Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

The meeting of the Board of Directors

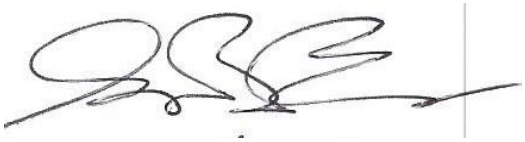
To be held on Tuesday, 30 April 2019 at 9:15am in the Boardroom, Doncaster Royal Infirmary

AGENDA
Part I

		Enclosures	Time
1.	Apologies for absence	(Verbal)	9:15am
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.	National End of Life Care Audit 2018 Karen Lanaghan – End of Life Care Coordinator	Presentation	9:20am
	Reports for Decision		
5.	Use of Trust Seal Richard Parker – Chief Executive Gareth Jones – Trust Board Secretary	Enclosure B	9:40am
	Reports for assurance		
6.	Finance Report as at 31 March 2019 Jon Sargeant – Director of Finance	Enclosure C	9:45am
7.	Thematic People and Organisational Development Report Karen Barnard – Director of People and Organisational Development	Enclosure D	10:00am
8.	Performance Report – 31 March 2019 Led by David Purdue – Chief Operating Officer	Enclosure E	10:15am
9.	Board Assurance Framework & Corporate Risk Register Quarterly Update - Q4 Gareth Jones – Trust Board Secretary	Enclosure F	10:35am
	BREAK		**10:45am**

10.	Chairs Assurance Logs for Board Committee held 23 April 2019 and 24 April 2019 Neil Rhodes – Chair of Finance and Performance Committee Linn Phipps – Chair of Quality and Effectiveness Committee	Enclosure G (QEC *to follow)*	11:00am
11.	Pressure Ulcers - Revised definition and measurement Moira Hardy – Director of Nursing, Midwifery & Allied Health Professionals	Enclosure H	11:10am
12.	Executive Team Objectives Richard Parker – Chief Executive	Enclosure I	11:25am
	Reports for information		
13.	Chair and NEDs' Report Suzy Brain England – Chair	Enclosure J (*to follow*)	11:35am
14.	Chief Executive's Report Richard Parker –Chief Executive	Enclosure K	
15.	Minutes of the Management Board, 11 March 2019 Richard Parker – Chief Executive	Enclosure L	
16.	Minutes of the Finance and Performance Committee, 22 March 2019 Neil Rhodes – Chair of Finance and Performance Committee	Enclosure M	
17.	Minutes of the Quality and Effectiveness Committee, 20 February 2019 Linn Phipps – Chair of Quality and Effectiveness Committee	Enclosure N	
18.	Board of Directors Agenda Calendar Gareth Jones – Trust Board Secretary	Enclosure O	11:45am
Minutes			
19.	To approve the minutes of the previous meeting held on 26 March 2019	Enclosure P	11:50am
20.	**Any other business (to be agreed with the Chair prior to the meeting)**		
21.	**Governor questions regarding the business of the meeting**		
22.	**Date and time of next meeting** Date: 21 May 2019 Time: 09:15 Venue: Boardroom, Bassetlaw District Hospital		11:55am
23.	**Withdrawal of Press and Public** Board to resolve: That representatives of the press and other members of the public be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which		

would be prejudicial to the public interest.



Suzy Brain England
Chair of the Board

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Action Notes

Meeting: Board of Directors

Date of meeting: 26 March 2019

Location: Boardroom, DRI

Attendees: SBE, RP, KB, AC, CS, SMc, LP, PD DP, JS, SS, KSm, MP, ES, KSu

Apologies: NR, MH, GJ

No.	Minute No	Action	Responsibility	Target Date	Update
1.	**19/1/12**	Nicole Chavaudra of Bassetlaw CCG to be invited to present an update on Bassetlaw Place Plan in six months.	**GJ**	**July 2019**	On Board Calendar – no yet due.
2.	**19/1/65**	Each committee chair to refresh their TOR in terms of Health and Safety responsibilities and provide a recommendation to Board on how to proceed going forward.	**KS, LP, NR**	**May 2019**	A paper to be shared via the Trust Board Secretary and Director of Estates and Facilities at the Executive Team on behalf of the Chairs of the Sub-Committees.
3.	**19/1/66**	Environmental Issues workshop or seminar for Board on Capital Programmes and Environmental impacts to be arranged.	**KEJ / GJ**	**Date to be arranged.**	To be undertaken following Board of Directors Meeting – date TBC.

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

No.	Minute No	Action	Responsibility	Target Date	Update
4.	**19/1/82**	Hospital cancellation rate – figures rather than percentages of cancellations to be included in the performance report.	**DP**	**~~March~~ April 2019**	To be included for next reporting.
5.	**19/2/9**	A deep dive of staff mandatory training requirements and compliance for Information Governance to be undertaken and provided to members of the Board by email.	**SM**	**March 2019**	
6.	**19/2/12**	IT issues workshop for Board on the decommissioning of faxes, reduced written letter correspondence and improved use of email.	**SM**	**Date to be arranged.**	
7.	**19/2/54**	A deep dive of the quality report detailing care hours per day to be undertaken at QEC.	**MH / LP**	**~~May~~ June 2019**	
8.	**19/3/11**	Ensure Standing Financial Instructions, Standing Orders and Scheme of Delegation made gender neutral.	**JS/GJ**	**March 2019**	

Doncaster and Bassetlaw Teaching Hospitals
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No.	Minute No	Action	Responsibility	Target Date	Update
9.	**19/3/21**	Set Aspiration to sign up to the living wage and discuss this at ISC/PLACE level	**KB**	**July 2019**	
10.	**19/3/29**	Complaints resolution – Consider capturing the level of complaints upheld	**CS**	**May 2019**	
11.	**19/3/32**	SET – Meeting to be convened to consider what learning could be taken from other organisations in respect of SET compliance rates.	**KB/KSm/SMc**	**May 2019**	
12.	**19/3/42**	Mock CQC Inspections – Share schedule of inspections with NEDs.	**CS**	**April 2019**	COMPLETED

Date of next meeting: 30 April 2019
Action notes prepared by: K Sullivan
Circulation: SBE, RP, KB, MH, DP, JS, SS, MP, CS, SM

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Title	**Use of Trust Seal**		
Report to:	**Board of Directors**	Date:	**30 April 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
106	Lease of part of land at Doncaster Royal Infirmary, Bassetlaw Hospital, and Montagu Hospital sites between DBTH and Saba Park Services UK Limited	Richard Parker Chief Executive	3 April 2019
		Jon Sargeant Director of Finance	
107	Contract for security, car parking, smoking enforcement, and capital investment between DBTH and Saba Park Services UK Limited.	Jon Sargeant Director of Finance	3 April 2019
		David Purdue Deputy Chief Executive	
108	Contract for the provision of services relating to Tier 3 Adults Weight Management Service between Doncaster Council and DBTH.	Richard Parker Chief Executive	24 April 2019
		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	**Financial Performance – Month 12 - March 2019**		
Report to	**Trust Board**	**Date**	**30th April 2019**
Author	**Jon Sargeant - Director of Finance**		
Purpose			Tick one as appropriate
	Decision		
	Assurance		
	Information		X

Executive summary containing key messages and issues
The draft year-end financial position reported in this paper shows that the Trust has delivered its control total for 2018/19, with a £23k favourable variance. Please note this position is subject to review by external audit, the agreement of balances process and prior to bonus PSF funding which has now been notified by NHSi to be £10.7m. Including the additional PSF funding, the Trust has delivered a surplus financial position. The Trust's key remaining risk entering Month 12 was the delivery of the WL recovery plan, which attracts incentive payments of c.£2.4m. £2.1m of this amount has been recognised in the M12 financial position from DCCG, however the £0.3m due from Bassetlaw has not been included in the position. This is due to Bassetlaw setting out in correspondence to the Trust that the WL position has not been achieved for them, in order for the Trust to receive this incentive payment. Discussions are ongoing the Bassetlaw CCG as the year end waiting list position is validated.
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 draft year-end financial position shows that the Trust has delivered its control total for 2018/19, with a £23k favourable variance (before additional PSF of £10.7m). This position is subject to review by audit.
- The Trust's deficit for month 12 (March 2019) was £1.1m, which is an adverse variance against plan of £1.4m before PSF. This is however a favourable variance against forecast of £2.7m in month. The cumulative position to the end of month 12 is an £22.8m deficit before PSF, which is £23k favourable to plan and £3.9m favourable to forecast before and after PSF. Including PSF the Trust delivered a surplus of £4.6m in Month 12, reflecting that the full quarter of PSF has been accounted for in M12 due to the Trust achieving the Control Total and delivering A&E performance.
- The achievement with regards to the Cost Improvement Programme.

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

FINANCIAL PERFORMANCE

P12 March 2019

DONCASTER AND BASSETLAW TEACHING HOSPITALS NHS FOUNDATION TRUST

P12 March 2019

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	964	1,269 A	(2,851) F	22,926	(212) F	(3,955) F	23,138
Income	(36,903)	(4,976) F	(4,232) F	(386,488)	(10,712) F	(3,526) F	(375,776)
Donated Asset Income	140	163 A	161 A	(96)	189 A	165 A	(285)
Operating Expenditure	34,013	3,528 A	1,755 A	393,176	7,878 A	228 A	385,298
Pay	22,416	444 A	540 A	264,026	3,991 A	(365) F	260,034
Non Pay & Reserves	11,597	3,084 A	1,215 A	129,151	3,887 A	593 A	125,264
Financing costs	3,853	2,717 A	(374) F	16,238	2,622 A	(657) F	
I&E Performancee excluding PSF	**1,103**	**1,432 A**	**(2,690) F**	**22,830**	**(23) F**	**(3,791) F**	**22,853**
PSF (previously STF)	(5,683)	(3,788) F	(3,788) A	(16,238)	0 A	0 A	(16,238)
I&E Performance including PSF	**(4,579)**	**(2,356) F**	**(6,478) F**	**6,592**	**(23) F**	**(3,791) 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	235	360 A	499 A	2,561	2,281 A	459 A	4841
Drugs	134	(75) F	(98) F	725	(25) F	(25) F	700
Clinical Supplies	58	3 A	47 A	484	100 A	375 A	584
Non Clinical Supplies	0	0 A	0 A	0	0 A	0 A	0
Non Pay Operating Expenses	203	2,085 A	923 A	2,795	6,993 A	2,766 A	9787
Income	543	(313) F	(356) F	5,576	(3,663) F	(3,725) F	1913
Total	**1,173**	**2,060 A**	**1,014 A**	12,140	**5,685 A**	**(150) F**	**17,825**

3. Statement of Financial Position

All figures £m	Opening Balance	Current Balance	Movement in year
Non Current Assets	**209,108**	**205,230**	**3,878**
Current Assets	49,291	51,264	-1,973
Current Liabilities	-54,834	-95,054	40,220
Non Current liabilities	-81,105	-44,680	-36,425
Total Assets Employed	**122,460**	**116,760**	**5,700**
Total Tax Payers Equity	**-122,460**	**-116,760**	**-5,700**

4. Other

Performance Indicator	Monthly Performance		YTD Performance		Annual
	Plan £'000	Actual £'000	Plan £'000	Actual £'000	Plan £'000
Cash Balance	1,900	19,740	1,900	19,740	1,900
Capital Expenditure	1,505	5,350	13,911	11,074	13,911

5. Workforce

	Funded WTE	Actual WTE	Bank WTE	Agency WTE	Total in Post WTE
Current Month	5955.11	5443.51	256.52	102.81	5802.84
Previous Month	5922.46	5564.90	220.37	107.11	5892.38
Movement	-32.65	121.39	-36.15	4.30	89.54

Key

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

Note: Position reported above is before bonus £10.7m PSF notified by NHSi.

1. Executive Summary

The draft year-end financial position reported above shows that the Trust has delivered its control total for 2018/19, with a £23k favourable variance. Please note this position is subject to review by external audit, the agreement of balances process and prior to bonus PSF funding which has now been notified by NHSi to be £10.7m. Including the additional PSF funding, the Trust has delivered a surplus financial position.

The Trust's deficit for month 12 (March 2019) was £1.1m (before PSF), which is an adverse variance against plan of £1.4m. This is however a favourable variance against forecast of £2.7m in month. The cumulative position to the end of month 12 is an £22.8m deficit before PSF, which is £23k favourable to plan and £3.8m favourable to forecast before and after PSF. Including PSF the Trust delivered a surplus of £4.6m in Month 12, reflecting that the full quarter of PSF (£5.7m) has been accounted for in M12 due to the Trust achieving the Control Total.

The Trust's key remaining risk entering Month 12 was the delivery of the WL recovery plan, which attracts incentive payments of c.£2.4m. £2.1m of this amount has been recognised in the M12 financial position from DCCG, however the £0.3m due from Bassetlaw has not been included in the position. This is due to Bassetlaw setting out in correspondence to the Trust that the WL position has not been achieved for them, in order for the Trust to receive this incentive payment. Discussions are ongoing the Bassetlaw CCG as the year end waiting list position is validated.

The prior period adjustment for depreciation (c.£2.7m) has been recognised in the Month 12 position as expected per previous reports to the Committee.

The YTD income position at the end of month 12 is £10,712k favourable to plan and £3,526k favourable to forecast. The in-month income position is £8,765k favourable to plan (including PSF) and £8,021k favourable to forecast (£3,526k favourable to forecast YTD). The income position includes c.£3.7m of additional non-recurrent funding from Doncaster CCG, £2.1m waiting list incentive funding from Doncaster CCG, c.£1.8m of ICS funding, £0.4m additional block money from Bassetlaw CCG and includes PSF funding for the whole year.

The favourable income movement in month against plan is due to over-performance in clinical income by £3,935k (excluding PSF adjustment) and over-performance on non-clinical of £1,041k. The reasons for the clinical income movement against plan is due to £311k (which is 1/12th of the non-recurrent monies received from Doncaster CCG for winter/block contracts), £69k additional block payment from Bassetlaw CCG, £2.1m waiting list incentive funding from Doncaster, activity based income improvements of c.£100k, achievement of 100% CQUIN's (£388k improvement against plan), £500k reversal of coding risk at Month 11 and £338k of additional non-recurrent income has been received in month 12 which includes funding for cancer pilot schemes, diabetes etc.

Non NHS Clinical Income and Other Income is (£1,041k) ahead of plan in month 12 and (£4,072k) YTD, and against forecast there is an in month over-performance of (£594k). The over-performance relates mainly to Education Income Streams, RTA income and Recharges with a corresponding increase in expenditure in month.

Doncaster CCG has a favorable YTD variance against the Trust's plan of £3,626k (favorable variance against contract of £3,814k) and Bassetlaw CCG has a favorable income variance of (£2,943k) against the Trust's plan (£3,547k favorable against contract), both excluding the impact of Non PbR drugs.

Income Group	Annual Budget	In Month Budget	In Month Actual	In Month Variance		YTD Budget	YTD Actual	YTD Variance	
Commissioner Income	-312,434	-26,634	-31,119	-4,485	F	-312,434	-322,446	-10,012	F
Drugs	-24,187	-2,021	-1,471	550	A	-24,187	-20,815	3,372	A
PSF	-16,238	-1,894	-5,683	-3,788	F	-16,238	-16,238	0	F
Trading Income	-39,155	-3,271	-4,312	-1,041	F	-39,155	-43,227	-4,072	F
Grand Total	**-392,014**	**-33,820**	**-42,585**	**-8,765**	**F**	**-392,014**	**-402,726**	**-10,712**	**F**

Income Group	In Month Actual	In Month Forecast	In Month Variance		YTD Actual	YTD Forecast	YTD Variance	
Commissioner Income	-31,119	-27,308	-3,811	F	-322,446	-319,528	-2,918	F
Drugs	-1,471	-1,804	333	A	-20,815	-21,653	838	A
PSF	-5,683	-1,894	-3,789	F	-16,238	-16,238	0	F
Trading Income	-4,312	-3,559	-753	F	-43,227	-41,781	-1,446	F
Grand Total	**-42,585**	**-34,565**	**-8,021**	**F**	**-402,726**	**-399,200**	**-3,526**	**F**

In month the expenditure position was £1.8m adverse to forecast, of which pay was £540k adverse to forecast and non-pay £1.9m adverse to forecast. The YTD expenditure position at the end of Month 12 is £7.9m adverse to plan, £228k adverse to forecast (with pay £365k favourable to forecast and non-pay £1.4m adverse to forecast). Non-PbR drugs were significantly lower than planned levels (c.£2.8m 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	21,972	22,416	444	A	21,875	540	A	260,034	264,026	3,991	A	264,391	-365	F	260,034	259,654
2. Non-Pay	10,302	12,855	2,553	A	10,912	1,939	A	124,166	129,645	5,479	A	128,216	1,424	A	124,166	122,157
3. Reserves	-1,788	-1,258	530	A	-533	-725	F	1,098	-494	-1,592	F	337	-831	F	1,098	2,073
Total Expenditure Position	**30,485**	**34,013**	**3,528**	**A**	**32,255**	**1,755**	**A**	**385,298**	**393,176**	**7,878**	**A**	**392,944**	**228**	**A**	**385,298**	**383,884**

Capital expenditure YTD is £11,074k against the YTD plan of £13,911k, £2,837k behind plan (£1,070k above plan excluding CT/HASU). YTD actuals against the revised plan are £1,011k above plan. The main reason for the over spend against revised plan relates to additional capital spend in month 12 relating the Digital Transformation £900k. The digital transformation scheme was funded through the drawdown of additional PDC in month as agreed with NHSi.

The cash balance at the end of March was £19.7m against a plan of £1.9m. The main movements include; the receipt of 18/19 Q4 PSF funds (£2m more than anticipated), delayed capital expenditure (£2.8m), receipt of Q3 PSF twice (£4.9m to be repaid in April 2019) and additional income from local CCG's. In month, the cash position has increased by £7.1m, mainly due to the additional income received from local CCG's.

In March 2019, savings of £1,173k (last month £1,222k) are reported, against a forecast of £2,187k, therefore an under achievement of £1,014k in month. The underachievement is due to phasing of the planned WOS Q4 scheme versus the actual delivery of the Block Contract scheme. The yearend position is an overachievement against M7 forecast of £150k.

2. Conclusion

The draft year-end financial position shows that the Trust has delivered its control total for 2018/19, with a £23k favourable variance (before additional PSF funding). Please note this position is subject to review by audit.

3. Recommendations

The Board is asked to note:

- The draft year-end financial position shows that the Trust has delivered its control total for 2018/19, with a £23k favourable variance (before additional PSF of £10.7m). This position is subject to review by audit.
- The Trust's deficit for month 12 (March 2019) was £1.1m, which is an adverse variance against plan of £1.4m before PSF. This is however a favourable variance against forecast of £2.7m in month. The cumulative

position to the end of month 12 is an £22.8m deficit before PSF, which is £23k favourable to plan and £3.9m favourable to forecast before and after PSF. Including PSF the Trust delivered a surplus of £4.6m in Month 12, reflecting that the full quarter of PSF has been accounted for in M12 due to the Trust achieving the Control Total and delivering A&E performance.

- The achievement with regards to the Cost Improvement Programme.

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Title	NHS Workforce Implementation Plan and local update		
Report to	Board of Directors	**Date**	April 2019
Author	Karen Barnard, Director of People & OD		
Purpose			Tick one as appropriate
	Decision		
	Assurance		x
	Information		x

Executive summary containing key messages and issues

In late January 2019 Baroness Dido Harding was asked to lead the development of the NHS Workforce Implementation Plan – Julian Hartley, CEO Leeds Teaching Hospitals, was seconded to the programme of work as Senior Responsible Officer until April 2019 when the interim plan was expected to be published (with the final plan due to be published after the autumn comprehensive spending review). In April 2019 Prerana Issar commenced as NHS Chief People Officer and has picked up the lead role for continuing this programme of work. The Long Term Plan recognised that the NHS can only achieve its outcomes if there is sufficient staff with the right skills and that they are given adequate support to work effectively. In a letter from Dido and Julian to Trusts there was a clear statement:

> *'To deliver 21st century care for our patients, we will need a transformed workforce – engaged, motivated and supported; with compassionate and inclusive leadership and working in positive cultures; with sufficient nursing staff and the right number of staff across all disciplines and all regions. We know that we don't simply need more of the same, but also a new skill mix which is more responsive to local patient and population needs. Finally, these actions will need to be delivered through a new workforce operating model where the right activities are done at the right level, whether this is employers, Integrated Care Systems (ICSs), regional or national bodies.*'

Within the letter five themes were described together with potential actions for 2019/20 – these themes are described below together with work we as a Trust are already auctioning/involved in:

Theme 1: **We can make a significant difference to our ability to recruit and retain staff by making the NHS a better place to work.**

Potential actions for 2019/20:

- Consultation on a new deal with staff, building on the NHS Constitution, setting out what they can expect from the NHS as a world-class and modern employer
- Associated campaign to engage all our people; framework to support Boards on how to engage

with their people; good practice case studies of employers that are at the vanguard on this agenda

- Further action to improve health and wellbeing, including implementing the recommendations from the recently published *NHS staff and learners' mental wellbeing commission*
- Next steps on tackling violence and aggression, and bullying and harassment
- Embedding the Workforce Race Equality Standard and consulting on Workforce Disability Standard
- Expanding the NHS Improvement retention programme to all trusts and developing an equivalent program for Primary Care
- Streamlining induction and training processes, and passporting training and qualifications across different employers and settings
- Review of the impact of pensions policy on retention and options to resolve.

Local work underway:

- Reinforcement of our values within appraisal discussions and leadership development programmes
- Platinum award for health and wellbeing; review of support available to staff who are experiencing stress, anxiety, depression; review of manual handling training and support to staff to reduce incidences of MSK absence
- Continued participation in NHSI's Retention programme (see appendix for the driver diagram and planned actions) –specific focus on retaining newly qualified nurses and midwives. In addition collaborative work in relation to values based recruitment and exit interviews
- Agreed passporting of SET training in place across the ICS which removes the requirement for all SET training to be undertaken upon commencement with the Trust
- Re-launch of the staff lottery and the bidding process to access the fund, generated through the lottery, the purpose of which is to "Enhance the health and wellbeing of staff members through improved environment, opportunities and services". Bids are expected to detail how they fit the following criteria:
  - Staff Health and Wellbeing
  - Staff Engagement
  - Staff Satisfaction
  - Teamwork
  - The working environment
  - Recognition.
- Whilst the Trust benchmarks favourably in relation to safe working – bullying/harassment within the staff survey there are still improvements to be made – by reinforcing our Trust values within our appraisal system and within our leadership programmes we seek to reduce any incidences of bullying and harassment.

<u>Theme 2:</u> **If our workforce plan is to succeed we must start by making real changes to improve the leadership culture in the NHS.**

Potential actions for 2019/20:

- Review of the support provided to challenged organisations by NHSI/E to ensure it reflects the inclusive and compassionate leadership we know delivers
  - Develop a consistent, whole system approach for identifying, assessing, developing, deploying and supporting our talent to include:
  - rolling out regional talent boards

- resources to support development of system leadership skills
- consulting on common job descriptions, competency, values and behaviour frameworks for board level roles and other recommendations from recent reports by Tom Kark QC and Sir Ron Kerr
- reviewing investment in talent management programs for all our staff

- Co-production of new 'leadership compact' between NHS Improvement/NHS England and Chief Executive Officers/Accountable Officers and Chairs which will set out the, values, behaviours and competencies expected of senior leaders, and the support and development those senior leaders should expect in return
- Review of the national oversight frameworks to ensure they are reflecting the inclusive and compassionate leadership we know delivers, specifically the Care Quality Commission/NHS Improvement well-led framework, NHS Improvement Single Oversight Framework and NHS England Improvement and Assessment Framework to enable measurement of culture, leadership, inclusion and organisational health.

Local work underway:

- Team Doncaster has commissioned OD leads to develop a programme in relation to systems working
- Hosted networks across the ICS will lead to the development of common job descriptions and competences being developed for specialities within those networks
- Shadow Board programme recently launched during 2019/20
- Develop Belong Here leadership development programme in place; further bespoke programmes being developed, eg Band 6 therapists
- Masterclass season for the leadership community in place accessing key note speakers
- Leading to Outstanding programme being developed for divisional leadership team
- Re-launch of coaching support from within the Trust.

<u>Theme 3:</u> **Although there are workforce shortages in a number of professions, disciplines and regions, the biggest single challenge we currently face nationally is in the nursing and midwifery profession.**

Potential actions for 2019/20:

- 5,000 expansion of clinical placements for impact September 2019 intake
- New annual campaign and targeted approaches to school leavers, in particular 15 to 17-year olds (linked to volunteering and work experience programmes to maximise opportunities for exposure to health careers)
- Review of current Return to Practice processes to determine whether these can make a further contribution to increasing supply
- Details of the job guarantee offer, and an approach to preceptorship and early career support as part of an expanded retention programme.

Local work underway:

- Review of the Trust's ability to increase clinical placements – piloting placement expansion across South Yorkshire in line with our partnership with Lincoln University and BPP; formal introduction of LEM (Learning Environment Manager) role on wards to support learners of all professions
- Continue to ensure the Trust receives excellent feedback regarding our learner experience
- Widening Participation framework in place – links with Hall Cross Academy, Doncaster UTC and Doncaster College. New discussions taking place with Retford Oaks in Bassetlaw. Two events run

in 2019 (Bassetlaw and Doncaster Hospitals) to share the breadth of healthcare professions to year 8 students and adults. Planned careers event at Doncaster Dome during 2019 which we are leading. Work experience framework in place

- Review of midwifery preceptorship undertaken following the commencement of the current Head of Midwifery.
- Through NHSI's retention programme the Trust will introduce a structured approach to career progression for nursing staff. Through the collaborative element of this programme we will also explore how Trusts can work together in order to offer nurses a breadth of opportunities.
- Whilst the focus above has been on nursing staff within the Trust we have recognised that we must also focus on our specialty doctors (SAS doctors) as we have a number of gaps – we are committed to implementing the SAS charter which includes expectations around job planning, development (such as access to CESR programme), access to facilities and organisational involvement such as specialty business meetings.

Theme 4: **To deliver on the vision of 21st century care set out in the LTP will not simply require 'more of the same' but a different skill mix, new types of roles and different ways of working.**

Potential actions for 2019/20:

- Tools and good practice case studies to support systems to maximise the use of the apprenticeship levy
- 4 new multi-professional credentials and details of the next set for development
- Review of priorities areas for CPD investment
- Establishment of sustainable NHS Digital Academy; plans to ensure new areas such as AI are included in curricula; establishment of a board level leadership development model; and a digital workforce planning exercise.

Local work underway:

- Apprenticeship levy used to train trainee Assistant Practitioners (24 have qualified; a further cohort to commence) and trainee Nursing Associates (19 currently in training).
- Apprenticeship levy used for range of leadership qualifications including MSc and MBAs
- Entry roles to be apprentices unless unable to offer sustainable support to those apprentices
- Transfer of levy to primary care by the Trust to support development of nursing associates (this is the first transfer of its kind)
- Opportunity through the EPR programme of work to upskill staff in digital skills
- The option of cost effective student nurse apprenticeships being explored
- The Trust is an integral part of the Advanced Practice faculty within the ICS
- Further work required to consider how to introduce Physician's Associates into our workforce.

Theme 5: **We must look again at respective roles and responsibilities for workforce across the national bodies and their regional teams, ICSs, and local employers, to ensure we are doing the right things at the right level.**

Potential actions for 2019/20:

- Clarity about the roles and responsibilities of the national bodies and their regional teams, STPs/ICSs and local employers on workforce, with a roadmap for greater devolution of responsibilities and resources to STPs/ICSs and the support offer from regional teams
- Details of the critical path to establish single, real time, workforce dataset available to national,

system and local bodies, built up from local systems.

Local work underway:

- ESR self-service project approved to be implemented during 2019; this project will require cleansing of hierarchy set up and data contained within ESR together with alignment with the finance ledger.
- The Trust is a key player within the ICS workforce infrastructure including the LWAB and South Yorkshire Regional Excellence Centre which has a particular focus on support roles including how the apprenticeship levy can be best utilised

The paper also makes reference to the recent publication of 'Closing the Gap' produced by the Health Foundation, the Kings Fund and Nuffield Trust which pays particular attention to the shortages in the nursing and GP workforce.

The focus of the 2019/20 milestones for the People & OD strategy will be to ensure that the Trust has an effective workforce planning framework to deliver the local requirements of the workforce implementation plan.

Key questions posed by the report

Is the Board assured of the work underway to respond to the anticipated workforce implementation plan including our focus through NHSI's retention programme?

How this report contributes to the delivery of the strategic objectives

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

How this report impacts on current risks or highlights new risks

This report details the current and future work programme to support the risks below within the BAF

Inability to recruit right staff and have staff with right skills leading to(i) Increase in temporary expenditure(ii) Inability to meet FYFV and Trust strategy(iii) Inability to provide viable services

Failure to improve staff morale leading to(i) Recruitment and retention issues(ii) Impact on reputation(iii) Increased staff sickness levels

Recommendation(s) and next steps

The Board is asked to note the content of this paper.

Workforce implementation plan (in support of the NHS Long term plan)

In late January 2019 Baroness Dido Harding was asked to lead the development of the NHS Workforce Implementation Plan – Julian Hartley was seconded to the programme of work as Senior Responsible Officer until April 2019 when the interim plan was expected to be published with the final plan due to be published after the autumn comprehensive spending review. In April 2019 Prerana Issar commenced as NHS Chief People Officer and has picked up the lead role for continuing this programme of work. The long term plan recognised that the NHS can only achieve its outcomes if there is sufficient staff with the right skills and that they are given adequate support to work effectively.

The development of the workforce implementation plan has been undertaken on an inclusive basis seeking feedback from across the NHS and wider. In March Trusts received a letter from Julian Hartley and Dido Harding detailing the thinking at that point and seeking further engagement from across the NHS as to whether the right areas were being considered. In that letter they stated:

> *'To deliver 21st century care for our patients, we will need a transformed workforce – engaged, motivated and supported; with compassionate and inclusive leadership and working in positive cultures; with sufficient nursing staff and the right number of staff across all disciplines and all regions. We know that we don't simply need more of the same, but also a new skill mix which is more responsive to local patient and population needs. Finally, these actions will need to be delivered through a new workforce operating model where the right activities are done at the right level, whether this is employers, Integrated Care Systems (ICSs), regional or national bodies.'*

Below are the themes directly replicated from the letter with their suggested actions for 2019/20. An update has also been provided detailing the work we as a Trust are currently engaged in either at Trust level, at Place level or across the ICS. We await the interim report.

Theme 1:	**We can make a significant difference to our ability to recruit and retain staff by making the NHS a better place to work.**

Our vision: We know many people feel the NHS is a great place to work, but people tell us it could be much better. We know that the added stress from gaps in rotas can cause burnout, while the Pearson report on NHS staff and leaners' mental wellbeing sets out some of the most serious cases of harm to our people's mental health and wellbeing. Similar themes emerge from the recently published results of the 2018 NHS Staff Survey where worryingly more people have reported experiencing bullying harassment and abuse in their workplace in the last 12 months.

