response to the One Doncaster Report and Doncaster Post-16 Review. This is not a legally binding document.

It recognises the commitment of our partner institutions to work together and to support one another, within an ethos of trust, respect and care, to support the education of the young people within the Borough of Doncaster. We are committed to improving social mobility and offering our young people better opportunities to help them realise their full potential

Our coalition has been formed by the named institutions to facilitate collaborative working; DN Colleges Group (Doncaster College), Hall Cross Academy, Hungerhill School (Doncaster UTC), all who work closely with Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust.

Our collaborative response to the Post-16 Review recognises our co-location in the Centre of Doncaster and responds to the specific proposal that our partnership works with the Teaching Hospital in Doncaster to explore the development of vocational pathways around health, care and science.

We will continue to operate as individual legal entities with separate governance arrangements. We are not representative of all schools and colleges, nor do we see our proposals as exclusive. Wider partnership and collaboration, across all post-16 provision in the Borough, is essential to improve the quality, capacity and inclusiveness of Doncaster's post-16 education system.

Strategic Intent

In response to the Post-16 Review, we jointly confirm our strategic intent to formally collaborate to improve outcomes and social mobility for young people in Doncaster.

- **To align our existing partnerships, our thinking and our resources** to ensure **a central focus on our students** and what we need to do to become a **high performing Borough**.
- To build on the **opportunities provided by our co-location** in the centre of Doncaster.
- To provide a response which is **unique to Doncaster**, maximises local opportunities and addresses local issues.
- To continue to **work in partnership to ensure strong alignment with the post-16 education system as a whole** and to ensure mutual support to improve outcomes.
- To ensure **viability**, **economies of scale** and future **scalability**
- Underpinned by a **formal agreement** to set out the principles of our **co-leadership** and ensure **accountability**.
- In partnership with the Teaching Hospital to develop, promote and support pathways into health, care and medical science occupations.

Guiding Principles of Our Collaboration

1. A multi campus, universal and inclusive offer at the heart of the Borough.
2. A guarantee of a place for every sixteen year old, backed up by high quality, accessibility and wider choice.
3. Promote parity of esteem between academic and technical education, including the development of a joint prospectus and greater visibility of alternative routes.
4. Clear pathways to local routes of employment and deep engagement with employers e.g. in health and medical, engineering, rail, creative digital.
5. Transport should not provide a barrier to choice and access.

All partners have a shared interest in:

- Ambition and aspiration for ourselves, our institution & our students
- Attainment and welfare of all students
- High quality, impartial and accessible careers education, information, advice and guidance
- Seeking best value and efficiency

Memorandum of understanding to take effect from: 01/10/2018

Signed: _____

For: DN Colleges Group (Doncaster College)

Date: _____

Signed: _____

For: Hall Cross Academy

Date: _____

Signed: _____

For: Hungerhill School

Date: _____

Signed: _____

For: Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

Date: _____

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Title	**Q2 Estates & Facilities Performance Report**		
Report to	**Board of Directors**	**Date**	**29th January 2019**
Author	**Kirsty Edmondson-Jones**		

Purpose		Tick one as appropriate
	Decision	
	Assurance	X
	Information	

Executive summary containing key messages and issues
The Quarter 3, October - December, Estates and Facilities Performance report provides Board of Directors with a quarterly review of performance. The report shows performance in Q3 in the following areas: • Appraisal remained Green exceeding the Trust target of 90% with 94.07% • Trust cleanliness scores exceeded the KPI of 90%, with DRI maintain 96% for the third quarter running • Sodexo achieved 95% Patient Satisfaction for the first time Further work is required to: • Achieve Trust SET target of 90% • Reduce sickness rates • Continue ongoing work to review and enhance PPM tasks
Key questions posed by the report
Are Board of Directors assured of progress made during Q3 to improve the performance of Estates and Facilities services?
How this report contributes to the delivery of the strategic objectives
The paper updates BOD in the wider Corporate Risk (F&P4) relating to the failure to ensure a suitable estates infrastructure is in place.

How this report impacts on current risks or highlights new risks
Recommendation(s) and next steps
Board of Directors are asked to note the content of this paper and progress made.

Doncaster and Bassetlaw
Teaching Hospitals
NHS Foundation Trust

Quarter 3. Oct-Dec 18
Estates and Facilities
Performance Report

Estates and Facilities Q3 Performance Report
July - September 2018

1. Executive Summary

This performance report provides Board of Directors with a quarterly update against the performance of Estates and Facilities Services (E&F) for Quarter 3, October to December 2018.

The report provides assurance to Board of Directors of the performance of Estates & Facilities services in line with the Trust's objectives.

At A Glance

Performance Measure	KPI/Target	Actual	Variance	RAG		Comments
Appraisal	90%	94.07%	4.07%		↑	
SET	90%	73.16%	-17%		↓	
Sickness	3.50%	6.00%	2.50%		↓	
Catering Patient Satisfaction	95%	95%	0%		↑	Achieved 95% in December
Cleaning DRI	90%	96%	6%		→	
Cleaning BDGH	90%	91%	1%		↑	
Cleaning MMH	90%	91%	1%		↑	
Portering DRI	Complete within 30m	60%	up 5%		↑	KPI% tba
Portering BDGH	Complete within 30m	88%	same		→	KPI% tba
Portering MMH	Complete within 30m	63%	down 1%		↓	KPI% tba
Estates PPM DRI/MMH	Increase Completion	256	256 more than Q2		↑	KPI% tba
Estates PPM BDGH	Increase Completion	197	197 more than Q2		↑	KPI% tba
Estates Reactive DRI/MMH	90% Cat 1	100%	10%		↑	
Estates Reactive BDGH	90% Cat 1	0%	0%			no cat 1 jobs Q3
MTS Corrective	Reduce to 4 days	4.6 day	3.4 days		↑	Need to recruit
MTS BDGH	100%	100%	46%		↑	
MTS MMH	100%	100%	0%		↑	
MTS DRI	100%	82%	18%		→	on target

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

2. Management Information

2.1 Appraisal

The Directorate has consistently maintained its performance of 94.07% for quarter 3 against the Trust target of 90%.

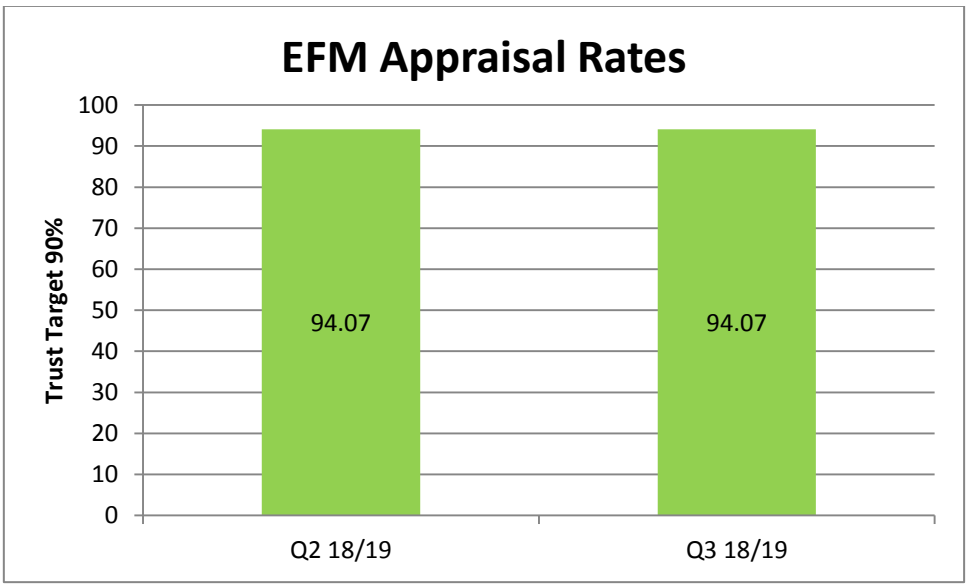


Table 1

2.2 Statutory and Essential Training (SET)

Work continues to ensure E&F achieve 90% SET having experienced significant churn with a number of staff falling out of compliance in Q2 and Q3, ending Q3 with reduction of 3.64% compared to Q2. Whilst SET booklet training is being completed against the Trust target, difficulties are being experienced accessing Conflict Resolution training. This delays the completion of the full package of SET training, and the ability of the Directorate to exceed to 90% Trust target. Work is underway to identify how access can be increased to Conflict Resolution training in terms of increasing the frequency of courses and assessing course length.

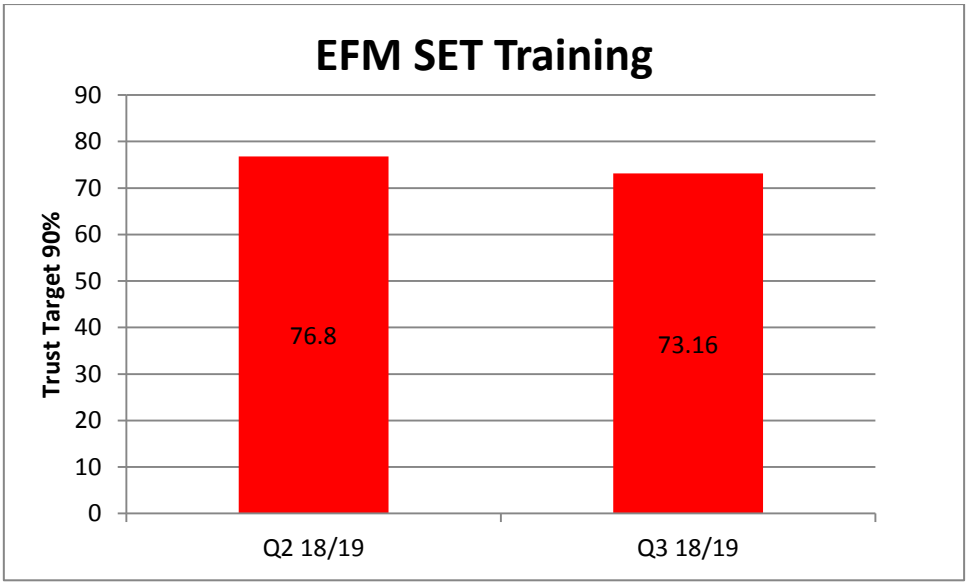


Table 2

2.3 Sickness

The Directorate ended 17/18 as an outlier with an overall cumulative total of 6.56% against a Trust target of 3.5%. Work to resolve long-term sickness and to effectively manage short-term sickness has been underway, and despite a sharp rise in Q3 to 7.11%, the cumulative total of 6% is a small increase of 0.32% compared to Q2.

3 Facilities Performance

3.1 Hospital Cleanliness

All Trust sites exceeded the KPI target of 90% cleanliness in the third quarter, with DRI continuing to achieve an average of 96%, and both BDGH and MMH achieving an average of 91%.

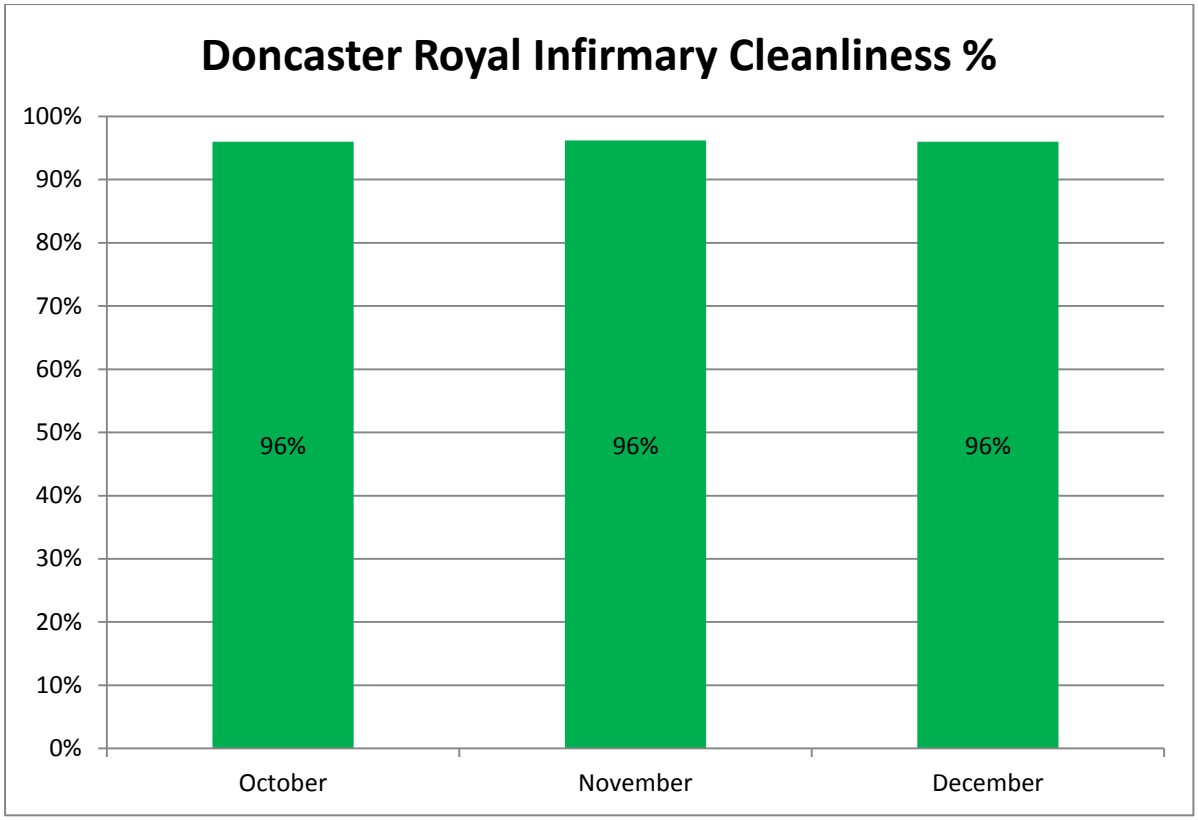


Table 3

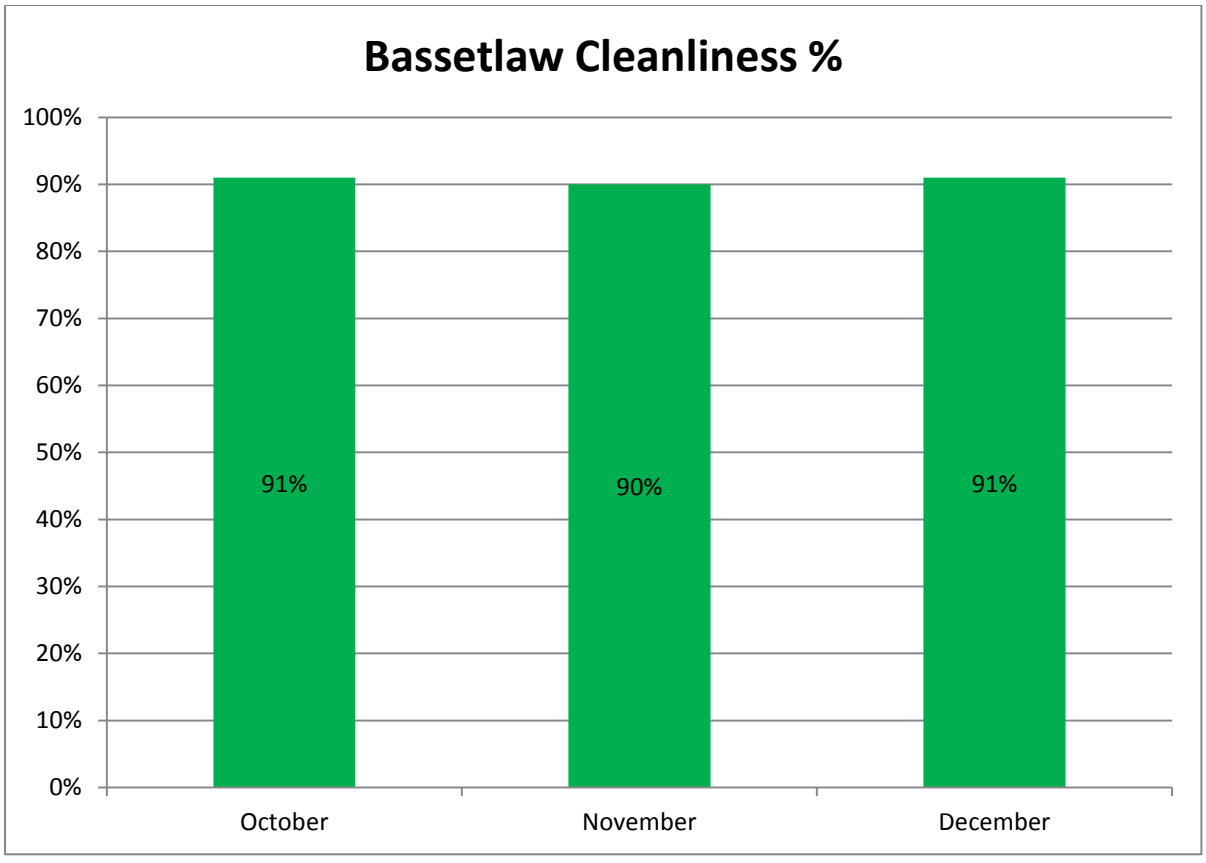


Table 4

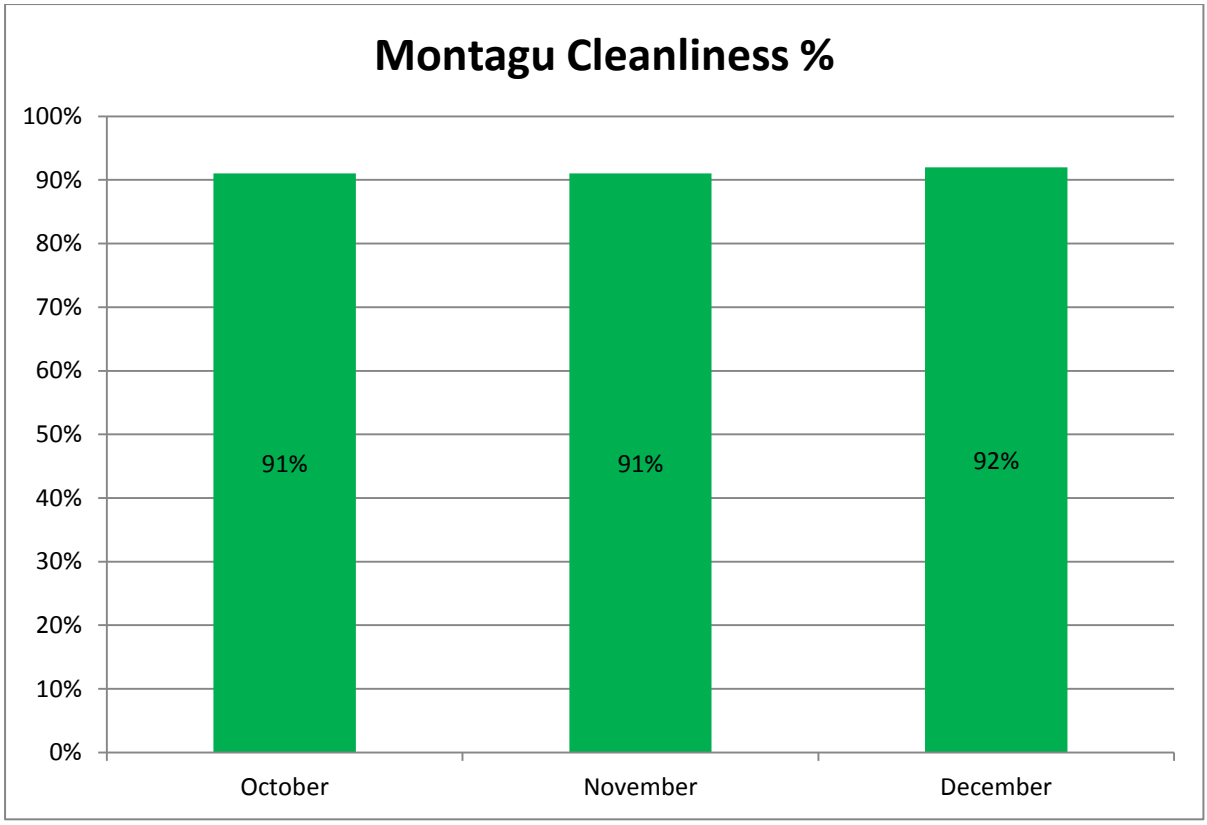


Table 5

3.2 Portering Response

In the third quarter DRI improved performance by 5% on the previous quarter to 60%, with BDGH maintaining the same performance of 88%, and MMH reducing by 1% to 63%. Vacancies affect performance, and the department is working with HR&OD to introduce 'On the Day' recruitment in order to considerably speed up the recruitment process for Service Assistant roles as there is currently a high attrition rate due to the lengthy process.

The lift modernisation programme of East Ward Block lifts 4, 5 and 6 commenced at DRI on 15th October and concluded on 23rd January. The lifts were taken out of service consecutively, and once returned to service have provided a more reliable service, reducing delays to patient movement.

Work is now required to agree internal service level agreements and to set KPI targets for the achievement of portering task completion within 30 minutes. This work requires consultation with our internal customers.

The performance data below provides the basic information on the percentage of jobs completed within 30 minutes, however the Teletracking system used to receive and allocate

tasks is much more sophisticated and provides 10 categories ranging from 'Urgent – Immediate' to 'Low Priority – Within the Day'. As jobs are requested they are assigned to categories according to urgency and nature of the task. As KPI's are agreed with stakeholders future reporting may also be provided split by category, as with Estates reactive tasks.

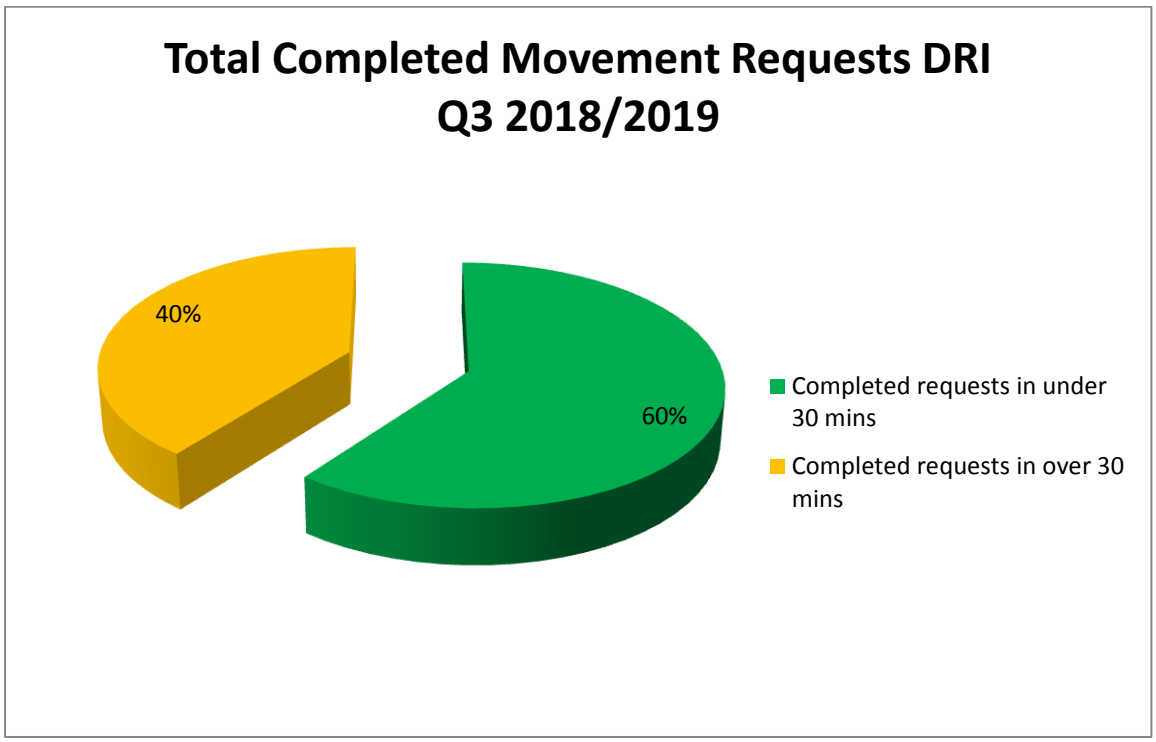
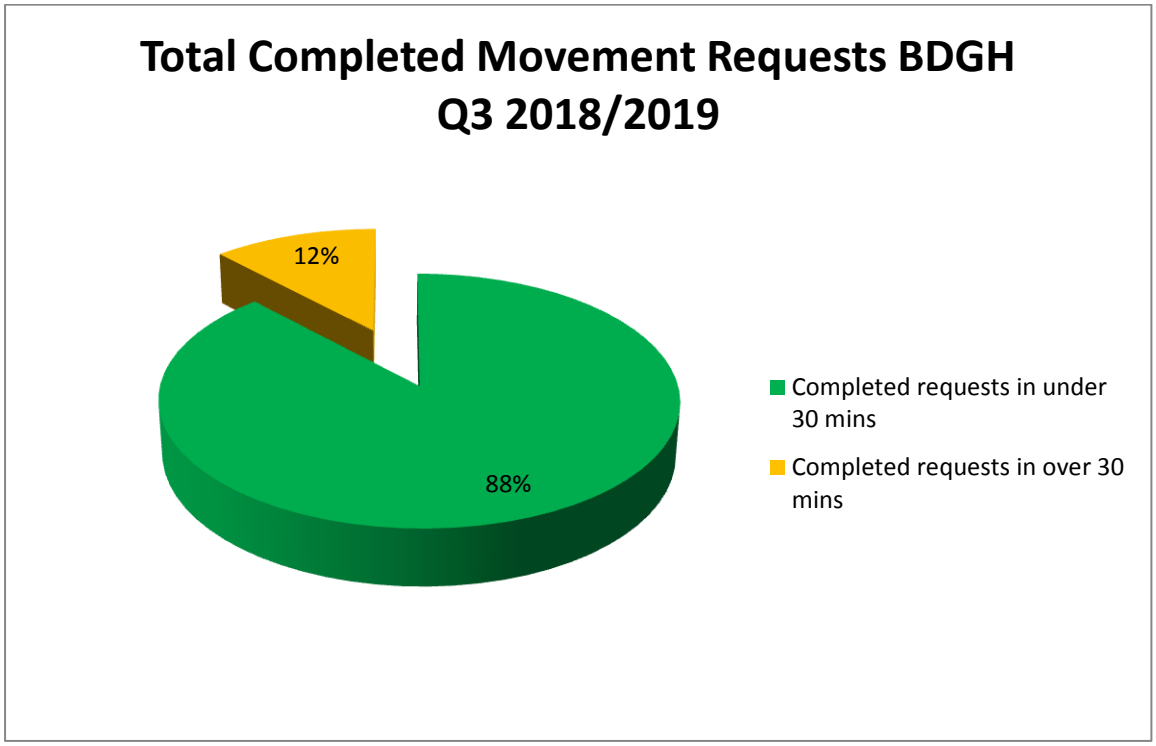


Table 6



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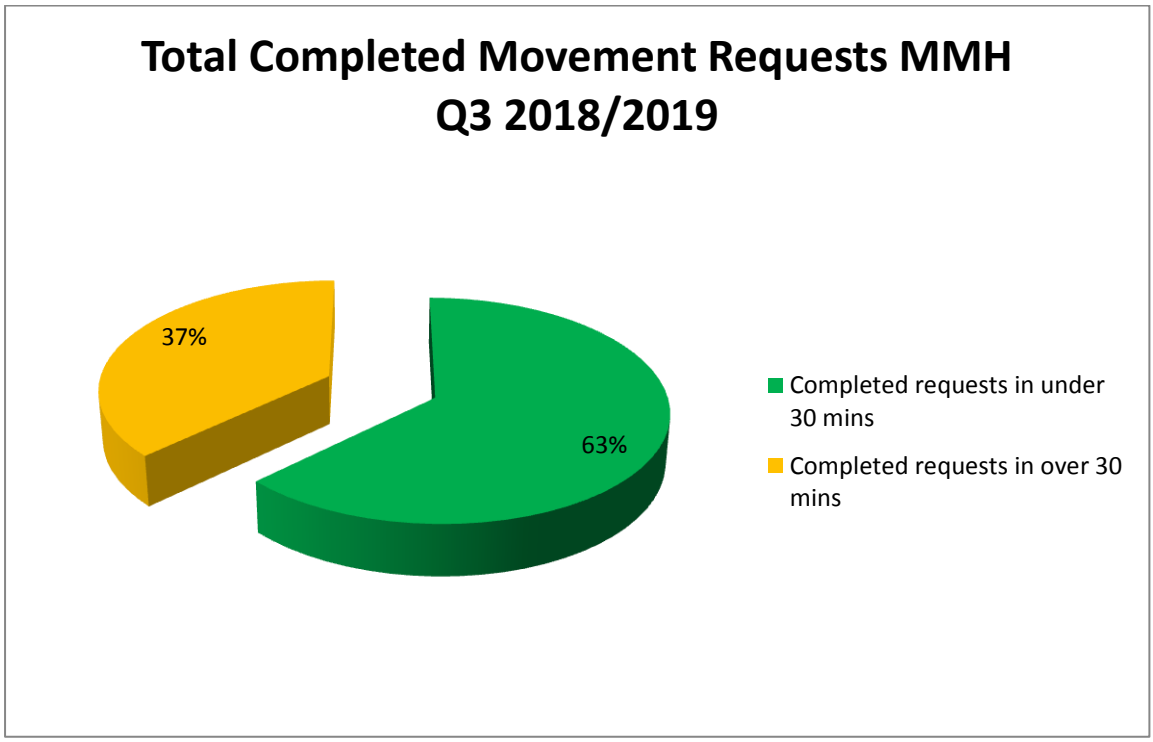


Table 8

4 Catering

4.1 Patient Satisfaction

In response to the issues raised on 26th July by Governors, together with contract breaches identified by the Trust's retained Catering Contract Management Team regarding the standard of the Patient Catering Service, the Trust issued Sodexo with a formal Contractual Performance Warning Notice on 3rd August relating the following five areas:

- Late Meal Deliveries – KPI 3
- Failure to achieve Quality Standards -KPI 7
- Failure to provide Staff Establishment Information – KPI 8
- Failure to achieve Food Hygiene Rating of 5 stars at MMH – KPI 11
- Late/Missing Monthly Management Information – Service Level

As can be seen in the table below, Patient Satisfaction Surveys for December show that, as well as Sodexo continuing to hit their monthly target of >500 surveys completed, they have now achieved their Contract KPI 7 of 95%.

	Sep 18	Oct 18	Nov 18	Dec 18	Increase+/decrease- from previous month
How would you rate the Hospital Food?	88%	94%	93%	94%	+1%
Were you offered a suitable choice of food?	93%	90%	93%	95%	+2%
Overall how satisfied were you with the catering service?	84%	91%	92%	88%	-4%
Combined satisfaction score KPI 7	**91%**	**92%**	**93%**	**95%**	**+2%**

Table 9

4.2Complaints/Datix

As can be seen at table 10, overall the number of incidents/complaints being received via Datix has reduced from a height of 60 in one week in early September and a monthly total of 143, to a monthly total of 88 for October, 62 for November, and 57 for December.

Complaints and issues now appear to be focusing on the accuracy of meal orders, as a result Sodexo, together with Trust Dietetic staff, have undertaken further training with menu collators and ward staff, and a meeting has taken place to discuss any other measures which can be taken in order to eradicate such issues. There has been only one Datix in December relating to 'Safety', which would usually signify an issue with a specialist diet meal.

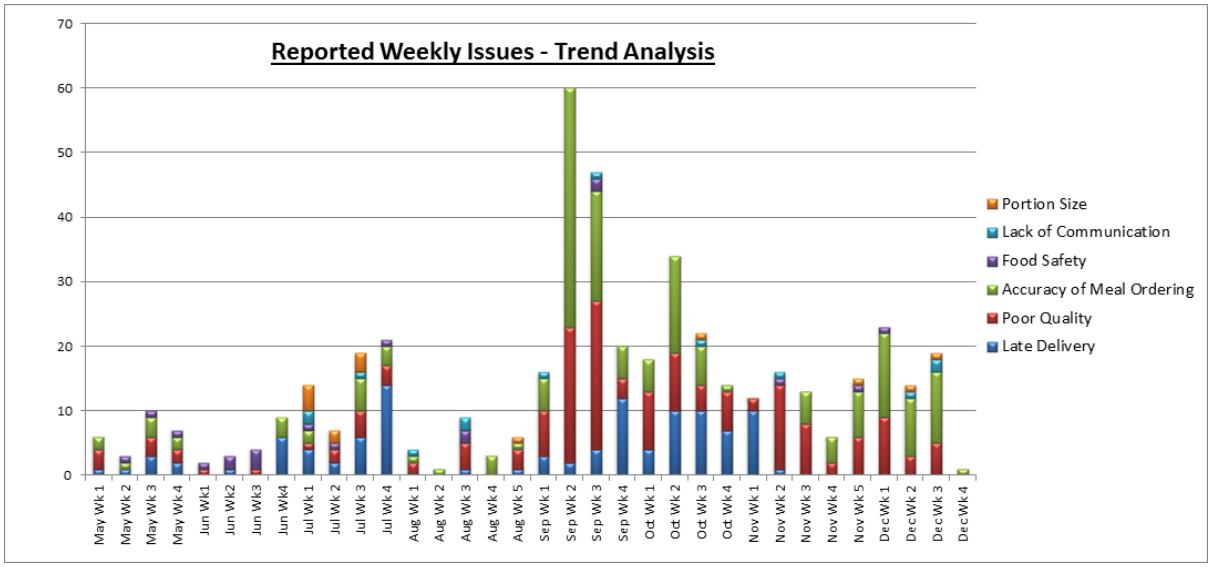


Table 10

By way of assurance, Finance and Performance Committee continue to receive more detailed monthly updates on Sodexo's performance. Actions required to comply with other KPI and Service Level breaches have also now been completed as Sodexo have provided staff establishment information against KPI 8, and are now providing monthly management information within contractual timescales. The one remaining breach at MMH EHO 4 stars, KPI 11 non-achievement of 5 Star Food Hygiene Rating, will hopefully be rectified on the next Environmental Health Officer inspection, date tbc and not within Sodexo's control.

Governors have been asked to continue their suspension of the assessment of the catering service in order to allow Sodexo the opportunity to implement their remedial actions and embed improved systems and processes. However, we will welcome Governor input from the end of February and discussed a standardised approach to assessment, potentially via the use of PLACE assessment tools, at the last Patient Environment Group on 13th December.