We need to make the NHS an employer of excellence – valuing, supporting, developing and investing in our people. To do this we must create a modern employment culture fit for the 21st century, to meet the expectations of the people joining the NHS now and retain the people currently working in the NHS. This means significantly increasing flexible working through a combination of technology and a change in HR practices, giving people greater choice over their working patterns and helping them achieve a better work-life balance. Our people should expect a varied career and the ability to maintain a portfolio of personal and professional interests.

We need to widen participation in both education and training, and NHS careers, so that the workforce in 10 years' time better reflects the population it serves. It means maximising the contribution of our clinical and non-clinical workforce, as well as our volunteers and the broader workforce.

We must prioritise the physical and mental health and wellbeing of our staff. All NHS staff should expect to work in an environment where their concerns are welcomed and taken seriously, and they don't suffer any negative consequences if they raise concerns. We must weed out discrimination, violence, bullying and harassment across the NHS, and provide better support for people who have been at the receiving end of unacceptable behaviours and actions.

Much of this starts with good line management practices – focussing on the management basics such as ensuring staff are able to take their breaks, have access to hot food, somewhere to rest and recharge, and a manager who thanks them when they work late.

Potential actions for 2019/20

- Consultation on a new deal with staff, building on the NHS Constitution, setting out what they can expect from the NHS as a world-class and modern employer
- Associated campaign to engage all our people; framework to support Boards on how to engage with their people; good practice case studies of employers that are at the vanguard on this agenda
- Further action to improve health and wellbeing, including implementing the recommendations from the recently published '*NHS staff and learners' mental wellbeing commission'*
- Next steps on tackling violence and aggression, and bullying and harassment
- Embedding the Workforce Race Equality Standard and consulting on Workforce Disability Standard
- Expanding the NHS Improvement retention programme to all trusts and developing an equivalent program for Primary Care
- Streamlining induction and training processes, and passporting training and qualifications across different employers and settings
- Review of the impact of pension's policy on retention and options to resolve.

Local work underway

- Reinforcement of our values within appraisal discussions and leadership development programmes
- Platinum award for health and wellbeing; review of support available to staff who are experiencing stress, anxiety, depression; review of manual handling training and support to staff to reduce incidences of MSK absence
- Continued participation in NHSI's Retention programme (see appendix for the driver diagram and planned actions) –specific focus on retaining and developing newly qualified nurses and midwives and how we continue to develop staff nurses throughout their career. In addition collaborative work across the ICS in relation to values based recruitment and exit interviews
- Agreed passporting of SET training in place across the ICS which removes the requirement for all SET training to be undertaken upon commencement with the Trust
- Re-launch of the staff lottery and the bidding process to access the fund, generated through the lottery, the purpose of which is to *"Enhance the health and wellbeing of staff members through*

improved environment, opportunities and services". Bids are expected to detail how they fit the following criteria:

- Staff Health and Wellbeing
- Staff Engagement
- Staff Satisfaction
- Teamwork
- The working environment
- Recognition.

- Whilst the Trust benchmarks favourably in relation to safe working – bullying/harassment within the staff survey there are still improvements to be made – by reinforcing our Trust values within our appraisal system and within our leadership programmes we seek to reduce any incidences of bullying and harassment.

Theme 2: **If our workforce plan is to succeed we must start by making real changes to improve the leadership culture in the NHS.**

Our vision: Our ability to continue to recruit and retain the best staff depends on us creating a positive and engaging culture – a culture which needs to start at the very top of the NHS. There is clear evidence that organisations with highly engaged staff deliver high quality and sustainable care for patients. It is no coincidence that these organisations also use established quality improvement methods, which draw on staff and service users' knowledge and experience to continuously improve services.

It is also clear that this positive leadership is not consistently demonstrated across the system in national bodies, providers or commissioners. If we are to deliver the promise of the LTP we need to acknowledge this and improve our leadership culture and capacity. We need to support and encourage our very best leaders to take on the most difficult roles, and create a pipeline of clinical and non-clinical talent ready to take on Board leadership positions in future.

We all recognise the increased need for system collaboration and service transformation means new and different leadership challenges, in particular for our most senior people. These challenges also apply to the senior leaders of the national bodies as we come together to establish new structures and ways of working. This provides a valuable opportunity to co-produce a new deal with our leaders that sets out the 'gives and gets'.

This is not just about Board leadership. Middle management often sets the culture of our organisations for our front-line staff. We need to do more to embed strong management skills and support and develop our middle managers to lead through engagement and improvement, rather than command and control.

Potential actions for 2019/20

- Review of the support provided to challenged organisations by NHSI/E to ensure it reflects the inclusive and compassionate leadership we know delivers
- Develop a consistent, whole system approach for identifying, assessing, developing, deploying and supporting our talent to include:
  - rolling out regional talent boards
  - resources to support development of system leadership skills
  - consulting on common job descriptions, competency, values and behaviour frameworks for board level roles and other recommendations from recent reports by Tom Kark QC and Sir Ron Kerr

- reviewing investment in talent management programs for all our staff.

- Co-production of new 'leadership compact' between NHS Improvement/NHS England and Chief Executive Officers/Accountable Officers and Chairs which will set out the, values, behaviours and competencies expected of senior leaders, and the support and development those senior leaders should expect in return
- Review of the national oversight frameworks to ensure they are reflecting the inclusive and compassionate leadership we know delivers, specifically the Care Quality Commission/NHS Improvement well-led framework, NHS Improvement Single Oversight Framework and NHS England Improvement and Assessment Framework to enable measurement of culture, leadership, inclusion and organisational health.

Local work underway

- Team Doncaster has commissioned OD leads to develop a programme in relation to systems working
- Hosted networks across the ICS will lead to the development of common job descriptions and competences being developed for specialities within those networks
- Shadow Board programme recently launched during 2019/20
- Develop Belong Here leadership development programme in place; further bespoke programmes being developed, eg Band 6 therapists
- Masterclass season for our leadership community in place accessing key note speakers
- Leading to Outstanding programme being developed for divisional leadership teams
- Re-launch of coaching support from within the Trust.

Theme 3:	**Although there are workforce shortages in a number of professions, disciplines and regions, the biggest single challenge we currently face nationally is in the nursing and midwifery profession.**

Our vision: We currently have vacancies across all branches of nursing, with the most significant shortages in mental health, learning disability and community nursing. We have also seen a decline in mature students choosing to train as nurses. Our initial analysis suggests that this position is unlikely to improve in the near future without a serious focus on the supply, development and retention of the nursing and midwifery workforce.

We recognise the urgent need to boost entrants to nursing and midwifery courses, and we are examining all available options. In addition, there are actions that we can take in 2019/20, within existing budgets, including a focus on improving retention, reinvigorating the undergraduate nursing pipeline, and recruiting overseas nurses.

In parallel, we must increase our efforts to make nursing a more attractive career choice, so we have more entrants to the profession. We will also need to maximise system capacity by more actively engaging with our Higher Education Institutions (HEIs) to ensure there are enough places for those wanting to enter education and training.

We must explore the routes into the profession, focussing on maximising the contribution of the apprenticeship and new Nursing Associate routes. We know we also need to bridge the gap from education to employment by supporting our nurses better to manage this transition. We will explore an expansion of Health Education England's RePAIR initiative to stem attrition during training; the role of a job guarantee scheme to match graduates with employers; increase the focus on newly qualified

nurses in NHS Improvement's retention programme; and enable our nurses to move within and between employers and sectors, so they can have fulfilling careers.

Finally, we must foster a culture of continuous development that supports our nursing and midwifery staff to meet their personal aspirations, as well as meeting the needs of the NHS through the development of new and advanced practice.

Potential actions for 2019/20

- 5,000 expansion of clinical placements for impact September 2019 intake
- New annual campaign and targeted approaches to school leavers, in particular 15 to 17-year olds (linked to volunteering and work experience programmes to maximise opportunities for exposure to health careers)
- Review of current Return to Practice processes to determine whether these can make a further contribution to increasing supply
- Details of the job guarantee offer, and an approach to preceptorship and early career support as part of an expanded retention programme.

Local work underway

- Review of the Trust's ability to increase clinical placements– piloting placement expansion across South Yorkshire in line with our partnership with Lincoln University and BPP; formal introduction of LEM (Learning Environment Manager) role on wards to support learners of all professions
- Continue to ensure the Trust receives excellent feedback regarding our learner experience
- Widening Participation framework in place – links with Hall Cross Academy, Doncaster UTC and Doncaster College. New discussions taking place with Retford Oaks in Bassetlaw. Two events run in 2019 (Bassetlaw and Doncaster Hospitals) to share the breadth of healthcare professions to year 8 students and adults. Planned careers event at Doncaster Dome during 2019 being led by the Trust. Work experience framework in place.
- Review of midwifery preceptorship undertaken following the commencement of the current Head of Midwifery.
- Through NHSI's retention programme the Trust will introduce a structured approach to career progression for nursing staff. Through the collaborative element of this programme we will also explore how Trusts can work together in order to offer nurses a breadth of opportunities.
- Whilst the focus above has been on nursing staff within the Trust we have recognised that we must also focus on our specialty doctors (SAS doctors) as we have a number of gaps – we are committed to implementing the SAS charter which includes expectations around job planning, development (such as access to CESR programme), access to facilities and organisational involvement such as specialty business meetings.

Theme 4:	**To deliver on the vision of 21st century care set out in the Long Term Plan will not simply require 'more of the same' but a different skill mix, new types of roles and different ways of working.**

Our vision: To deliver the model of care set out in the LTP will require the transformation of our workforce. While this is already underway in some parts of our workforce, with the introduction of critical new roles such as Physician Associates and Nursing Associates, we must accelerate our efforts to bring about a different skill mix and new ways of working to meet patient and population need. The creation of a more flexible and adaptive workforce will require the further development and upskilling

of our people to enable us to make the best use of their talents, as well as ensuring we can get the most from critical new roles and our wider workforce of volunteers and partners.

To deliver truly population-based care we will need to change the way we work, with multidisciplinary team models across professions, care settings and organisations becoming the norm. We will need to facilitate this movement of staff by recognising relevant skills and training acquired in different settings, and removing barriers to integrated care provision. We will also need to harness the potential of technology to enable our people to work more flexibly and spend more time with patients, as well as equip them with the skills needed to operate in a world constantly evolving as a result of digital and genomic innovation.

The Apprenticeship Levy represents an important opportunity to widen participation and secure valuable new skills for our workforce, and ICSs will need to work together to use the levy funding available to them to secure the skills required locally. The newly established National Academy of Advancing Practice will also lead development of and agree the standards for multi-professional credentials, which are another means of safely and effectively widening the skill mix of our workforce.

We must ensure that we fully embed and maximise the contribution made by new roles, such as Nursing Associates and Physician Associates, including by planning for a sustainable pipeline and clarifying career pathways. We now have a shared national definition of advanced level practice. During 2019/20 we will support employers to identify and fully utilise this part of our workforce, including by updating ESR so that we are able to track numbers of advanced practitioners and better plan their deployment.

It is clear that we have not been investing sufficiently in Continuing Professional Development (CPD) and the development of our workforce more broadly. We know that this has an important bearing on the morale, and ultimately the retention, of our people. It is also a critical enabler of new and extended practice which will enable our people to adapt to the changing skill mix that will be required in the future. This is why we want to review how current funding is being targeted to ensure it is being used to upskill our people.

Finally, our people will need to be equipped to make the most of the digital age. We will use a range of learning programmes to drive digital skills leadership for system and organisational leaders through both the established Digital Academy and other education providers, providing the development for change leaders and aspiring leaders. We will launch an easy to use learning hub where content on everything from robotics to genomics will be easily accessible to all.

Potential actions for 2019/20

- Tools and good practice case studies to support systems to maximise the use of the apprenticeship levy
- 4 new multi-professional credentials and details of the next set for development
- Review of priorities areas for CPD investment
- Establishment of sustainable NHS Digital Academy; plans to ensure new areas such as AI are included in curricula; establishment of a board level leadership development model; and a digital workforce planning exercise.

Local work underway

- Apprenticeship levy used to train trainee Assistant Practitioners (24 have qualified; a further cohort to commence) and trainee Nursing Associates (19 currently in training).
- Apprenticeship levy used for range of leadership qualifications including MSc and MBAs
- Entry roles to be apprentices unless unable to offer sustainable support to those apprentices
- Transfer of levy to primary care by the Trust to support development of nursing associates – this is the first transfer of its kind
- Opportunity through the EPR programme of work to upskill staff in digital skills
- The option of cost effective student nurse apprenticeships being explored
- The Trust is an integral part of the Advanced Practice faculty within the ICS
- Further work required to consider how to introduce Physician's Associates into our workforce.

Theme 5: **We must look again at respective roles and responsibilities for workforce across the national bodies and their regional teams, ICSs, and local employers, to ensure we are doing the right things at the right level.**

Our vision: The LTP is clear that the main organising unit of our health system will be ICSs, and all local health economies will move to become ICSs over the next 5 years. It is clear that different organisations and geographies have different workforce demands, different cultures and different local labour markets, so the way we recruit, retain and develop our people is going to be critical to the success of ICSs.

We will clarify the respective roles and responsibilities of the national bodies, aligning these under a shared strategic vision, to eliminate duplication and provide an enhanced support offer for local systems. This will mean supporting the development of more robust local workforce plans that together inform national plans, and are more than a product of simply reconciling activity and finances. We must equally equip systems to transform their workforce, helping them to identify skills gaps, think creatively about how to address these and remove any barriers to new ways of working.

We will therefore seek to devolve more workforce activities to local systems, with the accompanying resources, as they are ready. These decisions will be informed by a framework that allows for benchmarking to determine whether the necessary enablers are in place and codifies the support that emerging ICSs can expect from NHS Improvement/NHS England and Health Education England regional teams.

Finally, we understand that to plan our workforce effectively we need a single, real time, workforce dataset available to national, system and local bodies. We must also take steps to address the gaps in our workforce data, beginning with Primary Care.

Potential actions for 2019/20

- Clarity about the roles and responsibilities of the national bodies and their regional teams, STPs/ICSs and local employers on workforce, with a roadmap for greater devolution of responsibilities and resources to STPs/ICSs and the support offer from regional teams
- Details of the critical path to establish single, real time, workforce dataset available to national, system and local bodies, built up from local systems.

Local work underway

- ESR self-service project approved to be implemented during 2019; this project will require cleansing of the hierarchy set up and data contained within ESR together with alignment with the finance ledger.
- The Trust is a key player within the ICS workforce infrastructure including the LWAB and South Yorkshire Regional Excellence Centre which has a particular focus on support roles including how the apprenticeship levy can be best utilised
- NHS Confederation has recently produced a consultation document (links below) regarding the role of ICSs in relation to workforce – the proposals within the consultation reflect the changes we are discussing within the ICS

  https://www.nhsconfed.org/news/2019/03/for-integrated-care-systems-to-succeed-they-need-freedom-and-resources

  https://www.nhsconfed.org/resources/2019/03/defining-the-role-of-integrated-care-systems-in-workforce-development

Closing the Gap

In March 2019 the Health Foundation, The Kings Fund and Nuffield Trust published the report *'Closing the Gap – key areas for action on the health and care workforce'.* (https://www.health.org.uk/publications/reports/closing-the-gap). The key message is that staffing is the make-or-break issue for the NHS in England. Workforce shortages are already having a direct impact on patient care and staff experience. Urgent action is now required to avoid a vicious cycle of growing shortages and declining quality. The workforce implementation plan to be published later this year presents a pivotal opportunity to do this. In the report they set out a series of policy action that evidence suggested should be at the heart of the workforce implementation plan. The report focuses on nursing and general practice where the workforce problems are particularly severe. The report states that there are no silver bullets, but the high impact policy actions which, if properly funded and well implemented across the NHS, would over time create a sustainable model for general practice and help eliminate nursing shortages.

The areas of focus within the report are:

- Increasing nursing numbers
- Team-based general practice
- Making the NHS a better place to work and build a career for all staff
- Social Care
- Workforce planning in the future.

Increasing nursing numbers – through increasing the number of training places, reducing attrition rates during training and retaining nurses in employment. As detailed above, the Trust is seeking to ensure we are able to expand the volume of clinical placements to accommodate additional training places – we have already expanded nursing placement to accommodate student nurses from Lincoln University and BPP. From 2020 there will be changes to pre-registration standards which we are reviewing and considering the impact. Locally we understand that attrition rates from Sheffield are at lower levels than elsewhere – this will be validated along with working jointly with the Universities to ensure we can maximise the numbers of students who qualify in healthcare professions. We are

participating in cohort 4 of NHSI's retention programme which has particular focus on nurses and midwives.

Team-based general practice – this section considers the potential to expand the roles within general practice to include pharmacists and physiotherapists – we need to be conscious of the potential impact on provider organisations such as ours on this workforce.

Making the NHS a better place to work and build a career for all staff – this section closely links to the development of the workforce implementation plan – the reports suggests building on what is already within the NHS Constitution for staff; how to boost retention rates; pay and reward post 2021; impact of changes to pensions policy; impact of technological advances and changing patient needs on the workforce development needs of staff; compassionate and inclusive leadership as detailed within Developing People Improving Care (https://improvement.nhs.uk/resources/developing-people-improving-care/).

Social Care – the report considers this workforce due to the close interrelationship with the NHS and the vacancy levels of around 10-12% of the workforce – within the ICS our regional excellence centre includes membership of adult social care – the recent ECHO (extended clinical health outcomes) programme focuses on the ability for staff within care homes to access health related training through e-learning – Doncaster is the first hub to work outside of Sheffield within the ICS – the first area is end of life training.

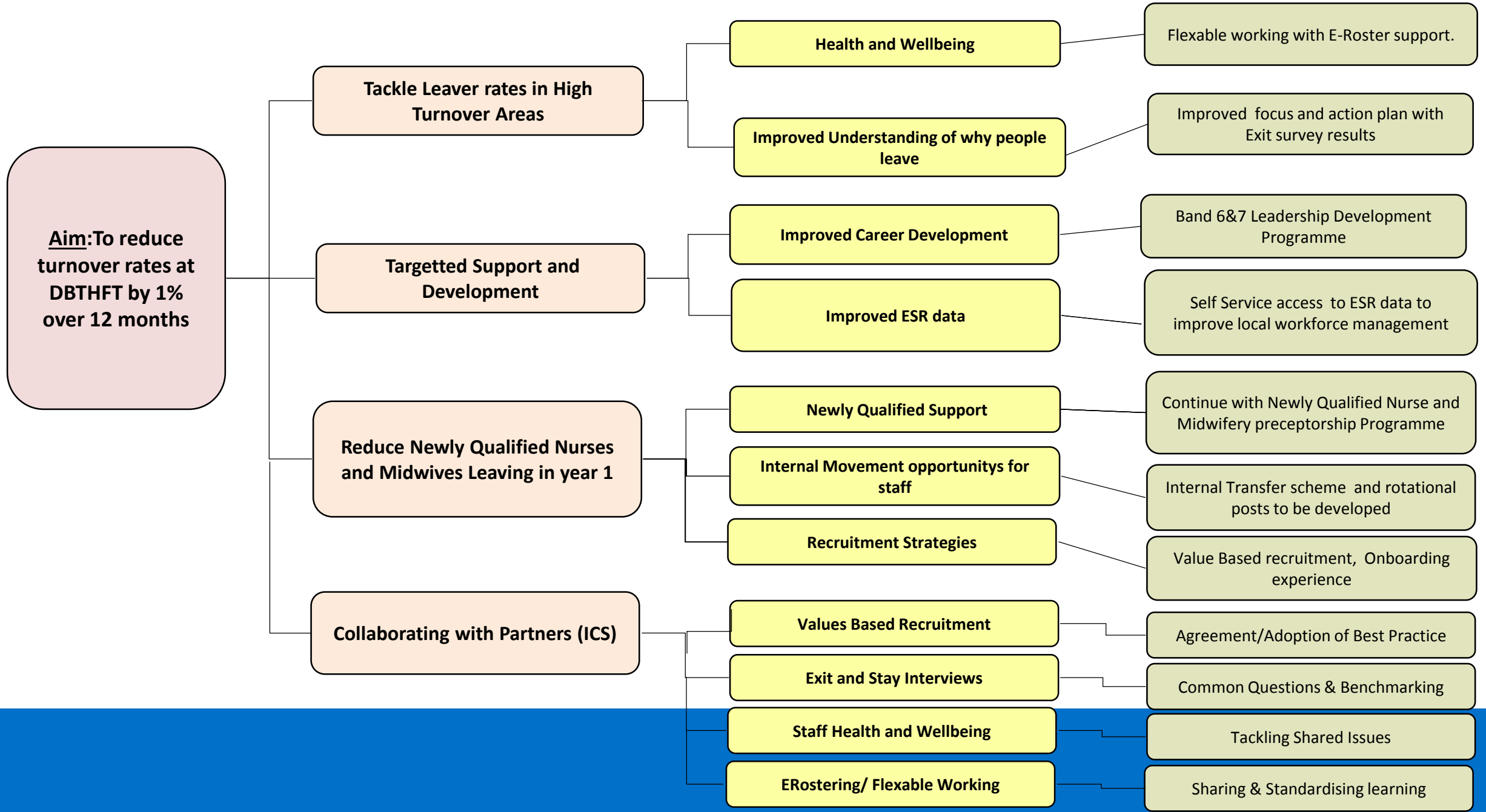
Workforce Planning in the future – the message within the report is that the workforce implementation plan needs to address the roles, responsibilities, skills and capabilities needed across the system for more effective workforce planning (in addition to policy areas). The key focus of the People & OD strategy during 2019/20 will be to ensure we have a workforce planning framework enabling operational teams supported by the P&OD team to develop mature workforce plans and to articulate the development requirements such as new roles and upskilling their current team members.

NHSI Retention Programme

Members will recall that the acute Trusts within the ICS have joined cohort 4 of NHSI's retention collaborative – this cohort is focusing specifically on nursing and midwifery. Whilst we have explored areas of joint collaboration (values based recruitment and exit interviews) each Trust has reviewed its own retention data to determine its priorities. Within the appendix to this report is an extract from the presentation to NHSI of our identified priority areas of action, namely:

- Flexible working
- Band 6 & 7 Leadership development programme
- Band 5 skills in practice
- Internal transfer/career coaching scheme

Regular reports will be received by the Workforce, Education and Research committee to ensure that progress is being made and impacting on retention rates and feedback from the nursing workforce which in turn will be reported to QEC.


Aim:To reduce turnover rates at DBTHFT by 1% over 12 months
Tackle Leaver rates in High Turnover Areas
Health and Wellbeing
Flexable working with E-Roster support.
Improved Understanding of why people leave
Improved focus and action plan with Exit survey results
Targetted Support and Development
Improved Career Development
Band 6&7 Leadership Development Programme
Improved ESR data
Self Service access to ESR data to improve local workforce management
Reduce Newly Qualified Nurses and Midwives Leaving in year 1
Newly Qualified Support
Continue with Newly Qualified Nurse and Midwifery preceptorship Programme
Internal Movement opportunitys for staff
Internal Transfer scheme and rotational posts to be developed
Recruitment Strategies
Value Based recruitment, Onboarding experience
Collaborating with Partners (ICS)
Values Based Recruitment
Agreement/Adoption of Best Practice
Exit and Stay Interviews
Common Questions & Benchmarking
Staff Health and Wellbeing
Tackling Shared Issues
ERostering/ Flexable Working
Sharing & Standardising learning

Key Initiatives

- Band 6 & 7 Leadership Development Programme
- Internal Transfer / Career Coaching Scheme
- B5 skills in practice
- Flexible Working

Band 6 & 7 Leadership Development

To support the development of leaders within our Trust, we are offering employees at varying levels leadership and management programmes

Develop

Aimed at new managers with little or no leadership experience. Suitable for clinical , non clinical , and medical roles

Belong

For staff in middle management roles, with line management responsibilities

Includes 'Insights' to explore how they lead and personal strengths

Thrive

For more Senior leaders responsible for large teams.

Includes A Healthcare Leadership Model 360 degree Appraisal

SOUND bites

- Stress awareness
- Quality of appraisals
- Personal resilience
- Candid conversations
- Living the We care values and Behaviours

Hear Masterclasses

opportunity to hear from external high profile experts, who share their journey and lived experiences, in order to impart their knowledge of leading within organisations.

www.dbth.nhs.uk

Internal Transfer/ Career Coaching Scheme & Rotational Programme

- Rotational Programme for new and existing Qualified nurses
- Providing opportunities for new and experiences nurses to gain skills and knowledge in a variety of areas
- Formation of Rotational Policy
- Link with recruitment for vacancy position’s

- An internal transfer process for staff interested in a sideways move.
- Careers Clinic offering personal career advice to staff considering an internal transfer.
- Formation of policy required to govern the transfer of staff
- Drop in sessions throughout the year

Flexible Working

Offer flexible working to retain staff

- Seasonal Working
- Job shares
- Part time
- Term time contracts
- Flexible Retirement
- Self Rostering
- Career Break
- Staggered Hours
- Flexi – Time
- Secondments
- Compressed Hours
- Annualised Hours
- Home or Tele Working

Actions

Support Managers with flexible working requests

Empower Managers to understand staff's need for the request

ERoster and HR Support

B5 Skills in Practice Programme

Develop a skills programme to develop existing Nurses offering;

- Clear plan of opportunities available to upskill clinical and leadership skills
- Opportunities to shadow senior nursing colleagues (matrons, ADoNs and specialist nurses)
- Development of shared governance boards to empower staff nurses in organisational decision making

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Title	**INTEGRATED PERFORMANCE REPORT (IPR)**		
Report to	**Board of Directors**	**Date**	**30th April 2019**
Author	**Jon Sargeant - Director of Finance** **David Purdue – Director of Operations / Deputy CE** **Andy Thomas - Project Director**		
Purpose			Tick one as appropriate
	Decision		
	Assurance		X
	Information		

Executive summary containing key messages and issues
Please find attached the monthly Integrated Performance Report (IPR) for the trust. It should be noted that, given the timelag in the generation and validation of elements of the data contained in this report, it is not always possible for it to be generated in time to be distributed with the rest of the F&P papers. Where this is not possible it will, unfortunately, need to be forwarded later. However, this later distribution will, in all cases, be prior to the F&P Committee itself. The report itself is split into two parts: 1. The Summary IPR – this summarises performance both in-month and year-to-date and provided a forecast to the year end. 2. Commentary on exceptions – this analysis is provided by operational teams where targets have not been met. Key items to note in the trust's performance are: • A&E / ED "4 hour waiters" performance was 93.1% in month resulting in a YTD figure of 92.6%. Whilst this is below the national 95% target it exceeds the 91% target included in the trusts contracts for 2018/19. This is despite increased activity year on

year. Indeed the trust's performance was the 20th best nationally for the year.

- RTT performance against the "18 week" target was 88.8% YTD. This is below the national 92% target and the locally agreed 89.1% target. Actions are in place to improve performance against this measure into 2019/20.

- The Diagnostics tests "6 weeks wait" of 99% was marginally missed with trust wide performance of 98.8%. The majority of the waits longer than 6 weeks relate to Nerve Conduction and Urodynamics. Additional capacity has now been added to these services.

- Cancer performance has improved with all aggregate targets achieved in month. However, the this was not sufficient to lift the '2 week wait' figures for the year to above target.

- Elective activity, both daycases and inpatient, is below plan for the year. Actions are in place to improve the position for 2019/20.

- Outpatient activity is, overall, above plan for the year. This is particularly the case amongst follow up appointments (as opposed to 1st appointments).

- Stroke performance is mixed with some targets being achieved and others not. In particular the "directly admitted within 4 hours" is below plan for both March 2019 and the figures for the year.
-

Key questions posed by the report

Are the committee sufficiently assured by the actions taken to ensure that the operational performance of the trust for 2019/20 delivers the various performance targets ?

How this report contributes to the delivery of the strategic objectives

This report relates to strategic aims 2 and the following areas as identified in the Trust's BAF and CRR.

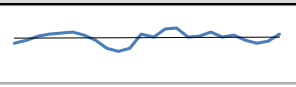
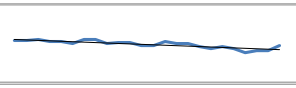
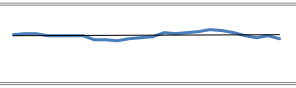
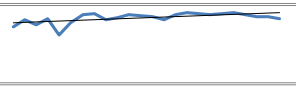
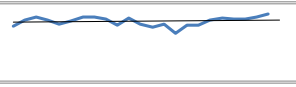
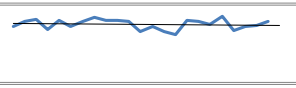
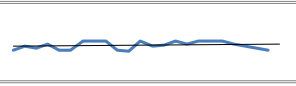
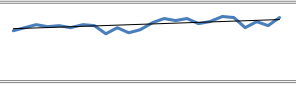
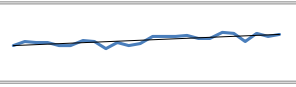
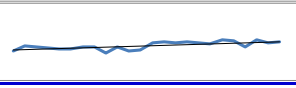
- F&P 6 - Failure to achieve compliance and delivery aspects of the SOF, CQC and other regulatory standards.
- F&P 19 - Failure to achieve income targets arising from issues with activity

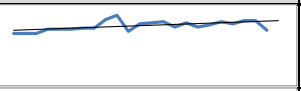
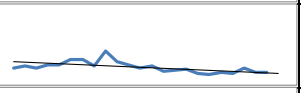
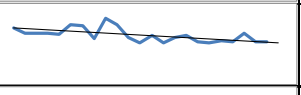
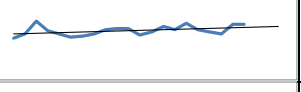
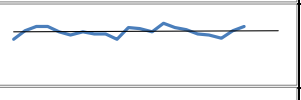
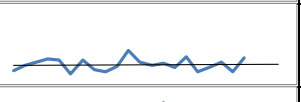
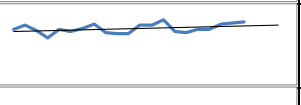
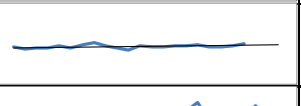
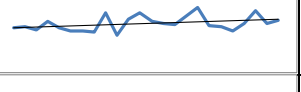
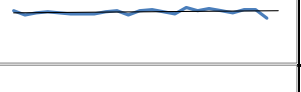
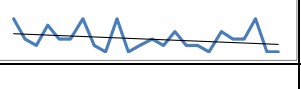
How this report impacts on current risks or highlights new risks

Update on the risks relating to the delivery of 2018/19 operational performance and for that of 2019/20 going forwards.