5 Estates Performance

5.1 Planned Preventative Maintenance (PPM) DRI/MMH

The completion of PPM's ensures the aged estate is being maintained appropriately, and where risks have been identified, PPM's are increased as mitigation to manage the risk. For Q3 additional information has been provided at tables 16 and 21, for DRI/MMH and BDGH respectively, which shows the priority and descriptions of PPM and reactive categories held within PLANET FM. PLANET FM is the Trust's CAFM (Computer Aided Facilities Management)

system, which is used to deliver the Estates Helpdesk and Labour Management System through handheld devices. There are two categories of PPM, category 3 is a statutory task, and category 5 is non-statutory.

Work to review PPM's on PLANET has been underway in its first phase for approximately 18 months using a risk based methodology whereby additonal PPM's have been added rather than remove any thought to be redundant in this first phase. This has resulted in significant increases in PPM's added to the system, as has been reported in each quarter. The second phase will see the cleansing and removal of redundant PPM's, such as those in place for equipment no longer in use or work now contracted out, in order that performance data provides a more accurate reflection of the completion of the required PPM's.

Examples of category 3 statutory PPM's include daily generator checks, monthly lift servicing, water outlet flushing, fire alarms faults. Examples of category 5 non-statutory PPM's include emptying plaster traps, litter patrols, general gardening duties and external lighting checks. Currently PPM's are reported for increases to completion rates, once work to cleanse the PPM's on the PLANET system has concluded and data is more accurate, targets will be agreed for both PPM categories to report against.

In addition to cleansing the system, work has commenced to review the Estates workforce and skill-mix across all sites utilising Continuous Improvement/NHSi LEAN methodology and support from regional EFM NHSi leads. As previously reported, LEAN tools have already been adopted by the Department and are proving effective in streamlining processes and driving out waste in order to improve overall Estates performance including PPM and reactive maintenance.

In quarter 3 at DRI/MMH there was an overall increase of jobs for completion in this quarter with 794 more jobs programmed and a quarter total of 5,804, as can be seen at table 12. Of those, 3,213 were completed, which represents an increase of 256 jobs compared to Q2 at table 11. Whilst completion rates increased, missed jobs also increased to 2,591.

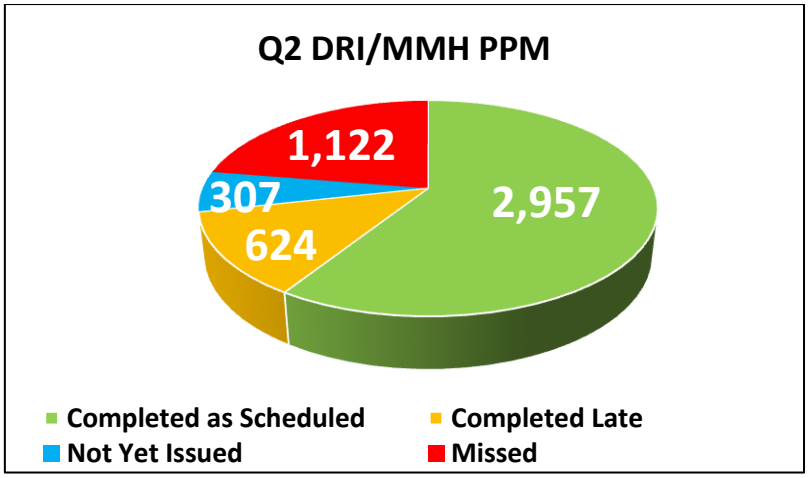


Table 11

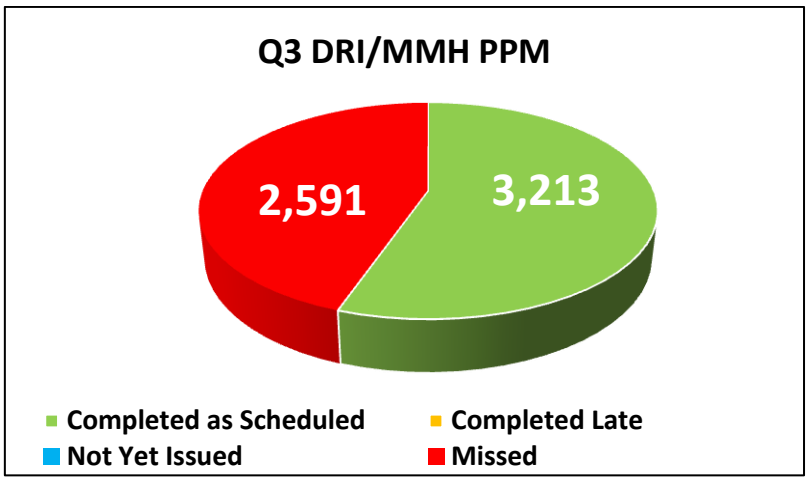


Table 12

5.2 Reactive Maintenance DRI/MMH

Completion of Reactive Maintenance tasks was maintained in Q3 with 100% of Cat 1 jobs being competed on time. The data at table 15 also shows that 87% of Cat 2 jobs were completed within the required timeframe, and whilst this is a 10% reduction compared to Q2, still exceeds the KPI of 80%.

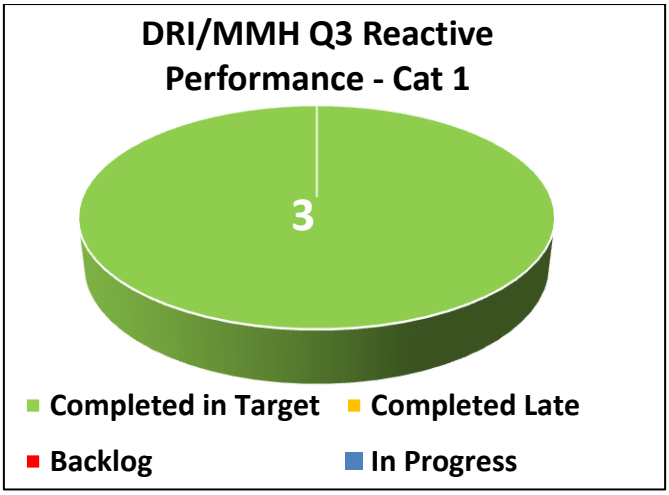


Table 13

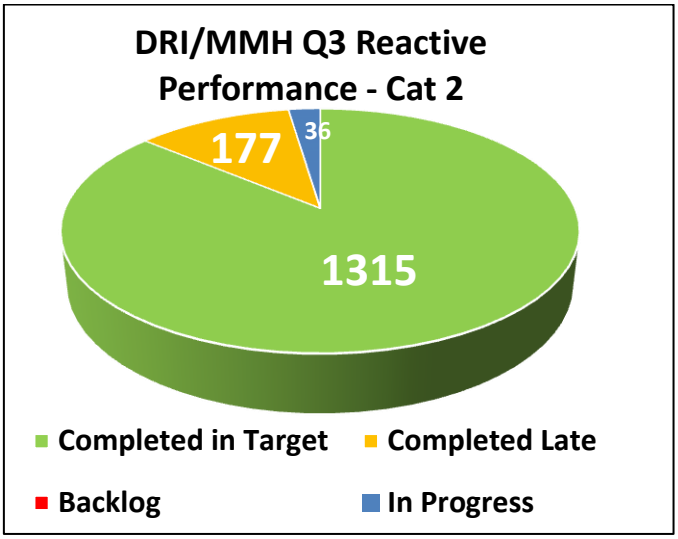


Table 14

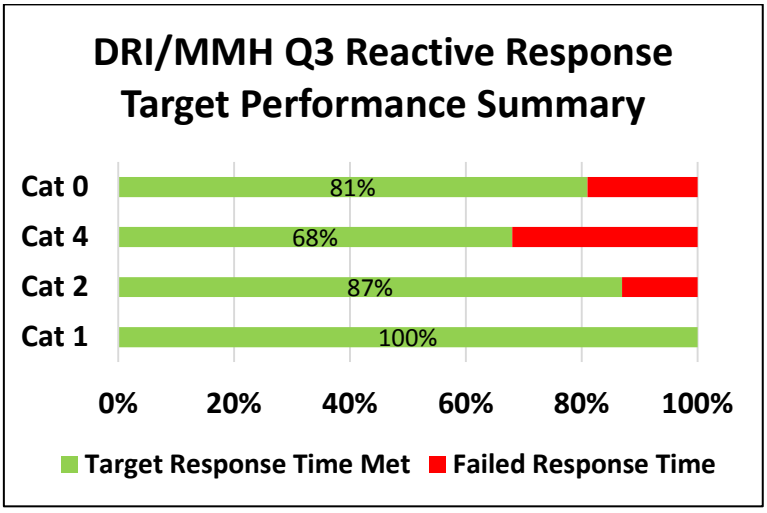


Table 15

Priority	Description	Attend (hrs)	Complete (hrs)	KPI%	Q3% DRI/MMH
0	Long Term Works	-	-	0	0
1	Emergency	1	8	100	100
2	Urgent	8	16	80	87
3	Statutory PPM	-	-	tba	tba
4	Non Urgent	40	80	50	68
5	Non Statutory PPM	-	-	tba	tba
6	Minor Works	-	-	0	0
7	Follow On	-	-	0	0
8	Contractor	-	-	0	0

Table 16

5.3 Planned Preventative Maintenance BDGH

Table 18 shows that there were no missed PPM's at BDGH within this quarter, and an overall increase of 197 as compared to Q2 with a total of 1,092 for Q3.

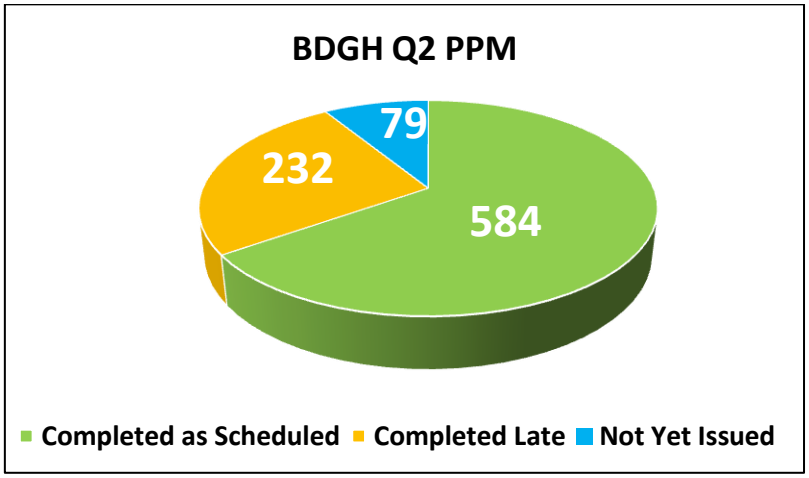


Table 17

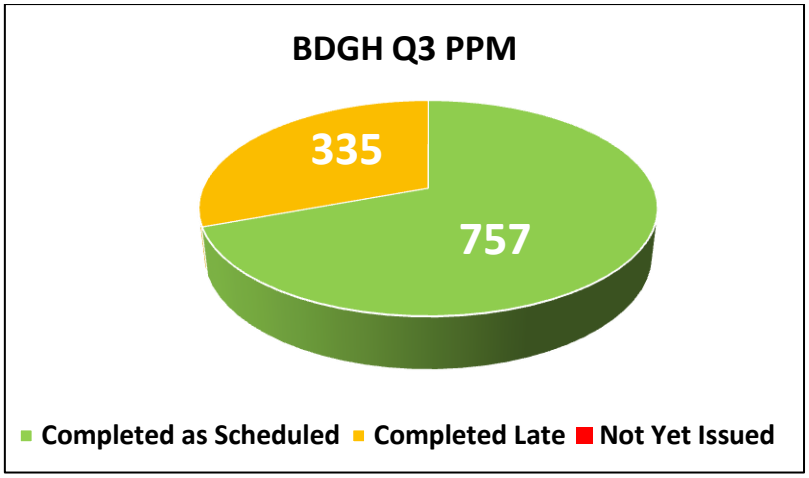


Table 18

5.4 Reactive Maintenance BDGH

Within this period there were no Category 1 jobs at BDGH. There was a total of 487 reactive Cat 2 jobs, of which 79% were completed missing the KPI target of 80% by just 1%.

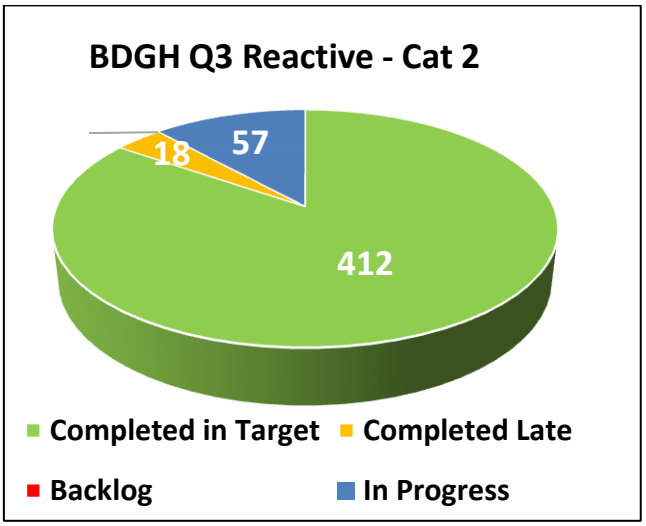


Table 19

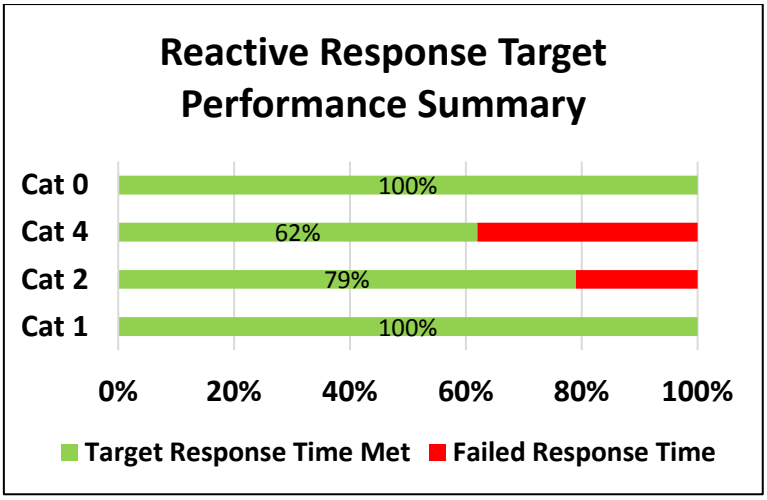


Table 20

Priority	Description	Attend (hrs)	Complete (hrs)	KPI%	Q3% BDGH
0	Long Term Works	-	-	0	0
1	Emergency	1	8	100	100
2	Urgent	8	16	80	79
3	Statutory PPM	-	-	tba	tba
4	Non Urgent	40	80	50	62
5	Non Statutory PPM	-	-	tba	tba
6	Minor Works	-	-	0	0
7	Follow On	-	-	0	0
8	Contractor	-	-	0	0

Table 21

6 Medical Technical Services (MTS)

At the end of 2017/18 a new target was identified by the MTS team of completion of Corrective Repairs tasks within 4 days. Previously the average completion rate was between 8 and 14 days, and by the end of Q1 this had been reduced significantly to just 3 days. Despite an increase in Q2 to 8 days as a result of vacancies, this has now reduced to an average of 4.6 days for Q3.

Qtr3

Month	Corrective repairs	Average completion time	Inspection /preventative maintenance jobs logged
Oct	326	5 days	614
Nov	221	6 days	704
Dec	98	3 days	289

Table 22

Total number of new assets commissioned and entering service this quarter **271**

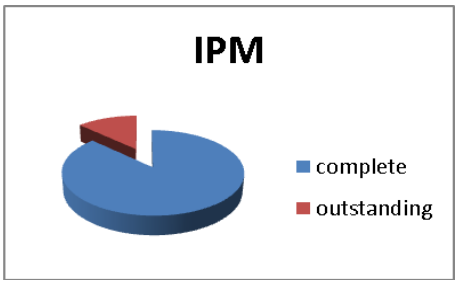
Total number of assets condemned and disposed of this quarter **161**

6.1 Inspection/Preventative Maintenance Program for Medical Devices

There are 109 wards/departments encompassing the Doncaster & Bassetlaw Teaching Hospitals NHS Foundation Trust sites, including outlying areas. The inspection program involves MTS staff attending each clinical area on an annual basis checking, testing and carrying out routine maintenance on all medical devices found. A risk reduction report is issued following each completed inspection with recommendations and actions required.

Examples of the types of equipment seen during these inspections are: oxygen flowmeters, suction equipment, defibrillators, infusion devices and syringe pumps. ECG recorders, thermometers and basic observation equipment such as non-invasive blood pressure machines and pulse oximetry are also checked.

Progress against the current annual programme is shown below, with both MMH and BDGH already complete ahead of time, and just 18% remaining to be completed in Q4 at DRI.



Site	% in date or complete in 18/19
MMH	100
DRI	82
BDGH	100

6.2 Re-Turn Centre

The innovative 'Re-Turn Centre' run by Medical Technical Services is an in-house 'e-bay' for goods and items that would have previously been disposed of. The disposal of goods and items costs the Trust significant expenditure in the removal of waste in skips, and in the purchase of new equipment which could have been avoided. Soft launched in April, the momentum is gradually building and the department is becoming more able to manage supply and demand and the storage of surplus assets.

Recent publicity has increased the utilisation of the Re-Turn centre which to date has Re-Turned 198 assets back to use with an estimated value of £44,245 on cost avoidance at the end of Q3. Chairs and desks remain the most requested item.

7 Conclusion and Recommendations

The data presented shows the performance achieved in Q3 of 18/19 for Estates and Facilities, such as the continued performance against appraisal rates exceeding the Trust target of 90% by 4.07%, cleanliness scores exceeding the KPI's, and the achievement by Sodexo of the 95% Patient Satisfaction for Catering services for the first time in December. Work to achieve SET training targets and to reduce sickness rates continues. The additional data provided this quarter also describes the ongoing work to review and enhance Planned Preventative Maintenance tasks on the PLANET system, work which is linked to the review of the Estates workforce and skill-mix with the support of NHSi EFM and LEAN specialists.

The Board of Directors is asked to note the content of this E&F Q3 Performance report.

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Title	**Chair's Assurance Logs – January 2019**		
Report to	**Board of Directors**	**Date**	**29 January 2019**
Author	**Neil Rhodes**		
Purpose			Tick one as appropriate
	Decision		
	Assurance		X
	Information		

Executive summary containing key messages and issues
Attached as an appendix is the reports from the chair of the one board committees held in January 2019: 22 January 2019 - Finance and Performance Committee The report sets out assurances obtained during the meeting plus any new risks and escalations to Board.
Key questions posed by the report
Is Board able to take confidence from the various assurances given in the attached document?
How this report contributes to the delivery of the strategic objectives
N/A
How this report impacts on current risks or highlights new risks
As highlighted in the paper.
Recommendation(s) and next steps
(1) To note the reports.

Chair's Log - Finance and Performance Committee 22.1.19

Overview

The meeting received a broadly encouraging financial picture and some reassurance as to progress to deliver the control total, which is with discussed below. We also had a further deep dive into the management of Referral To Treatment performance.

Performance, on the whole, was reassuring, subject to the concerns we explored in depth around RTT.

The Director of Estates presented her monthly update of progress with Sodexho in improving the quality and timeliness of patient meals. As I noted last month, issues clearly still remain to be resolved but progress now appears to be being made in improving patient satisfaction.

We received and quality assured a business case for an Electronic Record Proposal, which we commended to the Board.

A good deal of our time was spent discussing both the predicted outturn for the year and the process in place for developing next year's annual plans across the Trust, with considerable assurance being gained and members' attention is particularly directed to that section of this report.

Assurance area – Performance

Performance Report

The Board meeting will receive a separate performance report which will give a more detailed appreciation of the picture. In broad terms Trust performance once again remains sound, although RTT at 87.9% was down 2.1% against a target of 90%.

However, after a second deep dive into RTT, with a detailed discussion of performance improvement plans by specialty the Committee was able to take reassurance from the Chief Operating Officer's presentation.

A first draft of performance data, presented in a different style by the Director of Finance, benefitted from an extensive level of feedback about content and style. Jon Sargeant committed to producing a fuller pack for the next meeting capturing once again the comparative data and detailed analysis of areas in exception. Timing of reports meant that the new core data report and COO's performance paper were unable to be reconciled prior to the meeting, however it is not anticipated this will be a problem for future meetings.

Assurance area – Workforce Management

We considered the Workforce report that addressed –

- The profile of vacant posts
- Agency spend
- Staff sickness

Committee members were reassured by the detail of the paper but concerned to learn that a significant problem in terms of a failure by the Deanery to allocate registrar level A and E doctors to the Trust for this segment of the year had not been shared with them. The Director of Finance was able to report that the Deanery accepted the omission and had agreed to make some financial recompense.

Assurance area – Overall Financial Picture and Closing the Financial Gap

A more detailed picture of finances is set out in the separate finance paper. However, F+P heard with approval that the Trust had met PSF thresholds for Quarter 3. That is no small achievement.

Winter pressures continue to be a concern and the situation is being closely monitored.

Jon Sargeant told us there had been significant positive financial progress this month in that dialogue with both principal CCGs and the ICS had gained agreement to financial measures that would help us bridge the hole in our efficiency plans by the impracticability of the WOS business case this year. In addition to this CIPS had performed broadly in line with expectations and income slightly ahead of expectations.

I reported last month that an accounting issue from previous years means the depreciation of certain major assets, which should have taken place in those years but did not, now needs to be reflected in our accounts. Although largely a technical adjustment, if held against our control total for just one year it could mean an adverse movement of circa £3m. This means that, despite the positive developments, outturn predictions remained in the realistic case scenario at around a £3.7m shortfall. The Director of Finance is engaged in dialogue with NHSi to try to resolve this non-operational matter.

Assurance area – Governance and Risk

F+P received and noted the current risk register. The relevant risks had been considered actively with each paper received at the meeting.

A paper discussing the Auditors' Committee Effectiveness Review was received and given detailed consideration, with agreement that the Trust Board Secretary would adjust procedures to embrace the spirit of the recommendations.

The Director of Estates presented an overview of progress with Sodexho in improving the

quality and timeliness of patient meals. Issues clearly still remain to be resolved but progress continues to be made with positive improvement. The appointment of a new senior manager to operate our contract, by Sodexho is now imminent. I can confirm that Governor involvement in quality assuring meal service will resume in February.

Assurance area – Strategy and Planning

Because of illness the Enabling Strategy Quarterly Exception Report was deferred to the February meeting. The February meeting (originally scheduled for a school holiday week) has been moved to 25 February to ensure it is quorate.

Neil Rhodes
Chair – Finance and Performance Committee
26.1.19

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Title	**Chair's and NEDs' Report**		
Report to	**Board of Directors**	**Date**	**29 January 2019**
Author	**Suzy Brain England, Chair of the Board**		
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 December 2018 and January 2019
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 – January 2019

In opening my report may I take this opportunity to wish all Board members, staff, governors and patients a Happy New Year.

NHS Providers Board

On 9 January I attended NHS Providers Board meeting, much of the morning was devoted to reviewing progress against the 2016 - 19 strategy; then considering the external environment in which we operate drafting a refreshed 2019-22 strategy. The draft strategy will be subject to consultation with NHS Providers' staff and members, with final publication and implementation anticipated in April 2019. The remaining afternoon session was devoted to Board business.

NHS Providers Governor Advisory Committee (GAC)

The following week, Peter Abell (GAC Chair) and I attended the first GAC meeting of 2019. Members were able to engage in a variety of discussion topics, including a CQC engagement session, proposals for regional development workshops and the Governor Focus Conference 2019. Committee members reviewed performance in Quarter 2 and 3 2018/9 and were able to share local feedback on ICS and governing body matters.

I was delighted to be invited to chair the regional workshop to be held in Leeds on 4 April 2019 which will bring together around 50 governors from the region to discuss current health policy, working with stakeholders, relationships between the Council of Governors and the Board, and engaging with members.

Invitations for the 2019 Governor Focus Conference have already been shared by the Trust Board office, the conference will take place on 9th May 2019, at the Congress Centre in London. The Trust is guaranteed two places, in addition to those allocated to myself and Peter Abell as GAC members.

Governor Election Information Sessions

Governor information sessions have taken place this month at both our Doncaster and Bassetlaw sites. There are a total of thirteen governor vacancies to be filled, the breakdown of which is detailed below:

- 8 x Public Doncaster
- 2 x Public Bassetlaw
- 1 x Staff Medical and Dental
- 1 x Staff Non-clinical
- 1 x Staff Nursing and Midwifery

Nominations are now being received with a closing date of 11 February 2019. Those who attended the information sessions were able to hear about the Trust, its structure, workforce and vision for the future from Richard Parker and David Purdue. The role of a governor and their powers were summarised and there was an opportunity for existing governors, Mike Addenbrooke, Peter Abell and Bev Marshall to share their own personal experiences. Finally, Simon Clarke from the Electoral Reform Services was on hand to advise on the election process itself.

Thank you to everyone who supported and attended the sessions and if you know of someone either in your day to day work or as part of other networks who may be a potential candidate please do encourage them to contact Gareth Jones, Trust Board Secretary, for more information. Gareth can be contacted on gareth.jones22@nhs.net or on 01302 644157.

New Appointments

This month I have had the pleasure of meeting with our new Efficiency Director, Paul Mapley who will lead on the Trust's Cost Improvement Programme, as part of the Director of Finance's team and Dr Mike Whiteside, who was appointed to the role of Clinical Chief Information Officer (CCIO) in October 2018. Mike will undertake this role alongside his consultant post in the Medicine division; the role within the health industry combines the expertise of a medical clinician with the IT knowledge of a Chief Information Officer (CIO). Mike will work closely with clinical staff and Simon Marsh (CIO) to develop technology in support of the Trust's clinical strategy.

Chair of NHS England Visits South Yorkshire & Bassetlaw ICS

On 23 January, alongside Sir Andrew Cash, SY&B ICS Lead, fellow SY&B ICS Chairs and ICS colleagues I welcomed Lord David Prior, Chair of NHS England and senior members of his team to the region. The full day tour showcased integrated work with SY&B partner organisations.

The tour started with a visit to Larwood Medical Practice - Primary Care Home (PCH) in Worksop. PCHs were developed in 2015 to improve integration between health and social care services across populations between 30-50,000. Larwood Health Partnership and Bawtry and Blyth Medical were one of 15 pilot sites to work jointly together for the benefit of their patient population.

In Doncaster we were welcomed at Changing Lives in Doncaster town centre; Changing Lives is a national, registered charity which provides specialist support for vulnerable people and their families. The service demonstrates partnership working across Team Doncaster and we

were able to hear from both staff and service users of the positive impact the provision has on people's lives.

The final visit of the day was to Weston Park Hospital, Sheffield. A briefing on the SY&B Cancer strategy, proposed developments and workforce innovations were discussed and we were able to meet with colleagues, including those staff whose role had been developed as part of the workforce transformation strategy.

Appointment to Doncaster Chamber Board

This month I joined Doncaster Chamber's Board as a co-opted director. This is a great opportunity for me personally and as Chair of the Board to be involved in local business matters. Also, as Chair of the largest employer in Doncaster it will provide openings for me to drive the workforce agenda within the Doncaster Place Plan.

NED Reports

Alan Chan

Just before Christmas Alan attended the Doncaster Chamber's Annual General Meeting on behalf of the Trust to understand more about how local businesses may feature in the context of the Trust and to understand if there are any opportunities of collaboration.

Kath Smart

Kath recently attended a number of 1:1 meetings, with Simon Marsh to discuss the Electronic Patient Record proposal; Gareth Jones as part of the new Board Secretary's induction; and Jon Sergeant to discuss the proposed change to the financial forecast to NHSI after the discussion at December's Board meeting.

Kath visited Rehab 1 & 2 Wards at Mexborough Montagu just before Christmas alongside the lead Physiotherapist, John Brinkley and Matron, Michelle Thorpe.

As Chair of Audit Committee, Kath was keen to understand the groups who report into the Committee and attended her first Health & Safety Committee in January. This offered opportunity to talk to members, sight of the evidence which supports the Trusts H&S arrangements, and to provide feedback to the Chair on what assurances the Audit Committee would like to see.

Kath also chaired the appointment panel for a Consultant in Obstetrics & Gynaecology with a successful conditional offer being made.

Pat Drake

During January Pat chaired the governor brief, in Suzy's absence, at which governors received a presentation on safeguarding matters, delivered by Rick Dickinson, Deputy Director of Nursing , Midwifery & AHP and Elizabeth Boyle, Named Nurse for Safeguarding Children and Safeguarding Team Manager.

In addition to statutory meetings Pat has met with Simon Marsh, Chief Information Officer, to discuss the progress of the Electronic Patient Record. Also, following the three day Rapid Improvement event in Maternity Pat attended the report out session which demonstrated a significant amount of staff effort/contribution, with clear plans for change.

Supported by Stacey Nutt, Lead Cancer Nurse and Karen Lanaghan, End of Life Nurse, Pat visited the Chatsfield Suite and the Macmillan information pod, recently sited in Outpatients.

Finally, Pat chaired the panel for the appointment of an Orthopaedic consultant.

Linn Phipps

For periodic assurance Linn has attended the Patient Experience and Engagement and the Clinical Governance (CGC) Committees. She also joined the CGC's special risk review meeting, and deepened her understanding and assurance on the Trusts' Serious Incident process by attending a SI Panel. Linn had a further meeting with her Board buddy, particularly to discuss the Trust's engagement of patients and the public, and she also met up with Marie Purdue and Clare Ainsley on the Trust's approach to strategic milestones. She attended one of the Chief Executive's listening events.

As part of pre-Christmas celebrations Linn and the Trust's choir performed in the foyer at DRI, Linn also sang at the Trust's Bassetlaw Carol Service, which was also attended by her fellow Non-executive colleagues, Pat Drake and Sheena McDonnell.

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Chief Executive's Report

29 January 2019

Trust champions Britain's Armed Forces

I am proud to share the news that in mid-January, we publically pledged our commitment to Britain's Armed Forces covenant.

On Friday 18 January, I was joined by the President of the Reserve Forces' and Cadets' Association for Yorkshire and The Humber, and Her Majesty's Lord-Lieutenant of South Yorkshire, Andrew Coombes Esq. to sign the Armed Forces Covenant. We were also joined by Mr Andrew Bruce, Consultant Orthopaedic Surgeon at the Trust and Army Reservist, and our Chair, Suzy Brain England OBE.

Under the covenant we promise to support the military community and ensure that those who serve, or who have served in the armed forces, and their families, are treated fairly. More than 150 companies and organisations across the region have signed the covenant and Doncaster and Bassetlaw Teaching Hospitals is now one of 16 NHS Trusts to do so.

Doncaster Health Teams encourage people to rethink their drink

The Trust joined forces with Rotherham, Doncaster and South Humber NHS Foundation Trust (RDaSH), NHS Doncaster Clinical Commissioning Group and Doncaster Council earlier this month to ask local people to sign up for Alcohol Change UK's 'Dry January' and give their body a 'holiday' from alcohol.

The NHS recommends that people should not regularly drink more than 14 units of alcohol a week to ensure we remain healthy and prevent alcohol related liver diseases. All organisations have been encouraging patients to register for Dry January and one of our Consultant Gastroenterologists, Dr Anurag Agrawal, continues to work within this partnership to encourage local people to cut down their alcohol consumption.

The search for new hospital Governors begins

Elections opened on 7 January 2019 for 10 public Governors and three staff Governors at the Trust.

Governors play a vital role in representing the public and influencing how their local hospitals make plans to improve and develop services. The representatives also hold the Non-executive Directors on the Board to account and ask important questions on behalf of local residents, to ensure the Trust continues to deliver high quality services.

Nomination packs are available on the Trust's website www.dbth.nhs.uk. The closing date for entries is 11 February 2019 and successful candidates will take up role 1 April 2019.

I would encourage any and all local residents with an interest in the Trust to apply. As an organisation we benefit immensely from the skill, expertise and insight of our governors, and with 10 places now up for election, we look forward to the new perspective these individuals will bring to DBTH.

Changes to Doncaster Royal Infirmary's Park and Ride

Following improvements to the Park and Ride service between Doncaster Racecourse and Doncaster Royal Infirmary, patients and visitors will be charged a small fee of 50p to travel on the bus.

Due to the need to operate newer and more modern buses in order to improve experience of our patients and staff the cost to the Trust of this service has increased and we have decided to implement a small fee in order to maintain the service.

There will be no charge for those showing a Local Authority Bus Pass or a Disability Permit, in addition to an extension of the same concessions offered by the Trust for on-site parking for patients and their visitors in connection with renal, cancer, intensive care, critical care, palliative care, parents and guardians of children on neonatal and special care baby units.

Staff presenting an official NHS ID badge will also travel free.

These changes will not apply to the shuttle bus services that run between Doncaster Royal Infirmary and Montagu Hospital, or the service which connects Doncaster and Bassetlaw Hospitals. Patients, visitors and staff who use these buses to travel between sites will continue to do so for free.

NHS Long Term Plan Published

The NHS Long Term Plan was published on 7 January 2019 and sets out the future of the NHS over a 10 year period.

The plan was developed in partnership with patients and their families, frontline health and care staff and healthcare experts. There has been a focus on three concerns; funding, staffing and increasing inequalities and pressures from a growing and ageing population, and the plan aims to future proof the NHS up to the services 80th birthday. As a Trust, we welcome the plan and are currently exploring how it fits with our current five year strategy. The Long Term Plan can be read here: https://www.longtermplan.nhs.uk/

Appointment of Chief Clinical Information Officer

In late 2018, the Trust appointed Dr Mike Whiteside as our new Chief Clinical Information Officer. Specific to the healthcare industry, this role is quickly become a necessity within the NHS. The idea is to have a designated individual who is responsible for enhancing the use of technology within a given organisation, in order to benefit both patients and clinical practice. This means that a Chief Clinical Information Officer (CCIO) needs to be familiar with IT, complementing the medical expertise that is required for their day job.

An Acute Physician, working at Doncaster Royal Infirmary (DRI) and Bassetlaw Hospital, Dr Whiteside is undeniably a perfect fit for the role. He will be working alongside the Trust's IT team in order to ensure that technology is meeting the needs of clinicians.

There are many exciting digital opportunities in the pipeline for DBTH, news of which we will be sharing shortly.

New Years Honours

Finally, it is with pleasure and surprise that I received an OBE within the Queen's New Year's Honours List for services towards 'sustainable care'.

Throughout my career within the NHS I have worked with extraordinarily talented individuals, who have used their talents to the benefit of countless patients. To have been able to contribute to improving the delivery of care throughout my career has been an absolute privilege, and as such I am extremely grateful to receive such recognition.

I would also like to share this award with my colleagues at DBTH. Members of the team go above and beyond in the delivery of high quality care, striving each day to do even better in the next. I am enormously proud to lead this organisation and hope to do so for many years to come.