Recommendation(s) and next steps

The Committee is asked to note and comment as appropriate on the attached

Category	Indicator	Latest Month Reported	National Target	National Benchmarking	CURRENT MONTH			YEAR-TO-DATE			YEAR END FORECAST			Trend Graph (April 17 - stated month)	COMMENTS	REF ADDITIONAL INFORMATION
					Target	Actual	Variance	Target	Actual	Variance	Target	Actual	Variance			
NHSI Compliance Framework	A&E: Max wait four hours from arrival/admission/transfer/discharge	Mar 19	95%	86.4%	91.0%	93.1%	2.1%	91.0%	92.6%	1.6%	N/A				Target for the year achieved	A
	Max time of 18 weeks from point of referral to treatment- incomplete pathway	Mar-19	92%	86.6%	90.0%	88.8%	-1.2%	*90.0%*	*88.8%*	-1.2%	N/A				Target for the year not achieved	B
	Waiting list size (from 1/4/19) - 18 Weeks referral to treatment -Incomplete Pathways	Mar-19	.N/A	.N/A	31,423	31,199	-224	31,423	31,199	-224	N/A				Target for 2019/20 only	
	% waiting less than 6 weeks from referral for a diagnostics test	Mar-19	99%	96.7%	99.0%	98.8%	-0.2%	*99.0%*	*98.8%*	-0.2%	N/A				Target for the year not achieved	C
Cancer	Two week wait from referral to date first seen: all urgent cancer referrals	Feb-19	93.0%	93.7%	93.0%	*96.1%*	*3.1%*	*93.0%*	*89.7%*	*-3.3%*	*93.0%*	*90.2%*	*-2.8%*		Improvement expended to year end but unlikey to be sufficient to achieve target.	D
	Two week wait from referral to date first seen: symptomatic breast patients	Feb-19	93.0%	86.1%	93.0%	*93.2%*	*0.2%*	*93.0%*	*90.3%*	*-2.7%*	*93.0%*	*90.8%*	*-2.2%*		Improvement expended to year end but unlikey to be sufficient to achieve target.	
	31 day wait for diagnosis to first treatment- all cancers	Feb-19	96.0%	97.1%	96.0%	*98.6%*	*2.6%*	*96.0%*	*99.4%*	*3.4%*	*96.0%*	*99.4%*	*3.4%*		Continuing good performance	
	31 day wait for second or subsequent treatment: surgery	Feb-19	94.0%	93.6%	94.0%	*100.0%*	*6.0%*	*94.0%*	*98.7%*	*4.7%*	*94.0%*	*99.0%*	*5.0%*		Continuing good performance	
	31 day wait for second or subsequent treatment: anti cancer drug treatments	Feb-19	98.0%	99.5%	98.0%	*100.0%*	*2.0%*	*98.0%*	*100.0%*	*2.0%*	*98.0%*	*100.0%*	*2.0%*		Continuing good performance	
	31 day wait for second or subsequent treatment: radiotherapy	Feb-19	94.0%	97.9%	94.0%	100.0%	*6.0%*	*94.0%*	*100.0%*	*6.0%*	*94.0%*	*100.0%*	*6.0%*		Continuing good performance	
	62 day wait for first treatment from urgent GP referral to treatment	Feb-19	85.0%	81.0%	85.0%	90.0%	5.0%	85.0%	*85.9%*	0.9%	85.0%	*86.3%*	1.3%		Continuing good performance	
	62 day wait for first treatment from consultant screening service referral	Feb-19	90.0%	88.6%	90.0%	100.0%	*10.0%*	*90.0%*	*92.8%*	*2.8%*	*90.0%*	*93.4%*	*3.4%*		Continuing good performance	
Activity	Daycase Activity - Discharges	Mar-19		.N/A	4,382	4,246	(136)	50,207	48,136	(2,071)	N/A				Target not achieved	
	Other Elective Activity - Discharges	Mar-19		.N/A	865	850	(15)	9,821	8,725	(1,096)	N/A				Target not achieved	
	Outpatient new activity (Contracted levels achieved)	Mar-19		.N/A	11,373	12,122	749	141,404	139,224	(2,179)	N/A				Target not achieved	
	Outpatient Follow Up activity (Contracted levels achieved)	Mar-19		.N/A	23,140	23,921	781	274,379	281,232	6,853	N/A				Target not achieved	

Category	Indicator	Latest Month Reported	National Target	National Benchmarking	CURRENT MONTH			YEAR-TO-DATE			YEAR END FORECAST			Trend Graph (April 17 - stated month)	COMMENTS	REF ADDITIONAL INFORMATION
					Target	Actual	Variance	Target	Actual	Variance	Target	Actual	Variance			
Ambulance Handover Times	Ambulance Handovers Breaches -Number waited >15 & <30 Minutes	Feb-19		.N/A	1,571	707	(864)	12,564	8,728	(3,836)	18,846	10,861	*(7,985)*			
	Ambulance Handovers Breaches-Number waited >30 & < 60 Minutes	Feb-19		.N/A	159	35	(124)	1,275	473	(802)	1,912	574	*(1,338)*			
	Ambulance Handovers Breaches -Number waited >60 Minutes	Feb-19		.N/A	22	1	(21)	172	46	(126)	258	53	*(205)*			
Stroke	Proportion of patients scanned within 1 hour of clock start (Trust)	Jan-19	48.0%	.N/A	48.0%	*60.3%*	*12.3%*	*48.0%*	*63.2%*	*15.2%*	*48.0%*	*62.0%*	*14.0%*			***E***
	Proportion directly admitted to a stroke unit within 4 hours of clock start	Jan-19	90.0%	.N/A	90.0%	*66.1%*	*-23.9%*	*90.0%*	*67.4%*	*-22.6%*	*90.0%*	*66.0%*	*-24.0%*			
	Percentage of all patients given thrombolysis	Jan-19	20.0%	.N/A	20.0%	*4.8%*	*-15.2%*	*20.0%*	*8.0%*	*-12.0%*	*20.0%*	*8.0%*	*-12.0%*			
	Percentage treated by a stroke skilled Early Supported Discharge team	Jan-19	40.0%	.N/A	40.0%	*77.6%*	*37.6%*	*40.0%*	*74.7%*	*34.7%*	*40.0%*	*75.2%*	*35.2%*			
	Percentage discharged given a named person to contact after discharge	Jan-19	95.0%	.N/A	95.0%	*100.0%*	*5.0%*	*95.0%*	*90.7%*	*-4.3%*	*95.0%*	*92.2%*	*-2.8%*		Process now in place to ensure target met on a monthly basis.	
Theatres & Outpatients	Cancelled Operations (For non-medical reasons)	Mar-19		1.0%	0.8%	*1.3%*	*0.5%*	*0.8%*	*1.3%*	*0.5%*	*N/A*					***F***
	Cancelled Operations-28 Day Standard	Mar-19		.N/A	0	*2*	*2*	*0*	*16*	*16*	*N/A*					
	Out Patients: DNA Rate	Mar-19		.N/A	7.6%	*8.9%*	*1.3%*	*7.6%*	*10.2%*	*2.5%*	*N/A*					
	Out Patients: Hospital Cancellation Rate	Mar-19		.N/A	4.5%	*13.6%*	*9.1%*	*4.5%*	*15.8%*	*11.3%*	*N/A*					
Effective	Emergency Readmissions within 30 days (PbR Methodology)	Feb-19		.N/A	TBC	5.4%		*TBC*	*6.5%*		*TBC*	*6.1%*				
Safe	Infection Control C.Diff	Mar-19		.N/A	4	0	*(4)*	30.0	20.0	*(10)*	N/A				Target achieved	
	Infection Control MRSA	Mar-19		.N/A	0	0	0	0	0	*0*	N/A			**N/A**	Target achieved	

Doncaster & Bassetlaw Teaching Hospitals NHS Foundation Trust
PERFORMANCE EXCEPTION REPORT – March 2019

A : 4hr Access Target

Trust

In March 2019 the Trust achieved performance of 93.12 % against the 4hr access standard of 95%, in comparison to 93.23% in March 2018.

This position placed DBTH, 20th nationally for the year.

The quarter performance met the PSF requirements.

The Trust managed 15068 ED attendances across sites and streams, during March 2019. This is 1299 more patients than in March 2018 seeing an increase of 8.62%.

1070 patients were not treated within 4 hours:-

- 562 – A&E Doctor Review
- 154 – Bed waits
- 169 – Clinical Exception
- 185 – Other

The acuity of patients has impacted on the flow and admission of patients with winter pressures continuing to impact on bed demand and staffing.

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

Doncaster Royal Infirmary

DRI achieved performance of 91.30% against the 4hr access standard of 95%, in comparison to 91.91% in March 2018.

DRI managed 9263 ED attendances across sites and streams, during March 2019. This is 747 more patients than in March 2018 seeing an increase of 8.06%.

Bassetlaw District General Hospital

BDGH achieved performance of 93.82% against the 4hr access standard of 95%, in comparison to 93.67% in March 2018.

BDGH managed 4274 ED attendances across sites and streams, during March 2019. This is 446 more patients than in March 2018 seeing an increase of 10.4%.

MMH, minor injuries saw an increase in attendances of 7.4% in March

B : Referral to Treatment (RTT)

The Trust has delivered the trajectories set by the CCGs for the performance in March

The Trust Level month end performance for March 2019 is 88.8%

The Trust has achieved 89.3% for Doncaster CCG.

The total number of Incomplete Pathways at Trust Level, Doncaster CCG and Bassetlaw CCG is lower than it was in March 2018 by 239.
DCCG -762
BCCG -67
The total number of Incomplete Pathways has decreased by 802 between February and March 2019, however the number of incomplete pathways over 18 weeks decreased by 510 hence the performance has improved. The total number of Incomplete Pathways with a decision to admit for treatment has decreased by 158 between February and March 2019. The number of new RTT periods in March was 818 more than in February but March was a longer month. There were 831 more Non Admitted and 221 more admitted clock stops in March than in February.

March's Specialty level Trust RTT performance, against a target of 92%, can be found below:

Specialty Group	Under 18 Weeks	18 Weeks & Over	Total	Percentage
General Surgery	2398	378	2776	86.4%
Urology	1386	206	1592	87.1%
T&O	5061	807	5868	86.2%
ENT	2664	500	3164	84.2%
Ophthalmology	2532	210	2742	92.3%
Oral Surgery	1734	177	1911	90.7%
General Medicine	1788	212	2000	89.4%
Cardiology	1740	237	1977	88.0%
Dermatology	1664	161	1825	91.2%
Thoracic Medicine	803	51	854	94.0%
Rheumatology	749	139	888	84.3%
Geriatric Medicine	201	24	225	89.3%
Gynaecology	1352	42	1394	97.0%
Others	3633	350	3983	91.2%
Trust Total	**27705**	**3494**	**31199**	**88.8%**

C : Diagnostics

In March 2019 the Trust achieved 98.78% against the 6ww Diagnostic Performance standard of 99% (98.81% at NHS Doncaster and 98.57% at NHS Bassetlaw).

There were 128 trust level breaches in total - the majority of these were Nerve Conduction (74) and Urodynamics (25).

Exam Type	<6W	>=6W	Total	Performance
MRI	1509	3	1512	99.80%
CT	1893	4	1897	99.79%
Non-Obstetric Ultrasound	5045	1	5046	99.98%
Barium Enema	0	0	0	
DEXA	369	0	369	100.00%
Audiology	343	14	357	96.08%
Echo	221	0	221	100.00%
Nerve Conduction	150	74	224	66.96%
Sleep Study	13	0	13	100.00%
Urodynamic	32	25	57	56.14%
Colonoscopy	218	0	218	100.00%
Flexible Sigmoidoscopy	86	0	86	100.00%
Cystoscopy	142	7	149	95.30%
Gastroscopy	342	0	342	100.00%
Total	**10363**	**128**	**10491**	**98.78%**

	Waiters <6W	Waiters >=6W	Total	Performance
Trust	10363	128	10491	98.78%
NHS Doncaster	6647	80	6727	98.81%
NHS Bassetlaw	2614	38	2652	98.57%

The 99% target was missed in 4 areas:

- Audiology – 96.08% - 14 breaches out of 357 waiters – *Additional clinic capacity provided, but due to admin error was not opened on ERS – this has now been rectified.*

- Nerve Conduction – 66.96% - 74 breaches out of 224 waiters – *Sickness within the DBTH team reduced capacity significantly. An outside agency was brought in to provide some additional capacity. Plan to use outsource company for April activity to cover shortfall. In addition, Sheffield have given notice on SLA from May 2019 – out to tender for new SLA*

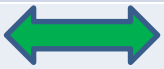
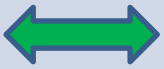
- Urodynamics – 56.14% - 25 breaches out of 57 waiters – ++ *breaches due to hospital cancellation due to lack of capacity(undertaken by consultant & nurse)Matron & Business Manager to review / improve booking process -by end of Q1*

- Cystoscopy – 95.30% - 7 breaches out of 149 waiters - *capacity in service - as above*

D : Cancer Performance

The following information relates to Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust performance in February 2019. The action plan to improve 62 day consultant upgrades is now underway with expectations of improving performance over time.

February Performance

Standard	Local Performance %	Position from Previous Month
TWW	96.1%	
31 day	98.6%	
62 day	90%	
31 day Sub – Surgery	100%	
31 day Sub – Drugs	100%	
31 day Sub – Other	100%	
62 day Screening	100%	
62 day Con Upgrades	81.5%	
Breast Symptomatic	93.2%	

62 day Cancer performance
The 62 day standard was achieved by the Trust in February 2019; rising to 90%.

The key issues remain around complex pathways and shared breaches.

Two Week Wait Performance
The two week wait standard was achieved by the Trust in February 2019 rising to 96.1%.

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

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

TWW Performance by specialty for February 2019

	2ww	Non 2ww Symptomatic Breast Referrals	31 Day - Classic	31Day Sub - Surgery	31 Day Sub - Drugs	31 Day Sub - Palliative	62 Day - Classic	62 Day Screening	62 Day Consultant Upgrades
Operational Std	93%	93%	96%	94%	98%	94%	85%	90%	TBA
Breast	97.2%	93.2%	100%	100%			100%	100%	100%
Gynaecology	100%		100%				90%	100%	100%
Haematology	100%		100%		100%		100%		
Head & Neck	85.5%						100%		
Lower GI	97.4%		100%				76.5%		0%
Lung	100%		100%				71.4%		75%
Sarcoma									
Skin	94.4%		90%				100%		100%
Upper GI	96.5%		100%				81%		
Urological	94.8%		100%	100%			83.3%		90.9%

EXCEPTIONS

CWT Standard	Tumour Group	Performance against CWT standard	High Level View
Two Week Wait	H&N	85.5%	12 Patients – 1 patient choice, 2 administrative delay - unable to contact patient (required OMFS opd) , 9 Clinic cancellations ,
31 day	Skin	90%	2 patients - 1 patient choice, 1 listed incorrectly
62 day	LGI	76.5%	3 patients – 1 local –Medical Reasons , 2 shared care – 1 complex diagnostic pathway,1 pathway delays to diagnostic
	Lung	71.4%	2 patients– both shared care – 1 Complex diagnostic pathway, 1 pathway delays.
	UGI	83.3%	3 patients– 1 local and 2 shared care, all complex diagnostic pathway.
	Urology	81%	5 patients – 2 local - Elective capacity for diagnostics . 3 shared care - Pathway delays and 3 elective capacity (STH),
62 day Con Upgrade	Lower GI	0%	2 patients – shared care – 1 Elective capacity (STH) 1 pathway delays

	Lung	75%	2 patients – shared care – 1 equipment failure, 1 delayed for Medical Reasons

E : Stroke

Performance January 2019

The Trust level percentage for Direct Admission to the Stroke Unit was 65.1% against a 90% target.

1. Direct Admission	Target = 90%			
	CCG			
Direct Admission within 4 Hours	Bassetlaw	Doncaster	Other	**Total**
Yes	7	33	1	**41**
No	10	9	3	**22**
Grand Total	**17**	**42**	**4**	**63**
Performance	41.2%	78.6%	25.0%	**65.1%**

1. Direct Admission		
Category	Sub Category	Total
Organisational	Beds	2
	Pathway	14
	Staff Availability	1
Clinical	Patient Presentation	1
	Patient Needs	4
Patient Choice	Declined	
Awaiting further validation		

There were 22 Trust level breaches for direct admission, the main reasons for these were:-

- Multiple referrals to the ward at the same time – necessary delays for patient safety
- Late referrals due to secondary diagnosis of stroke
- Delay with transfer from Bassetlaw to Doncaster due to transport
- Awaiting Neurology review

F : Cancelled Operations

In March 2019 1.3% of Trust operations were cancelled; this is in line with the range of performance %. 59 operations were theatre cancellations for clinical reasons and 8 for non-theatre reasons. The key issue was HSDU at Bassetlaw (11 cases cancelled due to no kit ordered – human error).

1 x cancelled operation in Ophthalmology was not re-booked within 28 days. This is currently being reviewed by the clinical lead to agree on the most appropriate way forward.

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Title	**Board Assurance Framework & Corporate Risk Register**		
Report to	**Board of Directors**	**Date**	**30 April 2019**
Author	**Gareth Jones, Trust Board Secretary**		
Purpose			Tick one as appropriate
	Decision		
	Assurance		X
	Information		

Executive summary containing key messages and issues

The attached Corporate Risk Register and Board Assurance Framework present the end of Quarter 4 2018/19 position. Risk reviews will take place with executives over the coming weeks and ratings and controls will change accordingly.

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

No	Risk	Q1/initial score	End of year	Direction
F&P1 (CRR)	Failure to achieve compliance with financial performance and achieve financial plan and subsequent cash implications	L4 x I4 = 16	L4 x I4 = 16	⟷
Q&E1	Failure to engage and communicate with staff and representatives in relation to immediate challenges and strategic development	L4 x I4 = 16	L4 x I4 = 16	⟷
ANCR1	Risk of fraud	L2 x I4 = 8	L2 x I4 = 8	⟷
Q&E2	Lack of adequate CT scanning capacity at DRI	L3 x I3 = 9	L3 x I3 = 9	⟷
F&P3	Failure to deliver Cost Improvement	L4 x I4 = 16	L4 x I4 = 16	⟷

	Plans in this financial year			
Q&E3	Inability to sustain the Paediatrics service at Bassetlaw	L2 x I2 = 4	L2 x I2 = 4	
F&P4	Failure to ensure that estates infrastructure is adequately maintained and upgraded in line with current legislation, standards and guidance.	L4 x I5 = 20	L4 x I5 = 20	
Q&E4	Failure to ensure adequate medical records system	L2 x I3 = 6	L2 x I3 = 6	
F&P5	Failing to address the effects of the agency cap	L4 x I4 = 16	L4 x I4 = 16	
Q&E5	Failure to engage with patients and staff around the quality of care and proposed service changes	L3 x I3 = 9	L3 x I3 = 9	
F&P6 (shared with QEC) (CRR)	Failure to achieve compliance with performance and delivery aspects of the Single Oversight Framework, CQC and other regulatory standards	L4 x I4 = 16	L4 x I4 = 16	
Q&E6	Failure to improve staff morale	L3 x I4 = 12	L3 x I4 =12	
Q&E7	Failure to adequately prepare for CQC inspection	L2 x I3 = 6	L2 x I3 = 6	
F&P8	Inability to recruit right staff and have staff with right skills	L4 x I4 = 16	L4 x I4 = 16	
Q&E8	Failure to achieve complaint reply performance standards	L2 x I2 = 4	L2 x I2 = 4	
F&P9	Breakdown of relationship with key partners and stakeholders	L3 x I4 = 12	L3 x I4 = 12	
Q&E9	Failure to adequately treat patients due to unavailability and lack of supply of medicines	Ld x I3=15	L4 x I4 = 16	
F&P10	Failure to ensure business continuity	L2 x I4 = 8	L2 x I4 = 8	

	/ respond appropriately to major incidents			
Q&E11	Failure to mitigate the impact of an ambitious effectiveness and efficiency programme on quality of care	L3 x I4 = 12	L3 x I4 = 12	
F&P11	Failure to protect against cyber attack	L3 x I5 = 15	L3 x I5 = 15	
F&P12	Failure to ensure that estates infrastructure is adequately maintained and upgraded in accordance with the Regulatory Reform (Fire Safety) Order 2005 and other current legislation standards and guidance	L4 x I5 = 20	L4 x I5 = 20	
F&P13	Inability to meet Trust's needs for capital investment	L4 x I4 = 16	L4 x I4 = 16	
Q&E13 (CRR)	Initial ED triage assessment processes	N/A	L4 x I4 = 16 (added Dec 18)	
F&P14	Reduction in hospital activity and subsequent income due to increase in community provision	L3 x I4 = 12	L3 x I3 = 9	
Q&E14 (CRR)	Staffing for registered children's nurses in ED on DRI and BDGH sites	N/A	L4 x I4 = 16 (added Dec 18)	
F&P15	Commissioner plans do not come to fruition and do not achieve the required levels of acute service reduction	L3 x I3 = 9	L4 x I3 = 12	
F&P16	Uncertainty over ICS financial regime including single financial control total	L3 x I4 = 12	L2 x I4 = 8	
F&P18 / QEC10	Failure to deliver strategic direction	L2 x I5 = 10	L2 x I5 = 10	
F&P19	Failure to achieve income targets arising from issues with activity	L3 x I5 = 15	L2 x I5 = 10	
F&P20 / Q&E12	Risk of critical lift failure	L4 x I5 = 20	L4 x I5 = 20	

In addition, the Trust has commenced work on a revised Risk Management Policy and escalation framework with colleagues in Clinical Governance. An improved recording and reporting of risk and utilisation of the Datixweb system is anticipated as a result of this review.

Key questions posed by the report

- N/A

How this report contributes to the delivery of the strategic objectives

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

How this report impacts on current risks or highlights new risks

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

Recommendations

Board is asked to note the report.

Strategic Aim 1 - We will work with patients to continue to develop accessible, high quality and responsive services.												
RISKS	LINK TO CRR	EXEC	CURRENT RR	DIRECTION OF TRAVEL	Q1	Q2	Q3	Q4	CONTROLS	ASSURANCE	GAPS IN ASSURANCE	ACTION TO ADDRESS GAPS	TARGET RR
Failure to sustain a viable specialist and non-specialist range of services leading to (i) Regulatory action (ii) Impact on reputation	F&P7	Medical Director/Chief Operating Officer	L2 x I3 = 6	↓	6	6	6	REMOVED	(i) Participation in WTP and Hospital Services Review (ii) Commissioner engagement (iii) Involvement/influence NHSE commissioning intentions (iv) R & D support for specialist services (v) Quarterly Executive discussions with STH (vi) Contribution to reconfiguration discussions (vii) Meetings with SCH and RDaSH (ix) Sustained services - no threat to the organisation. Hospital Services Review undertaken. Implementing HASU expected go live 01st April 2019.	(i) Peer review programe outcome (ii) Patient outcome and service quality as published by National Registries (iii) Agreement with Sheffield over vascular services (iv) Publication of Hospital Services Review workstreams (September 2017) (v) Hospital Services Review published (May 2018) (vi) Particpation in review of specialist services (vii) Decision on HASU	(i) Review of vascular services (ii) Joint working with SCH and RDaSH	(i) MD leading review of vascular (ii) Meetings with SCH and RDaSH	L2 x I2 = 4
Failure to protect against cyber attack leading to (i) Trust becoming non-operational (ii) Inability to provide clinical services (ii) Negative impact on reputation	F&P11	Chief Information Officer	L3 x I5 = 15	↔	15	15	15	15	(i) Penetration test of systems to identify gaps and risks; (ii) Firewalls, passwords, anti-virus equipment. (iii) Policies and reinforcement through communication to staff; (iv) Staff awareness through Certified Security Professional course and other training; (v) Trigger alerts; (vi) Care Cert system at NHS Digital (vii) All servers and systems patched to appropriate level (viii) Computers and network infrastructure get security patches automatically applied (ix) Monthly cyber security report (x) Pilot trust for NHS Digital work (xi) Digital garage work (xii) Regular returns to the centre (xiii) DSP Toolkit Review	(i) Trust unaffected by cyber attack in May 2017 (ii) Governors briefing June, 2017 (iii) Cyber maturity audit and action plan reported via ANCR to Board, September 2017 and updated March 2018 (iv) Annual IT audit (v) Report to Audit Committee on IT Security - Penetration Test of Trust sites update, September 2018 Report shared with Audit Committe.	(i) Progress against Internal Audit action plan to be presented to ANCR every six months (ii) Change to Data Security & Protection toolkit	(i) Phishing exercise (Autumn 2018). (ii) Paper to ANCR re DSP (November 2018). (iii) DSP Toolkit review taking place. (iv) Audit by KMPG. Results to Audit Committee following March results.	L3 x I4 = 12
Failure to ensure adequate medical records system leading to (i) Impact on safety (ii) Impact on reputation	Q&E4	Chief Operating Officer	L2x I3 = 6	↔	6	6	6	6	(i) Review of bays and action plans in place (ii) RFID business case agreed (iii) Plans to make DRI a closed library (iv) RFID System operational (v) IM&T Strategy	(i) Storage bays reviewed (ii) Presentation before Board in August 2017 on RFID (iii) RFID installed, October 2017 (iv) Draft information strategy in place (v) Presentation from Nervecentre at ET and Governor Forum, October 2018	(i) Elecrtonic Patient Record System (ii) Development of Business Case for EPR (iii) Resolution of paper records	(i) Progress towards EPR System (ongoing) (ii) Work around paper records (to be determined following EPR implementation)	L2 x I2 = 4
Failure to engage with patients and staff around the quality of care and proposed service changes leading to (i) Negative patient and public reaction towards the Trust (ii) Impact on reputation (iii) Impact on staff morale (iv) Risk of long-term recruitment issues (v) Risk of delay to any service changes	Q&E5	Director of Nursing, Midwifery and AHPs/ Medical Director	L3 x I3 = 9	↔	9	9	9	9	(i) Consultations on major service changes (ii) CCC report to Board (iii) Friends and Family Test (iv) Monitoring through Patient Engagement & Expderience Committee (including CCG & Healthwatch membership) (v) Training on communication (vi) Work on learning from deaths (vii) Governor walkabouts (viii) Ward QAT (ix) Picker national surveys (x) Social media e.g. Facebook, Twitter (xi) Media & social media policy (xii) Governor/ NED briefings (xiii) MP briefings/ meetings (xiv) Governor training (xv) Meetings with local journalists (xvi) Face to face briefings with services (xvii) Staff engagement events, briefings and workshops (xviii) Communications with staff on Hospital Services Review (xix) Internal staff surveys	(i) Consultation on HASU and children's tier 2 surgery (ii) Consultation on new strategic direction (iii) Bassetlaw Governors engagement work with the public (iv) Case law and advice taken in respect of service changes (v) F4H Strategy special, September 2017 (vi) Strategy stand at AMM (vii) Communications team is responsive on traditional and social media (viii) New, engaging website (ix) Invested in strong relationships with local journalists and MPs (x) Ensuring internal and external communications are aligned and staff engagement is considered in external comms process (xi) Communications Strategy approved by Board, October 2017 (xii) Ongoing meetings with commissioners and primary care across the patch (xiii) Medical Director's discussions with governors (xiv) CEO and MD meeting with Blaw CCG and John Man Bassetlaw MP on plans at BDGH.	(i) Improve patient engagement and listening activities to strengthen patients and public voice (ii) Adopt ReSPECT process Trust wide (iii) Launch and embed #hellomynameis (iv) Implementation of "Always events" (v) Identify opportunities for quality improvement through feedback (vi) HSR consultation (vi) Outcomes of improvement practice work.	(i) Increase engagement activities Q1-Q4 2018-19 (ii) Process adopted Trust wide Q1 2019 (iii) hellomynameis relaunched and embedded Q4 2017-18 - Q4 2018-19 (iv) Increased activities 2019 onwards (v) Increased opportunities for feedback Q1-4 2018-19 (vi) Finalisation of improvement practice work (commenced Q3)	L2 x I2 = 4
Failure to adequately prepare for CQC inspection leading to (i) Sub-optimal performance in inspection (ii) Risk of regulatory involvement (iii) Impact on reputation	Q&E7	Director of Nursing, Midwifery and Allied Health Professionals	L3 x I2 = 6	↑	6	4	4	6	(i) Self-assessment and mock inspection processes (ii) Engagement meetings with CQC (iii) Nottinghamshire Looked after Children and Safeguarding monitored by Trust Safeguarding People's Board (iv) Action plans montiored by Clinical Governance Committee	(i) IRMER inspection and action plan in place (ii) Reports to Board and QEC (iii) CQC Insights (iv) Positive mock inspections (v) CQC report received July 2018 (vi) Board and QEC consideration of action plans (vii) Action plan following inspection sent to CQC	(i) Action plan to move to 'outstanding' (ii) Mock inspectons Internal Audit to undertaken unannounced inspection of ED (Spring 2019) Internal Audit to undertaken unannounced inspection of Maternity (Summer 2019)	(i) Action plan in development (Autumn 2018) (ii) Workshop on moving to outstanding (October 2018) (iii) LEAN work informing True North statement (Autumn 2018)	L1 x I2 = 2
Failure to achieve complaint reply performance standards leading to (i) Impact on reputation (ii) Impact on patient experience	Q&E8	Director of Nursing, Midwifery and Allied Health Professionals	L2 x I2 = 4	↔	6	4	4	4	(i) Live complaints tracker developed (ii) Weekly PET/CG meetings to monitor progress/review agreed timescales and manage the complainants expectations. (iii) Weekly meetings with the Head of Patient Safety & Experience, Deputy Director of Quality & Governance and DoN which includes escalation. (iv) Quality dashboard includes CG performance presented at Clinical Governance Committee on a monthly basis. (v) Monitored through Patient Experience & Engagement Committee.	(i) Patient Experience Strategy approved (ii) Positive Q3 and Q4 results presented to Board in January 2017/18 and Q1 2018/19 (iii) Positive performance reported to Board throughout Summer 2018	(i) Consistent improved performance in complaints handling (ii) Complaints procsses subject to improvement practice work (A3)	(i) Reports to PEEC and QEC (Autumn 2018) (ii) A3 to be developed Awaiting internal audit review and reccomendations (Spring 2019)	L2 x I1 = 2

Failure to deliver GDPR mandated subject access requests due to increased demand against existing resource leading to (i) ICO intervention (ii) Regulatory fines (iii) Reputational impact	F&P17	Chief Information Officer	L4 x I3 = 12	⟷	12	12	12	12	(i) Historical baseline assessment (ii) Monitor impact for first three months (iii) Information Governance Committee monitoring (iv) Finance and Performance Committee report in initial months (v) Suitably qualified Data Protection Officer appointed (vi) Suitably trained staff (vii) Communications campaign and processes in place	(i) DPO appointment made (ii) Report to Finance and Performance Committee, April and May 2018 (iii) Report to Board of Directors, May 2018 (iv) Active action plan in place (v) Notices to members, staff and patients regarding GDPR Shared with Governor Brief. (vi) Paper provided to ANCR re DSP. (vii) Presentation and paper shared at Governor Brief	(i) As set out in action plan sent to Board, May 2018 (ii) Internal audit (to be scheduled later in 2019). (iii) Change to Data Security & Protection toolkit.	(i) DPO taking forward actions and reporting into IG Committee (2018/19) and ANCR.	L2 x I2 = 4
Failure to adequately treat patients due to unavailability and lack of supply of medicines leading to (i) Impact on safety of patients (ii) Impact on patient experience (iii) Potential delays to treatment (iv) Impact on trust reputation (v) Increased workload in pharmacy procurement (vi) Financial impact for the Trust	Q&E9	Chief Operating Officer	L4 x I4 = 16	⟷	15	15	16	16	(i) Support from Regional Procurement Team (ii) Arrangement of substitute drugs and medicines (iii) Databse of supply issues managed by RPT (iv) Daily updates on shortages (v) Holding to account of wholesalers for non-delivery of their contractual obligations and monitoring the performance of wholesalers in the region (vi) Local holding to account through account business managers (vii) Escalation measures to Deputy Chief Pharmacist for persistent and acute issues (viii) Logistics team communicating shortages to the ward and pharmacy team if stock not available for supply	(i) Temporary improvements to the supply chain (ii) Updates from CMU (Commercial Medicines Unit of NHSE) (iii) Risk interrogation to QEC (April 2018) (iv) Government technical notes (v) Letter and guidance on 'No Deal' Brexit, August 2018	(i) Longer term improvements to supply chain (ii) Awareness amongst relevant staff (iii) Set out in QEC risk interogation report, reported April 2018	(i) Gaps to be added to database (ongoing) (ii) Action plan as set out to QEC during risk interrogation (Autumn 2018)	L3 x I3 = 9
Failure to mitigate the impact of an ambitious effectiveness and efficiency programme on quality of care leading to (a) Poor patient and family experience (b) Regulatory action (c) Impact on Trust's reputation (d) Low staff morale	Q&E11	Medical Director / Director of Nursing, Midwifery and Allied Health Professionals	L3x I4 =12	⟷	12	12	12	12	(i) Medical Director and Director of Nursing involved in Quality Impact Assessment process (ii) DNS, COO and MD involved in Efficiency and Effectiveness Committee (iii) DNS, COO and MD in agreeing the effectiveness and efficiency measures through ET (iv) Friends and Family Test (v) PLACE assessments (vi) CQC inspections and mock-inspections (vii) Regular meetings with NHS Improvement (viii) Ward visits programme (ix) Patient Experience Committee	(i) Reports to Clinical Governance Committee and Quality and Effectiveness Committee (ii) Recent quality accounts continuing to show good performance (iii) Trust has track record of delivering effectiveness and efficiency measures (iv) No wards 'red' for quality in previous month (v) QPIA process and outcomes reported to QEC and CGC. (vi) Positive PLACE assessments. (vii) QEC Meeting reviewed process and example cases (October 2018)	(i) Not yet identified EEPs (ii) QPIA on all schemes that come through or which change (iii) QEC exmaination of CIP process	(i) QPIA process 2018/19 (ongoing)	L1 x I4 = 4

Strategic Aim 2 - We will ensure our services are high performing, developing and enhancing elective care facilities at Bassetlaw Hospital and Montagu Hospital and ensuring the appropriate capacity for increasing specialist and emergency care at Doncaster Royal Infirmary.