Minutes of the Meeting of the Management Board
of
Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust
on
Monday 10 December 2018 at 2:00pm
in the Boardroom, DRI

Present:

Richard Parker (Chair)	Chief Executive
David Purdue	Deputy Chief Executive & Chief Operating Officer
Karen Barnard	Director of People & Organisational Development
Antonia Durham Hall	Divisional Director – Surgery & Cancer
Nick Mallaband	Divisional Director – Medicine
Jon Sargeant	Director of Finance
Jochen Seidel	Divisional Director – Clinical Specialities

In attendance:

Kirsty Edmondson-Jones	Director of Estates & Facilities
Simon Marsh	Chief Information Officer
Marie Purdue	Director of Strategy & Improvement
Kate Sullivan	Corporate Governance Officer
Andy Thomas	Project Director
Adam Tingle	Acting Head of Communications & Engagement
Willy Pillay	Deputy Medical Director (For Sewa Singh) *(Part)*

Apologies:

Eki Emovon	Divisional Director - Children and Families
Sewa Singh	Medical Director
Moira Hardy	Director of Nursing, Midwifery and Allied Health Professionals

Action

Apologies

MB/18/12/1 The Chief Executive welcomed Gareth Jones to his first meeting and introductions were made around the table. Apologies as recorded above were noted.

CQC Update

MB/18/12/2 An unannounced CQC visit had taken place over 3 days from 27 November 2018; this was a follow up to the December 2017 inspection to check progress made since that time. The visit focused primarily on the Emergency Department (ED) and paediatric services within ED. The CQC had highlighted a number of concerns and had written to the Trust asking for a review of the

ED front door assessment / triage service and paediatric staffing levels. Failure to robustly address the concerns, within allocated timeframes, could lead to CQC escalating their concerns through the regulatory framework; the deadline for response was later the same day and the Director of Nursing, Midwifery & Allied Health Professionals was currently finalising the letter of response.

MB/18/12/3 A CQC action plan was in place to be overseen by the Clinical Governance Committee (CGC) and Quality & Effectiveness Committee (QEC). The decision had been taken to change the triage system and also to enhance the processes by which the Trust ensured a minimum of one RGN Children's Nurse was on duty in ED at all times. The Trust would also establish some working groups to consider whether the issues had been dealt with effectively and to ensure action plans were in place for the future. It was noted that both issues would be entered on the Trusts risk registers. **GJ**

MB/18/12/4 Management Board discussed concerns raised by the CQC about front door assessment / triage service model at the 2017 inspection; Jochen Seidel queried what changes had been made at that time and why further changes had been required. It was noted that the Front Door Assessment Service was a CCG commissioned model and during the 2017 CQC visit there had been differences of opinion between the Trust and the CQC on the merits of the model. The Trust had had made changes following the visit however during the most recent visit the CQC had taken a more in depth look at the service. With regards to Paediatric services it was noted that the Royal College of Nursing (RCN) had introduced new guidance in June 2018 and the Trust had this time been assessed against CQC the revised guidance.

MB/18/12/5 The CQC update was NOTED.

Minutes of last meeting

MB/18/12/6 The minutes of the meeting held on 19 November were approved as an accurate record subject to the following:

MB/18/11/44 – 'It was agreed to go ahead with independent clinic codes for the orthopaedic SAS Doctors referred to." *to be added to the end of the paragraph*
MB/18/11/37 – '..the rota*" to be amended to* "..the first on-call rota"
MB/18/11/39 – "..concern that the service was not sustainable" to be amended to "concern that the out of hours service was not sustainable."

Matters arising and action notes

MB/18/12/7 The action log was reviewed and updated.

Action 3 – It had been agreed to discuss with the CCG and Urgent & Emergency Care Steering Group potential risks relating to ability to provide safe anaesthetic and paediatric/obstetric cover at Bassetlaw Hospital. The Chief Executive (CE) provided feedback from discussions with the CCG the previous week about the matter. There was a wide ranging discussion about the issue in the context of the political environment / public perceptions. The CE advised that the matter was to be taken forward as part of an overall transformation proposal for Bassetlaw Hospital which would include a full review of transport at both sites and would consider wider issues such as recruitment. The Executive Team would agree who would lead on the transformation proposal and would consider the process for delivering it to CCG.

Performance & Assurance Framework

MB/18/12/8 The Director of Finance presented the report which set out the proposed new Performance Assurance Framework (PAF) for the Trust. It outlined:

- The methodology to be used to assess or 'score' the performance of each clinical division and corporate directorate.
- How, and at what level, the performance of each team is reviewed and scrutinized.
- The escalation process to be used where performance issues remain unresolved.

Whilst performance targets were quantified in Appendix B these were indicative at this stage and would be subject to further validation and review. This would be undertaken in collaboration with the divisions and directorates concerned. In particular the need to expand and strengthen the "Quality" measures included and further work would be prioritized and undertaken in collaboration with the Medical Director.

MB/18/12/9 Attention was drawn to page 9 of the report which set out the assessment and scoring processes. It was noted that meetings would commence from January 2019. The PAF was reviewed and discussed, in particular the escalation process, triggers and how performance would be rated / flagged. It was clarified that the proposed new meetings would be in additional to finance escalation meetings but would not cover the same data/issues; concern was raised that escalation could potentially result in DDs being required to attend multiple meetings. Management Board discussed what the process would look like and expectations in terms of RTT and outpatient performance for the rest of the year. The DoF agreed to take away a number of suggestions including developing some visual management tools and including links to the improvement programme. Nick Mallaband suggested including a process for earned autonomy and this was discussed; Executives agreed in principal to writing in potential earned autonomy subject to **AJ/JS**

checking against the Trust's Standing Financial Instructions (SFIs).

MB/18/12/10 Management Board REVIEWED and NOTED the PAF and AGREED:

- For further work to be undertaken to expand/strengthen the quality measures used.
- For the revised document to be considered at the next F&P Committee for approval.
- For the revised document to be considered at the next QEC for approval.

Leadership & organisational Development Framework

MB/18/12/11 The Director of People & Organisational Development presented the Leadership & organisational Development Framework which had been reviewed by the Executive Team. Management Board were invited to comment on the document before it was submitted to the Board for approval the following week. Feedback would be forwarded outside the meeting.

MB/18/12/12 The Leadership & Organisational Development Framework was NOTED.

STRATEGY

Patient Experience & Engagement Strategy Update

MB/18/12/13 The report was included in the papers. The Director of Nursing, Midwifery & Allied Health Professionals, who was due to present the update, was working on the CQC response letter therefore the item would be brought forward to January 2019 for discussion. **MH**

Communications & Engagement Strategy

MB/18/12/14 Adam Tingle, Acting Head of Communications and Engagement, presented the update and provided details of work being undertaken to deliver the Strategy and key milestones; This included proactive management of the Trust's reputation, creating a culture of involving people and supporting effective communications and engagement in order to support performance delivery. There had been good progress to achieve key milestones and he gave a detailed update on work on the Trust Website, press profile, social media networks and internal communications. An overview of key challenges, interdependencies, opportunities and achievements was also provided. Management Board welcomed the update and commended the good work done so far.

Richard Parker left the meeting @ 3:00pm
David Purdue took over the Chair

MB/18/12/15 The update was NOTED.

Finance Report

MB/18/12/16 Management Board considered a report of the Director of Finance (DoF) that set out in detail the Trust's financial position at month 7 (October 2018), which was a surplus of £45k, an adverse variance against plan in month of £1.4m. The cumulative position to the end of month 7 was an £11.9m deficit, which was £1.4m adverse to plan. This was the first month that the Trust had earned more than it had spent and this was positive but Management Board were reminded that the in month financial position was c.£360k worse than the forecast (realistic case). At the time of reporting 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.

MB/18/12/17 Whilst work continued to close the financial gap, delivery of CIPs remained a significant risk. Within this there was a risk in relation to delivery of the Wholly Owned Subsidiary (WOS) CIP (£3m) due to a pause in the process as a result of the national consultation. It had been assumed in the realistic forecast position that either the CIP relating to the WOS would be delivered or that the control total would be amended for this. Since the time of reporting there had been a number of discussions NHSI about this; following the consultation a new checklist had been issued, this included extra work to be undertaken in order to proceed with the case. Because of this and the timeline for the approval process it was increasingly unlikely the process could be completed before the end of the financial year. Further to this, should NHSi consider the case to be a 'significant transaction', Governor approval might also be required and this could protract the process even further. With regard to any adjustment to the control total the Trust had been advised that a significant number of other Trusts were in the same position and that there would be no adjustment to control totals. The matter was discussed and the DoF provided details of the new process for taking forward the WOS proposal.

MB/18/12/18 Management Board were reminded that the Trust had identified a historical depreciation risk of £3.9m. The DoF shared the background to the issue. The position had been discussed with external audit whose initial review of the accounting treatment agreed with the Trust's position that this was likely to be a prior period adjustment (subject to audit at year end). The Trust had declared this to NHSi who had subsequently advised that even if treated as a prior year adjustment, technically it would still count towards the Trust's control total; The DoF explained the reasons for this which related to the depreciation having to go through the government balance sheet. As a result of this and the issues relating to the WOS it was noted that the financial gap to achieve the forecast had increased to £7m since the time of reporting.

MB/18/12/19 There was a wide ranging discussion about the update in the context of, amongst other things, the ICS Capital bid, and the potential impact of Brexit and/or a potential general election including how this would affect the Trusts ability to progress with ICS work.

MB/18/12/20 Management Board NOTED the report and the risks to delivery of the Trust's control total.

Corporate Risk Register

MB/18/12/21 Management Board considered a report of the Trust Board Secretary which set out the latest corporate risk register for consideration. No risks Had been escalated via Datix in the month. One risk, "Failure to adequately treat patients due to unavailability & lack of supply of medicines", had seen a change to its rating following a review by the Executive Team and discussions with the Medical Director due to implications posed by Brexit and the timely access to medicines and medical consumables passing through customs in the UK.

MB/18/12/22 The Corporate Risk Register was NOTED.

Divisional Issues

MB/18/12/23 Patient Communications – DBTH Digital Partner

MB/18/12/24 Emma Challans, Deputy Chief Operating Officer (DCOO), provided an update the Trusts new digital partner 'DrDoctor, this would give patients the ability to view and manage their upcoming appointments through their smartphone or online. The system was being introduced to, amongst other things, reduce missed appointments/DNAs as well as improve the patient experience and clinic utilisation. The presentation was included in the papers. An overview of the mobilisation phase, governance, KPIs and roll out plan were provided along with examples of what the patient portal would look like on a phone or PC. The system would be rolled out over several phases offering 2 levels of functionality, Level 1 would provide confirmation and reminders of appointments including an electronic appointment letter and level 2 would also allow patients to change/cancel appointments. From December 2018 Phase 1 roll out would see the system introduced to three specialities, two on Level 1 and one on Level 2. The system would be rolled out over all key specialities from months 3 to 9. A 20-30% reduction in DNAs was expected.

MB/18/12/25 How the system would work was discussed in detail and a range of questions were asked. It was noted that alternative appointments offered to patients would keep to the 18 week pathway. Work was ongoing with specialities to ensure electronic appointment letters had the correct information including directions/maps. High level engagement across Divisions/specialities would

be key to the success of the roll out.

MB/18/12/26 There was brief discussion about interoperability with other systems such as the Kiosks and CaMIS; The Chief Operating Officer advised that an interface would need to be built/purchased in order to link systems. This led to discussion about proposed savings and the governance structure of the scheme; the Director of Finance (DoF) raised several questions about whether all the resource and staff time going in to the project had been taken in to account and where the monthly steering group and work stream meetings were reporting in to. Financial KPIs needed to be set for savings and these should be monitored as part of the roll out. It was agreed to take the questions though the Elective Steering Group, Antonia Durham-Hall gave assurance that time would be allocated to consider the issues raised.

MB/18/12/27 Management Board considered the age profile of patients in certain specialities proposed for roll-out and the likelihood that these patients would have smartphones. Antonia-Durham Hall raised concern about this noting that for example in Ophthalmology a significant proportion of patients were elderly. The DCOO advised that some testing had been done and had feedback suggested this wasn't an issue. It was agreed to monitor this and take learning on this from the 1st phase of the roll out.

MB/18/12/28 The Patient Communications – DBTH Digital Partner Update was DISCUSSED and NOTED

MB/18/12/29 **Recruitment of Consultants**

MB/18/12/30 The following proposals for a replacement consultant was presented for consideration:

Acute Medicine - The case was APPROVED subject to approval of the job plan and person specification by the Medical Directors office and amendment of the Divisional structure.

Information Items to note

MB/18/12/31 The Chief Executive's Report, Business Intelligence Report and minutes from Corporate Investment Group meeting in October 2018 were all NOTED.

ICS Update

MB/18/12/32 *Richard Parker returned to the meeting*

The Chief Executive provided an update on the recent meeting about PLACE; key issues had included challenges around the financial and performance structure. He also provided a detailed update on recent challenges faced by STH in terms of RTT performance in the context of a recent fire improvement

notice they had received. As a result part of STH had been closed to allow for a full structural analysis resulting in the closure of a significant number of beds and this was expected to extend for several months. Some activity had been moved to surrounding hospitals and DBTH had been asked to repatriate its patients as quickly as possible. Management Board discussed the wider implications of this the context of ICS System Performance. There was discussion about partnership working across the ICS, how monies were shared and the ICS Capital bid and there was a brief discussion about the Trusts past experiences with the fire service in terms of fire improvement notices.

MB/18/12/33 The ICS Update was NOTED

Any Other Business

MB/18/12/34 **Equipment Group Meeting**– Antonia Durham-Hall raised concern that a bid to replace some medical equipment had been rejected for a second time by the medical equipment group which had requested more information for a second time. 3 items of equipment were non-functioning; it was noted that this matter had been escalated to risk registers; the matter was discussed in detail and the Director of Finance clarified the information needed.

Clinical Admin Review – In response to a query from Antonia Durham-Hall it was clarified that all VCFs were now going through subject to the submission of forward plans. The Chief Operating Officer provided an update on the process and timelines. The plan for the Surgery & Cancer Division was awaiting final review and would be submitted as soon as possible.

Items for escalation from sub-committees

MB/18/12/35 None.

Date and time of next meeting

MB/18/12/36 The next meeting of Management Board would take place 14 January 2019 at 2pm in the Boardroom.

DONCASTER & BASSETLAW TEACHING HOSPITALS NHS FOUNDATION TRUST

Minutes of the Finance & Performance Committee
held at 9:00am Friday 23 November 2018
in the Boardroom, DRI

PRESENT	:	Neil Rhodes, Non-Executive Director (Chair) Kath Smart, Non-Executive Director Jon Sargeant, Director of Finance Karen Barnard, Director of People & Organisational Development Claire Jenkinson, Deputy Chief Operating Officer *(Part - for David Purdue)*
ALSO IN ATTENDANCE:		Justin Fowler - Senior Management Accountant, Projects and Planning Lesley Hammond, General Manager - Emergency Division *(Part – performance report)* Stacey Nutt, Lead Cancer Nurse *(Part – performance report)* Kate Sullivan, Corporate Governance Officer
OBSERVERS	:	None
APOLOGIES	:	Pat Drake, Non-executive Director Dr Kirsty Edmondson Jones, Director of Facilities & Estates Simon Marsh, Chief Information Officer Bev Marshall, Governor Observer David Purdue, Deputy Chief Executive & Chief Operating Officer Marie Purdue, Director of Strategy & Transformation

Action

Agenda Review

18/11/1 The agenda was reviewed. The performance report would be brought forward to accommodate those attending for the Deputy Chief Executive & Chief Operating Officer and the Finance Report would be considered after the deep dive on capital plans. No other business was declared.

Apologies for Absence

18/11/2 Apologies as recorded above were noted.

Action Notes from Previous Meeting

18/11/3 **18/10/24 - Non-medical Waits** – More information was to be included in next quarterly report (January 2019). Kath Smart requested that this be scheduled as a deep dive. **DP**

18/10/34 - Sickness / Absence – It had been agreed to look into how the matter of consultant data not being readily available could be resolved; Lesley Hammond provided an update on progress. It had been harder to resolve this than expected and the matter was briefly discussed Kath Smart added that the issues triangulated with comments made at a recent Medical Divisional meeting she had attended. **KB**

This led to a broader discussion about how divisional meetings were structured and there was feedback from Non-Executive Directors on meetings they had attended; the picture in terms of attitude and intentions was already very positive. Kath Smart had been pleased to see representatives from HR and Finance at the meeting and also with the level of self-critique. The matter was revisited later during the meeting and there was

discussion around the development of Divisional senior management team (SMT) meetings. It was suggested was that general managers may wish to develop an enabling framework for a corporate approach/agenda for SMT meetings to encourage appropriate and standardised coverage of performance, quality, financial and personnel issues. The intention would be to have a comparable level of information sharing across divisions, with the opportunity for senior staff to grow and develop their understanding of, and contribution to, the business of the division as well as their own particular function. It was agreed to take this through the Senior Leadership Forum due to take place in the new year. **DP/KB**

Performance Report

18/11/4 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 and exception reports.

18/11/5 It was noted that following a meeting between the Committee Chair, Non-Executive Directors (NEDs) and the Director of Finance (DoF) a new approach to monitoring Trust performance had been agreed. The DoF shared with the Committee his outline of a new presentation of performance data that would build trend analysis into the At-a-glance table and share an independent commentary in relation to potential areas of concern to be explored, supported by context and mitigating action provided by the relevant business areas. This would also provide the basis for a shortened and condensed Board summary, rather than the current position, where the Board received as much performance data as the F&P Committee. The new performance report would be brought to the December 2018 meeting and the condensed Board report would be available in January 2019.