RISKS	LINK TO CRR	EXEC	CURRENT RR	DIRECTION OF TRAVEL	Q1	Q2	Q3	Q4	CONTROLS	ASSURANCE	GAPS IN ASSURANCE	ACTION TO ADDRESS GAPS	TARGET RR
Failure to achieve compliance with financial performance and achieve financial plan and subsequent cash implications leading to (i) Adverse impact on Trust's financial position (ii) Adverse impact on operational performance (iii) Impact on reputation (iv) Regulatory action	F&P1	Director of Finance	L4 x I4= 16	⇔	16	16	16	16	(i) Business and budget planning processes. (ii) Financial governance policies and procedures. (iii) Monthly monitoring of financial performance. (iv) Data analysis of trends and action to address deterioration. (v) Continued liaison with budget holders to identify risks to delivery. (vii) Detailed monitoring by Finance and Performance Committee. (viii) Budgets set on recurrent outturn resulting in a more robust financial plan. (ix) Budgets signed off by care groups and corporate departments. (x) Monthly monitoring at Board and directorate level. (xi) Uncommitted general contingency reserve. (xii) Regular finance meetings with budget holders. (xiii) Performance review meetings with NHSI. (xiv) All directorates signed up to control total. (xv) Appointment of suitably quaified Efficiency Director. (xvi) Revised forecast agreed with Board 29th January 2019. (xvii) Six weekly control meeting with NHSI. (xviii) Formation of Efficiency and Effectiveness Committee.	(i) Exceeded control total in 2016/17 (ii) Production of 2017/18 budget (iii) Unqualified opinion on 2016/17 accounts (vi) Accounts submitted to NHSI by deadline (v) Financial plans submitted to NHSI (vi) Board approval of budgets (vii) Budget setting approved by Finance and Performance Committee (viii) Minutes of accountability and NHSI meetings (ix) External Audit review of financial performance (within Annual Accounts work) (x) First round of accountability meetings taken place (xi) BDO governance review (xii) Regular finance reports to F&P (xiii) Strong performance in month 10 (xiv) Significant assurance audit with limited number of improvements on core financial systems (xv) External audit 2017/18 (xvi) Efficiency Director appointed (xvii) Financal performance regime implemented	(i) Achievement of strategic projects (ii) Review of equipment and maintenance (iii) Review of private patient options (iv) Unidentified CIP (v) Workforce Plans (vi) Maternity issues - CCG (vii) Demand and capacity planning	(i) Project groups established and cases being brought to Board (ii) Review of equipment and maintenance (March 2019) (iii) Understand options for private-patient (December 2019) (iv) Plan to address the unidentified CIP and workforce (ongoing) (v) Performance Assurance Framwork.	L2 x I4 = 8
Failure to deliver Cost Improvement Plans in this financial year leading to (i) Negative impact on Turnaround (ii) Negative impact on Trust's financial positon (iii) Loss of PSF funding	F&P3	Director of Finance	L4 x I4 = 16	⇔	16	16	16	16	(i) Full Quality Risk Assessment and operational deliverability assessment of plans. (ii) Regular consideration of schemes by Management Board and Executive Team. (iii) Collaboration with other providers, to identify joint opportunities. (iv) CIP tracker developed to provide visibility of progress agianst plan. (v) Engagement in working together programme. (vi) PMO led by new Effeiciecy Director, with associated management processes, key deliverables, risk logs and reporting to Finance and Performance Committee. (vii) Implementation of innovation from external reviews. (viii) Regular meetings with NHSI to track progress. (ix) Regenerated E&E Committee. (x) CIP recovery meetings (fortnightly) with each group. (xi) Escalation of schemes to F&P Committee (xii) Appointment of suitably quaified Efficiency Director.	(i) Performance against CIP for 16/17 of £11.9m. (ii) Monthly CIP reports to Finance and Performance and Board. (iii) Assurance provided to NHSI at quarterly meetings. (iv) New PMO governance processes agreed and implemented. (v) BDO governance review. (vi) Delivery of CIP in 2017/18 of £10.3m. (vii) Schemes in place for 2018/19. (viii) Director of Efficiency appointed - 1 January 2019. (ix) KPMG report on CIPs - significant assurance.	(i) Outstanding recurrent CIP target to be found (ii) Consistent reporting of on track CIP schemes (iii) See F&P1	(i) Work with Executive Team on high risk and unidentified schemes (ii) Schemes to be reported to F&P each month (ongoing) (iii) See Risk F&P1 (iv) Performance Assurance Framework	L1 x I4 = 4
Failure to achieve income targets arising from issues with activity leading to (i) the Trust not being paid for the work it is doing and subsequent impact on the financial plan (ii) reputational impact arising from a financial shortfall (iii) potential regulatory action arising from a financial shortfall	F&P19	Director of Finance	L2 x I5 = 10	⇔	15	10	10	10	(i) PTL meetings. (ii) Accountability meetings. (iii) Meetings with CCGs. (iv) Holding to account through Finance and Performance Committee. (v) Regular monitoring of activity plans. (vi) Care groups signed up to deliver activity. (vii) Enhanced PTL Meetings* (viii) Use of GOOROO (ix) Monitoring of prospective booking (x) Qli scheduling programme	(i) Accountability meetings taking place. (ii) Audit of maternity income. (iii) Delivery of income from M1 - 6.	(i) Capacity and demand plan (ii) Activity modelling	(i) Capacity and demand plan and actvity modelling (Autumn 2018) - elective and outpatient firsts	L1 x I4 = 4
Failure to ensure that estates infrastructure is adequately maintained and upgraded in line with current legislation, standards and guidance. **Note:** A number of different distinct risks are contained within this overarching entry. For further details please consult the E&F risk register. leading to (i) Breaches of regulatory compliance and enforcement (ii) Claims brought against the Trust (iii) Inability to provide safe services (iv) Negative impact on reputation (v) Reduced levels of business resilience (vi) Inefficient energy use (increased cost) (vii) Increased breakdowns leading to operational disruption (viii) Restriction to site development	F&P4	Director of Estates and Facilities	L4 x I5 = 20	⇔	20	20	20	20	(i) Annual business plan supports identification of issues by Care Groups / Directorates (ii) Risk-based capital investment plans (iii) Maintenance and support service contracts (iv) Independent Authorising Engineers appointed for key services, providing annual audits and technical guidance (v) Revised business planning process for all capital investments (vi) Estate condition and backlog maintenance assessment undertaken via 6-7 facet survey (vi) Progress and monitoring of actions undertaken through compliance committees e.g. health and safety committee (vii) Board level health and safety training undertaken, October 2017 (viii) Completion of in-depth high voltage scheme (June 2017) (ix) Emergeny Capital Theatre Bid	(i) Presentations to Finance and Performance and Governors Briefings (ii) Catering contract agreed May 2017 (iii) New service assistants in post April 2017 (iv) Completed 6/7 facet survey (v) Asbetos and window surveys complete (vi) Asbestos management plan up to date (vii) Window risk assessments complete (viii) Water management protocols complete and progress commenced (ix) Electrical infrastructure surveys complete (xii) Waste contract completed and delivered (xiii) New catering contract signed (xiv) New gas main (xv) Continuously premise assurance model (xvi) Estates Strategy approved by Board and capital plan (xvii) Estates strategy audited (significant assurance) (xviii) Capital programme 18/19 agreed (xix) PAM agreed April 2018 - good requires minimal improvement (xx) 6/7 facet survey work agreed (xxi) Seven year investment plan in place (xxii) Regular EFM KPI Reports to BoD and six monthly H&S KPI reports t ANCR (xxiii) PAM and ERIC completed	(ii) EFM transformation project	(i) Transformation project awaiting strategic development business case (December2018) (ii) Seek additional funding to rectify condition and backlog maintenance issues	L2 x I5 = 10
Risk of critical lift failure leading to (a) Reduction in vertical transportation capacity in the affected area (b) Impact on clinical care delivery (c) General access and egress in the affected area	F&P20 / Q&E12	Director of Estates and Facilities	L4 x I5 = 20	⇔	20	20	20	20	(i) Reporting to Estates Committee and Clinical Governance Committee (ii) PLACE assessments (iii) Contract monitoring arrangements (iv) Issues raised through Governor Forum and Patient Experience Committee (v) Issues and complaints statistics (vi) Service contract with Lift service provider which includes X 2 resident lift engineers on site permanently (vii) Lift refurbishment complete (lifts 4, 5, 6 and East Ward Block)	(i) Report to Part 2 Board, 26 June 2018 (ii) Confirmation of ability to use STF funding (iii) Catering updates to F&P, Board and Council of Governors (iv) Communication through ET and to Governors (v) Lifts down now back in commission	(i) Full lift survey to be undertaken in 2019/20 to develop capital for replacement	(i) Full site survey of lift conditions being undertaken in order to develop modernisation of programme.	L2 x I5 = 10

Failing to address the effects of the agency cap leading to (i) Negative patient and public reaction towards the Trust (ii) Impact on reputation	F&P5	Director of People and OD/ Chief Operating Officer/Medical Director	L4 x I4 = 16	⇔	16	16	16	16	(i) Teaching hospital status communicated through recruitment. (ii) Care Group to escalate recruitment difficulties to MD/COO. (iii) Use of Trust staff in first instance to address gaps wherever possible. (iv) Signed memo of understanding between all Trusts in the WTP to abide by a standard set of principles. (v) P&OD / Workforce reports to BoD. (vi) Workforce and Education Committee. (vii) Agency spend and breaches going to Exec Team and Finance and Performance. (viii) Better system around rate-to-fill and fill rates. (ix) Use of social media to attract new candidates. (x) Relationships with universities. (xi) GMC Survey. (xii) Medical agency locum panel. (xiii) Grip & Control work including scrutiny of qualified nurses. (xiv) Use of alternative workforce.	(i) Recruitment report to Board May 2017. (ii) Workforce and Education Committee assurance reports to QEC & F&P. (iii) Agency spend and breaches going to Exec Team and F&P. (iv) Improved rate-to-fill and fill rates. (v) Latest GMC Survey, in upper quartiles for a number of specialties. (vi) F&P monitoring agency spend and reporting to Board. (vii) Agency spend to F&P. (viii) Weekly flash reports and meetings. (ix) Bassetlaw@ work. (x) QiMET process. (xi) Nursing workforce within 3% cap. (xii) Report to Board July 2018. (xiii) KPMG audit report and institution of grip and control measures. (xiv) Use of model hospital data. (xv) NHS Professionals collaborative contract in place. (xvi) Medical bank in place. (xvii) Additional grip and control for agency spend. (xviii) Reviewing NHSI Model Hospital Portal data.	(i) Develop new service model to mitigate medical staff shortage, working across the Trust. (ii) Develop and progress workforce from using alternative workforce for service delivery. (iii) Agree with Trusts in WTP to minimise cap breaches. (iv) Decrease local agency spend. (v) Flexible use of staff across ICS system. (vi) Results from collaborative bank pilot to review. (vi) NHSP Collaborative Bank worked up for implemented. (vii) New grip nd control measures in operation. Divisional workforce plans need to adress exisiting shortfalls.	(i) Hospital@ work - T&O issues (Autumn 2018). (ii) In discussion with recruitment agencies to fill gaps (ongoing). (iii) Local Workforce Action Board work taking place. (iv) Grip and control meetings taking place weekly. Nursing and medical staff.	L3 x I2 = 6
Failure to achieve compliance with performance and delivery aspects of the Single Oversight Framework, CQC and other regulatory standards leading to (i) Regulatory action (ii) Impact on reputation	F&P6	Chief Operating Officer	L4 x I4 = 16	⇔	16	16	16	16	(i) Performance Management and Accountability Framework. (ii) Business planning processes (iii) Relevant policies and procedures. (iv) Daily, weekly & monthly monitoring of targets. (v) Regular monitoring of compliance. (vi) Data analysis of trends and action to address shortfalls. (vii) Continued liaison with leads to identify risks to delivery. (viii) CQC Compliance Governance and Assurance Process. (ix) External reviews policy. (x) Monitoring at monthly Care Group accountability meetings. (xi) A&E QAT process. (xii) Demand and capacity planning proccesses. (xiii) Weekly review of A&E Action plan in accountability meeting chaired by COO. (xiv) Licence to Operate linked to SOF.	(i) Full and unconditional registration with CQC. (ii) Business Intelligence and Performance Reports . (iii) Annual Report & Quality Account. (iv) CE quarterly objectives report (BoD - quarterly). (v) Internal audit of CQC readiness. (vi) CQC Intelligent Monitoring reports & risk ratings. (vii) In Group 2 on four hour waits. (viii) A&E Improvement Progarmme North - showcasing best practice. (ix) System Perfect. (x) Removal of breach fo licence. (xi) Estates performance reported to Board (April 2018). (xii) CQC inspection report and action plan. (xiii) Winter Plan considered by Board, September 2018. (xiv) High evel presentation to Board on CQC outstanding. (xv) Elective care work - feedback from NHSI positive.	(i) Action plan towards outstanding. (ii) 62 day cancer acton plan - urology	(i) Action plan for outstanding due Autumn 2018. (ii) 62 day action plan end Q3 - Completed. Q4 in progress.	L3 x I3 = 9
Failure to ensure that estates infrastructure is adequately maintained and upgraded in accordance with the Regulatory Reform (Fire Safety) Order 2005 and other current legislation standards and guidance. **Note:** a number of different distinct risks are conatained within this overarching entry. For further details please consult the EF risk register. leading to (i) Breaches of regulatory compliance could result in Enforcement or Prohibition notices issued by the Fire and Rescue Services (ii) Claims brought against the Trust (iii) Inability to provide safe services (iv) Negative impact on reputation	F&P12	Director of Estates and Facilities	L4 x I5 = 20	⇔	20	20	20	20	(i) Regular external inspections from SYRS and Notts Fire Service (ii) Improved fire safety risk assessments and evacuation strategies (iii) Improved Fire Safety Training (iv) Programme upgrade of fire detection systems (v) Programme upgrade of structural fire precautions (compartments) (vi) External Audit Fire Authorised Engineer (vii) Fire safety training Trust Board and Exec Team (viii) Further Development of Fire Safety Response Team structure (ix) Risk based Capital Investment plans identified by estate condition and backlog maintenance assessments via 6 - 7 facet surveys (x) Progress and monitoring of actions undertaken through compliance committees eg health and safety committee (xi) Emergency Capital Bids to NHSi to accelerate fire improvement programme	(i) Physical works to DRI and MMH (ii) Fire safety action plan (iii) Report to Board in June 2017 (iv) Fire safety training scheduled July 2017 (v) Staff trained in fire safety - June 2017 (vi) Compartmentalisation, fire stopping, fire doors, fire dampers to the East Ward Block (DRI) basement, ground floor and level seven and other areas across the site (vii) Upgrade of existing, and provision of additional, fire alarm and detection systems at DRI and Montagu Hospital. (viii) Approval of evacuation strategies for W&Cs and East Block. (ix) HSE inspections of Women's Block (x) Montagu evactuation strategy approved, December 2017 (xi) Priority list for fire strategies presented to Board (xii) Fire training delivered to deputy directors across organisation (xii) Training on evacuation strategies	(i) Full compliance with requirements of Fire Service (ii) Actions to address Deficiency Notice at Bassetlaw - partially complete	(i) Training to be rolled out across 2018/19 (Rolling programme). (ii) GMs and Hons to be fire trained.	L2 x I5 = 10
Inability to meet Trust's needs for capital investment leading to (i) Inability to sustain improveemnts in Trust's estate. (ii) Negative impact on patient safety. (iii) Negative impact on reputation.	F&P13	Director of Finance	L4 x I4 = 16	⇔	16	16	16	16	(i) Finance reports to Board and Finance and Performance Committee. (ii) Capital governance governance structure - Corporate Investment Group and Capital Monitoring Group. (iii) Guidance and templates for investment and disinvestment. (iv) Proactive prioritiation of schemes. (v) Range of capital groups established and led by directors.	(i) DBTH part of bidding process for ICS funds and ET to agree priorities. (ii) Five year review of capital requirements which have been prioritised. (iii) Submitted bid for rebuild and IT.	(i) Development of ICS schemes - business cases. (ii) Approval of CT scheme by DOH.	(i) Board to approve ICS business case. (ii) Wait for CT decision - 6-8 weeks (October 2018)	L1 x I4 = 4
Lack of adequate CT scanning capacity at DRI leading to (i) Negative impact on patient safety. (ii) Inability to safely manage the emergency and inpatient activity.	Q&E2	Chief Operating Officer	L3 x I3 = 9	⇔	9	9	9	9	(i) Allocation within 2017/18 capital programme. (ii) Engagement with care group directors. (iii) Mobile CT. (iv) HASU project steering group.	(i) Business case cleared at CIG. (ii) Initial dicussions at F&P and ICS level. (iii) Case approved at Board, February 2018. (iv) CT donation. (v) Positive feedback from NHSI. Work commenced on two new CT scanners - discussed at BoD in Jan 2019 Utilisation of Bassetlaw CT scan and van days Mobile CT scanner.	(i) Approval from DOH. (i) CT scanning implementation.	(i) Awaiting approval from DOH (October 2018) (ii) CT Build Janaury 2019	L2 x I2 = 4
Uncertainty over ICS financial regime including single financial control total leading to (i) Impact on Trust's finances and control total (ii) Negative impact on reputation	F&P16	Director of Finance	L2 x I4 = 8	⇔	12	8	8	8	(i) Chair and exec attendance at ICS meetings. (ii) Leadership at ICS level. (iii) Developing governance structure.	(i) Ongoing discussions with ICS and at national level. (ii) Framework approved June 2018. (iii) Paper to board explaining options (Summer 2018). (iv) Decision by Board to agree option 2. (v) Initial governance workshop took place September 2018. (vii) Monitorring at FD meeting (viii) Exec Steering Group	(i) Uncertainty over ICS governance structure.	(i) Further governance work taking place (ongoing) (ii) Ambiguity of national guidance on application of surplus to the SYB system control total.	L2 x I2 = 4
Risk of fraud leading to (i) Impact on Trust's finance (ii) Negative impact on reputation	ANCR1	Director of Finance	L2 x I4 = 8	⇔	8	8	8	8	(i) Local Counter Fraud Specialist work plan and investigations (ii) Fraud awareness training. (iii) DH Counter-Fraud regime and oversight (iv) Liaison with DOF and Chair of ANCR (v) Staff fraud questionnaire. (vi) Board level awareness, October 2018.	(i) Quarterly and annual LCFS reports (ii) Achievement of satisfactory NHS Protect Quality Assessment outcome (iii) Full completion of 2016/17 operational fraud plan and 2017/18 plan in place (iv) Completion of fraud staff survey (vii) 79% completed fraud awareness training in 2017/18 (viii) NHS Protect assurance report to Board, October and November 2017	N/A	N/A	L1 x I4 = 4

Strategic Aim 3 - We will increase partnership working to benefit people and communities.													
RISKS	LINK TO CRR	EXEC	CURRENT RR	DIRECTION OF TRAVEL	Q1	Q2	Q3	Q4	CONTROLS	ASSURANCE	GAPS IN ASSURANCE	ACTION TO ADDRESS GAPS	TARGET RR
Breakdown of relationship with key partners and stakeholders leading to (i) Negative impact on strategic objectives (ii) Negative impact on reputation	F&P9	Director of Strategy and Improvement	L3 x4 = 12	⇔	12	12	12	12	(i) Partnership working processes - Working Together, STP, Accountable Care Systems, HWB. (ii) Engagement with commissioners & other local trusts. (iii) Attendance at CCG governing body meetings. (iv) CE meetings with NHS England. (v) Regular briefings to Members of Parliament. (vi) Partner Governor seats on the Council of Governors. (vii) Regular item on Exec Team for feeding back.	(i) CE Reports to Board. (ii) Updates on HWB activity. (iii) Updates regarding Working Together and STP programme via CE report (BoD). (iv) Committees in common and STP MoUs. (v) Support from commissioners. (vi) Bassetlaw and Doncaster Place Plans endorsed. (vii) Well Led Governance Review reinforces the Trust's partnership arrangements. (viii) ACS Conference for Governors taken place, October 2017 and with NEDs, May 2018. (ix) CiC meetings underway. (x) Collaborative Partnership Agreements with Doncaster and Bassetlaw signed, April and May 2018. (xi) Outcome of legal challenges known and not, as yet, affecting ICS. (xii) ICS MoU considered by Board, September 2018. (xiii) CEO commenced formal secondment with ICS. (xiv) ICS MoU signed.	(i) ACS events planned with MPs and councillors. (ii) Joint meetings with SCH and RDaSH.	(i) Engagement at PLACE level under consideration (Autumn 2018) (ii) Engagement meetings with SCH and RDaSH (Autumn 2018)	L2 x I4 = 8
Failure to deliver strategic direction leading to (i) Negative impact on patients (ii) Inability to configure services in the best interests of patients (iii) Negative perception of partners and staff	F&P18/QEC10	Director of Strategy and Improvement	L2 x I5 = 10	⇔	10	10	10	10	(i) Process for strategy review based on quarterly exception reporting and annual report to Board. (ii) Quarterly discussion at Executive Team on strategy. (iii) LEAN Programme work. (iv) Capital steering groups set up to consider approach to clinical site development work. (v) Operational groups taking forward individual enabling strategies (IT Steering Group, Estates Group, etc). (vi) Board committees with certain enabling strategies under their remit. (vii) Dedicated resource within Strategy and Transformation.	(i) Overall strategic direction agreed, Summer 2017. (ii) Enabling strategies approved by Board, 2017/18. (iii) Board process for reviewing strategies agreed, April 2018. (iv) Strategy review within board committee terms of reference. (v) Key milestones agreed by ET, April 2018. (vi) Strategy communicated to staff through Buzz and Foundations for Health. (vii) Deep dives and exception reporting mechanism established (June 2018)	(i) Firmer arrangements for committee review of milestones and KPIs to be agreed. (ii) Achivement of strategic milestones. (iii) Capital to achieve long term aims. (iv) Realisation of Improvement Practice work.	(i) Process for milestones and KPIs in development. (ii) Monitoring and achivement of action plans agreed at Board (2018-19) (iii) ICS capital bids (Autumn 2018). (iv) Improvement Practice Programme 2018-19.	L1 x I5 = 5
Failure to ensure business continuity / respond appropriately to major incidents leading to (i) Negative impact on reputation (ii) Regulatory enforcement (iii) Negative impact on performance	F&P10	Chief Operating Officer	L2 x I4 = 8	⇔	8	8	8	8	(i) Business continuity plans (ii) Business Continuity Policy (iii) Statement of Compliance against National Core Standards for EPRR (iv) BRSG which monitors BC planning progress (v) Business Continuity Group linked to operational structures (vi) Major Incident Plan (vii) Training of A&E staff on CBRN incidents (viii) Emergency response plans in place (annually reviewed) - Evacuation of a hospital site - Mass Casualty Plan - Pandemic Influenza Plan - Severe Eather Plan - Prison Plan - CBRNE plan (ix) Incident Control Rooms in line with EPRR Command and Control guidelines (x) Communications exercises undertaken twice yearly as required by statute (xi) Command & control training for BoD & senior managers on-call (xii) Revision of plans following test exercises. (xiii) On-call senior mangement trained - Leading in a crisis and public enquiry simulation (xiv) New generator and power witchover (Childrens completed).	(i) Power outage testing Summer 2017 (ii) Annual confirmation of compliance against National Core Standards for Emergency Preparedness, Resilience and Response (BoD, Nov 2016) (iii) Test exercises: Sickness, fuel (2016) (iv) Internal Audit follow-up review of business continuity arrangements (v) Risk assessment of major incident and business continuity plans with NHS England (2015) (vi)Y&H peer review of major incident plans 2016. (vii) External review of HAZMAT - compliant (September 2015) (viii) Hazardous Substances policy agreed by Board 29.11.2016 (ix) Tabletop exercises undertaken, SY risk assessment completed and two power cuts (x) Working with Care Groups to develop relevant desktop exercises. (xi) Trust unaffected by system-wide cyber attack, May 2017 (xii) Winter planning agreed by Board in July 2017 (xiii) Compliance with Annual Statement of Compliance against the NHS Core Standards for Emergency Preparedness, Resilience and Response (2017/18) (xiv) Presentation to Board on Emergency Planning, November 2017 (xv) Business continuity exercise (mostly completed), December 2017 (xiv) Further review of processes following power outage (Winter 2018). - work undertaken (xv) Cold weather plan tested. Significant assurance agaisnt latest core standards. (xvi) Esclation Policy for management of major incident - Trust/Council. (xvii) June 2018 testing complete. (xviii) Polcies agreed by MB. (xix) EPRR action plan agreed by Board.	(i) Testing by internal audit. (ii) Brexit plan. (iii) LHRP ratification.	(i) Internal audits (end of 2018/19) (ii) Brexit planning ongoing. (iii) East block tower work to be undertaken in March 2019.	L2 x I3 = 6

Strategic Aim 4 - We will support the development of enhanced community based services, prevention and self-care.													
RISKS	LINK TO CRR	EXEC	CURRENT RR	DIRECTION OF TRAVEL	Q1	Q2	Q3	Q4	CONTROLS	ASSURANCE	GAPS IN ASSURANCE	ACTION TO ADDRESS GAPS	TARGET RR
Inability to sustain the Paediatrics service at Bassetlaw leading to (i) Withdrawal of overnight service (ii) Negative impact on local community	Q&E3	Chief Operating Officer	L2 x I2 = 4	⟺	4	4	4	4	(i) Consultant led paediatric assessment unit in place. (ii) Arrangements for transferring overnight stays to DRI. (iii) Communication with CCG and HOSC. (iv) Arrangements with Sheffield Children's Hospital. (v) Ongoing paediatric nurse recruitment.	(i) Reports on transferrals (ii) Positive response to recruitment (iii) Discussions with Notts Health O&S Committee in July 2017 (iv) Report to Board, August 2017 regarding future of overnight paediatric service (v) CEO's presentation to Governors, September 2017 (vi) Decision taken by Bassetlaw CCG, October 2017 (vii) Overview and Scrutiny Committee in January 2019 to update on current plans.	(i) Recruitment of medical and nursing staff.	(i) Regular recruitment exercises. (ii) Review of peadiatric competencies for ED - Additional training for Adult Nurses in Bassetlaw ED. (iii) Continue to advertise nursing posts. Paediatrics being review as part of Hospital Services review.	L1x I2 = 2
Reduction in hospital activity and subsequent income due to increase in community provision leading to (i) Increased pressure on acute services (ii) Negative impact on financial plan	F&P14	Director of Finance	L3 x I3 = 9	⟺	12	12	9	9	(i) Measures to ensure ward base matches with cost base (ii) Contract negotiation (III) Nursing workforce report (iv) Agency bank report (v) Corporate Investment Group processes (vi) Business change processes for associated service changes (vii) Contract changes to go to F&P (viii) Monitorring and bidding against appropriate services.	(i) OBTH input into Place Plan (ii) Assessment received for MoU	(i) Understanding of impact of Place Plan and ICS (ii) Lack of clarity over Doncaster Place Plans.	(i) Meetings taking place with Council and other partners to assess impact (ongoing) (ii) Doncaster Place Meeting	L4 x I2 = 8
Commissioner plans do not come to fruition and do not achieve the required levels of acute service reduction leading to (i) Increased pressure on acute services (ii) Negative impact on strategic direction (iii) Negative impact on financial plan	F&P15	Chief Operating Offcer	L4 x I3 = 12	⟺	9	9	12	12	(i) Potential to dual run services (ii) Contractual negotiations (iii) External advice on contractual changes (iv) Consideration of changes through ACPs (v) Gooroo work (vi) Meetings between DOFs of Trust and CCGs	(i) Active monitoring of position (ii) Place Plans in place (iii) Clinical services strategy in place (iv) Both sides committed to outputs from Gooroo work.	(i) Alignment of expectations between Trust and CCG	(i) Ongoing negotiations and plans (Autumn 2018) (ii) CCG agreed to fund additional activity which needs to be undertaken to maintain contract and activity.	L2 x I3 = 6