18/11/6 Performance over the past month had been again broadly sound. The Committee had input from Deputy Chief Operating Officer, Claire Jenkinson, Lead Cancer Nurse Stacey Nutt and Medicine General Manager Lesley Hammond.

18/11/7 4hr Access - There was an in depth discussion around 4 hour access and tactics to sustain and improve performance to enable the March 2019 target of 95% to be met. Key points included:

- System Perfect and Patient Engagement – System Perfect had gone well and there had been significant engagement with patients and members of the public with over 100,000 views of online videos and over 2500 responses to a survey.
- Check in screens would be in place by 1st December
- Joint work with IM&T was ongoing to track all patients coming though ED to reduce waiting times, especially those sent to X-ray
- Winter pressures - Lessons learnt from last winter were outlined.
- Holding to account – The Trust compared performance to other Trusts on a daily basis.
- Regular meetings were being held to discussed streaming and look at conversion rates.

18/11/8 RTT - There was a similarly searching conversation around RTT and linkages to delivering contract commitments/income, including the Committee requesting further assurances on trajectories and delivery plans to achieve both the RTT & contract requirements. It was noted that the Trust position was 88.5% in October, an improvement against the previous month. The DBTH contract for 2018/19 expected the Trust to maintain the March 2018 position of 89.1% and the waiting list size to be lower than it was at the end of March 2018. Plans were being developed with individual specialities but progress to

get back on track had been slower than expected.

18/11/9 Weekly meetings were being held with specialities to review plans and the Deputy COO provided an update on progress and where they were in terms of maturity; this was mixed with some being very good and others just starting to develop. Work was ongoing with the finance team to look at RTT trajectories from a finance perspective. Kath Smart shared her observations from the Divisional meeting she had attended on how the RTT data had been used and the DoF enquired about confidence levels at divisional level that overall plans would deliver the both contract and RTT. This was discussed in detail; whilst some specialities had responded to say they could achieve plan others were not clear how the plans would be achieved. Examples were given of the information being shared at divisional and speciality level to support teams with RTT delivery. The DoF emphasised the importance of divisions and specialities understanding the linkages to delivering contract commitments and income; he would pick this up at accountability meetings. Following further detailed discussion it was agreed to bring a deep dive on RTT and linkages to delivering contract commitments/income, including further assurances on trajectories and delivery plans to achieve both the RTT & contract. **DP**

18/11/10 Stroke – NEDs noted that whilst remaining above the target, stroke performance had declined over the previous 3 months; this was discussed and it was agreed to provide an update in next report. The Chair noted that this highlighted the need for trend data to be included in the performance report. **DP**

18/11/11 Cancer – 62 Day performance. Key issues remained around breaches predominantly due the shared care pathways, complex diagnostic pathways or patient choice. Stacey Nutt shared feedback from a recent meeting with NHSI about the 62 day target; They had been pleased with progress and had welcomed the introduction of the one-stop prostate clinic; one patient who had attended the clinic had a total cancer pathway of only 9 days and this was commended.

18/11/12 Cancer – 2 week wait performance – Although the September position for two week wait had improved in month to 91.1%, moving from 87.1% last month, this was not compliant with the national target of 93%. In response to a query from Kath Smart examples of what would be classed as an administrative delay were provided. This would include where the Trust had made 3 attempts to contact a patient by telephone without success. Work was ongoing with CCGs to ensure GPs explained to patients the reasons for a 2 week wait referral and being clearer that this was due to suspected cancer.

The Performance Report was DISCUSSED and NOTED.

Deep Dive Capital

18/11/13 The Committee received a deep dive presentation from Just Fowler, Senior Management Accountant, in relation to the progress of the 2018/19 capital plan. The presentation, which was included in the papers, outlined the current position, contingency, sources of funding, governance, forecast and risks.

18/11/14 Current position – The capital plan had been reprioritised in August 2018 and signed off by the Board. A detailed analysis of the original and revised plan were provided. The forecast capital spend for 2018/19 was £13.3m, this included the internal plan of £9.1m and £4.2m for the joint CT/HASU scheme. Year to date performance against the revised plan was £1m behind plan. Details of progress on individual plans were provided including reasons for slippage and expected timeframes and these were discussed. The position regarding the CT/HASU plan was shared; the plan had been locally signed off by NHS Improvement (NHSI), approval from the DoH was now awaited and the DoF gave details of the issues. The Trust continued with enabling work to ensure it was ready as

soon as the plan was signed off.

18/11/15 £1m of contingency was built into the plan. £479k of this had been allocated to schemes through the Corporate Investment Group (CIG) business case process; details of schemes were provided. £521k was still to be allocated; this was currently under review. A table listing sources of funding, including explanations, was included in the papers.

18/11/16 Governance – The Trust had reinstated the Capital Monitoring Committee and set up 3 Capital sub-groups; Estates Capital Group, Medical Equipment Capital Group and IT Capital Group. The CIG process that incorporated capital and business cases had been refreshed and the budget setting process for capital had been revised. A flow chart illustrated how all groups and committees linked in to the capital approval process. The Committee asked how well the new Divisions were linked in to those groups and this was discussed; it was noted that all Executive Director and Divisional Directors sat on CIG.

18/11/17 Risks – Key risks included the risk of capital funds not being utilised; Capital spend was £1m (29%) behind plan at month 7 and further slippage in the Estates schemes, due to access to departments for example, could result in significant underspends in year and, or a pre-commitment of spend to be funded in 2019/2020. In response to a query from the Chair about areas for concern the DoF advised that at this stage good assurance was being received on ability to achieve plans and slippage was being closely monitored.

The Deep Dive on Capital was NOTED.

Finance Report

18/11/18 The Director of Finance presented to the Committee a paper which summarised performance for month 7. In month performance was a surplus of £45k, which was an adverse variance against plan in month of £1.4m. The cumulative position to the end of month 7 was an £11.9m deficit, which is £1.4m adverse to plan. The in month financial position was c.£360k worse than forecast (realistic case). 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.

18/11/19 The report was discussed in detail. The Committee noted that although monthly financial performance showed income exceeding expenditure for the second month, the Trust had expected a far greater surplus against forecast in month and confidence levels that the Trust could achieve the control total was now not as strong. The DoF outlined key issues:

18/11/20 Income – In-month income was favourable to plan but this was mainly due to non-clinical income; the DoF provided details of what this was made up of. However, the YTD income position at the end of Month 7 was £2.8m adverse to plan. The key issue was NHS Clinical Income £558k behind plan in month and £3.4m adverse YTD. This was discussed in detail. The Committee noted that Commissioners were now starting to accept that the Trust's plans, rather than their commissioned levels, were a more realistic reflection of the level of demand. Although delivering more than commissioned levels the Trust was not delivering the elective and day case work it had planned and upon which financial forecast were based. The DoF gave details of discussions at Divisional Meetings; Robust plans were required from Divisions to maximise income that delivered in line with plan for elective and outpatients. These plans had yet to be shared and validated and elective work continued to underachieve. Areas of concern were discussed and the Committee scrutinised, line by line, the table which showed clinical income performance for October compared to the Trust's plan by point of delivery and there was a lengthy discussion about how RTT plans were linked to the financial plans, how the Trust was ensuring divisions understood exactly what was expected, how performance was being monitored

and what escalation processes were in place.

18/11/21 CCGs – The Committee considered the table which showed the CCG position against the Trust's plan and contract position agreed with the CCGs. This excluded any impact of Non PbR Drugs which was shown separately. The Committee noted that the YTD variance for Doncaster CCG was £1m adverse to the Trust's plan. The Trust had shared plans and trajectories to achive the NHSI waiting list target for March 2019 and the DoF provided an update on discussions with the CCG about how this would be achieved.

18/11/22 Pay – Pay was £966k adverse to budget in Month 7. The YTD position is £2,301k adverse to budget. The key variances were set out in the report. There had been a reduction in agency spend and there had been good progress in terms of recruiting doctors. There had been a total of 86 new starters in October, which was offset by 54 leavers, meaning a net increase of 32 starters compared to a net increase of 15 staff in September. Work continued to better understand how sickness absence was being managed in some areas.

18/11/23 Non pay expenditure was £384k higher than plan in month and £1,068k above plan to date. The DoF gave details of the main areas of overspend. The Committee asked for assurance that Divisions were suitably focused on both pay and non-pay budgets and this was discussed; the DoF provided details of the escalation process and discussions with Divisions.

18/11/24 CIP – Whilst work continued to close the financial gap, delivery of CIPs remained a significant risk. Within this there was also a risk in relation to delivery of the WOS CIP (£3m) due to the current pause in the process as a result of the NHSI national consultation. It was currently assumed in the 'realistic' forecast position that either the CIP relating to the WOS would be delivered or that the control total will be amended for this. The DoF provided details of the current position regarding the WOS including an update on discussions with NHSI. The monthly CIP target continued to rise in subsequent months, particularly in quarter 4, so it was vital that existing schemes remain on course and that new ones came on stream as planned. The Committee reviewed variances for each work stream line by line and considered the variance analysis, mitigations, areas of concern and overall status of work-up of several work streams in detail including; strategic change, divisional local schemes, theatre scheduling, block contract negotiations, outpatient cap, bed plan / length of stay and the clinical admin review.

18/11/25 The report included a rag rated diagram of work streams based on value and complexity. The DoF shared details of key issues and clarified those schemes that were not expected to deliver in year.

18/11/26 The Committee noted that rear loaded plans tended to mean key delivery times would coincide with winter pressures; as a consequence, the Trust needed to ensure well developed plans early in the year. An objective assessment of the likely out-turn of schemes had been undertaken with c.£11.976m deemed achievable (this being the 'green' 'amber' schemes). This left c. £5.849m of high risk 'red' schemes that needed urgent attention if to be part of the 2018/19 CIP Programme and support delivery of the Trust's year end control total. The Committee asked for assurance around the process for making changes to schemes and this was discussed; all changes should be taken through the PMO and Efficiency & Effectiveness Committee (EEC). It was noted that Divisional Directors had now been invited to attend the EEC

18/11/27 Winter pressures – The Committee noted that the previous year use of winter pressures monies had helped with closing the financial gap. This year divisional leads needed clarity around their winter pressures budgets and the Trust must avoid thinking of it as a contingency or mitigation for any struggling schemes. Winter pressures monies could

only be spend once and must not be counted twice.

18/11/28 The Finance report was DISCUSSED and the Committee NOTED the following:

- The Trust's surplus for month 7 (October 2018) was £45k, which is an adverse variance against plan in month of £1.4m. The cumulative position to the end of month 7 is a £11.9m deficit, which is £1.4m adverse to plan and c. £360k adverse to forecast (realistic case).
- The progress in closing the gap on the Cost Improvement Programme.
- The forecast scenarios presented including the risks set out in this paper.

Corporate Risk Register and BAF Highlights

18/11/29 The Corporate Governance Officer 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 previous meeting. 3 risks had seen changes to their ratings following review by executives and these were shown on page 1 of the covering report.

The Corporate Risk Register and BAF Highlights were NOTED.

Workforce Report

18/11/30 The Director of People & Organisational Development presented the report which provided data in relation to months 6 & 7 including vacancy levels, agency spend and usage, sickness rates, rostering data, appraisals and SET. The vacancy rate in month 7 was 6.41% against a target of 5%; when taking into account the use of temporary staff the vacancy rate was 1.81%, although this varied by staff group. Sickness rates had seen a further reduction in month 6 to 3.97% and to 4.15% cumulatively; this was briefly discussed in the context of previous discussions about confidence levels in the reported sickness absence for medical and dental staff; this was being picked up at accountability meetings and it was noted that the committee was to receive an update on this in the future. The Committee noted that although agency spend was above target there had been an in-month improvement and there was a brief discussion about the how the Trust was ensuring the most efficient use of agency staff.

The Workforce Report was DISCUSSED and NOTED.

Catering Contract Performance

18/11/31 Further to concerns raised by Governors the Committee had requested regular updates on progress to complete the agreed remedial plan and improvement in the quality of the outsourced catering service. This was the second update to be received; it provided information on progress to comply with a formal contractual performance warning notice issued by the Trust in August 2018 and an update on actions that had been completed. Due to a prior commitment, the Director of Facilities and Estates had been unable to attend the meeting present the report; a further update was requested for the next meeting. **KEJ**

The Catering Contract Performance report was NOTED.

Sub-committee Minutes

18/11/32 The minutes of the Cash Committee meeting held on 2 October 2018 and the minutes of

the Workforce & Education Committee meeting held on 17 September 2018 were NOTED.

Items for Information

18/11/33 **Strategy Updates -** The Committee NOTED progress in relation to the Estates Strategy and IM&T Strategy. The papers were considered as information papers owing to the need to give time to financial items on the agenda and the fact they had recently been reviewed, with a full presentation at Management Board. The Committee discussed the tracking of strategies and the best use of organisational time. The Chair noted the multiple occasions on which the same presentation was being received by various committees and internal boards without change. A suggestion was made that to avoid multiple presentations and free committee time the Trust might consider a single Strategy Progress Workshop, where all strategy progress would be reported with detailed scrutiny being undertaken at individual, responsible executive level. **MP/Exec Team**

18/11/34 **Brexit Preparations** - The Committee NOTED the report of the Emergency Planning Manager relating to the Brexit Plan which had recently been considered by Management Board. Work has commenced to identify the impacts which may affect the Trust, in order that arrangements may be put in place to prepare for the consequences of differing scenarios (including a no deal outcome). The report provides information on the Trust's approach. The Committee were reassured that contingency planning was taking place along with continual monitoring of the developing situation.

Minutes of the meeting held on 20 August 2018

18/11/35 The minutes of the meeting held on 20 September 2018 were APPROVED as a correct record.

Work plan

18/11/36 The Work Plan was NOTED.

Items for escalation to the Board of Directors

18/11/37 None.

Closing Remarks

18/11/38 There was a brief discussion about the recommendations of the Internal Audit (IA) Committee Effectives Review which had been shared with the Chairs of F&P, QEC and ARC. A meeting was being planned to take place the following week with IA, the Chair of the Board and the Chairs of the Board Committees the following week to consider the recommendations. It was expected the report would be brought to the next meeting.

Time and date of next meeting:

Date: 17 December 2018
Time: 9:00am
Venue: Boardroom, DRI

Signed: …….. **……**

Neil Rhodes **Date**

DONCASTER & BASSETLAW TEACHING HOSPITALS NHS FOUNDATION TRUST

Minutes of the Finance & Performance Committee
held at 9:00am Friday 17 December 2018
in the Boardroom, DRI

PRESENT	:	Neil Rhodes, Non-Executive Director (Chair) Pat Drake, Non-executive Director Kath Smart, Non-Executive Director Jon Sargeant, Director of Finance Karen Barnard, Director of People & Organisational Development David Purdue, Deputy Chief Executive & Chief Operating Officer
ALSO IN ATTENDANCE:		Alex Crickmare, Deputy Director of Finance Gareth Jones, Trust Board Secretary Kate Sullivan, Corporate Governance Officer Emma Challans, Deputy Chief Operating Officer (part) Amy Tucker, Stroke Nurse Specialist (part) Alice Waweru, Matron (part) Dr Kirsty Edmondson Jones, Director of Facilities & Estates (Part)
OBSERVERS	:	Bev Marshall, Governor Observer
APOLOGIES	:	Simon Marsh, Chief Information Officer

Action

Agenda Review

18/12/1 The agenda was reviewed. Pat Drake picked up a point picked raised through the Internal Audit Committee Effectiveness Review around the level of discussion about risk and this was briefly discussed. The matter was reflected on later in the meeting during discussion around what the Committee would like to see on report cover sheets and the following was agreed:

ACTION - Ensure report cover sheets clearly set out:

- The purpose of paper
- What was being asked of F&P
- Links to BAF Risks and to verbally note this at the start of each report.

18/12/2 The Chair welcomed Gareth Jones, the new Trust Board Secretary to his first meeting and on behalf of the Committee he thanked Kate Sullivan for her work to support the Committee prior to Gareth's appointment.

Apologies for Absence

18/12/3 Apologies as recorded above were noted; Kath Smart would arrive at 9:30am.

Action Notes from Previous Meeting

18/12/4 The Action notes were reviewed and updated.

Pat Drake requested and update on winter plans, including financial plans; this would be covered under the performance report.

Referral to Treatment (RTT) Recovery Plan

18/12/5 The Committee received a detailed update from the Deputy Chief Executive & Chief Operating Officer on the waiting list position and RTT position, by speciality, at month 8 (November 2018). The Referral to Treatment Target, for active waiters below 18 weeks was set at 92%. The Trust's contract for 2018/19 expected the Trust to maintain the March 2018 position of 89.1% and the waiting list size to be lower than it was at the end of March 2018. The Trusts position was 88.5% in October, an improvement against last month. The report also showed the actual versus contract position and the percentage increase/decrease in referrals during Month 8. The overall waiting list position at Month 7 (October 2018) was 1208 more patients that at 31 March 2018.

18/12/6 The Committee were updated on the key areas of concern; Oral Surgery, Trauma & Orthopaedics and GI. Updates were provided on actions taken / plans in place and work at speciality level. The Committee explored the report in depth and discussed in detail reasons for increases in referrals, referral patterns, fluctuations in referrals and how the Trust was ensuring capacity to deal with this. An update was also provided on discussions with commissioners about funding where referrals had been higher that contract levels.