Strategic Aim 5 - As a Teaching Hospital we are committed to continuously developing the skills, innovation and leadership of our staff to provide high quality, efficient and effective care.													
RISKS	**LINK TO CRR**	**EXEC**	**CURRENT RR**	**DIRECTION OF TRAVEL**	**Q1**	**Q2**	**Q3**	**Q4**	**CONTROLS**	**ASSURANCE**	**GAPS IN ASSURANCE**	**ACTION TO ADDRESS GAPS**	**TARGET RR**
Inability to recruit right staff and have staff with right skills leading to (i) Increase in temporary expenditure (ii) Inability to meet FYFV and Trust strategy (iii) Inability to provide viable services	F&P8	Director of People & OD	L4 x I4 = 16	⇔	16	16	16	16	(i) HR policies and procedures. (ii) Monitoring of use of agency staff through robust processes to stay within cap. (iii) Medical staff recruitment action plans. (iv) Care Group Business Plans – workforce plans. (v) E-Rostering processes. (vi) VCF processes - bolstered. (vii) Consultant appointment approval processes. (viii) NHS Professionals processes & management information. (ix) Pilot of Assistant Practitioner role. (x) Links with universities, increasing local placements. (xi) Developing bands 1-4 nursing roles. (xii) Nurse associate roles - exploration. (xiii) Increasing the attractiveness of the website, social media and open days. (xiv) Open days for recruitment (June 2019)	(i) Increased fill-rate, above national averages in most areas. (ii) Recruitment report to Board, May 2017. (iii) Regular NHSI reporting which is reported to Exec Team, increased to bank as well as agency. (iv) Benchmarking work. (v) WTP work. (vi) New style agency report reported monthly to Exec Team. (vii) Work with ICS Local Workforce Action Board. (viii) Accountability arrangements embedded. (ix) Regular reports to F&P. (x) Review of cohort recruitment. (xi) Work on apprenticeships. (x) We Care for Junior Doctors work. (xi) People & OD Strategy. (xii) QiMET work. (xiii) P&OD structure in place. (xiv) Hall Cross Foundation School work. (xv) Pilot for international recruitment for Junior Drs. (xvi) Expanding Medical Training Initiative recruitment.	(i) Leadership Strategy. (ii) Radiographers work ongoing. (iii) Actions identified in strategic milestones. (iv) LWAB work taking place.	(i) Recruitment for radiographers in place - skill mix (Autumn 2018). (ii) LWAB actions. (iii) Q4 2018/19 (iv) Refreshing recruitment material and branding. (v) Recruitment with Napal. (vi) Open days for recruitment (June 2019)	L2 x I4 = 8
Failure to engage and communicate with staff and representatives in relation to immediate challenges and strategic development leading to (i) Deterioration in management-staff relationships (ii) Negative impact on performance (iii) Negative impact on reputation	Q&E1	Director of People & OD	L4 x I4 = 16	⇔	16	16	16	16	(i) Process to engage with LNC. (ii) Process to engage with Partnership Forum. (iii) HR policies and procedures. (iv) Staff engagement project strands. (v) Staff experience group. (vi) Listening events by CEO. (vi) E&E Committee communications plan. (vii) One-page strategy summaries. (viii) Staff social media sites. (ix) Staff Experience Meetings	(i) Suspensions/exclusions reports to ANCR. (ii) P&OD reports to Board. (iii) Briefings regarding staff engagement during restructures. (iv) Records of ongoing engagement via Partnership Forum. (v) Staff Survey results. (vi) Grievance and employment tribunal rates. (vii) Outcomes of negotiation & work with staff side. (x) Delivery of engagement plan KPIs. (xi) Listening events - Autumn 2018. (xii) Buzz and social media interaction. (xi) Meetings with staff regarding Hospital Services Review. (xii) Staff survey action plans to Board, May 2018. (xiii) Partnership Board meetings with executive directors. (xiv) Update on progress agaisnt action plan at Board in December 2018.	(i) Staff survey action plans fully signed up to. (ii) Relationship with new chair of Partnership Forum. (iii) Actions identified in strategic milestones. (iv) Actions identified in deep dive risk interrogation, QEC (August 2018) (v) Relaunch staff experience group.	(i) Divisional action plans to be implemented and monitored through accountability meetings. (ii) Development of staff side relationships (Autumn 2018). (iii) Q4 2018-19	L2 x I4 = 8
Failure to improve staff morale leading to (i) Recruitment and retention issues (ii) Impact on reputation (iii) Increased staff sickness levels	Q&E6	Director of People and OD	L3 x I4 = 12	⇔	12	12	12	12	(i) Monitoring by staff experience group. (ii) Revised appraisal process. (iii) Chief Executive's listening exercises and 'you said, we did'. (iv) Staff involved in strategy engagement. (v) Management passport qualification developed. (vi) Localised action plans. (vii) Staff survey action plan monitored by Board and QEC. (viii) Revamped staff brief. (xi) 'Bugbears and bright ideas' approach. (x) Agreed approach to staffside - management meetings. (xi) Achievment of teaching hospital status.	(i) Feedback from Friends and Family Q2. (ii) Feedback from CEO's listening events and lunchtime meetings with consultants. (iii) Bugbears and bright ideas outcomes. (iv) Report to QEC and Board, June 2017, on staff survey action plan. (v) People and OD Strategy approved by Board in October 2017. (vi) Improvements in staff survey results. (vii) Action plans approved by Board (April 2018). (viii) Progress update on actions to Board in December 2018.	(i) Consistent positive scores for staff Friends and Family Test. (ii) Consistent positive scores for staff survey. (iii) Actions identified in strategic milestones. (iv) Active monitoring against departmental action plans. (v) Conclusion of clinical admin review.	(i) Additional listening exercises. (ii) P&OD action plans (Various). (iii) Q4 2018-19. (iv) BPs to update on progress against each of action plans. (v) Clinical admin review concluded (January 2019 - interviews held recruitment ongoing). (vi) Planning future actions for 2019. (vii) Staff Survey to be highlighted under new PAF.	L2 x I4 = 8

Doncaster & Bassetlaw Teaching Hospitals Corporate Risk Register

No.	Description of Risk		Exec owner	Relevant committee	Original Risk Score 1:Low…5:Extreme		Overall Original Risk Score	Controls	Current Risk Score 1:Low 5:Extreme		Overall Current Risk Score	Target Risk Score 1:Low 5:Extreme		New and developing controls	Owner and target date
	Source (Lack of….Failure to ….)	Consequences (Results in ….Leads to ….)			Like-lihood	Impact			Like-lihood	Impact		Like-lihood	Impact		
F&P1	Failure to achieve compliance with financial performance and achieve financial plan	(i) Adverse impact on Trust's financial position (ii) Adverse impact on operational performance (iii) Impact on reputation (iv) Regulatory action	Director of Finance	Finance & Performance	4	5	20	(i) Business and budget planning processes. (ii) Financial governance policies and procedures. (iii) Monthly monitoring of financial performance. (iv) Data analysis of trends and action to address deterioration. (v) Continued liaison with budget holders to identify risks to delivery. (vi) Demand and capacity planning proccesses. (vii) Detailed monitoring by Finance and Performance Committee. (viii) Budgets set on recurrent outturn resulting in a more robust financial plan. (ix) Budgets signed off by care groups and corporate departments. (x) Monthly monitoring at Board and directorate level. (xi) Uncommitted general contingency reserve. (xii) Regular finance meetings with budget holders. (xiii) Performance review meetings with NHSI. (xiv) All directorates signed up to control total. (xv) Appointment of suitably quaified Efficiency Director. (xvi) Revised forecast agreed with Board 29th January 2019. (xvii) Six weekly control meeting with NHSi. (xviii) Formation of Efficiency and Effectiveness Committee.	5	4	20	2	5	(i) Additional grip and conrol mechnaisms. (ii) Performance Assurance Framework.	Each month
F&P3	Failure to deliver Cost Improvement Plans in this financial year	(i) Negative impact on Turnaround (ii) Negative impact on Trust's financial positon (iii) Loss of STF funding	Director of Finance	Finance & Performance	4	5	20	(i) Full Quality Risk Assessment and operational deliverability assessment of plans. (ii) Regular consideration of schemes by Management Board and Executive Team. (iii) Collaboration with other providers, to identify joint opportunities. (iv) CIP tracker developed to provide visibility of progress agianst plan. (v) Engagement in working together programme. (vi) PMO led by new Effeiciecy Director, with associated management processes, key deliverables, risk logs and reporting to Finance and Performance Committee. (vii) Implementation of innovation from external reviews. (viii) Regular meetings with NHSI to track progress. (ix) Regenerated E&E Committee. (x) CIP recovery meetings (fortnightly) with each group. (xi) Escalation of schemes to F&P Committee (xii) Appointment of suitably quaified Efficiency Director.	4	4	16	1	5	(i) Additional grip and conrol mechnaisms. (ii) Performance and Assurance Framework.	Each month
F&P4	Failure to ensure that estates infrastructure is adequately maintained and upgraded in line with current legislation, standards and guidance. **Note:** A number of different distinct risks are contained within this overarching entry. For further details please consult the E&F risk register.	(i) Breaches of regulatory compliance and enforcement (ii) Claims brought against the Trust (iii) Inability to provide safe services (iv) Negative impact on reputation (v) Reduced levels of business resilience (vi) Inefficient energy use (increased cost) (vii) Increased breakdowns leading to operational disruption (viii) Restriction to site development	Director of Estates and Facilities	Finance & Performance	5	5	25	(i) Annual business plan supports identification of issues by Care Groups / Directorates (ii) Risk-based capital investment plans (iii) Maintenance and support service contracts (iv) Independent Authorising Engineers appointed for key services, providing annual audits and technical guidance (v) Revised business planning process for all capital investments (vi) Estate condition and backlog maintenance assessment undertaken via 6-7 facet survey (vi) Progress and monitoring of actions undertaken through compliance committees e.g. health and safety committee (vii) Board level health and safety training undertaken, October 2017 (viii) Completion of in-depth high voltage scheme (June 2017) (ix) Emergeny Capital Theatre Bid	4	5	20	2	5	(i) Test buisness continuity and disaster recovery plans (ii) Rolling programme of Board / Senior Staff training (iii) Seek additional funding to rectify condition and backlog maintenance issues	DP - ongoing KEJ - ongoing
F&P5	Failing to address the effects of the medical agency cap	(i) Negative patient and public reaction towards the Trust (ii) Impact on reputation	Director of People and OD/ Chief Operating Officer/Medical Director	Finance & Performance	5	4	20	(i) Teaching hospital status communicated through recruitment. (ii) Care Group to escalate recruitment difficulties to MD/COO. (iii) Use of Trust staff in first instance to address gaps wherever possible. (iv) Signed memo of understanding between all Trusts in the WTP to abide by a standard set of principles. (v) P&OD / Workforce reports to BoD. (vi) Workforce and Education Committee. (vii) Agency spend and breaches going to Exec Team and Finance and Performance. (viii) Better system around rate-to-fill and fill rates. (ix) Use of social media to attract new candidates. (x) Relationships with universities. (xi) GMC Survey. (xii) Medical agency locum panel. (xiii) BDO Grip & Control work. (xiv) Use of alternative workforce.	4	4	16	3	2	(i) Develop new service model to mitigate medical staff shortage. (ii) Develop and progress workforce from using alternative workforce for service delivery.	KB/SS/DP - ongoing As above

F&P6	Failure to achieve compliance with performance and delivery aspects of the Single Oversight Framework, CQC and other regulatory standards	(i) Regulatory action (ii) Impact on reputation	Chief Operating Officer	Finance & Performance (impact on performance) Quality & Effectiveness (impact on quality)	5	4	20	(i) Performance Management and Accountability Framework. (ii) Business planning processes (iii) Relevant policies and procedures. (iv) Daily, weekly & monthly monitoring of targets. (v) Regular monitoring of compliance. (vi) Data analysis of trends and action to address shortfalls. (vii) Continued liaison with leads to identify risks to delivery. (viii) CQC Compliance Governance and Assurance Process. (ix) External reviews policy. (x) Monitoring at monthly Care Group accountability meetings. (xi) A&E QAT process. (xii) Demand and capacity planning proccesses. (xiii) Weekly review of A&E Action plan in accountability meeting chaired by COO. (xiv) Licence to Operate linked to SOF	4	4	16	3	3	(i) Review of front door streaming	DP - Autumn 2018
F&P8	Inability to recruit right staff and have staff with right skills	(i) Increase in temporary expenditure (ii) Inability to meet FYFV and Trust strategy (iii) Inability to provide viable services	Diretcor of People & OD	Finance & Performance	5	4	20	(i) HR policies and procedures. (ii) Monitoring of use of agency staff through robust processes to stay within cap. (iii) Medical staff recruitment action plans. (iv) Care Group Business Plans – workforce plans. (v) E-Rostering processes. (vi) VCF processes - bolstered. (vii) Consultant appointment approval processes. (viii) NHS Professionals processes & management information. (ix) Pilot of Assistant Practitioner role. (x) Links with universities, increasing local placements. (xi) Developing bands 1-4 nursing roles. (xii) Nurse associate roles - exploration. (xiii) Increasing the attractiveness of the website, social media and open days. (xiv) Open days for recruitment (June 2019)	4	4	16	2	4	(i) Agency report development (ii) Care group management development (iii) Relaunch of Trust values	(i) Autumn 2018
F&P11	Failure to protect against cyber attack	(i) Trust becoming non-operational (ii) Inability to provide clinical services (ii) Negative impact on reputation	Chief Information Officer	Finance & Performance	5	5	25	(i) Penetration test of systems to identify gaps and risks; (ii) Firewalls, passwords, anti-virus equipment. (iii) Policies and reinforcement through communication to staff; (iv) Staff awareness through Certified Security Professional course and other training; (v) Trigger alerts; (vi) Care Cert system at NHS Digital (vii) All servers and systems patched to appropriate level (viii) Computers and network infrastructure get security patches automatically applied (ix) Monthly cyber security report (x) Pilot trust for NHS Digital work (xi) Digital garage work (xii) Regular returns to the centre	3	5	15	1	4	Controls proposed by recent cyber security audit including ongoing changes to systems and new patches being applied	SM - Autumn 2018
F&P12	Failure to ensure that estates infrastructure is adequately maintained and upgraded in accordance with the Regulatory Reform (Fire Safety) Order 2005 and other current legislation standards and guidance. **Note:** a number of different distinct risks are conatained within this overarching entry. For further details please consult the EF risk register.	(i) Breaches of regulatory compliance could result in Enforcement or Prohibition notices issued by the Fire and Rescue Services (ii) Claims brought against the Trust (iii) Inability to provide safe services (iv) Negative impact on reputation	Director of Estates and Facilities	Finance & Performance	5	5	25	(i) Regular external inspections from SYRS and Notts Fire Service (ii) Improved fire safety risk assessments and evacuation strategies (iii) Improved Fire Safety Training (iv) Programme upgrade of fire detection systems (v) Programme upgrade of structural fire precautions (compartments) (vi) External Audit Fire Authorised Engineer (vii) Fire safety training Trust Board and Exec Team (viii) Further Development of Fire Safety Response Team structure (ix) Risk based Capital Investment plans identified by estate condition and backlog maintenance assessments via 6 - 7 facet surveys (x) Progress and monitoring of actions undertaken through compliance committees eg health and safety committee (xi) Emergency Capital Bids to NHSi to accelerate fire improvement programme	4	5	20	2	5	(i) Ongoing training on fire safety with staff	KEJ - ongoing
F&P13	Inability to meet Trust's needs for capital investment	(i) Inability to sustain improveemnts in Trust's estate. (ii) Negative impact on patient safety. (iii) Negative impact on reputation.	Director of Finance	Finance & Performance	5	4	20	(i) Finance reports to Board and Finance and Performance Committee. (ii) Capital governance governance structure - Corporate Investment Group and Capital Monitoring Group. (iii) Guidance and templates for investment and disinvestment. (iv) Proactive prioritiation of schemes. (v) Range of capital groups established and led by directors. (vi)Trust investigating application for emergency capital to DOH	4	4	16	1	4	Clarity around process over STP capital projects.	Autumn 2018
Q&E1	Failure to engage and communicate with staff and representatives in relation to immediate challenges and strategic development	(i) Deterioration in management-staff relationships (ii) Negative impact on performance (iii) Negative impact on reputation	Director of People & OD	Quality & Effectiveness	5	4	20	(i) Process to engage with LNC. (ii) Process to engage with Partnership Forum. (iii) HR policies and procedures. (iv) Staff engagement project strands. (v) Staff experience group. (vi) Listening events by CEO. (vi) E&E Committee communications plan. (vii) One-page strategy summaries. (viii) Staff social media sites. (ix) Staff Experience Meetings	4	4	16	2	4	Proactive communications around particular issues	Ongoing

Q&E9	Failure to adequately treat patients due to inavilability and lack of supply of medicines	(i) Impact on safety of patients (ii) Impact on patient experience (iii) Potential delays to treatment (iv) Impact on trust reputation (v) Increased workload in pharmacy procurement	Chief Operating Officer	Quality & Effectiveness	5	4	20	(i) Support from Regional Procurement Team (ii) Arrangement of substitute drugs and medicines (iii) Databse of supply issues managed by RPT (iv) Daily updates on shortages (v) Holding to account of wholesalers for non-delivery of their contractual obligations and monitoring the performance of wholesalers in the region (vi) Local holding to account through account business managers (vii) Escalation measures to Deputy Chief Pharmacist for persistent and acute issues (viii) Logistics team communicating shortages to the ward and pharmacy team if stock not available for supply	4	4	16	2	3	(i) Adoption of a regional procurement online tool to track, manage and communicate supply shortages (ii) Updated workflows, process and procedures to ensure that internal communication and engagement is optimised, collaboration is enhanced and action plans and solutions are documented better (iii) Support sought from Regional QA teams to help quality assure imported or unlicensed medicines.	Autumn 2018
F&P20 / Q&E12	Risk of critical lift failure	(i) Reduction in vertical transportation capacity in the affected area (ii) Impact on clinical care delivery (iii) General access and egress in the affected area	Director of Estates and Facilities	Finance & Performance (impact on performance) Quality & Effectiveness (impact on quality)	4	5	20	(i) Reporting to Estates Committee and Clinical Governance Committee (ii) PLACE assessments (iii) Contract monitoring arrangements (iv) Issues raised through Governor Forum and Patient Experience Committee (v) Issues and complaints statistics (vi) Service contract with Lift service provider which includes X 2 resident lift engineers on site permanently. (vii) Lift refurbishment complete (lifts 4, 5, 6 and East Ward Block)	4	5	20	2	4	(i) Full lift survey to be undertaken in 2019/20 to develop capital for replacement	(i) ongoing
Q&E13	Initial ED triage assessment processes Following an unannounced CQC inspection involving the commissioned Front Door Assessment Service it has been identified that the initial triage and clinical assessment processes and clinical oversight of the waiting area, unwell children and adults may not be provided with the full assessments required to provide high quality care, which could potentially cause harm to patients.	(i) Impact on safety of patients (ii) Impact on patient experience (iii) Potential delays to treatment (iv) Impact on patient harm Impact on reputation	Director of Nursing	Quality & Effectiveness	4	4	16	(i) Previous traige model revised and changed to check in implemented (ii) Nurse with triage skills now undertaking initial assessment within a targeted 15minutes (iii) Triage includes relevant assessments for physiological observations where indicated (iv) Triage assessment location reviewed (v) Responsive escalation process to ensure staff resource (vi) Clinical Oversight of waiting rooms (vii) Report to ET. (viii) Governance process for escalation of concerns, Board, CGC, QEC (ix) Reporting to CQC fornightly since 27 December 2018 (2months) - satisified with information received. (x) Working group established December 2018 and meets weekly.	4	4	16	2	3	(i) Report to CQC fortnightly. (ii) Mock CQC inspection unannounced by internal audit to be undertaken. (iii) Standing item to ET weekly	(i) ongoing
Q&E14	Staffing for registered children's nurses in ED on DRI and BDGH sites Risk of insufficient workforce for providing care for unwell children, including registered children's nurse (RCN) on duty to the level expected by RCPCH standards expanding on previous Royal College of Nursing guidance, being unavailable 24/7, could lead to patient harm due to the absence of appropriately skilled staff.	(i) Impact on safety of patients (ii) Impact on patient experience (iii) Potential delays to treatment (iv) Impact on patient harm (v) Impact on workforce Impact on reputation	Director of Nursing	Quality & Effectiveness	4	4	16	(i) Senior oversight, management and escalation of RCN Staffing levels across ED and the Children's ward and departments. (ii) (iii) (iv) Temporary staffing set up with cascade arrangements for agency.Some dual trained RN's. Reviewing alternative agencies to improve temp staff with support from procurement. (v) Paediatric Module additional training for some staff. (vi) PAWS training provision (vii) Paediatric resuscitation training at L4 (APLS, EPALS) and L3 (PILS) (vii) Report to ET. (viii) Governance process for escalation of concerns, Board, CGC, QEC. (ix) (x) Enrolment of RGN (Adult) to Paediatric Courses at SHU. (xi) Reporting to CQC fornightly since 27 December 2018 (2months) - satisified with information received. (xii) 15 RCN's in recruitment process of which 6 are Band 6 and 9 are Band 5. 5 comenced in post February 2019. Further interviews planned March 2019 joint recruitment for ED and inpatient wards. (xiv) Working group established December 2018 and meets weekly.	4	4	16	2	3	(i) Report to CQC fortnightly. (ii) Standing item to ET Weekly	(i) Ongoing

	PROBABILITY
1 RARE	Less than 5%
2 UNLIKELY	5% to 20%
3 POSSIBLE	21% to 50%
4 LIKELY	51% to 80%
5 ALMOST CERTAIN	More than 80%

	BUSINESS OBJECTIVE	FINANCE	COMPLIANCE	SAFETY	REPUTATION	SERVICE DELIVERY
1 NEGLIGIBLE	Negligible impact/delay/ overspend/ difficulty	Minor loss < £1,000	Trivial, very short-term single non-compliance	Insignificant injury (no intervention)	Low level public awareness/ concern	Negligible impact/ unnoticed by service users
2 MINOR	Small impact/ delay/ overspend/ difficulty	Small loss £1,001-£10,000	Small, single, short-term non-compliance	Minor injury (local intervention)	Short-term local media coverage	Small impact/ small inconvenience
3 MODERATE	Medium scale impact/delay/ overspend/ difficulty	Moderate loss £10,001 - £100,000	Sustained single or a few short-term non-compliances	Moderate injury (professional intervention)	Longer-term local media coverage	Medium level impact/ moderate inconvenience
4 MAJOR	Significant impact/delay/ overspend/ difficulty	Significant loss £100,001 - £1,000,000	Multiple sustained non-compliances	Major injury (hospital stay)	Short-term national media coverage	Significant impact/ serious inconvenience
5 CATAS-STROPHIC	Substantial impact/delay/ overspend/ difficulty	Substantial loss > £1,000,000	Multiple, long-term, significant non-compliances	Fatal injury	Longer-term national media coverage	Substantial/ Complete service failure

Chair's Log - Finance and Performance Committee 23.4.19

Overview

Another positive report. Although I set it out in more detail below the headlines are –

- We have hit our control total for 2018/19 – no small achievement in the circumstances.
- In addition, extra monies have been awarded by NHSi (circa £10.7m) in recognition of a combination of factors including this year's operational performance, financial performance and acceptance of the control total for the year ahead.
- Performance remains broadly strong and improving across key indicators and in comparison to the rest of the system.

The committee held a deep dive into CIP governance and outturn of CIPs for the current year, receiving an in-depth presentation from Efficiency Director Paul Mapley

The committee also began to explore in more depth how the organisation tracks and uses overtime monies, receiving an initial data sharing presentation from Director of People and Organisational Development Karen Barnard.

Assurance area – Performance

Performance Report

The Board meeting will receive a separate performance report which will give a more detailed appreciation of the picture.

The new performance reporting approach was received for the second time and will be rolled out to the Board this month, although further work remains to be done to agree how the measures tracked by QEC might best be incorporated. You will recall the approach sees a cut down 'at-a-glance' table incorporating trends as well as key metrics and comparative, traffic lighted data. There is an independent analysis supported by subject matter expert comments on the questions raised by that analysis.

In broad terms Trust performance once again remains sound -

A&E / ED "4 hour waiters" performance was 93.1% in month resulting in a YTD figure of 92.6%. Whilst this is below the national 95% target it exceeds the 91% requirement.

RTT performance against the "18 week" target was 88.8% YTD. This is below the national 92% target and the locally agreed 89.1% target. However, actions are in place to improve performance against this measure into 2019/20.

The Diagnostics tests "6 weeks wait" of 99% was marginally missed with trust wide performance of 88.8%. The majority of the waits longer than 6 weeks relate to Nerve

Conduction and Urodynamics. Additional capacity has now been added to these services.

Cancer performance has improved with all aggregate targets achieved in month. However, the this was not sufficient to lift the '2 week wait' figures for the year to above target.

Elective activity, both daycases and inpatient, is below plan for the year. Actions are in place to improve the position for 2019/20.

Outpatient activity is, overall, above plan for the year. This is particularly the case amongst follow up appointments (as opposed to first appointments).

Assurance area – Workforce Management

We considered the Workforce report that addressed –

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

In parallel with the work undertaken in relation to wider performance the at-a-glance table for workforce data has developed and now also shows trend in all core elements by specialty. That is welcome and helpful information.

In summary F+P learned that we have a vacancy rate in month 12 of 9.1% against a target of 5%; when taking into account the use of temporary staff we have a 3.88%vacancy rate, although this does vary by staff group.

Agency targets have been set for each Division which have also been split by staff group. The Division of Clinical Specialties continues to spend below target; with regards to staff groups the use of agency workers to cover unqualified nurses has ceased and therefore spend up to month 12 is below target as is the admin and clerical and other staff groups.

Updated benchmark data has been provided from the model hospital portal for both vacancies and agency and bank spend which on the whole indicates that we benchmark favourably although there are areas which require focus. Within the refreshed efficiency programme the workforce workstream will focus on recruitment to vacancies, reduction in sickness absence, reduction in need to cover enhanced care needs, and agency prices (and demand).

Sickness absence rates for march have reduced to 4.03% with a year end figure of 4.39% which is lower than the preceding 2 years.

Following a request by Pat Drake, the committee also began to explore in more depth how the organisation tracks and uses overtime monies, receiving an initial data sharing presentation from Director of People and Organisational Development Karen Barnard.

We were surprised that the organisation does not routinely collect and analyse the data

at this level and the Director of Finance agreed to take the matter away and return with a more in-depth analysis and an assessment of the value to the organisation of more routine scrutiny of overtime in the round.

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 its control total for the year. As we outlined last month, that position has been achieved through a combination of factors including improved delivery of income across divisions, successful negotiations with CCG partners, delivery of certain CIPs and better control of agency spend.

In addition, extra monies have been awarded by NHSi (circa £10.7m) in recognition of a combination of factors including this year's operational performance, financial performance and acceptance of the control total for the year ahead. The Director of Finance will provide a more detailed overview and analysis of this verbally at the Board meeting.

Having fixed our internal CIP requirement for the year at broadly 3%, the committee turned its attention to how that would be delivered. We held a deep dive into CIP governance and outturn of CIPs for the current year, receiving an in-depth presentation from Efficiency Director Paul Mapley.

The outturn picture for the current year was mixed and much has been learned. We discussed the performance of individual plans and contributory factors in terms of level of delivery.

We gained substantial assurance from the systems that had now been put in place and apparent grip in relation to it. However, we will continue to monitor the situation closely over coming months.

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. We also discussed the provision of a more in-depth cover paper summarising the main activity and movements in the documents over the past month.

Neil Rhodes
Chair – Finance and Performance Committee
23.4.19

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Title	**Pressure Ulcers - Revised definition and measurement** **Revised local reporting systems and reporting to NRLS**		
Report to	**Board of Directors**	**Date**	**10 April 2019**
Author	**Cindy Storer - Acting Deputy Director of Nursing, Midwifery & Allied Health Professionals on behalf of** **Moira Hardy, Director of Nursing, Midwifery & Allied Health Professionals**		

Purpose		Tick one as appropriate
	Decision	
	Assurance	
	Information	✠

Executive summary containing key messages and issues
This paper updates Board of Directors on the recommendations from • Pressure ulcers : revised definition and measurement (NHS Improvement 2018) • Implementing the pressure ulcer framework in local reporting systems and reporting to NRLS (NHS Improvement 2019) Both recommendations have been introduced from 1st April 2019. The paper outlines number of severe pressure ulcers that would have been reported in the year 2018/19 had the new definitions been in force and the action to be taken to comply with the new recommendations.
Key questions posed by the report
N/A
How this report contributes to the delivery of the strategic objectives
Patients - Work with patients to continue to develop accessible, high quality and responsive services **People -** As a Teaching Hospital was are committed to continuously developing the skills, innovation and leadership of our staff to provide high quality, efficient and effective care **Prevention -** We will support the development of enhanced community based service, prevention and self-care.

How this report impacts on current risks or highlights new risks
Failure to achieve compliance with performance and delivery aspects of the Single Oversight Framework, CQC and other regulatory standards leading to; (i) Regulatory action (ii) Impact on reputation.
Recommendation(s) and next steps
The Board of Directors are asked to note the content of the paper in regard to • Pressure ulcers : revised definition and measurement (NHS Improvement 2018) • Implementing the pressure ulcer framework in local reporting systems and reporting to NRLS (NHS Improvement 2019).

Introduction

Pressure ulcers remain a concerning and mainly avoidable harm associated with healthcare delivery. In the NHS in England, 24,674 patients (NHS Safety Thermometer) were reported to have developed a new pressure ulcer between April 2015 and March 2016, and treating pressure damage costs the NHS more than £3.8 million every day.

It is recognised that collecting and interpreting data on the causes of harm is a key tenet of quality improvement approaches in healthcare. Accurate measurement must accompany a quality improvement method to make changes and improve outcomes for service users and patients.

The NHS Improvement recommendations are designed to support a more consistent approach to the definition and measurement of pressure ulcers at both local and national levels across all trusts.

Background

As part of a national patient safety agenda, NHS England has introduced several initiatives in recent years to reduce avoidable pressure ulcer (PU) harm. These include reporting prevalence through the NHS Safety Thermometer, incident reporting systems and the Strategic Executive Information System (StEIS) for reporting Serious Incidents. Despite the limitations of the Safety Thermometer's database (a monthly point prevalence tool), no other national system yet exists for reporting pressure ulcer incidence. Although these initiatives were implemented across the NHS, lack of comprehensive guidance has led to concerns about variation in local implementation (e.g. type of ulcer to be reported, classification system to be used) and subsequent inconsistency in reporting pressure ulcers. Literature reviews have also identified difficulties in interpreting adverse event data.

There is evidence that current systems used locally, regionally and nationally to monitor PU patient harm lack standardisation. They are also characterised by high levels of under-reporting. Yet despite their limitations, they have been used to compare trusts and in some cases lead to financial penalties. This work has led to 30 key recommendations to improve future PU monitoring (Pressure ulcers: revised definition and measurement document 2018).

These support a consistent approach to defining, measuring and reporting pressure ulcers with the intention of providing each trust with an accurate profile of pressure damage so it can improve quality by reducing the harm that patients experience.

Changes to pressure ulcer definition and measurement process

A scoping exercise has been undertaken by the Lead Nurse, Skin Integrity Team, to determine the changes required from 1st April 2019.