18/12/7 *Kath Smart entered the meeting.*

The Committee asked for assurance that actions plans would deliver the waiting list target for 31 March 2019, RTT, contract and delivery of the financial plan and the Chief Operating Officer gave a detailed update on actions plans and mitigations focussing on those areas rated 'Red'. The committee considered recent levels of emergency admissions and the impact of this on the Trusts ability to deliver RTT. There was a brief discussion about the outsourcing of work to the private sector to support RTT and how those referrals would be managed. The committee considered the financial implications of this and of any additional staffing required to deliver RTT plans; the Chief Operating Officer gave assurance that the Trust was working to deliver as much of the plan as possible within job plans, however there would be some additional staffing required. This led to discussion about vacancy management; Following visits to the Intensive Care Unit (ICU) by committee members there was a discussion about perceived challenges to securing replacement staff through the vacancy management process. The Committee were reassured that this was largely a matter of poor communication which the three executive members present undertook to address.

18/12/8 Overall the Committee drew reassurance from the plans shared. In the context of the NHSI letter which had set out expectations in terms of waiting list/ RTT performance to be achieved by 31 March 2019 the Committee considered how it would receive assurance going forward that plans were being monitored and that performance was going in the right direction and this was discussed.

DP

ACTION - RTT Recovery Plan (& linkages to delivery of financial plan) - Provide monthly update on red areas to include more granular information/update on progress to achieve action plans.

18/12/9 The Referral to Treatment (RTT) Recovery Plan was discussed and NOTED.

Stroke

18/12/10 Emma Challans, Deputy Chief Operating Officer supported by Amy Tucker, Stroke Nurse Specialist and Alice Waweru, Matron, presented an overview of the management of stroke patients. The presentation (included in the papers) provided an overview of the Trust's Stroke Performance, changes over the last 4 years to achieve this, further actions

identified that were being clinically driven and developments aligned to the introduction the ICS Hyper Acute Stroke Unit (HASU) model.

18/12/11 A regional performance table was included which compared the Trusts performance to other Trusts in the Yorkshire & Humber region against a range of stroke metrics; overall the Trust's performance compared well with no 'red' rated areas. The Committee received detailed performance updates, including issues identified and actions/mitigations in place, on admission to a stroke unit within 4 hrs, patients given Thrombolysis within 1 hr, patients discharged and provided with a named contact person and TIA Patients Assessed and Treated within 24 Hours *(high risk patients)*. Further actions were noted including monthly Stroke Operational meetings, a new Stroke Consultant to lead on Stroke Performance (SNNAP). The Committee explored and discussed the presentation in depth and were impressed by the quality and dedication of the staff. They shared a candid appreciation of the challenges in running a high performing service. The Committee felt they now had a better appreciation of the KPIs and especially the importance of the one hour thrombolysis measure.

18/12/12 In particular the Committee shared with senior colleagues concerns about the ring fencing of beds for stroke patients and the differential service the Trust's communities received from the ambulance service, depending upon which provider transported them.

ACTION – The Committee asked the Chief Operating Officer to raise with executive officers the leverage that could be applied to ensure a speedier ambulance transfer of patients, who had initially self-presented at Bassetlaw, through to DRI **DP**

18/12/13 The Stroke Performance Update was discussed and NOTED

Performance Report

18/12/14 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 and exception reports.

18/12/15 The 2 Week Wait (2ww) Cancer standard had been achieved in October for the first time in a long time and this was commended. Confidence levels were high that this could be maintained; the key factor to achieving the target was patient choice and the Trust would continue to work with Primary Care to influence this without causing undue distress to patients. In relation to the Emergency Department (ED) four hour wait standard; 92.9% was achieved in November 2018 against a 95% target, slightly better than the previous month and both better than the 87.6% national average and significantly better than the 85.8% peer average.

18/12/16 The Committee explored the report in detail and there was a wide ranging discussion about, amongst other things, 52 week waits, the new One-Stop Prostate Clinic, cancer performance across the region / ICS, 4hr access performance by site and winter plans. The committee reflected on what it would like to see from the new Integrated Performance Report to be received in January 2019 and a detailed update was CQC visit for which a detailed update was provided. Performance, on the whole, was reassuring, subject to the concerns explored in depth around RTT. In the context of comparison with peers and national averages many areas showed strength even if the Trust was not achieving the performance levels it aspired to.

18/12/17 The Performance Report was DISCUSSED and NOTED.

Workforce Report

18/12/18 The Committee considered the report which provided data in relation to month 8 including vacancy levels, agency spend and usage, sickness rates, and rostering data.

18/12/19 Vacancy levels in medical and dental, especially 'middle grade doctors', continued to be challenge this was being addressed. However, good results were shared in relation to the recruitment of nursing staff. In terms of staff retention, the Trust was gaining a better understanding of the reasons for staff leaving and returning with initial focus was on areas with the worst retention rates.

18/12/20 Although agency levels remained above year to date budget, the Committee was pleased to note a significant in-month reduction. The paper also showed the Trusts agency spend compared to Model Hospital benchmarks for the region against which the Trust compared positively.

18/12/21 Sickness rates had seen a rise in month 8 but there had been a further reduction in long term absence (over 4 weeks) to the lowest rate this financial year reflecting work to support staff to return to work more quickly. The committee discussed work to ensure a consistent approach to sickness management and noted that work was underway with the communications team to look at constructive messaging to staff about the impact of absence.

18/12/22 The Committee noted the key risks set out in the report relating to agency staffing and vacancy levels; overall the Committee felt assured that appropriate actions were being taken and that the assessment of the level of risk was appropriate. It was noted that a new report on the recruitment and retention strategy would be presented in the new year and the committee considered any further information that may be useful and whether there were any areas that may require some Internal Audit (IA) time in 2019/20 and this was discussed; The Committee requested further development of the useful at-a-glance table to enable ready year to date comparisons in relation to agency spend and sickness. The Director of People and Organisational Development also agreed to look at how to better compare current vacancy levels with those in earlier periods. The Committee commended the report and recognised the significant work that had gone in to developing it over recent months.

18/12/23 The Workforce Report was NOTED.

Catering Contract performance Update

18/12/24 The Director of Estates presented a detailed report on progress to improve the quality and timeliness of patient meals. The improved Patient Satisfaction Surveys and reduced Datix reports gave some assurance that the service was beginning to stabilise following the implementation of remedial actions by Sodexo. Work was ongoing to assess and embed improved systems and processes in order to achieve full compliance against contractual Service Levels and Key Performance Indicators prior to the formal Contractual Performance Warning Notice being withdrawn by the Trust. Sodexo were also progressing the recruitment process for a new on-site Contract Manager. It was noted that the query raised by Pat Drake relating to specialised diets had been covered in the previous report to the committee and the Chief Operating Officer reported that there had been no recent issues raised about this by Matrons. A detailed update on progress against the action plan was provided including an overview of work underway on outhanding actions. Assurance was provided that the Director of Nursing, Midwifery & Allied Health Professionals had communicated to staff the importance of logging issues on Datix and a simplified process had been introduced. The Chief Operating Officer was

able to confirm an improvement in service from his perspective. The Committee noted the progress made so far and welcomed direction of travel.

18/12/25 The committee discussed in detail the belt service model; they asked whether the Trust was assured about the long-term sustainability of this model and whether it was the right solution for the Trust and this was discussed in detail.

ACTION - The committee wished to better understand the process; the Director of Estates and Facilities would host a walk-through for the Chair, possibly to be accompanied by a governor. This would enable the patient meal to be tracked from order receipt, through assembly, to ward service. A date would be arranged. **KEJ**

18/12/26 The Catering Contract performance Update was NOTED.

Finance Report

18/12/27 The Committee received the report of the Director of Finance which set out the Financial Position at Month 8 (November 2018) which was a surplus of £295k, a small adverse variance against plan of £86k; however, this was a favourable variance against forecast (realistic case) of £779k in month. The Committee noted a cumulative position to the end of month 8 of an £11.6m deficit, which was £1.5m adverse to plan, but £811k favourable against forecast. 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. The papers included a further report which set out the process for changing the Trust's forecast year end position, should the Trust wish to do so. If a Trust wished to change the in year forecast position there was an NHS Improvement protocol that must be followed. A summary of the guidance for this was set out in the paper and this was noted. An update on the forecast position of the Trust was provided in the finance paper. A paper on the Annual Plan and Budget Setting would be brought to the next meeting. **JS**

18/12/28 A detailed analysis of all areas of financial performance were set out in the paper and the DoF took the Committee through the key risks, mitigations and actions which were discussed in detail. The Committee heard with approval that the Trust could meet PSF thresholds for Quarter 3 and this was welcomed. Clinical income against expectations was strong, largely due to improvement in a number of areas; there was still some concern that activity may not deliver on income but the position had improved and work continued with the Chief Operating Officer and Divisions to monitor this. In November 2018, CIP savings of £737k (£954k the previous month) were reported, against a forecast of £894k, therefore a shortfall of £157k in month. The cash position was slightly behind plan for first time in year; mainly due receipt of Q4 STF funds and delayed capital expenditure. Here had been some slippage on capital; The main reasons for the slippage were set out in the paper and an overview of planned mitigations was provided. In response to queries from Pat Drake and Kath Smart there was a detailed discussion about the assessment of the level of risk relating to slippage on capital plans in terms of, amongst other things, risks relating to back-log maintenance.

ACTION – It was agreed to review risks on risk registers to ensure risk ratings were appropriate. **GJ/JS/KEJ**

18/12/29 The Trusts focus was on realising year end delivery of the control total and the Director of Finance shared the detail underpinning the scenario projections of worst, realistic and best-case outturns for the year end. A Table on page 24 of the report showed that the gap to the control total before mitigations ranged from £10.4m in the realistic case, to £0.6m in the best case, to £13m in the worst case. After applying mitigations of £3.3m

the gap to control total improves to £7.1m in the realistic case (£4.7m best case, 12.5m worse case). In addition to the challenging position In terms of the development and delivery of Cost Improvement Plans (CIP) for the financial year there were two key issues to be dealt with; An accounting issue from previous years meant the depreciation of certain assets, which should have taken place in those years but did not, now needed to be reflected in the accounts. Although largely a technical adjustment, if held against the control total for just one year it could mean an adverse movement of circa £3.9m. The second issue was around inability to now realise savings of circa £3.2m by delivering a wholly owned subsidiary this year, owing to NHS Improvement requirements that were beyond the control of the Trust. The 'realistic' case scenario, which the Trust progressed towards, suggested the Trust could possibly absorb one but not both of these issues and still meet the control total; executive colleagues continued to work to resolve these matters and the DoF provided a detailed update on both issues.

18/12/30 External Agency costs were £8.8m for the first 8 months of the year which was £1.5m higher than the Trust's agency cap. Agency spend in November was c.£160k lower than October 18 with varying performance across divisons; The most significant variances were in the C&F and Medical Divisions. Most of this was driven by medical agency spend which was being reviewed with each of the services through the re-introduction of grip and control (G&C) meetings. The Committee heard that divisons were using different approaches to agency usage; compliance was being monitored through the G&C meetings.

18/12/31 *David Purdue left the meeting.*

18/12/32 The committee considered the infographic on Page 18 of the report which illustrated the CIP year end forecast showing the overall rag rating of each scheme by value and complexity. At the request of the Chair an update was provided on progress with the clinical admin review, theatres and medical productivity work streams. The Committee shared concern about the length of time taken to progress some of the work steams and this was discussed. There was a brief discussion about outline plans and potential efficiencies for 2019/20; it was crucial the new Divisional Directors were driving these schemes forward from the start.

18/12/33 The next quarter's delivery would be critical and winter pressures would add an additional layer of challenge. The Committee were reassured that winter pressures monies had now been clearly allocated to divisions and plans were in place.

18/12/34 The Committee NOTED:

- The Trust's surplus for month 8 (November 2018) was £295k, which is an adverse variance against plan in month of £86k. The cumulative position to the end of month 8 is a £11.6m deficit, which is £1.5m adverse to plan and c.£811k favourable to forecast (realistic case).
- The progress in closing the gap on the Cost Improvement Programme.
- The forecast scenarios presented including the risks set out in this paper.

The Committee is asked to support the change in forecast position at Month 9 which would show a gap to control total (before PSF) of £7.1m and noted that the Trust would continue to review and look for mitigations to improve this position.

2019/20 Budget Setting

18/12/35 The Committee received the report of the Deputy DoF which outlined the 2019/20 Financial Planning Framework including the principals, process and timeline for budget setting and capital plans. Planning guidance was expected to be received shortly; the

Deputy DoF gave a brief overview of the expected timeline. Ultimately budgets would be set within the final agreed plan and the budget setting process would be undertaken in a fair, equitable and transparent manner across the organisation. Budgets, cost pressures, developments and CIPs would be presented back to Management Board and Trust Executives for review and challenge before being recommended to F&P and Board for approval. He gave details of discussions with Divisional Directors and work planned to ensure plans triangulated to workforce activity.

18/12/36 The 2019/20 Budget Setting Report was NOTED

Corporate Risk Register and BAF Highlights

18/12/37 The Committee received and NOTED the Corporate Risk Register and BAF Highlights. The relevant risks had been considered actively with each paper received at the meeting.

Committee Effectiveness Review

18/12/38 The report would be brought forward to January 2019. **GJ**

The Committee Effectiveness Review was NOTED

Sub-committee Minutes

18/12/39 The minutes of the Cash Committee meeting held on 16 November Workforce & Education Committee Terms of Reference (ToRs) were NOTED.

Minutes of the meeting held on 23 November 2018

18/12/40 The minutes of the meeting held on 23 November 2018 were APPROVED as a correct record. The Chair proposed to move to a more condensed format for the minutes that focussed on actions and this was agreed.

Work plan

18/12/41 The Work Plan was NOTED.

Items for escalation to the Board of Directors

18/12/42 None.

Time and date of next meeting:

Date: 17 December 2018
Time: 9:00am
Venue: Boardroom, DRI

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

How are we doing? An overview

Key performance report: December 2018 (October data)

	A&E (95%)	RTT (92%)	Diagnostics 6 weeks	2ww (93%)	2ww breast (93%)	31 day (96%)	62 day (85%)	EIP (50%)	IAPT Access 4.75% Q4)	IAPT Recovery (50%)
South Yorkshire and Bassetlaw	91.3	92.3	0.4	94.3	93.6	95.5	76.8	80.7	4.8	52.3
Greater Manchester	●	●	●	●	●	●	●	●	●	●
Bucks, Oxfordshire and Berkshire West	●	●	●	●	●	●	●	●	●	●
Frimley Health	●	●	●	●	●	●	●	●	●	●
Dorset	●	●	●	●	●	●	●	●	●	●
Nottinghamshire	●	●	●	●	●	●	●	●	●	●
Blackpool & Fyde - Lancashire and S.Cumbria	●	●	●	●	●	●	●	●	●	●
Milton Keynes, Bedfordshire & Luton	●	●	●	●	●	●	●	●	●	●
Gloucestershire	●	●	●	●	●	●	●	●	●	●
Suffolk and NE Essex	●	●	●	●	●	●	●	●	●	●

The ICS financial position is reporting a year to date favourable variance against plan of £3.6m excluding PSF; all organisations are currently forecasting break even against plan before PSF.

How are we doing? An overview

Key performance report: December 2018 (October data)

	A&E (95%)	RTT (92%)	Diagnostics 6 weeks	2ww (93%)	2ww breast (93%)	31 day (96%)	62 day (85%)	EIP (50%)	IAPT Access 4.75% Q4)	IAPT Recovery (50%)
South Yorkshire and Bassetlaw	91.3	92.3	0.4	94.3	93.6	95.5	76.8	80.7	4.8	52.3
Greater Manchester										
Cheshire and Merseyside										
Cumbria and North East										
Humber, Coast and Vale										
Lancashire and South Cumbria										
West Yorkshire										

The ICS financial position is reporting a year to date favourable variance against plan of £3.6m excluding PSF; all organisations are currently forecasting break even against plan before PSF.

Board of Directors Agenda Calendar

STANDING ITEMS			OTHER / AD HOC ITEMS
MONTHLY	**QUARTERLY**	**BIANNUAL / ANNUAL**	
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	Report from the Chair of the ANCR committee (Verbal)	Budget Setting / Business Planning / Draft Annual Plan	Presentation – Data Security Protection (Presentation Slot P1 – Roy Underwood)
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		

As at 24 January 2019

	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			
SEPTEMBER 2019			
CE Report		Winter Plan	
Performance Report		EPPR	
MB Minutes		Annual Compliance against the National Core Standards for Emergency Preparedness, Resilience and Response (EPRR)	
Finance & Performance Minutes			
Finance Report			
Chairs' Assurance Logs			
OCTOBER 2019			
CE Report	ANCR minutes	Charitable Funds minutes	
Performance Report	Executive Team's Objectives		
MB Minutes			
Finance & Performance Minutes			

Finance Report			
Chairs' Assurance Logs			
NOVEMBER 2019			
CE Report	Board Assurance Framework & corporate risk register Q2		P&OD Update
Performance Report			Brexit Preparations
MB Minutes			
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JANUARY 2020			
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	
MB Minutes	Complaints, Compliments, Concerns and Comments Report		
Finance & Performance Minutes	QEC minutes		
Finance Report	Estates Quarterly Performance		
Chairs' Assurance Logs			

Minutes of the meeting of the Board of Directors
Held on Tuesday 18 December 2018
In the Fred and Ann Green Boardroom, Montagu Hospital

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 (part)
	Sewa Singh	Medical Director
	Kath Smart	Non-executive Director
In attendance:	Marie Purdue	Director of Strategy and Transformation
	Adam Tingle	Acting Head of Communications and Engagement
	Gareth Jones	Trust Board Secretary
	Liz Staveley Churton	Governor
	Peter Abell	Governor
	Clive Tattley	Governor
	Emma Shaheen	Head of Communications and Engagement (Observing)

ACTION

Welcome and apologies for absence

18/12/1 All directors were present. The Chair welcomed Emma Shaheen, Head of Communications and Engagement who is currently Maternity leave and was attending BOD as part of keeping in touch prior to returning to finishing maternity leave in March 2019.

Declarations of Interest

18/12/2 No interests were declared in the business of the public session of the meeting.

Actions from the previous minutes

18/12/3 The list of actions from previous meetings was noted and updated.

Presentation slot – Implementation of the Strategy Qii

18/12/4 The Board considered a presentation from Marie Purdue, Director of Strategy and Transformation.

18/12/5 The presentation outlined the key areas of work being led by the Strategy and Transformation Team with particular updates on Qii, trauma and orthopaedics, improvement plans and timelines, PLACE transformation

and business planning for Divisions in 2019.

18/12/6 In response to a question from Karen Barnard regarding staff experience and listening events, the Chief Executive provided feedback of a Trust in Leeds that had moved into the top 10% of staff survey satisfaction results following their Qii programme, having previously been one of the lowest scoring Trusts due to a lack staff involvement and feedback. It was acknowledged that there are major benefits of including staff in change processes and they are key to how we improve the quality, and drive the strategic direction of the Trust.

18/12/7 In response to a question from Pat Drake regarding the development of a MDT pathway document for complex fractured neck of femur, and stability of joint working moving forward, the Board was advised that a single record was being considered and a standard operating procedure for streamlining the pathway is currently in development by the Accountable Care Partnership. However, it is critical that staff lead the development of solutions.

18/12/8 In response to a question from Kath Smart about theatre opportunities and their alignment to the CIP plans, the Board was advised that these were pending implementation from April 2019.

18/12/9 In response to a question from Linn Phipps about encouraging all staff, including senior clinicians to be involved in the Qii project, the Medical Director informed the Board that a Qii session had been held on clinical governance and risk management, which had received good feedback and ideas from staff.

18/12/10 Mr Sewa Singh provided comment around ensuring the financial balance of the Trust whilst embedding Qii. Mr Singh said he is assured Qii will deliver sustainability but acknowledged it will take time to see the changes.

18/12/11 Richard Parker asked the Board to consider the use of wording when talking about cost improvement programmes (CIP) with a view to moving towards the terminology of reducing waste, as staff often feel less motivated by financial definitions.

18/12/12 The Chair of the Board reminded the committee of the importance of the Qii journey and improvements to the quality of patient experience and the financial sustainability of the Trust.

18/12/13 The Board NOTED the presentation.

Finance Report as at 30 November 2018

18/12/14 The Board considered a report by the Director of Finance that set out the Trust's financial position at month 8 as a cumulative £11.6m deficit, which is £1.5m adverse to plan, but £811k favourable against forecast.

18/12/15 The Trust needs to achieve a £6.6m deficit to deliver the year-end control total, and therefore needs to achieve a better than break-even position each month for the rest of the year.

18/12/16 Jon Sargeant advised the Board of the notification received from NHSi on a new set of rules on how Board should move forward on wholly owned subsidiaries This also sets out a new role for NHS Improvement. The Board were advised of the potential delay of 9 to 12 weeks that this process would add.

18/12/17 The Board was advised that following consideration and external advise a business case could not be presented for BOD review in 2018/ 19 and as a result the £3m saving has been removed from this years forecast. The Board will be asked to consider a decision on further progress with the plans for a wholly owned subsidiary in the new financial year 2019/20.

18/12/18 As reported via the Finance and Performance Committee on 17th December, the Trust will have a deficit of £10.4m in the quarter end return. Jon Sargeant therefore proposed that the Trust submits its forecast to NHS Improvement concluding that the Trust will not meet its control total this year. The Board will be required to complete a self-assurance form looking at its mitigations on the control total as well as its obligations to inform stakeholders.

18/12/19 The expected realistic deficit would be £7.1m, however, with mitigations in place this figure could be reduced to £4.5m with the gap relating to the £3m deficit from the wholly owned subsidiary.

18/12/20 Jon Sargeant reported a strong financial performance in terms of PSF with a positive variance of £295k in month. The Board received assurance that delivery of Q3 PSF could be expected if the Trust remains on plan.

18/12/21 Jon Sargeant reported that the capital plans were behind target but provided assurance that contingencies of £0.5m are in place.

18/12/22 In response to a question from Alan Chan about privately contracted work affecting the operating expenditure position, the Board was informed that no funding is being lost, or made, by the contracting out of procedures and all are being managed by the Trust.

18/12/23 In response to a question from Sheena McDonnell around the delay in estates spend, the Board was advised that the works had been designed and amended to ensure that the capital funding is fully utilised.

18/12/24 The Board was advised that the Finance and Performance Committee supports the Director of Finance and his team assessment on the delivery of the financial plans, accounts and depreciation, and in expressing the Trusts frustration to NHS Improvement around the impact of the new arrangements around wholly own subsidiaries on the Trusts financial

plans.

18/12/25 The Board NOTED:

(1) The Trust's surplus for month 8 (November 2018 was £295k, with which the adverse variance against plan in month was £86k. The cumulative position at the end of month 8 is a £11.6m deficit, which is £1.5m adverse to plan and c. £811k favourable to forecast (realistic case).

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

(3) The forecast scenarios presented, including the risks set out in the paper.

The Board SUPPORTED the change in forecast position at Month 9 which will show a gap to control total (before PSF) of £7.1m and NOTED that the Trust will continue to review and look for mitigations to improve its position.

Performance Report as at 30 November 2018

18/12/26 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 Develop that set out the operational and workforce performance in month 8, 2018/19.

18/12/27 Performance against key metrics included:

- RTT – The Trust achieved below target at 87.9%.
- Diagnostic wait is 99.51% against the standard of 99.5%
- 2 week waits – The Trust achieved 93.2% and was compliant with the national target of 93%.
- 4 Hour Access Target – The Trust achieved 92.9% against national standard of 95% but with better performance than 2017.
- Cancer targets – The 62 day performance achieved 83.0%, slipping against last month's reporting of 84.7%.
- HSMR – The Trust's rolling 12 month returned better than expected at 94.2.
- Appraisals – The Trust's appraisal completion remained at 78.85% however further reporting indicates the rates have improved to 80.65%

- SET Training - The Trust's SET training rate increased slightly to 81.7% at the end of November following the reduction recorded last month.

- Sickness Absence – The year to date figure has increased slightly at 4.29%

18/12/28 The Chief Operating Officer reported positively that the Trusts one stop prostate clinic had commenced with an average wait time of 11 days.

18/12/29 There was a brief discussion around laser and robotic surgery that had been undertaken at other Trusts, acknowledging that partners in Sheffield have made a request for a second surgical robot. The Chief Executive suggested that Board might wish to consider if a future conversation is needed around robotic surgery being an option for investment at Doncaster and Bassetlaw Hospitals. The Board agreed.

18/12/30 Considering the recent changes in opening times for Primary Care, Karen Barnard asked if the Trust expected to see a change in Emergency Department attendance. In response, the Board was advised the General Practice extended hours are for routine appointments so there would be no recognised different in accident and emergency attendances.

18/12/31 Following a concern raised at the Quality and Effectiveness Committee, Sheena McDonnell highlighted that medical staff appraisal data is not currently recorded on ESR. The Board was assured that this gap had been identified and rectified in more recent system updates. The Board was assured the Quality and Effectiveness Committee will receive feedback on progress.

18/12/32 Kath Smart expressed her concern over the recent Administration Review and sought clarification of when this would be finalised. David Purdue confirmed the Administration Review will finalise on 07th January 2019 and gave his apologies to the Board and administrative colleagues. The Chief Operating Officer confirmed an article to be shared in BUZZ.

18/12/33 Following a detailed conversation around recruitment, retention, education and training the Chair requested for Quality and Effectiveness Committee to do a deep dive on the trajectory of workforce over the next 5 years, identifying potential gaps, training and placement opportunities and succession planning.

18/12/34 Board NOTED the report.

People and Organisational Development Update – Staff Survey Action Plan

18/12/35 The Board considered a report of the Director of People and Organisational Development that provided Board with an update on

progress made against the Trust staff survey action plan and the results of the most recent Family and Friends Test.

18/12/36 Karen Barnard reported that staff recommendations as a place to have care or treatment remained static at 76%. Staff recommendation as a place to work had seen a small negative change from 59% to 58% and highlighted there had been a downward trend over the last 3 years from 2015 – 16 when the response rate was reported in the mid to high 70's.

18/12/37 The most recent staff survey reported very positively with 85% of staff indicating they had had an appraisal within the 2018/19 appraisal season. 22% of staff had reported that their appraisal helped them improve how they did their job.

18/12/38 The Director of People and Organisation Developed highlighted that 84% of respondents stated that the organisation took positive action on health and wellbeing. Furthermore, access to high quality training and education were also a positive theme.

18/12/39 The Chair of the Board reflected on the results of the staff survey from the previous year and expressed her disappointment that there had not been much of an increase in staff satisfaction despite enhancements in communication via BUZZ, the Trust website, Foundations for Health, and increased media releases in local newspapers. The Chair suggested that a review in the Trust's methodology of capturing staff feedback to be undertaken.

18/12/40 In response to the Chair, members of the Board provided suggestions on how we can improve staff communications and seek good practice, providing ideas such as smaller good news stories publicised on a regular basis and feedback to be given more often by the use of compliment and thank you postcards for personal staff achievements.

18/12/41 The Chief Executive Listening Events had seen low attendance in recent weeks and therefore a suggestion had been made for Senior Management Team to go to the Care Divisions to meet the staff.

18/12/42 Early initial indication of the staff survey results shows an increased response rate in the number of completed surveys although this is to be confirmed. The results from the full staff survey, which will be released in February 2019, will be compared to last year's results and triangulated with the Staff Family and Friends Test. Further results can be shared with Board in April 2019.

18/12/43 The Board NOTED the report.

Workforce Report

18/12/44 The Board considered a report of the Director of People and Organisational Development that listed the current position of key vacancies at the Trust.

18/12/45 There is an overall vacancy rate of 6.9% across the Trust with Nursing and Midwifery at 4.6%, Allied Health Professionals / Scientific and professions at 4% and medical staff at 13.8%.

18/12/46 The paper provided Board with an update on current plans for international recruitment and in addition provided an update on nursing vacancies, discussions with HEI's and the cohort of Trainee Nurse Associates who commenced their training this month.

18/12/47 The Board NOTED the content of the report and CONFIRMED they would require ongoing assurance that work is being undertaken by the Trust to reduce vacancy levels, reduce agency expenditure and improve their turnover and retention rates and that appropriate monitoring is in place.

Chairs Assurance Logs for Board Committee held 17 December 2018

18/12/48 The Board considered a report of the Chairs of Finance and Performance Committee and the Quality and Effectiveness Committee following their meetings on 17 December 2018.

18/12/49 The Finance and Performance Committee had undertaken deep dives into the management of Stroke patients and received a presentation from Emma Challans supported by Matron Alice Waweru and Senior Nurse Amy Tucker on the overview of the management of stroke patients.

18/12/50 The Finance and Performance Committee reviewed action plans to improve Referral to Treatment performance, received an overview of progress with Sodexo in improving the quality and timeliness of patient meals, considered risks to the organisation and discussed the overall wider financial picture and financial gap noting the challenges for the Trust.

18/12/51 The Quality and Effectiveness Committee reviewed the Communications and Engagement Strategy, Patient Experience and Engagement Strategy and the Quality Improvement and Innovation Strategy for assurance on progress against milestones and discussed the recommendations highlighted from the Committee Effectiveness Review undertaken by KMPG. Two Divisional Directors had observed QEC.

18/12/52 The Quality and Effectiveness Committee reviewed incidents and risks paying particular attention to two new risks identified as a result of the recent unannounced CQC inspection.

18/12/53 The CQC risks identified on the Board Assurance Framework:

(1) Following an unannounced CQC inspection involving the commissioned Front Door Assessment Service it has been identified that the initial triage and clinical assessment processes, clinical oversight of the waiting area, the full assessment of unwell children

and adults may not be providing high quality care consistently, which could potentially cause harm to patients.

(2) Risk of insufficient workforce 24/7 providing care for unwell children, as indicated in the revised standards for Registered Childrens Nurses (RCN) developed by the RCPCH, expanding on previous Royal College of Nursing guidance, which could lead to patient harm.

18/12/54 The Committee also identified and discussed the top five clinical risks identified by Divisions. The Board asked the Committee to ensure that risks are based on the Risk Management Matrix and escalated to Board level if deemed damage may arise to the organisation or individual as a result. It was agreed that these risks should be managed at QEC level prior to escalation to Board.

18/12/55 In response to the Medical Records risk identified by Divisions and discussed as part of the top 5 clinical risks, Mr Sewa Singh confirmed the risk related to the newly implemented records tracking system and not administration staffing within the department. David Purdue advised there has been no administrative vacancy freeze in medical records and all VCF's had been approved with band 2 vacancies out to advert. Linn Phipps to agree wording of the risk with David Purdue to ensure accuracy of the risk captured within the Quality and Effectiveness Chairs Log.

18/12/56 The Board NOTED the updates.

Leadership and Organisational Development Framework

18/12/57 The Board considered a report of the Director of People and Organisational Development that set out the framework of Leadership and Organisational development to support Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust's vision to be the safest Trust in England and Outstanding in all we do.

18/12/58 The Framework has been developed through conversation and engagement with leaders across the Trust and considered by the Executive Team and Management Board.

18/12/59 The Framework provides focus to 4 key components; Develop our Leaders, Support our Teams, Value our People and Create a Coaching Culture. A prospectus to support the framework is being finalised for the programmes for 2019.

18/12/60 The Board recognised the importance of ensuring more work is undertaken in respect of Leadership Development, particularly for our Black, Minority and Ethnic (BME) workforce and suggested the option of BME reverse mentoring.

18/12/61 The Board APPROVED the Framework.

CQC Inspection Update

18/12/62 The Chief Executive reminded Board Members of a previous discussion at the time of the last Board of Directors Meeting of the notification of an unannounced visit by the CQC with regard to services provided at DBTH.

18/12/63 Richard Parker reported that the unannounced visit took place over three days, 27 to 29 November 2018 inclusive and had a primary focus on the Emergency Department and the paediatric services within the ED department. Richard Parker provided the Board with an overview of the Framework by which the CQC assesses organisations rated as in need of improvement.

18/12/64 CQC highlighted a number of concerns within the Emergency Department including the front door assessment service / triage service, paediatric care and ambulance handovers times. The Chief Executive reported that a CQC action plan was underway overseen by the Clinical Governance Committee and QEC.

18/12/65 The Chief Executive had received a letter from the CQC making him aware of the concerns and that a failure to robustly address these, within allocated timeframes, could lead to CQC escalating their concerns through the regulatory framework. The Trusts action plans were provided to the CQC within the two-day timeframe.

18/12/66 Richard Parker reported of an immediate decision by the Trust to change the triage system. A decision had also been made to enhance the processes by which the Trust ensures that a minimum of one RGN Children's Nurse is on duty in ED at all times.

18/12/67 Richard provided confirmation to the Board that initial indications are that the CQC are satisfied that the Trust has taken appropriate initial actions. The full plan must now be delivered within the agreed timeframes.

18/12/68 It was noted that the Front Door Assessment Service was a CCG commissioned model. The Chair noted that there had been differences of opinion on the merits of the model. Richard provided assurance that feedback had been given on the positive benefits of the FDAS model and that the aim would be to build on the positives to improve.

18/12/69 It was raised that improvement should be sought of the communication process with the CQC Relationship Managers assigned to the Trust to ensure that any concerns are identified before inspection visits so that they can be considered and appropriately addressed. Should the Trust have been informed on any ongoing concerns with ED then these would have been changed in a timely manner.

18/12/70 Following a comment raised by Karen Barnard around staff involvement, Moira Hardy reported that it was recognised that staff feedback data needed to be collected during any change process to further support with shaping systems going forward. A survey monkey questionnaire to request baseline data to judge the changes in ED triage to be developed.

18/12/71 Pat Drake gave her appreciation to the Executive Team for their timely response and delivery of dealing with the CQC inspection and feedback.

18/12/72 The Board NOTED the update.

Reports for Information

18/12/73 The following items were NOTED:

- Chair and NEDS' report
- Chief Executive's report

Items to Note

18/12/74 The following item was NOTED:

- Board of Directors Agenda Calendar

Minutes

18/12/75 The minutes of the meeting of the Board of Directors on 27 November 2018 were APPROVED as a correct record.

Any other business

18/12/76 There were no items of other business raised.

Governors questions regarding business of the meeting

18/12/77 Referring to the workforce update, Peter Abell felt assured that the Trust had focused on some of the key issues and provided his congratulations to the Board for the work that had taken place. Peter provided a good news story in relation to producing leaders at the Trust on ward CCU C2.

18/12/78 Peter requested assurance from the Board that the workforce development and five-year plan linked with the baseline of the Carter Report. Peter was advised that the Trust had access to the Model Hospital Portal where comparison with other Trusts is made and can be undertaken at a national or local level. High bank and agency expenditure was noted but consideration needs to be given to comparison with multi-site Trusts. It is the Trusts ambition to move towards a directly appointed workforce to improve productivity and efficiency through reduction in bank and agency expenditure, particularly at consultant level.

18/12/79 Peter also thanked the Board for their transparency and openness with regard to the CQC visit.

Date and time of next meeting

18/12/80 10.00am on Tuesday 29 January 2019 in the Boardroom, Doncaster Royal Infirmary.

Exclusion of Press and Public

18/12/81 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