The changes required from a DBTH perspective for financial year 2019/20 are:

- A pressure ulcer that has developed due to the presence of a medical device should be referred to as a 'medical device related pressure ulcer' (MDRPU). These are currently referred to as device related pressure ulcers in the wider context (see appendix 1).
- A 'medical device related pressure ulcer' (MDRPU) is defined as a pressure ulcer that is a result from the use of devices designed and applied for diagnostic or therapeutic purposes.
- Medical device related pressure ulcers should be reported and identified by the notation of (d) after the report.
- A change of term is to be introduced from suspected deep tissue injury (SDTI) to deep tissue injury (DTI).
- A change of term is to be introduced from inherited (IN) to present on admission (POA).

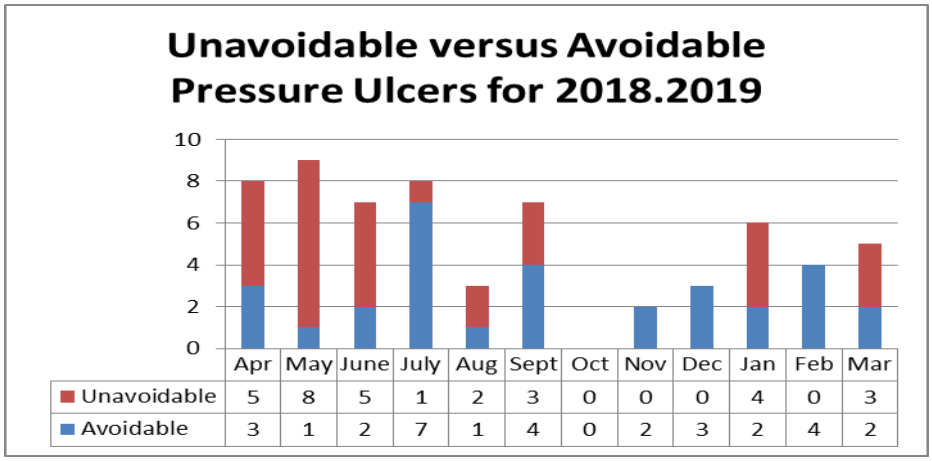
- A change of term is to be introduced from ungradable to unstageable.
- Moisture - associated skin damage (MASD) should be counted and reported in addition to pressure ulcers.
- The Department of Health and Social Care's definition of avoidable/unavoidable should not be used.
- All pressure ulcers including those that are considered avoidable and unavoidable should be incorporated in local Pressure Ulcer Monitoring.
- All cases should identify the patient using the NHS number not the hospital number.
- Only pressure ulcers that meet the criteria for a Serious Incident (SI) should be reported to the Clinical Commissioning Group.

In ceasing to use to The Department of Health and Social Care's definition of avoidable/unavoidable a shift in the numbers of the cases assigned to the Trust will be seen.
In addition as all pressure ulcers require reporting to the National Reporting and Learning System (NRLS) whether they developed during care provided at the Trust or were present on admission this will see a significant surge in the number of pressure ulcers reported to NRLS. This is because previously, pressure ulcers that were present on admission (Inherited) have not been uploaded to NRLS.
In 2018/19 there were 490 pressure ulcers reported to NRLS, should the same criteria have been used last year there would be an increase of 1137 cases reported to NRLS.

This will require some modification within the Datix system to permit these changes to be implemented, and this is currently underway.

Comparisons between Severe Hospital Acquired Unavoidable versus Avoidable Pressure Ulcers

Analysis has been carried out to identify the differences using cases reported during the 2018/2019 period.



	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
Unavoidable	5	8	5	1	2	3	0	0	0	4	0	3
Avoidable	3	1	2	7	1	4	0	2	3	2	4	2

Unavoidable	31
Avoidable	31
Totals	**62**

Actions to be taken

It can be seen in the above table that the Trust reported 31 severe hospital acquired pressure ulcers during 2018/2019. If the new definitions had been set in 2018/19 we would have reported 62 cases instead of 31. The NHS Improvement has acknowledged that these changes will have an impact on reporting as numbers reported will increase.

The following actions are therefore being implemented

- Revised educational strategy to incorporate all of the changes in terminology
- Changes to be made to the Skin Integrity Dashboard to reflect the changes in terminology
- Launch of the Pressure Ulcer Investigation Tool to support the reporting of pressure ulcers that meet the criteria for a Serious Incident (SI).
- Inclusion of Skin Integrity within the Ward Quality Assurance Toolkit for 2019/2020.
  Integration of the skin integrity dashboard into Datix to ensure referrals to the team are reported on Datix without adding to the Nursing workload.

Recommendation(s)

The Board of Directors are asked to note the content of the paper and the actions being taken with regards to the following

- Pressure ulcers : revised definition and measurement (NHS Improvement) strategy to incorporate all of the changes in terminology
- Implementing the pressure ulcer framework in local reporting systems and reporting to NRLS (NHS Improvement).

Appendix 1

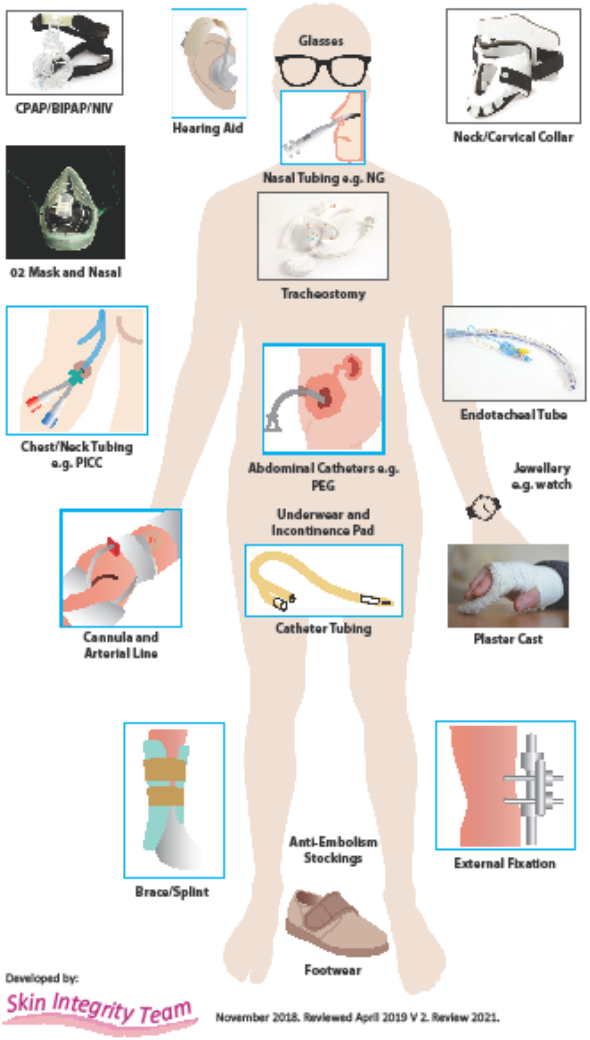
NHS Doncaster Clinical Commissioning Group

NHS Rotherham Doncaster and South Humber NHS Foundation Trust

NHS Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

Prevention of Medical Device-Related Pressure Ulcers (MDRPU)

- Pressure Ulcers that result from the use of devices designed and applied for diagnostic and therapeutic purposes are known as MDRPU
- A significant proportion of Pressure Ulcers in critically ill and immobile patients are related to the use of medical devices (Black et al, 2010)
- Many devices are made of plastic, rubber or silicone, which can cause rubbing or create pressure on the soft tissues (Jaul, 2010)
- All patients with a medical device are "at risk" of developing MDRPU (NHS Improvement 2018).



Assessment:

SELECT ensuring that the device is fitted correctly.

Management:

REPOSITION and/or offload the pressure from the device every two hours as a minimum in order to provide pressure relief.

INSPECT the skin beneath and around the medical device three times a day.

Consider the use of barrier protectants in order to minimise the risk of a MDRPU developing:

- Hydrofilm
- Cavilon
- Proshield
- Aderma.

Evaluation and referral:

ESCALATE any skin changes to the Nurse accountable for the patients care.

REPORT all pressure ulcer via:

DBTH	• Skin Integrity Dashboard • Datix Web.
RDaSH	• Safeguarding IR1 System • TPP System.

DOCUMENT accordingly:

DBTH	• Pressure Ulcer Prevention Care Plan. • Skin Integrity IPOC.

NB: Should the patient be too unstable to have any aspects of the MDRPU prevention plan carried out, this must be documented.

DBTH	• Nursing Daily Plan of Care.
RDaSH	• TPP System One • Give consideration to informed refusal and patients mental capacity to make informed choices.

References: NHS Improvement (2018) Pressure ulcers: revised definition and measurement summary and recommendations. Jaul (2010) Ostomy Wound Management. Black et al. (2010) International J of Wound Care.

Developed by: Skin Integrity Team

November 2018. Reviewed April 2019 V 2. Review 2021.

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Title	**Corporate Objectives 2018/19**		
Report to	**Board of Directors**	**Date**	**30 April 2019**
Author	**Richard Parker, Chief Executive** **Gareth Jones, Trust Board Secretary**		
Purpose			Tick one as appropriate
	Decision		
	Assurance		X
	Information		

Executive summary containing key messages and issues
The corporate objectives for 2018/19 were agreed at the Board of Directors in June 2018 following completion of the appraisals process. Progress for each objective in 2018/ 19 is provided in the attached update, with a RAG rating on progress at the end of quarter 4.
Key questions posed by the report
Is the Board sufficiently assured by progress in relation to the objectives for each director?
How this report contributes to the delivery of the strategic objectives
This paper contributes to all strategic objectives.
How this report impacts on current risks or highlights new risks
Relevant risks are highlighted in the appendix.
Recommendation(s) and next steps
The Board is asked to note the paper for assurance.

OBJECTIVE Chief Executive	EXPECTED OUTCOME	Q1 & Q2 UPDATE	Q3 UPDATE	Q4 UPDATE	CURRENT RAG RATING
Establish a Trust wide vision, values and commitment to achieve a step change in performance across a range of key quality and performance metrics.	Across a range of measures agreed with the Board of Directors and Council of Governors. Demonstrate improved performance and outcomes including, but not exclusive to achieving a CQC Outstanding assessment by 2020/ 2021 and a Single Oversight Assessment of 1 by 2020/ 2021	Preliminary work in establishing vision and values through the NHSI improvement practice work has been undertaken. CQC outstanding action plan in progress.	Work on the development of the Single Oversight assessment and the performance assurance framework has continued with revised performance reports to be presented to Board Sub Committees in February and the Performance Assurance Framework (PAF) in place from 1/4/19. Planning for 2019/ 20 is being developed to include the Divisional Improvement metrics as part of the PAF.	Board papers for April identify the revised format presented to Finance and Performance Committee and papers for use in the Corporate and Divisional Assurance meetings will be finalised for use from May 2019.	
Ensure a Trust wide commitment to high quality services delivered through robust financial management. Leading the delivery of an improved financial position, ensuring improved statutory and regulatory compliance.	Achieve a break even, or better, financial position by 2020/ 2021	The cumulative position at Q2 is an £11.9m deficit, £1k favourable to plan. The Trust needs to achieve a £6.6m deficit to deliver the year end control total but is currently forecasting achieve a deficit of £9.5m. Actions are underway to rectify this situation.	The Trust achieved the financial pan for Q3 achieving the PSF payments as a result of stronger performance in October, November and December. Actions to achieve the financial plan at the end of Q4 are in place but the financial climate remains extremely challenging.	The Trust achieved its control total for 2018/ 19 and received additional Provider Sustainability Funding to finish 2018/19 in a financial surplus against plan.	
Lead the delivery of the vision, values and benefits identified in the Trusts Strategic Direction.	Achieve the key milestones identified in the Trusts Strategic Direction	In Q2, 44 of the milestones were completed and seven were off track. Four remain off track from the previous quarter.	15 Q3 milestones completed, 9 off track, 16 off track from previous quarters. Work to integrate the NHSi improvement programme with the delivery of the Trusts	Progress on the delivery of the strategic direction continues. The NHSI improvement programme True	

			Strategic Direction is underway and will be developed in Q4 as part of the 2019/20 planning and contracting process.	North and Breakthrough Objectives have been integrated into the Trusts appraisal system for 2018/ 19 and work to ensure assurance with Divisional objectives is being completed.	
Ensure that the Trust builds upon the quality Improvement and Innovation strategy to ensure Trust wide engagement and benefit from the NHSI Lean Programme. Removing all forms of 'waste' at every level of the Trust.	Following the visioning event ensure a Trust focus and engagement on the 'True North Statement', ensuring a detailed plan and expected outcomes for year 1.	Exec Team up to date on improvement practice training and positive VSA events held on 2ww and with trauma and orthopaedic pathways.	There has been some slippage on practice training as a result in gaps within the NHSi team. This has now been addressed and additional support is being mobilised in Q4. Two further Rapid Improvement Events have now taken place and further events are planned in Q4. Progress reports continue to be provided to BOD on a bimonthly basis.	Details on the delivery of the detailed programmes is contained within the Director of Strategy and Planning's update. Feedback from the NHSi QI leads is that the Trust is making good progress within the programme.	
Maintain strong, open and honest relationships to maximise the Trusts influence within the Integrated Care System and Accountable Care Partnerships to achieve the maximum benefits for the Trust, Place and Integrated Care System.	Ensure appropriate representation at relevant ICS and ACP meetings and events, including where appropriate taking lead roles on behalf of the ICS and ACPs.	CEO commenced secondment within ICS on 1/10/2018. Members of Executive Team regularly attending system-wide meetings or sending deputies.	The Trust continues to actively support the development of the ICS and the delivery of the PLACE based plans	The Trust continues to actively support the development of the ICS and the delivery of the PLACE based plans	

Deputy Chief Executive & Chief Operating Officer					
Complete the Divisional management structures, strengthening the COO team and the Senior Management Teams to enable sustained improvements in key performance metrics.	Achieve trajectory, or national performance standards; Emergency Admissions, RTT (within the CCG contracted performance levels) Cancer services Diagnostic waits	Improvements in Cancer performance following restructure of the Cancer teams. RTT performance trajectory agreed with plans to address increases in waiting list size. 4hr access below trajectory partially due to overall 6.7% increase in attendances and staffing issues in ED.	Divisional restructure completed. 4hr access PSF achieved in Q3. RTT and activity plans in progress and in line with trajectories. Cancer team working effectively.	Performance levels above trajectories set for 4hr access, waiting list position and cancer.	
In collaboration with the Director of People and Organisational Development support the leadership development and succession planning programme, leading the work to develop the new Divisional Senior Management Teams.	Identify the learning and development needs of the Divisional Senior Management Teams establishing a sustainable leadership programme with measurable outcomes linked to improvements in the Trusts capacity and capabilities.	Divisional Directors have leadership development plans. Coaches agreed. Shadowing plans agreed. Awaiting confirmation of Shadow Board Programme from the Leadership Academy.	Plans in place for senior leadership teams. Reviewing process for talent management.	Programme commenced.	
Support the Trusts partnership working by taking lead responsibility for identified programmes of work.	Take a lead role within the two ACPs for agreed work programmes	Leading Urgent and Emergency Care for DCCG and BCCG. Working with SCH to improve Paediatric pathways. RDASH to review therapy and rehab pathways.	ICP plans progressing well.	UEC plans progressing as planned.	
Lead and deliver the identified Effectiveness and Efficiency Programmes:	Deliver the identified E&E programmes within plans and timeframes. Identifying additional opportunities to deliver the Trusts 2018/ 2019 financial plans.	Length of Stay project slightly behind plan but with mitigation plans in place. Admin structures agreed, will have agreed plans with Care Groups by end of Q2 Strategy, Plans in place for joint work with RDASH. Elective work-stream changes agreed.	Admin review plan completed. LoS below target due to issues over the summer. RDASH strategic plans will be in place for next year.	Admin review completed, training programme set. Bed plan for winter allowed for 4hr performance.	
Leading by example, Support the successful implementation and delivery of the Trusts Transformation and Lean Programmes.	Actively participate in the Trusts Lean Programme. Demonstrating the required leadership and assuming lead responsibilities where required.	Personal A3 completed. VSA of 2 week wait completed. Launched VSA for T&O.	Fully engaged in the programme.	Engaged in the programme. Visual management boards in place in performance areas.	
Medical Director					
Sustain improvement in care quality as	Deliver improvement in the quality	On a range of metrics, care quality has been	Care quality is being	We have	

evidenced by a range of metrics	of clinical care as evidenced by quality indicators agreed with the Quality and Effectiveness Committee, Clinical Governance Committee and Board of Governors.	maintained. The digital quality dashboard has been populated and is being shared with all staff to facilitate quality improvement activity.	maintained as evidenced by a range of quality metrics. Focussed work has begun on quality improvement in maternity, T&O and collecting more helpful patient feedback. The quality dashboard is now available to all staff.	completed the year with a range of quality metrics within planned trajectory or better. There has been good progress with the ante-natal care QI programme and we have set dates for a similar programme for intrapartum care which will start June 2019.	
Lead and deliver the identified Effectiveness and Efficiency Programmes: Theatre and pre assessment Medical Productivity	Deliver the identified E&E programmes within plans and timeframes. Identifying additional opportunities to deliver the Trusts 2018/ 2019 financial plans.	Most consultants' job plans are up to date. There remain one or two specialties where the process is ongoing. Revised pre-op process has gone live. We continue to work to optimise theatre utilisation.	The vast majority of consultant job plans including paediatrics have been reviewed and agreed. We have commenced work on SAS Dr job plans. Staff vacancies in the pre-op team have hampered progress in this work stream. Despite this, the process has been implemented at BDGH.	Consultant job planning has been completed apart from a small number of individuals. The revised and enhanced pre-op process has been implemented in BDGH whilst theatre scheduling has been revitalised since the restructure.	
Complete the maternity services transformation and improvement programme	Deliver all of the outcomes on the Royal College of Obs and Gynae Review, CQC recommendations, strategic objectives and Hospital Services Review. Demonstrating Improvements in maternity staff survey feedback and	The only outstanding actions from the RCOG action plan relate to improving staff morale and implementing cross-site working. Work is in train on the former and is planned for the latter.	The Rapid Improvement event covering antenatal care took place 23, 24 and 25 January 2019. With a very positive report out and 72 areas of	The maternity service transformation programme is making good progress as previously	

	maternity quality indicators.		waste identified.	described.	
Leading by example, support the successful implementation and delivery of the Trusts Transformation and Lean Programmes.	Actively participate in the Trusts Lean Programme. Demonstrating the required leadership and assuming lead responsibilities where required.	The Trust's Quality Improvement programme will shortly be used to revise and augment our maternity service.	As above.	The following QI programmes have made good progress – antenatal care, serious incident process, risk management process.	
In conjunction with the DNMAHP and Director of People and Organisational Development identify a plan to achieve CQC Outstanding by 2020/ 2021	Establish an appropriate plan to ensure that the Trust is able to demonstrate the standards required to achieve an Outstanding rating by 2020/ 2021.	Sessions are planned to map our path to achieving a CQC rating of outstanding.	Sessions have been held which are generating actions which will form the basis of an action plan to achieve CQC outstanding.	The action plan in response to CQC recommendations is making good progress and we have commenced work to empower staff and improve morale.	
Director of Nursing, Midwifery & Allied Health Professionals					
In conjunction with the Director of People and Organisational Development review governance arrangements in relation to education and research to oversee and support the development and implementation of academic directorate	Agree a structure for education and research by December 2018 to deliver a strategy for the development of academic Directorates as part of phase 2 of Teaching Hospital status.	Research now reporting into Workforce, Education and Research Committee. R&D strategy includes development of academic directorates.	Work to expand commercial study portfolio well established. Review of R&D underway to identify how it supports progression of phase 2 teaching hospital status and maximises academic opportunities.	Options paper presented to Executive Team March 2019. Preferred option to be developed into a discussion paper.	
Review and implement recruitment and retention strategies to minimise registered and non-registered vacancies across the organisation. Identifying strategies to implement new and changing roles.	Ensure that the Trust has a Nursing, Midwifery and Allied Health Professionals workforce plan which reduces workforce gaps to minimise the use of temporary workforce.	Workforce plan in development. Meeting planned with ICS CN's/HEE 26 Oct to focus on ICS workforce. Agency HCA discontinued with only NHSP providing temp non-registered staff.	As an ICS have joined cohort 4 of the NHS I retention programme. tNA programme commenced and plans to expand to Paediatric areas in summer 2019 Apprenticeship models	Practice Development Matron in post to take forward the NHS I retention programme for DBTH. Focus on registered	

			for Nursing being explored with Sunderland University.	nursing staff with 3 specific work streams.	
Implement improvements in patient experience and engagement	Implement the patient experience and engagement strategy in line with agreed milestones, which improves the Trusts patient survey and friends and family results.	PE&E Strategy due to update at December Management Board and QEC.	PE&E strategy update presented to QEC in December. Patient engagement in NHS I Improving Practice VSA for T&O. Plans to include patients in Maternity RI events. Divisional template is identifying how widely patient experience is captured.	PE&E strategy update presented to Management Board and QEC in April. Increasing ways of engaging with patients including via social media e.g. visiting times consultation. Milestones being met.	
Lead on the public health agenda in relation to smoking cessation and enforce a smoke free site by October 18 and achievement of the CQUIN by March 19.	Implementation of a revised strategy to establish a smoke free site and improved compliance with CQUIN requirements	CQUIN in relation to tobacco control on target to deliver. Main entrance work delayed to December 2018.	Main entrance work still not complete. PH48 self-assessment audit completed. Active partner in QUIT programme across ICS and with Notts Partial CQUIN payment achieved for one element in Q2.	Living wall in place at main entrance. PH48 self-assessment rated 6 out of 7 (green) in relation to taking comprehensive steps towards being a smoke free site. Smoke free site – 31 May. Comms to support with a countdown to the launch date. CO monitors delivered and to be rolled out to inpatient areas to support	

				2019/20 CQUIN. CQUINs payment 2018/19 achieved.	
Lead and deliver the identified Effectiveness and Efficiency Programmes:	Deliver the identified E&E programmes within plans and timeframes. Identifying additional opportunities to deliver the Trusts 2018/ 2019 financial plans.	Plans on track.	Plans on track.	Plans on track.	
In conjunction with the MD and Director of People and Organisational Development identify a plan to achieve CQC Outstanding by 2020/ 2021	Establish an appropriate plan to ensure that the Trust is able to demonstrate the standards required to achieve an Outstanding rating by 2020/ 2021.	Plan to deliver outstanding in progress. Meeting with Divisions and corporate departments planned 19 October 2018.	Meeting held in October with each Division represented. Divisions working on plans for improvement.	Workshops led by CQC relationship manager being held. Programme of mock inspections planned. Explore use of Datix module for capturing CQC action, evidence. Achievement of CQC good now part of PDAs.	
Leading by example, Support the successful implementation and delivery of the Trusts Transformation and Lean Programmes.	Actively participate in the Trusts Lean Programme. Demonstrating the required leadership and assuming lead responsibilities where required.	A3 for patient supporting cell completed. Patients contributed to first VSA. Personal A3 in development.	Process mapping event with PET held. Patient attendance at T&O VSA in October.	KATA training undertaken by member of team. Patient involvement in antenatal event. Increasing patient engagement part of PDAs.	
Director of Finance					
Complete the production of the Year End	The 2017/ 2018 annual accounts are approved by internal and external	Delivered on time with a clear audit report.			COMPLETED

accounts 2017/18	audit and accepted at the 2018 Annual General Meeting.				
Complete the restructuring of information services producing a ward to Board information scorecard to support assurance and a revised performance management framework.	Complete the restructuring of information services to deliver an enhanced service and a new ward to Board information scorecard and performance management framework.	Passed to DoF In Q2. Work started with a review of current reporting and the initial performance reporting to Board/F&P to be completed in Q2.	Outline PAF drawn up. Work on an information strategy to be completed by end of March including full audit of staffing and outputs from the department. New Performance Report designed for F&P.		
Manage and maximise the Capital allocation and bids Processes	Improved management of the 2018/ 2019 capital programme to maximise benefits.	Capital Budgets signed off by Trust Board before year start. Capital Governance paper agreed at Management Board and Trust Board. All meetings and groups meeting and working to agreed processes. Minutes being shared at F&P. Capital Budget being monitored routinely at F&P. Cash and Capital Cash Forecast being reviewed monthly at cash committee.	Capital budgets due to deliver full spend this year. Work ongoing to identify other sources for capital funds for future years including introducing bids for emergency capital to NHSi.		COMPLETED
Set Annual Financial Plans, monitor and recommend actions to ensure delivery	Delivery of the Trusts financial plan	Forecast shared with F&P and Board. Recovery plan being produced by executive.	Forecast shared with F&P and Board. Recovery plan being produced by executives.		COMPLETED
Develop the PMO to support the delivery of the 2018/ 2019 Effectiveness and Efficiency programmes and progress towards a break even or better financial position in 2020/ 2021	Actively support the delivery of the Trusts 2018/ 2019 Effectiveness and Efficiency programme and plans for 2019/ 2020.	Permanent Efficiency Director appointed and audit report giving significant assurance on Governance processes achieved. Initial total outline CIP identified however a number of schemes will require mitigation to deliver the full plan.	PMO restructured and substantive efficiency director appointed and now in post, along with lead consultant for clinical schemes.		COMPLETED
Lead and deliver the identified Effectiveness and Efficiency Programmes:	Deliver the identified E&E programmes within plans and timeframes. Identifying additional opportunities to deliver the Trusts 2018/ 2019 financial plans.	Effectiveness and Efficiency Committees taking place. Accountability architecture in place. Regular reports to F&P and Board on CIP delivery.	Effectiveness and Efficiency Committees taking place. Accountability architecture in place. Regular reports to F&P and Board on CIP delivery.	£12m delivered in year.	

Leading by example, Support the successful implementation and delivery of the Trusts Transformation and Lean Programmes.	Actively participate in the Trusts Lean Programme. Demonstrating the required leadership and assuming lead responsibilities where required.	Working through lean programme accreditation with other Executives.	Finance self-developed.		
Director of People and Organisational Development					
Implement a Trust Leadership Development framework including our approach to coaching, talent management and succession planning. Delivering improved training and development across the Trust.	Implementation of a Trust wide framework to deliver coaching, talent management and succession planning, including establishing a robust Board development programme with a combination of knowledge acquisition and team building.	Coaching proposition refreshed. Head of Leadership & OD commenced September. Refresh of management skills passport underway. Board development programme identified, and a number of sessions undertaken.	Leadership development framework launched. This includes coaching offering, management and leadership development programmes at varying levels and introduction of master classes	Continued offerings being developed and implemented, for example launch of leadership masterclasses, development of Leading to Outstanding programme underway.	
Implement systems and processes to ensure all areas of the Trust maximise workforce productivity. Including strategies to maximise the opportunities created by improved partnership working and the application of family friendly policies and flexible working.	Ensure the maximum use of e-roster systems, model hospital portal, grip and control processes and use of workforce information and technology to maximise workforce productivity.	Grip and control meetings in place. Internal audit review undertaken – action plan identified. Interface between NHSP and Allocate being implemented along with Safecare which will enable greater visibility of staffing requirements. ESR self-service introduced for employees including access to on line payslip.	Engagement with NHSI's Retention programme which includes access to support in best practice regarding flexible rostering. Resource approved to implement medical e-rostering.	Interface between E-roster an NHS Professionals complete. Business case approved to implement ESR self-service which will remove the need to paperwork. Recruitment tracking system purchased which will be implemented in Q1 of 2019/20.	
Establish and implement a robust and reliable workforce plan. Identifying robust recruitment and retention strategies and maximising the use of new and emerging roles.	All areas of the Trust will have effective workforce plans to ensure safe and sustainable staffing levels which reflect the changing needs of the Trust and minimising the use of	Care group workforce plans developed as part of business planning process. Reviewed as part of internal audit plan. Profession specific templates being completed by Divisions.	Cohort of trainee assistant practitioners has graduated; new cohort of trainee nursing associates	Workforce planning template included within business	

	temporary workforce.		recruited and commenced. ACP role to support Bassetlaw@ developed. Workforce planning template continues to be piloted with the intention of using it for 2019/20 business planning process.	planning process. Completion of annual planning template for NHS Improvement. Narrative within plans details the hard to recruit to roles.	
Establish and implement a Trust staff involvement and engagement plan to deliver improved staff survey results.	Re-launch of Trust's values to demonstrate the importance placed on staff by the leadership teams of the Trust.	Action plan in place; link in with Sharing how we care bulletin and health and wellbeing initiatives. Regular articles in Buzz. Included within management skills passport.	Progress report on action plan received by Board in December 2018. Improved response rate for 2018 survey. Refresh of approach to staff engagement underway.	Trust level action plan developed following 2018 results. Divisions developing their own action plans following the feedback they have received. KPIs will be included within 2019/20 performance assurance framework. Overall results similar to previous year.	
In conjunction with the Director of Nursing , Midwifery and Allied Health Professionals review governance arrangements in relation to education and research to oversee and support the development and implementation of academic directorate	Agree a structure for education and research by December 2018 to deliver a strategy for the development of academic Directorates as part of phase 2 of Teaching Hospital status.	R&D now forms part of the Workforce, Education & Research Committee to ensure appropriate governance and alignment of R&D with Education.	Work to expand commercial study portfolio well established. Review of R&D underway to identify how it supports progression of phase 2 teaching hospital status and maximises academic opportunities	Proposal developed and submitted to Executive Team. Further discussions required. Work underway to develop surgical academic directorate status which will	

				be prototype for future directorates.	
Lead and deliver the identified Effectiveness and Efficiency Programmes:	Deliver the identified E&E programmes within plans and timeframes. Identifying additional opportunities to deliver the Trusts 2018/ 2019 financial plans.	Management & corporate workstream on plan.	Management & corporate work stream on plan.	Management and corporate work stream delivered planned savings.	
In conjunction with the MD and DNMAHP identify a plan to achieve CQC Outstanding by 2020/ 2021	Establish an appropriate plan to ensure that the Trust is able to demonstrate the standards required to achieve an Outstanding rating by 2020/ 2021.	P&OD representatives will be attending clinical governance workshop. Discussions scheduled with P&OD senior leadership team.	P&OD strategy implementation plan being refreshed for 2019 onwards in line with aim for the Trust to be CQC Outstanding	Extended P&OD leadership team held workshop (included the involvement of NED buddy) to determine priorities for P&OD strategy for 2019-21 in line with expected journey to CQC outstanding. Links with staff survey action plan.	
Leading by example, Support the successful implementation and delivery of the Trusts Transformation and Lean Programmes.	Actively participate in the Trusts Lean Programme. Demonstrating the required leadership and assuming lead responsibilities where required.	Attended Executive team training modules. Commenced personal A3 coaching. Reviewing the process for conducting investigations. P&OD cell being developed.	P&OD cell developed. HR and TED cells developed to support T&O VSA/ Continue to attend executive team sessions. Process mapping for personal improvement practice ongoing.	Continued involvement of P&OD members within Qi work. Joint development with Qi of Leading to Outstanding programme for Divisional leadership teams. Ongoing work with executive coaching	

				programme.	
Director of Strategy and Improvement					
Lead on co-ordinating visioning event with the Executive Team to develop "True North" statement and ensure alignment of strategic priorities with further development of processes for monitoring implementation and assurance.	Working with NHSI, organise and lead the visioning event, identifying the Trusts 'True North Statement'. Developing a detailed year one plan to identify and secure the expected outcomes1.	Preliminary work in establishing vision and values through the NHSI improvement practice work has been undertaken. CQC outstanding action plan in progress. Purpose pyramid developed and shared with stakeholders. First Value Stream Analysis undertaken.	Vision and values incorporated into divisional and corporate planning documentation ready for 19/20 round. Work commenced with NHSI on policy deployment	Further development of True North and breakthrough objectives to align with Strategic Direction. Annual plan narrative developed and submitted with Finance. Joint development with P &OD on Leading to Outstanding programme for Divisional leadership teams.	
Develop the innovation and horizon scanning elements of Strategy & Transformation Team to inform strategic direction.	Ensure that the Trusts Strategic Direction reflects new and emerging policies, procedures and practices and remains fit for purpose.	Ongoing – horizon scanning in areas affected by VSA – feedback from Expo obtained	Continues – with focus on lean methodology and Kata	Additional Kata coaching places obtained for QI team as only one DBTH coach remaining - accessing support from another NHSI cohort 1 trust and contributing to their training.	
Actively contribute to the NHSI lean Improvement Programme and lead the successful implementation in DBTH. Have measurable evidence of improvements as a result of this within the first year.	Identified detailed outcomes for the programme in year one with draft work programmes for years two and three.	Contributed to workshops to develop NHSI Improvement practice model. Implementing as agreed with NHSI National Director of Lean Transformation. First VSA undertaken – improvement work commenced in Trauma & Orthopaedics and plan developed for 2018/19.	Further Rapid Improvement events (RIEs) including Emergency Department and Inpatient trauma. Supporting implementation of	RIEs undertaken this quarter include elective T&O, antenatal, and preparation for T&O theatres (RIE in April 19).	

			trauma management board and congoing coaching. Maternity QI event – planning commenced for RIE in Jan 19.	Coaching continues to achieve benefits realisation with realised benefits. Training plan updated with support of new NHSI consultant.	
Work with partners to support joint working where there are quality and financial benefits and support projects when "commissioned" by Executive colleagues Lead and deliver the identified Effectiveness and Efficiency Programmes:	Enhanced collaboration and partnership working to support quality improvements in patient pathways and improved productivity, efficiency and effectiveness.	Developed Strategic Change Manager role for Urgent & Emergency Care, hosted by DBTH, to support all stakeholders in Doncaster ACP. Commenced work with RDASH on Neuro Rehab and OPMH.	Strategy development for UEC in Doncaster developed. Work on prevention and self-care with partners commenced and mapping of existing services. Work with RDASH ongoing as Q3.	UEC services plan progressing in line with plan.	
Director of Estates and Facilities					
Deliver the 2018/ 2019 capital and revenue budgets spend within agreed financial limits by end of March 2019	Improved management of revenue and capital budgets to maximise the benefits to the Trust.	Budgets circa £200k over YTD, underspend on pay, revenue overspends contained to uncontrolled central costs such as utilities. Capital programme delayed start due to need for NHSi confirmation of treatment of £3m. Programme now catching up and looking to deliver in year.	18/19 budget at month 8 just 0.4% over budget at £49k against a £28m annual budget. Capital projection agreed in January	Capital programme delivered in year and in budget Overspend on revenue budget by £1m against £29m budget, circa £900k of that was known costs pressure energy, circa £500k and risk based accrual at year end circa £400k.	
Develop Site Strategies with the aim of divesting of poor estate with high levels of backlog.	Renewal or upgrade of existing estate; accessing ICS funding, identifying and developing commercial and public sector	Disposals achieved 5 Highland Grove and MMH Nurses Home Plot. £130m bid submitted June to ICS Inc.	Offer agreed for Chequer Road of £470k, services to relocate to CCH	Whilst work is ongoing on Chequer Road relocation, and	

	partnerships, and via internally generated Capital.	partnership with DMBC Working with CCG on relocation of service form Chequer Rd. Accommodation identified for 2 of 3 service form Chequer Rd at Devonshire House. Need to agree costs neutral rental with CCG and for 200m2 for Audiology Master planning BDGH delayed due to complexity of financial model – report due to Exec Q3	buildings at no greater cost than current circa £55k pa. Master planning at BDGH finalised, due to share with Exec Team end Jan early Feb. £137m capital bid rejected, now exploring emergency capital loan for Fire and Theatres work, alongside looking at JV opportunities for other elements of the bid	the final version of the BDGH Master Plan is still outstanding – these are due to be deliver. Emergency Capital bids progressing and £137m bid will be resubmitted in 2020.	
Increase Statutory Compliance by building upon improved performance against NHS Premises Assurance Model (PAM) 17/18	Enhancing the profile and actions of the Trusts Health & Safety Committee to ensure improved compliance and resilience of key services.	H&S Committee developing KPI's. Second 6 monthly H&S report to ANCR in September. Feedback to expand to cover more risks and include EFM Risk Register. Review of EFM risk register complete and to be circulated to Exec team in October ahead of next ANCR meeting. Estates staff training was agreed as £20k cost pressure – training for CP/AP's in progress.	Risk Register review completed, although monthly reviews are ongoing ANCR reporting of H&S now embedded, Trust H&S meeting attended by Chair of ANCR as an observer New PAM/H&S electronic Visual Management Board containing H&S KPI's being trialled, demonstration requested by Chair of ANCR, and possibly for Board H&S training CP/AP training underway	NHS PAM draft complete shows further year on year improvements with no red's now present. Due at May BoD meeting.	
Increase Staff Engagement	Building upon improved Staff Survey scores 2017/18 to improve scores to the Trust average, in addition to increasing uptake. Staff	Staff Survey Action Plan in progress. Trust-wide Director Drop-ins continue.	Staff Survey uptake doubled for 17/18 Results to be evaluated	Finished the year on 94% PADR's.	

	Survey action plan reviewed monthly at the Estates and Facilities Committee (DoEFM Chair).	PADR levels maintained above 90%. Staff Surveys for 18/19 will be available as paper based to increase uptake.	and action plan developed PADR 94% Director Drop-ins continue	Staff survey action plans being developed.	
Lead and deliver the identified Effectiveness and Efficiency Programmes:	Deliver the identified E&E programmes within plans and timeframes. Identifying additional opportunities to deliver the Trusts 2018/ 2019 financial plans.	On track and exceeded in some areas, list being developed for 19/20.	List being developed further for 19/20 £43k short of target CIP £493k, hoping to close gap	19/20 list of CIP's being progressed with the aim of exceeding 3%.	
Leading by example, Support the successful implementation and delivery of the Trusts Transformation and Lean Programmes.	Actively participate in the Trusts Lean Programme. Demonstrating the required leadership and assuming lead responsibilities where required.	Director attended NHSi LEAN training as part of Exec Team learning and development. NHSi LEAN combined within Leadership/Culture training undertaken by senior EFM team. EFM have become early adopter of NHSi LEAN with Visual management Boards in Place, 5 Wastes, SIPOC, and A3's for three workstreams SI/NHSi keeping track on work. T&O will visit Estates to see tools being used. NHSi Productivity Team to utilise DoEFM for Best practice films.	Early adopter Continuous Improvement/NHSi LEAN continuing, and now becoming embedded in other departments within EFM Business Case being developed for further Culture/OD training	Early adopter work continues Objective for 1920 will be to gain funding for further Culture/OD work for bands 1-4.	
Chief Information Officer					
Deliver the 2018/ 2019 capital and revenue budgets spend within agreed financial limits by end of March 2019	Improved management of revenue and capital budgets to maximise the benefits to the Trust	Official M5 figures show £220k overspend on revenue. Changes anticipated to M6 to include CIG approved revenue and budget transfers for staff. Expect M6 and rest of year to deliver on track. Capital on track.	Capital and revenue on track as at M9.	Capital completed and spent. Revenue position uncertain as I believe finance took a £185k accrual at year end. Including this, the known and flagged	

				issues of the switchboard rota cost pressure (£70k) and the PACS uplift (£70k) due to the supplier resolving the outstanding problems resulted in a total of £320k over budget. Still due to meet with finance to confirm end of year position.	
Deliver the 2018/19 activities defined in the IT Digital strategy	Ensure projects stay within capital limits and deliver to a satisfactory level of quality within the allocated resources.	Approved and funded projects on track. Bed management at Bassetlaw live October 2018. Portal live with 1200+ users. Further planned rollout activities for portal in rest of FY.	EPR business case developed and NHSE funding requested. Portal continuing to be developed and for external integrated care.	Delivered planned objectives.	
Deliver a satisfactory IT service for existing infrastructure and software demonstrating at least 99.9% availability.	Develop additional balanced scorecard and KPI's to demonstrate upper quartile performance against the rest of the Trust departments and, if feasible, against other Trusts within the ICS.	Service availability at 99.9%+. Outages subject to Root Cause analysis and feedback to operational procedures and vendors. Friendly Fridays introduced to support clinical directorates IT needs.	Service at 99.99%. challenges with second line support and increasing backlog of service requests due to staff shortages and long term sickness	Delivered 99.996% uptime for core clinical systems.	
Deliver GDPR readiness by May 2018. Continue to monitor effective information, data governance and cyber security controls	Ensure that the Trust achieves a Significant Assurance rating within the new DSP framework (replaces IG toolkit) by March 2019	GDPR Complete. DSP artefacts being delivered. Full DSP not yet defined so status is AMBER until this is known and workload understood.	DSP audit preparations underway for internal audit by KPMG in January.	Delivered DSP toolkit with significant assurance.	
A significant contribution to the development of technology at ACP, ICS or internally within the Trust that supports the transformation of the wider organisation.	Ensure appropriate representation at relevant ICS and ACP meetings and events, including where appropriate taking lead roles on behalf of the ICS and ACPs.	CIO is deputy ICS CIO and part of regional panels for funding. Fully supporting iDCR at Doncaster CCG and including activities and requirements for Bassetlaw CCG in portal in support of social and community care. DBTH a significant influencer at both ICS and ACP	CIO is now 2 days per week at CCG to deliver IT strategy et al for integrated care partnership board. Linkages into	Delivered everything requested on time and to the desired quality.	

		level.	Bassetlaw CCG continue.		
Lead and deliver the identified Effectiveness and Efficiency Programmes:	Deliver the identified E&E programmes within plans and timeframes. Identifying additional opportunities to deliver the Trusts 2018/ 2019 financial plans.	Departmental CIP's largely on track. Supported iFIT changes to contracts and functionality in support of ED. All developments have benefits that aim to increase overall trust efficiencies.	CIP's delivered for 18/19. Challenges with telephony performance being addressed in Q4	Targeted £90k, delivered £150k.	
Leading by example, Support the successful implementation and delivery of the Trusts Transformation and Lean Programmes.	Actively participate in the Trusts Lean Programme. Demonstrating the required leadership and assuming lead responsibilities where required.	Active participation.	Active participation. Service desk improvement model being developed.	Progress on specific programmes has been limited by due to competing priorities but the Team have contributed to other departments, especially to ED.	

Chief Executive's Report

30 April 2019

Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

System Perfect for Mental Health

Working with Partners in Doncaster and Bassetlaw, a week long exercise took place from Tuesday 26th March 2019 which looked at how health and social care pathways function when all hands are on deck and everything is working exactly as it should.

System Perfect is shared work which happens several times a year; the focus this time was on mental health services, raising awareness and encouraging conversations locally so people can access the support they need in their local communities.

Throughout the week, the System Perfect team sought to better understand the use of the emergency department for people when they experience mental health issues, as well as raising awareness of the wide range of services that operate across Doncaster and Bassetlaw to support and address individual mental health needs.

Follow the work, get involved and share your views and experiences on Twitter, using the hashtag #MHSystemPerfectSYB.

Health and Social Care Careers Event

I was pleased to see the joint approach to recruitment on Wednesday 27th March when Doncaster Royal Infirmary hosted the careers event for those wishing to pursue a role within the health and social care sector. The event was organised by Doncaster and Bassetlaw Teaching Hospitals (DBTH), Rotherham Doncaster and South Humber NHS Foundation Trust (RDaSH) and Sheffield Hallam University.

Attendees had the opportunity to find out about the different types of roles on offer within the local NHS, with healthcare professionals on-hand to answer questions, provide information and explain what career paths can be followed. Professions represented included; Nursing and Midwifery, Social Work, Operating Department Practice, Physiotherapy, Occupational Therapy and Radiography.

Alongside an interactive area to explore the various health and social careers on offer, representatives from the NHS, Sheffield Hallam University, The University of Sheffield, Student Finance England and local colleges spoke about the following topics; work experience opportunities and apprenticeships, admissions support for university, college options and finance support.

'Vaccinators' named 'best team' at Annual Awards

I am delighted to announce that the Trust's Flu Campaign Team have been named 'Best Team' at the NHS Employers' annual Flu Fighter awards held on 25th March at the Midland Hotel in Manchester.

Nominated for both 'Most Creative' and 'Best Team', vaccinators at DBTH were awarded the latter honour, with the judges commending the Trust's multi-disciplinary approach and emphasis on team working while displaying brilliant leadership throughout.

Each year, the Trust's flu campaign is spearheaded by a dedicated team of vaccinators made up of Occupational Health and Wellbeing practitioners and hospital clinicians of all grades and levels.

I am sure you will agree that this is a great achievement for the team!

Hospital nominated for prestigious efficiency award

I am delighted to announce that Doncaster and Bassetlaw Teaching Hospitals (DBTH) have been nominated for a Health Service Journal (HSJ) award for the implementation of innovative technology in the Emergency Department (ED).

Introduced back in 2018, the Smart ER system is accessed by a pair of kiosks set up in the ED waiting room. These can be used by any patient, or carer, to fill out a short digital form describing their injuries or ailments, as well as to answer a few general questions. Once the form has been completed, these details are then imported directly into the individual's medical record, ready for use in their upcoming consultation.

The application has been shortlisted for a HSJ Value Award. Nominated in the category of Emergency, Urgent and Trauma Care Efficiency Initiative of the Year, Smart-ER will be competing against other schemes from the across the country to pick up the illustrious prize. The winner will be announced on May 23, following the awards ceremony itself which will take place in Manchester Central.

New Chief Operating Officer

I am pleased to announce that after an extensive recruitment and selection process, we have appointed Rebecca Joyce as our new Chief Operating Officer (COO).

Rebecca, was a graduate of the NHS Management Training Scheme and has almost 20 years' experience in the NHS. She joins the Trust from Sheffield where she has held the post of Accountable Care Partnership Director since 2017, working across the NHS, Council and voluntary sector to develop a more integrated, prevention-orientated care system.

Originally from Worksop and having attended Portland Comprehensive School (now Outwood Academy), Rebecca joined the NHS in 2000 taking up acute and primary care roles across North West London, alongside working for the Aga Khan Health Network in Tanzania on the coordination of HIV and AIDs services. Following that she worked within senior hospital operational roles at

Imperial NHS Foundation Trust and Ealing Hospital. In 2007 she moved to Sheffield Teaching Hospitals to take up the role of Operations Director for Specialised Cancer, Medicine and Rehabilitation, before moving into more transformational and strategic roles and becoming the Service Improvement Director in 2014.

A wide and varied career within the NHS, these roles have provided Rebecca with a breadth of operational experience across community services, outpatients, urgent and general medicine, surgery, cancer and specialised services. I hope you will join me in wishing Rebecca the warmest of welcomes when she officially starts on 3 June 2019.

Annual 'Sharing How We Care' Conference

On Thursday 11 April, Doncaster and Bassetlaw Teaching Hospitals (DBTH) hosted its second annual 'Sharing How We Care' conference at the Holiday Inn in Warmsworth, Doncaster. I had great pleasure in being able to attend and open such an important event.

The hugely successful event, which was attended by more than 150 local nurses, doctors and healthcare professionals, was an opportunity to share innovations, best practice and learn from colleagues from within the Trust.

The conference kicked-off with a moving and thought-provoking discussion, courtesy of special guest James Titcombe OBE. A Patient Safety Specialist, James' infant son, Joshua, died at University Hospitals of Morecambe Bay NHS Foundation Trust nine days after his birth in November 2008.

Afterwards, attendees gathered together to showcase exciting developments and take part in a series of informative workshops. These activities touched on everything from patient safety, to recent projects such as 'Making Mealtimes Matter' and a drive to ensure that patients have an uninterrupted, quality sleep when staying at hospital. Proceedings were then brought to a close by Trust Chair, Suzy Brain England OBE who summed up the conference with a few inspirational words and a further commitment to the Trust's values of 'We Care'.

DBTH New Hospital Governors

Foundation Trust members have voted for their hospital governors in the latest round of elections at Doncaster and Bassetlaw Teaching Hospitals.

The election results were confirmed on 29 March and the successful candidates officially took up their seats on the Council of Governors on 1 April for a term of three years. The election introduces 10 new governors to the Council along with some re-elections to public seats.

I am pleased to announce that in the Doncaster Public constituency Mike Addenbrooke and David Northwood held on to their seats and were re-elected for a further term of office and new members to the Council of Governors are David Goodhead, Ann-Louise Bayley, Dave Harcombe, Susan McCreadie, Doug Wright and Geoffrey Johnson.

In Bassetlaw, over 600 voters re-elected Hazel Brand to her Bassetlaw Public Constituency seat for another three year and the other Bassetlaw seat will be filled by Steve Wells, following his retirement from the Trust as a Theatre Service Manager.

In the Staff Governor categories, we welcome Kay Brown newly elected to the Non-Clinical seat, Mandy Tyrell representing Nursing and Midwifery staff and Dr Panikkar for Medical and Dental.

Brenda Maslen and Shelley Brailsford are leaving the Council of Governors after 3 years in office. George Webb and Susan Overend stepped down after 15 years of service as Governors. On behalf of the Trust I would like to extend my thanks to all of our Governors, their input over the years has been invaluable.

NHS England and NHS Improvement changes

On 1 April NHS England (NHSE) and NHS Improvement (NHSi) came together in a new joint management structure, an integration identified as the way forward to achieve the vision of care set out in the NHS Long Term Plan.

They will move to a single chief executive and single chief operating officer (COO) model, with the single combined COO post covering both NHSE and NHSi and reporting directly to Simon Stevens as the Chief Executive of NHSE.

The COO will, for regulatory purposes, also be the identified Chief Executive of NHSi and, in that capacity, will report to the Chair of NHSi. They will be responsible for the operational delivery of the Long Term Plan, and the seven Regional Directors, the National Director for Emergency and Elective Care and the National Director of Improvement will report directly to them. Other changes as a result of this include disbanding the Deputy Chief Executive of NHS England directorate, moving to one Strategy Director and one Communications Director.

Ian Dalton, Chief Executive of NHSi has subsequently announced his resignation but NHSi continue to be the high level contact for provider chairs and chief executives. The Trust's regional point of contact is Richard Barker who is the Regional Director for North East and Yorkshire.

A Smokefree NHS

We have received a letter from Duncan Selbie, Chief Executive for Public Health England, thanking us for the positive actions we have taken as a trust towards making a smokefree NHS an everyday reality**.**

As a trust we scored 6/7 and are rated as green in the NHS smokefree survey. This means that the trust is considered to have demonstrated positive steps towards comprehensive smokefree status, defined as:

- every frontline professional discussing smoking with their patients
- stop smoking support offered on site or referral to local services
- no smoking anywhere in NHS buildings or grounds

A campaign will take place on the run up to World No Tobacco Day on 31 May to support the implementation of our plans.

Developing the South Yorkshire and Bassetlaw Regional Stroke Service

After significant work, clinical input and public consultation, changes to the way hyper acute stroke services are delivered across South Yorkshire and Bassetlaw were agreed last year and thanks to the staff involved, is something that is now being put in place. The changes are:

From 1 July 2019 – the hyper acute stroke service will cease at Rotherham NHS Foundation Trust. After this point, the majority of Rotherham's hyper acute stroke patients will be taken by ambulance for treatment at the Royal Hallamshire Hospital, Sheffield - with the remaining being taken to the hyper acute stroke site at Doncaster Royal Infirmary, depending on which is the closest.

From 1 October 2019 - the hyper acute stroke service will cease at Barnsley Hospital NHS Foundation Trust. This will mean that Barnsley patients will be taken to one of the regional hyper acute stroke centres - predominantly Doncaster Royal Infirmary or Pinderfields Hospital in Wakefield, depending on which is the closest.

Sodexo strike action

Sodexo catering staff are entering into industrial action on several dates during May.

We have been working very closely with Sodexo and the Unions and to ensure that there is minimal disruption to patient meals. Sodexo have available staff to provide essential patient meal services and at the time of writing the indication from Sodexo's business continuity plans are that hot meals will be available for patients during all of the following industrial action days:

- 1-3 May
- 7-9 May
- 15-17 May
- 20-22 May

For staff and visitors, there will be limited retail options available:

	All Dates
DRI	Subway 7am to 9pm
Bassetlaw	Hot Kitchen 8am to 6.30pm
Montagu	9am to 2pm

Hospital Sterilisation and Decontamination Unit (HSDU) transfer

On Monday 13 May, our Hospital Sterilisation and Decontamination Unit (HSDU) services will transfer from the Trust to STERIS Instrument Management Services (IMS).

This means that our current HSDU services will be relocating to a state-of-the-art facility just off of the Sheffield Parkway which operates 24 hours per day, seven days a week. The facility also has a full back-up of all utilities to maintain the service as part of a comprehensive business continuity plan.

With a focus on efficiency, instruments will be turned around to agreed timescales the maximum being 24 hours, the minimum being 5 hours. We will, for the first time, have the ability to check information on our instruments and where they are in the sterilisation and delivery process using a digital portal, providing greater visibility on when instruments will be back with us.

As an organisation, we want to thank our HSDU team for their patience and commitment during this transition process. In STERIS IMS, we believe we have a partner which values the expertise of our staff and will provide them with the facilities, support, and development opportunities they need.

DONCASTER & BASSETLAW TEACHING HOSPITALS NHS FOUNDATION TRUST

Minutes of the Finance & Performance Committee held at 9:00am Friday 22 March 2019 in the Boardroom, DRI

PRESENT	:	Neil Rhodes, Non-Executive Director (Chair) *(Part)* Pat Drake, Non-executive Director (Chaired from 11:30am) Kath Smart, Non-Executive Director Jon Sargeant, Director of Finance *(Part)* Karen Barnard, Director of People & Organisational Development David Purdue, Deputy Chief Executive & Chief Operating Officer
ALSO IN ATTENDANCE:		Alex Crickmar, Deputy Director of Finance Kate Sullivan, Corporate Governance Officer Dr Kirsty Edmondson Jones, Director of Facilities & Estates *(Part)* Andy Thomas, Project Director *(Part)* Dr Bushra Ismaiel, Designated Doctor for Safeguarding, Lead for Autism Pathway and Lead for Community Paediatrics *(Part)* Helen Burroughs, General Manager, Children and Families Division *(Part)*
OBSERVERS	:	Bev Marshall, Governor Observer
APOLOGIES	:	Gareth Jones, Trust Board Secretary

Action

Agenda Review

19/03/1 The agenda was reviewed. The Chair would attend until 11:30am from which point Pat Drake would Chair the meeting. The Efficiency Director was unable to attend therefore agenda item 4 - CIP 2019/20 Governance Process was deferred to the April meeting. The Director of Finance would attend the meeting until 11am as he was required to attend another meeting. **PM/JS**

19/03/2 There had been a request for a late item relating to Outpatient Pharmacy services. A presentation had been circulated the previous day. The item would replace agenda item 4.

Apologies for Absence

19/03/3 Apologies as recorded above were note.

Action Notes from Previous Meeting

19/03/4 The action log was reviewed and updated.

18/12/25 – In relation to oversight of the Sodexo contract the Chair reporting having had a walk-through of the catering service, accompanied by Mike Addenbrooke, public Governor and Vice Chair, earlier in the week. They were able to track the patient meal from order receipt, through assembly, to ward service and gained considerable reassurance from what they saw. They had also met with key staff and a future visit was being discussed to have a similar look at the retail offer from Sodexo on site for patients and visitors. Considerable assurance was gained from the visit.

Car Parking Security Service – The Contract presented to the Committee in February had

been reviewed outside of the meeting and subsequently taken through the February Board meeting where it had been approved. In response to query raised by Kath Smart about how the contract would be monitored going forward and what F&Ps role might be in this, the general matter of governance & oversight of contracts was discussed. The Director of Finance noted that the committee should not have a role in the operational monitoring of contract performance but agreed that there needed to be a mechanism for escalating significant underperformance of finance and performance aspects of contracts and an annual report on overall contract performance. The Chair invited the Committee to share their thoughts on this with him outside of the meeting and the matter would be picked up at a future planning meeting. Pat Drake raised a further query about the Park Hill contract; she noted that Governors had raised queries about the monitoring of clinical governance aspects of the contract through the Quality & Effectiveness Committee (QEC); in light of this she felt it was appropriate to consider Park Hill contract performance more widely. It was agreed to include this in an Annual Contract review report which would be brought to the June meeting. **JS**

Workforce Trends – The target date was changed to April 2019

OPD Pharmacy

19/03/5 The Committee received an update from Andy Thomas, Project Director, concerning the outpatient pharmacy service; an overview of the current service and key issues was provided. The service was currently provided within the Trust by Wells, a commercial pharmacy provider. After being identified as the preferred supplier for the pharmacy contract, when it was retendered in late 2018, Wells had now withdrawn following a strategic decision by the Group's Board. Market intelligence had revealed that other suppliers were also withdrawing from the market of providing similar services. Wells had undertaken to provide the service for a further 6 to 9 months. The Trust was currently assessing 4 options, including running an in-house service, working with another external company or setting up subsidiary company to run the service for the Trust. Detailed financial modelling had been done for 2 of the options. The Executive Team had undertaken an option appraisal and had found Option B, setting up a Wholly Owned Subsidiary to run the service, to be the preferred option; it was noted that this was the NHS preferred model adopted by a number of other Trusts. An outline of key points for all options was provided along with detailed financial modelling for Option B.

19/03/6 The Committee discussed the matter in detail focussing on the subsidiary option; the Committee probed the option appraisal process, impact on existing Well's employees, whether the service would be like for like, financial implications / benefits, implementation risks, the level of Board costs set out in the financial modelling, NHS guidance relating to the process for setting up a subsidiary, governance processes and Board certificate covers. It was clarified that there were currently 10 members of staff (8.6WTEs) employed by Wells working at the Trust. Several questions were rasied about the level of powers to be retained by the Trust Board and this was discussed. The committee also considered how the matter would be communicated to staff and unions; it was important to clearly communicate that this would not impact on existing Trust staff and that the Trust would be looking to retain existing Wells employees though a TUPE arrangement to a new subsidiary.

19/03/7 The Committee NOTED that an outline business case was being developed to be considered by the Trust Board and that a full business case would be brought to the next meeting. It was agreed to ensure the business case included:

- A communications strategy
- Proposed governance arrangements **AT/JS**

- Details of the powers reserved for the Trust Board.

Community Paediatrics Pathway

19/03/8 The Chair welcomed Dr Bushra Ismaiel, Lead for Community Paediatrics and Helen Burroughs, General Manager, Children and Families Division, to the meeting. It was noted that in response to concern raised at previous meetings with regard to paediatric non-medical wait performance, the Committee had commissioned the deep dive on the matter. Dr Bushra Ismaiel delivered an in depth presentation on the matter which included an overview of the community paediatric team at the Trust including their roles and responsibilities along with an overview of the scope of community paediatrics in Doncaster and Bassetlaw. She provided a detailed update on continued progress since 2014 to improve the community paediatric service including improvements to the referral process, the quality of referrals, booking rules, better links with schools and support for children prior to referral and during the waiting time, support for parents after a general development assessment (GDA), better decisions and outcomes made at the first appointment (In the best interest of the child) and improvements in practice in terms of child protection. Since September 2016 the number of children waiting for a new appointment had reduced from 671 children with a 14 month wait to 80 children with a 14 week wait (at March 2019).

19/03/9 An overview of key challenges was provided, these included 2 key vacancies, one for a consultant and one for a speciality doctor, there was also a lack of community nursing team support and a need for cover for the Downs Syndrome pathway as there was no capacity and there was no lead paediatrician for CDC which was currently led by a therapist.

19/03/10 The Committee welcomed the presentation. They commended the significant improvements made and recognised the hard work and commitment of Bushra and the community paediatric team over several years to achieve this. It was encouraging to see stronger links to education and the innovative work to improve the paediatric pathways. However, the current waiting time for a first appointment of 14 weeks still felt like a long time and the waiting time post GDA remained significant; the Committee asked if there was anything else that could be done to improve this. The Team continued to work innovatively to improve the waiting time but the key issue was capacity; the committee asked about the level of confidence in terms of recruiting to key vacancies to address this and this was discussed.

19/03/11 The Committee NOTED the Community paediatric Pathway Update

Financial Plan and Budget Setting 2019/20 – Final Submission

19/03/12 The Committee received the report of the Director of Finance (DoF) and the Deputy DoF which presented the Trust's financial plan for 2019/20 including the income and expenditure plan/budgets, capital plans, cash requirements and cost improvement programme. The paper set out the key assumptions that underpin the financial plan and budgets.

19/03/13 The draft financial plan was submitted to NHS Improvement on the 12th February in line with the National timetable. The final financial plan was due for submission by the 4 April 2019. At the draft planning stage, there was a gap of £23.9m to the Trust's control total. Through the budget setting process this gap had reduced to £22.1m before CIPs. The Trust plans to deliver CIPs of 3% (13.2m) in 2019/20 which made the gap to the control total £8.9m. A number of potential mitigations were then required to close this gap to allow the Trust to deliver its control total.

19/03/14 The other key risks and assumptions in the plan to note were set out in the paper and included:

- £13.2m CIPs (3% of expenditure) are required to deliver the control total. A significant proportion of this was currently assessed as high risk (section 6 of the paper provided further details)

- Contract Agreement - Since the time of reporting the contract with Doncaster CCG had been agreed and signed. The Trust was close to signing the contract with NHS England. The DoF provided a candid and detailed update on contract negotiations with Bassetlaw CCG including the reasons why the two organisations had been unable to reach an agreement so far; a further meeting with Bassetlaw CCG was planned for later the same day.

19/03/15 Budget setting – In February the Committee supported the budget setting principals and processes for 2019/20 financial planning. Since that time significant work had been undertaken at divisional level and the Gap to the control total, subject to contract negotiations, now stood at £8.9m with £13.2m of CIPs to deliver. There was more work do to with budget holders and there had been a focussed meeting of the Efficiency & Effectiveness Committee the same week to set out expectations. In response to a query from the Chair about the extent to which the £13.2m CIP could be realised through recurrent savings, the DoF advised that the Trust was looking at this and he gave a number of examples. There was also a wide ranging discussion about potential mitigations to close the £8.9m gap and the DoF went through a number of options.

19/03/16 The report included a detailed update on income and expenditure plans including the key amendments to the financial plan and budgets since those presented to F&P in February 2019; these were highlighted in a bridge chart. The movement between the 2018/19 forecast outturn and the final financial plan for 2019/20 was also set out in a bridge chart. The report included an update on contract negotiations, income by point of delivery, process and background to budget setting, non-pay, summary of pay expenditure budgets, reserves, progress on cost improvement programmes since the previous meeting, capital programme and the cash position.

19/03/17 It was noted that one of the key movements between 2018/19 forecast outturn to the 2019/20 was that the pay position removed expenditure of £27.4m included in outturn relating to temporary staffing (agency, additional sessions etc.).The budget setting process funds all vacancies within establishments that would have previously been covered with temporary staffing of £23.9m. In response to several queries from the Chair about this there was an in depth discussion about the rational for this movement and the DoF provided further details.

19/03/18 It was noted that based on the report the DoF would be recommending that the Trust accepted the 2019/20 control total; there would be further discussions at the Board meeting the following week.

Jon Sargent left the meeting to attend a contract negotiation meeting

19/03/19 The Deputy DoF took the committee through the key amendments to the financial plan and budgets since those presented to F&P in February 2019 (highlighted in the bridge chart on page 4) and the movement between the 2018/19 forecast outturn and the final financial plan for 2019/20 (set out in the bridge chart on page 6), line by line, in depth. The Committee welcomed the detailed update and that key risks had been set out clearly; The bridge charts had been particularly helpful.

19/03/20 Reflecting on discussions around CIP plans it was agreed to schedule a deep dive on the CIP relating to the outpatient (OPD) cap for a future meeting. **DP**

19/03/21 The Committee NOTED the reports and;

- SUPPORTED the financial plan to be approved by the Trust Board and then submitted to NHS Improvement, including agreeing the key assumptions and noting the risks to delivery.
- SUPPORTED the income and expenditure plan/budgets, capital plans and cost improvement programme to go to Trust Board for approval.

Yearend Accounts – Planning update and Accounting Policies

19/03/22 The Committee received the report of the Head of Financial Control which, as part of planning for the year-end accounts process, brought together relevant updates on matters relating to accounting standards and areas of risk as well as general updates which would affect the preparation of the accounts. Also included within the paper was the draft accounting policies note, which had been drafted from the Government Accounting Manual, with a summary table showing the differences between the 2017/18 note and the proposed 2018/19 note.

19/03/23 Going Concern - The Trust was required to confirm its belief that the 2018/19 annual accounts should be prepared on a going concern basis. Despite the fact that the Trust was forecasting a deficit in year, as well as a deficit against original plan, it maintained the support of commissioners and NHS Improvement. As such, there was a belief that the Trust would remain operating in its current form for at least the 12 month period after the sign-off of the annual accounts. A Going Concern paper, including evidence, would be brought to the next meeting.

19/03/24 Revaluation – In mid-January 2019, the Royal Institute of Chartered Surveyors (RICS) released clarification guidance with relation to the useful economic lives that depreciation is calculated upon. This appeared to affect different Trusts in different ways, depending on their valuer and the method that was used. Kath Smart reflected on recent negative publicity about recent work done in the regard for other Trusts and this was discussed. Alex Crickmar gave assurance that the Trust was challenging its valuers and the Trusts auditors would get their valuers to check valuations; this approach was endorsed.

19/03/25 The Committee NOTED the proposed Accounting Policies Note and the updates relating to the year-end accounts preparation.

Finance Report

19/03/26 The Committee received the report of the Director of Finance which set out the Financial Position at Month 11 (February 2019) which was a favourable variance against plan of £855k before PSF funding and a favourable variance against forecast of £644k in month. The cumulative position to the end of month 11 was a £21.7m deficit before PSF Funding, which was £1,455k favourable to plan (£2,334k adverse to plan including PSF) and £1,452k favourable to forecast.

19/03/27 The Trust now expected to deliver its control total at year end and this was welcomed. This was a result of; the improved position against forecast and plan (especially in income), following final discussions with Doncaster CCG who were funding any undelivered CQUINs monies and delivery of the waiting list recovery plan, the funding agreed from the ICS and reduced spend on agency in February by more than forecast.

The Trust's key remaining risk was the delivery of the Waiting List recovery plan, which attracted incentive payments of c.£2.4m, which was yet to be included in the Trust's position.

19/03/28 The Committee NOTED:

- The Trust's deficit for month 11 (February 2019) was £224k, which was a favourable variance against plan of £855k before PSF. This was a favourable variance against forecast of £644k in month. The cumulative position to the end of month 11 was a £21.7m deficit before PSF, which was £1,455k favourable to plan (£2,334k adverse to plan including PSF) and £1,452k favourable to forecast.
- The achievement with regards to the Cost Improvement Programme.
- The improved financial position and that the Trust was forecasting to deliver its control total at year end subject to delivery of the Waiting List position.
- The risks set out in this paper.

Neil Rhodes left the meeting

Integrated Performance Report

19/03/29 The Committee considered the new monthly Integrated Performance Report (IPR) which was being properly received for the first time. The report was presented in three parts :

1. The Summary IPR – This summarised performance both in-month and year-to-date and provided a forecast to the year end.

2. Commentary on exceptions – this analysis was provided by operational teams where targets have not been met.

3. Analysis of the proposed national changes to A&E targets

19/03/30 The Chair welcomed the report and acknowledged the significant work put in to developing it. The report would be rolled out to Board after agreeing how the measures tracked by QEC might best be incorporated. The report included a refreshed 'at-a-glance' table incorporating trends as well as key metrics and comparative, traffic lighted data. The independent analysis supported by subject matter expert comments on the questions raised by that analysis was particularly welcomed. The Deputy Chief Executive and Chief Operating Officer provided the Committee with a detailed overview of performance; in broad terms Trust performance once again remained sound. It was noted that there continued to be an increase in the level of ED attendances. Two Week Wait cancer performance continued to improve and RTT was now exceeding trajectory. There was, however, an increase in cancelled operations owing to a lack of HDU capacity. The Committee welcomed the helpful overview of proposed changes to Emergency Department targets.

19/03/31 The Integrated Performance Report was NOTED

RTT

The Committee received the fourth update from the Deputy Chief Executive & Chief Operating Officer on the waiting list position and RTT position, by speciality: the report was tabled. This time it included a weekly and monthly performance summary and highlighted performance by speciality (rag rated). An update on red areas and key issues by speciality was provided. External validation of RTT had started; the initial review had identified a few issues relating to staff understanding of the process and some education for staff would be developed. Confidence was high that the Trust would achieve the

target waiting list size by 31 March 2019. Income was now exceeding trajectory and this was welcomed.

19/03/32 The RTT Update was NOTED

Workforce Report

19/03/33 The Committee considered the report which provided data in relation to month 11 including the vacancy profile, agency spend and usage, sickness rates, and rostering data. Links to BAF risks highlighted on the report cover sheet were welcomed. The vacancy rate was 7.1% against a target of 5%; when taking into account the use of temporary staff this was a 1.7% vacancy rate, although this varied by staff group. Agency targets had been set for each Division which, importantly, had also been split by staff group and management grip was tightening as a consequence. To date, the Agency target has been exceeded but £2m less had been spent this financial year compared with the previous year. Updated benchmark data had been provided from the model hospital portal for both vacancies and agency and bank spend which, on the whole, indicated that the Trust benchmarked favourably although there are areas which required focus. Within the refreshed efficiency programme the workforce work stream would focus on recruitment to vacancies, reduction in sickness absence, reduction in need to cover enhanced care needs, and agency prices (and demand). It was noted that sickness rates had returned to October levels.

19/03/34 An update was provided on progress with recruitment including an update on open days for nurses and midwives. The Trust also planned international recruitment and this was briefly discussed. In response to a query from Bev Marshall the Director of People and Organisational Development provided assurance that overseas recruits started as Health Care workers and did not commence in post as nurses until they had passed a series of tests; their visas were also dependent upon this.

19/03/35 Kath Smart reflected on a recent discussion at the Audit & Risk Committee (ARC) about an Internal Audit (IA) recommendation relating to return to work documentation not being recorded on the Electronic Staff Record (ESR). The Chair of the Board had raised a similar point about statutory and essential to work training (SET) and she noted that ARC had agreed for IA look at use of ESR; the scope of the audit was yet to be agreed. The Director of People & Organisational Development advised that the Trust planned to introduce ESR self-service; this would give managers access to update a range of records including sickness absence and training records. The implementation was planned for Q3 2019/20; The Committee welcomed this.

19/03/36 The Workforce Report was Discussed and NOTED.

Corporate Risk Register and BAF Highlights

19/03/37 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. The Committee noted that Care Groups, rather than Divisions were still referred to in the BAF that some of the due dates for controls seemed to be overdue/out of date. The Trust Board would ensure both all controls were updated for the next meeting with a timeline for completion. **GJ**

Sub-committee Minutes

19/03/38 The minutes of the Cash Committee meeting held on 25 February 2019 were NOTED

Minutes of the meeting held on Feb

19/03/39 **Not Available – to be approved at the next meeting.**

Work plan

19/03/40 The Work Plan was NOTED.

Items for escalation to the Board of Directors

19/03/41 None.

Time and date of next meeting:

Date: 23 April 2019
Time: 9:00am
Venue: Boardroom, Bassetlaw Hospital

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

Minutes of the Meeting of the Management Board
of
Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust
on
Monday 11th March 2019 at 2:00pm
in the Boardroom, Bassetlaw Hospital

Present:

Richard Parker OBE (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
Eki Emovon	Divisional Director - Children and Families (Part)
Moira Hardy	Director of Nursing, Midwifery and Allied Health Professionals
Sewa Singh	Medical Director
Jochen Seidel	Divisional Director – Clinical Specialities
Nick Mallaband	Divisional Director – Medicine

In attendance:

Kirsty Edmondson-Jones	Director of Estates & Facilities
Gareth Jones	Trust Board Secretary (part)
Ken Anderson	Head of IT Programmes and Development
Marie Purdue	Director of Strategy & Improvement
Marion Ball	PA to Marie Purdue (capturing the actions for 2019/20 planning item)
Simon Marsh	Chief Information Officer
Helen Burroughs	General Manager
Mandy Espey	General Manager
Kirsty Clarke	Head of Nursing – Surgery and Cancer Division
Marie Hardacre	Head of Nursing - Emergency
Kate Carville	Associate Director of Nursing
Anthony Jones	Deputy Director of People and Organisational Development
Petra Bryan	Head of Quality Improvement
Lesley Barnett	Associate Director of Nursing

Apologies:

Jon Sargeant	Director of Finance

Action

Welcome, Introductions and apologies

MB/19/3/1 Mr Parker welcomed all to the meeting and explained that the Management

Board would review the Corporate and Divisional Plans for 2019/20 as the main item of the meeting. Mr Parker advised the meeting would take a format of setting the scene and building on the Quality Improvement process to reduce waste and increase efficiency and effectiveness. Apologies as recorded above were noted.

Actions last meeting

MB/19/3/2 The action log was discussed and updates acknowledged.

Minutes of the meeting held on 11th February 2019

MB/19/3/3 The minutes of the meeting held on 11 February 2019 were agreed as a true record with the following amendment:

- Members in the attendance list to be identified for the relevant item relating to the emergency care standards presentation.

2019/20 Planning

MB/19/3/4 The Director of Strategy and Transformation delivered a workshop on Divisional Plans and Corporate Directorate plans for 2019/20. Each Directorate was provided with time to present and discuss their plans to the members of Management Board and noted any actions arising.

MB/19/3/5 Mr Parker advised that the Trust had reported another surplus in month for the fifth consecutive month and was on track to achieve the control total for 2018/19. The aim of the session was to continue to build on this and ensure that plans aligned, and progress in 2019/20 was of equal measure for the Divisions and Senior Management Team.

MB/19/3/6 Mr Parker also reported that contracting discussions with the CCG were nearing conclusion with the expected outcome being the requirement for a 3% efficiency target. Mr Parker advised of the four breakthrough objectives for achievement this year and that the plans needed to link with the Trusts Strategy and True North objectives.

MB/19/3/7 Presentations were received for each Division and Corporate Directorates. The update was NOTED.

Any Other Business

MB/19/3/8 Management Board had received a paper relating to a Clinical Risk Review that had been undertaken however it was agreed to defer this item to the next meeting as further work needed to be undertaken.

Date and time of next meeting

MB/19/3/9 The next meeting of Management Board would take place 15 April 2019 at 2pm in the Boardroom at Doncaster Royal Infirmary.

DONCASTER & BASSETLAW TEACHING HOSPITALS NHS FOUNDATION TRUST

Minutes of the Quality & Effectiveness Committee held at 2pm on Wednesday 20 February 2019 in the Boardroom, DRI

PRESENT	:	Linn Phipps, Non-executive Director (Chair) Pat Drake, Non-executive Director Sheena MacDonnell, Non-executive Director Karen Barnard, Director of People & OD Moira Hardy, Director of Nursing, Midwifery & Allied Health Professionals David Purdue, Deputy CE & Chief Operating Officer *(part)* Sewa Singh, Medical Director
IN ATTENDANCE	:	Peter Abell, Governor Observer Nick Mallaband – Divisional Director Medicine *(part)* Kate Sullivan, Corporate Governance Officer Clive Tattley, Governor Observer expecting Cindy Storer, Deputy Director of Quality & Governance Laura DiCiacca, Lead for the Integrated Discharge Teams & Head of Acute Therapies Emma Adams, Research Management & Governance Manager *(part)* Kate Carville, Associate Director of Nursing, Medicine Division *(part)* Stephen, NHSI (Observer)
APOLOGIES:		Marie Purdue, Director of Strategy & Improvement Andrew Beardsall, Doncaster and Bassetlaw CCGs

Action

Introduction

19/02/1 The Chair welcomed Stephen from NHSI who observed part of the meeting, Nick Mallaband, Divisional Director of Medicine, and Divisional Associate Director of Nursing Kate Carville.

The Chair outlined the agreement reached around Children & Young People (C&YP) issues raised by Governors in relation to the Quality & Effectives Committee (QEC) and other governance bodies. Governors were due to receive a briefing on 9 April, to be attended by the Chair, and this should clarify which bodies (e.g. The Children and Families Board) should be reviewing what information. QEC Members, including Governors, would have an opportunity at the June QEC to raise assurance issues around Children and Families, including Maternity, when the relevant Divisional Director would be presenting to the Committee.

The Chair expressed her appreciation for the hard work that had gone in to producing excellent papers and she commented that nearly all had very clear cover sheets, enabling the Committee to focus on key issues and areas of more limited assurance.

19/02/2 Reflecting on the papers the following was agreed: to ensure that all papers and appendices and appendices were bookmarked in the PDF pack, all papers had front sheets, all front sheets should include clear links to BAF risks, embedded documents should be extracted and attached as appendices. **KS/ALL**

Agenda Review & Terms of Reference

19/02/3 The Terms of reference were NOTED. The agenda was reviewed.

Apologies

19/02/4 Apologies as listed above were noted.

Action Log

19/02/5 The action log was reviewed, and updates noted.

My Vision for Quality – Nick Mallaband

19/02/6 The Committee received the report of Nick Mallaband, Divisional Director (DD) and Kate Carville, Associate Director of Nursing, on their vison for quality for the Medicine Division. The report used an adaptation of the six assurance questions which had been agreed between the Chair and Medical Director. It also included a detailed presentation of a range of current data for quality, patient safety and patient experience for the Division as well as the full Divisional CQC Action Plan. The paper was discussed in detail.

19/02/7 Discussion focussed particularly on areas where QEC could support the Division's drive for quality, such as concerns about transport and Estates. The DD clarified his concerns about long waits for inter-hospital transport for acute Medical patients requiring transfer from Bassetlaw Hospital to DRI and added that similar issues were also being experienced in paediatrics. He felt that transport issues would likely become more acute with the move to greater sub-regional integration and hub working. Pat Drake noted that this triangulated with concerns raised at the Finance & Performance Committee (F&P), picked up though performance report data: she shared key points from discussion at that Committee. It was agreed to draw this to the attention of the Trust Chair and Chief Executive, in their roles on regional bodies, and noted that issues around transport would be discussed at the next Management Board (MB). The QEC Planning Group would reflect on how QEC could support the Medicine Division with regard to the issues raised about patient transport and estates issues. **Planning Group**

19/02/8 Kate Carville shared a number of concerns about "smaller" estates and facilities problems being unsatisfactorily resolved, and the impact on staff morale; this was helpful "anecdotal" information which would be further probed at the April QEC meeting and the QEC Planning Group would consider how anecdotal information could be incorporated in to future reports. The Chair noted that it had been agreed at the Trust Board to bring a strategic item to QEC, on the contribution of facilities & estates to the quality & safety agenda and any associated risks.

19/02/9 Sheena MacDonnell probed for assurance around the implications of aspiring to

achieving a CQC rating of Outstanding, for example did the division anticipate issues around staff retention and the DD shared his thoughts on this in terms of work pressures on staff. It was noted that the Trust benchmarked well in terms of staff retention but the DD felt there were things that could be improved; for example the working environment, better responsiveness of the organisation to things like facilities issues, better feedback to staff (you've said, we've done) and study budgets for training, for example for nurse practitioners.

19/02/10 The Chair commended the quality of the paper and expressed appreciation for the hard work that had gone in to producing it. The Medical Division Vision for Quality Report was NOTED.

Patient Experience of the Discharge Process

19/02/11 The Committee received the report of David Purdue, Chief Operating Officer (COO) and Deputy Chief Executive (CE), and Laura DiCiacca, Integrated Discharge Team Lead and Head of Acute Therapies. The report included a detailed update on the early discharge planning process and QEC was assured on the many good practices including working with families and maximizing morning discharge after surgery / treatment. The report also included recent data for discharges before midday, patient feedback on various aspects of the discharge process, key issues highlighted by this and 2 case studies. The Chair noted that the patient satisfaction rate for timeliness of discharge for maternity services was relatively low and this was briefly discussed. It was agreed to look in to this and to provide more information after the meeting. **DP/LDC**

19/02/12 The Patient Experience of the Discharge Process Report was NOTED.

Mini Deep Dive Cancelled Operations

19/02/13 The Committee received a presentation from David Purdue, COO and Deputy CE on Cancelled Operations. It was noted that the Board had delegated oversight of this to QEC and as such QEC had commissioned a mini deep dive on the subject.

19/02/14 The presentation highlighted key issues, good practices and achievements, reasons for cancellations and causes for concern. The COO clarified what the data was telling the committee and further explained the data and reasons for cancellation, which was often linked to optimising overall patient outcomes. QEC was assured that current performance was close to target, and that efforts were being made to pre-alert patients where there was a risk of cancellation so as to minimise actual on-the-day cancellations. The COO assured QEC on how the Trust was minimising cancellations within a range of wider considerations, and that the Trust was actively pursuing improvement actions most within its grasp, for example equipment and staffing.

19/02/15 The Mini Deep Dive Cancelled Operations was NOTED

Progress against Enabling Strategy Milestones

19/02/16 QEC reviewed the Clinical Site Strategy, and Research & Development Strategy, for assurance on progress against milestones. An overview of key challenges, interdependencies, opportunities and achievements for both strategies was also

provided.

19/02/17 Clinical Site Strategy

The COO / Deputy CEE updated the committee on progress. In response to a query from the Chair he explained that the scope of 3 steering groups had been narrowed in order to focus on the key areas that could be delivered. The Groups had been very beneficial, particularly in terms of engagement with clinical directors and influencing change. Sheena Mc Donnell asked about key challenges and how these related to risks and there was a brief discussion about planned changes during which it was clarified that, at this stage, there was no planned change to the footprint of the Trusts sites, this work was about changing how the Trust utilised the site to the greatest benefit

19/02/18 R&D Strategy

The Chair welcomed Emma Adams, Research Management & Governance Manager to the meeting and she thanked Emma for the detailed presentation. Sheena McDonnell expressed concern about the loss of research opportunities due to the lack of a clinical area, Pat Drake raised QECs original concern about measures, and the Chair sought assurance that the Trust had formally adopted a target that all staff should feel able to participate in research. Emma gave assurance that this was a formal target and described some the activities being undertaken. She confirmed that R&D had been developing KPIs and action plans were in place for key deliverables. There was a brief discussion about whether there might be opportunities to conduct clinical trials in the future, how that might be funded and whether this was included in future plans. Peter Abell fed back on a recent visit to the R&D department; he described the working environment as very crowded and this was discussed. Noting that research partnerships may be fruitful in resolving the accommodation issues, it was agreed to draw this to the attention of the Trust Chair and CE, in their roles on partnership bodies.

19/02/19 The Clinical Site Strategy and the R&D Strategy were DISCUSSED and NOTED

LEADERSHIP AND IMPROVEMENT

19/02/20 Workforce & Education Assurance Report

19/02/21 The Committee received the report which used the assurance questions format and was accompanied by an additional detailed report which included sets of data for each area. The Director of People & Organisational Development summarised the key areas of focus and areas for concern and assurance that mitigations were in place to address concerns.

19/02/22 It was noted that the staff survey data would be published shortly (embargoed until 26 February 2019); in anticipation of those results the paper included an additional section which provided some thoughts on how the Trust might improve those results in the coming year. There would be a presentation to the Confidential Board meeting the following week and it was agreed to have a more detailed discussion on this at next QEC, to include key themes, what we were learning from other Trusts to enable moving to CQC “outstanding” as well as The Future Workforce. Sheena McDonnell emphasised the need to focus on a limited

number of areas to improve in relation to the anticipated response to the staff survey results. During further discussion it was also agreed for the planning group to consider asking DDs to include an update on their Staff Survey results and actions plans in their reports to QEC. The Committee discussed links between the staff survey results and quality and Sheena McDonnell emphasised the importance of staff feeling listened to and that they had influence on the work they did. **KB**

19/02/23 The Workforce and Education Assurance Report was NOTED.

QUALITY AND CARE

Quality Assurance Report

19/02/24 The Committee received the report which comprised four parts:

a. Quality dashboard
b. Nursing Workforce Quality Metrics Assurance Report (Hard Truths)
c. Clinical Governance Report
d. Patient Story (Michaels Story; aftermath of knee surgery)

It brought together information across a range of areas and used the 6 assurance questions.

19/02/25 (a) Quality Dashboard (a)

19/02/26 The quality dashboard brought together a range of performance indicators that reflected the processes or outcomes of care and patients. The data included benchmarking data using HealthCare Evaluation Data (HED) and local data from Trust systems. QEC probed how it was are assured that staff were really using the Quality Dashboard, and whether it was improving quality outcomes, and this was discussed. The Medical Director shared several examples of how the Quality Dashboard was being used but there was limited assurance at this early stage on impact. The Medical Director emphasised the critical importance of developing a systematic approach to collecting and using "soft" feedback from patients, and narrative on patient experience and he expanded on this in detail. It was uncertain at this stage how soft feedback could be built into the Quality Dashboard. There was a wide-ranging discussion about soft feedback, different ways of collecting this information, how the Trust could make it easier for patients to provide it and how this might be presented. Pat Drake reminded QEC of the need for patients to influence strategic planning of services as well as commenting on their own care.

19/02/27 The Medical Director provided an update on work with colleagues to look at processes, measures and team objectives for learning from deaths and the number of mortality reviews to be undertaken. In response to a query from Pat Drake he gave an update on progress with recruitment to the bereavement team. The Chair commented on the positive staff response to agreeing to tough but achievable targets (agreed at QEC) around reviewing deaths and closing older open incidents, noting that this had clearly been helpful.

19/02/28 (b) Nursing Workforce Metrics Assurance Report (b) taken before quality dashboard

The report included detailed information relating to Nursing and Midwifery Workforce; highlighting issues which may impact upon the Trust's ability to provide appropriate staffing levels and skill mixes. It also provided an update on the implementation of Care Hours per Patient Day (CHPPD), which had been a required national return since 01 May 2016 and the data submitted to UNIFY.

19/02/29 It was noted that the Royal College of Nursing's (RCN) Baseline Accident and Emergency Staffing Tool® (BEST®) had been undertaken in both Emergency Departments (EDs), November 2018 at DRI and January 2019 at BDGH. Further to the BEST® assessments, there had been a change in the guidance about the number of Registered Children's Nurses in a District General Hospital ED. The standard had essentially doubled the resource to 2 RCN's 24 hours a day. The Chair asked for assurance that the new standard was achievable; While there were challenges to recruitment, as this was a national change, optimisation had been taken, following the CQC unannounced inspection in November 2018. An assessment of the workforce model had been undertaken by the Associate Director of Nursing for Medicine. Their recommendation was set out in the report. The Director of Nursing, Midwifery & Allied Health Professionals (DNM&AHPs) gave assurance that Associate Directors of Nursing were fully informed on the issues. She advised that all Trusts were in the same situation and she shared details of approaches taken at other organisations. Pat Drake probed about training budgets for nursing staff including budgeting for release of staff to undertake the training.

19/02/30 The Chair asked for assurance that risks relating to the CQC Inspection, in particular the Risk relating to the Trusts ability to meet the new guidance for the number of Registered Children's Nurses in a District General Hospital ED had been risk assessed: It was noted that the DNM&AHPs was due to meet with the Trust Board Secretary to update risk registers. **MH/GJ**

19/02/31 (c) Clinical Governance Report

19/02/32 **Risk Management Report** - The Risk Management Report presented to CGC in January 2019 was attached to the papers for information. It was reported that in December, the Trust saw the lowest ever reporting of incidents (since the implementation of DatixWeb). This correlated with the drop in the NRLS reporting rate to 28.5 incidents / 1000 bed days, demonstrating a decrease of 5.2 incidents/1000 bed days. Pat Drake asked for assurance that the Trust had considered whether there was an element of under reporting, she shared feedback from a recent governance meeting where this had been discussed. The matter was discussed and the Medical Director acknowledged that issues had been identified in some areas in terms of staff reporting not having time to enter incidents on to Datix; he gave assurance this was being addressed. The Chair asked about progress with the review of risks held below the corporate risk

register and with revising the risk review process: It was agreed that there would be an update to April QEC.

19/02/33 **Actions from Serious Incidents (SIs) -** Pat Drake raised questions about achieving the timeframes for completing SIs; the Medical Director gave assurance that there had been good progress with this.

19/02/34 The Chair welcomed the updates on the Internal Audit reviews of Clinical Governance and Serious Incidents, and noted that this was now be covered through a standing agenda item; the Committee NOTED the update on Radiations Incidents.

19/02/35 (d) Patient Story

19/02/36 The Committee received a detailed report on a patient story, Michael: aftermath of knee surgery. The report detailed what had been learnt and what could have been done differently and it was planned for clinicians to share the story with staff. The story dated back to 2009, it related to the case of a patient who had been given the option to receive his surgery sooner if this was outsourced to a private hospital, which he accepted, and issues relating to the care he received post operatively. The key learning points were around the immediate post-operative care received. The story and the key learning points were discussed in detail. The Medical Director noted that quality & outcome measures for outsourced patients were now part of outsourcing contracts. He emphasises that the purpose of these stories was to ensure the organisation learnt from that and that these things did not happen again.

19/02/37 Questions on information items for assurance (10b).

19/02/38 The Quality Assurance Report was DISCUSSED and NOTED.

19/02/39 **Governor questions regarding the first half of the business sections of the meeting:** Clive Tattley raised the matter of Trust responsibility for issues arising from treatment of patient outsourced to a private hospital noting that he had raised a similar point though the Clinical Governance Committee (CGC) and Peter Abell commented on data on Care Hours Per Patient. Bother matters were briefly discussed

19/02/40 GOVERNANCE AND RISK

Board Assurance Framework and Corporate Risk Register

19/02/41 The Trust Board Secretary updated the Committee on changes to the Board Assurance Framework (BAF) and Corporate Risk Register (CRR) since the last meeting of the Committee. A list of current risks and their alignment to the respective committees was provided for information. Two new risks arising from the CQC inspection had been allocated to QEC. The Medical Director gave feedback on his risk review rationalisation meeting held in December 2018. The Chair proposed a wider discussion on risk at the next meeting, to include; new risk processes going to the Clinical Governance Committee (CGC) and Management Board (MB) in March, assurance on the approach to "corporate

risks" with a risk score greater than 15, IA report on risk escalation processes, assurance on staff use of risk registers, and potentially a further deep dive.
Pat Drake asked again that the cover sheet for all papers, "How this report impacts on current risks or highlights new risks", be better populated, especially in relation to the BAF and the Chair asked for a definition of when and how we decide an action (e.g. Action Plans) is closed, giving examples of why she was seeking this assurance.

19/02/42 The Board Assurance and Corporate Risk Register were NOTED.

Progress with IA recommendations

19/02/43 The Committee received and NOTED a new regular report that summarised Internal Audit (IA) recommendations relevant to QEC that remained outstanding at the time of reporting to the last Audit & Risk Committee (ARC) meeting.

Having noted that there appeared to be inconsistency in when an issue/ action/ recommendation was deemed "closed", it was agreed that guidance on this would be sought from Internal Audit. **KS**

ITEMS FOR INFORMATION

Minutes of sub-committees

19/02/44 The minutes of the following committees were NOTED:

- Clinical Governance Committee meeting held on 16 November 2018 & 21 December 2018
- Workforce, Education & Research Committee meeting held on 12 November 2018

The Chair noted that there was still not much feedback from QEC to daughter committees; she suggested sub-committees include a standing agenda item for feedback from QEC; e.g. a copy of the Chair's report to the Board or an abbreviation of this. The Medical Director supported this approach.

19/02/45 The Information items below were NOTED:

19/02/46

- PEEC Q3 Report
- Enabling Strategy Quarterly Exception Report (Q3 2018/19)
- CQC Update on actions from the December 2017 and November 2018 unannounced inspections
- Update on Progress with Inpatient Survey Action Plan
- Bi-Annual Summary of SIs including Lessons Learnt
- CGC Risk Management Report on Incidents

PEEC Report – the Committee noted that this had now been helpfully restructured around the 4 quadrants of the PEE Strategy, and metrics and areas of soft feedback were being mapped to the 4 quadrants, which would enable a measure of quality improvement to be devised. The potential role of volunteers in capturing feedback was highlighted, including for the Friends and Family Test.

The Committee were pleased to note that the majority of papers had cover sheets and that these linked the reports to the risk registers. Report authors were reminded of the importance of providing cover sheets.

19/02/47 National Reports / Areas of National Concern

19/02/48 The Committee received and NOTED for information the NHS Improvement (NHSI) proposal on Developing a Patient Safety Strategy.

Minutes of the meetings held on 17 December 2018

19/02/49 The minutes were APPROVED as a true record.

Work Plan

19/02/50 The Committee received and NOTED the Work Plan which was accompanied by a brief report which summarised changes made following review by the Chair of QEC, the Corporate Governance Officer and the Clinical Governance Officer.

19/02/51 Any other business
None raised

Governor questions regarding the second half of the business sections of the meeting

19/02/52 Governors commented that there had been no change to the risk level of a number of the risks ratings for some time, including those relating to the CQC and asked if this had been reviewed; The Trust Board Secretary acknowledged the point; lots of work was ongoing to review the risk registers and updates would be reflected in the next report.

19/02/53 Items escalated form sub-committees
None

19/02/54 Items for escalation to the Board of Directors
None

19/02/55 Identification of New Risks

No new risks had been identified. The Chair drew attention to all of the QEC risks on the CRR. Over the course of the year QEC had worked to ensure it had considered these through the planned reports and deep dive presentations; working through them from highest level risks first. The Chair reminded colleagues of the importance of linking these risks to their reports by highlighting them in the front sheets. She invited the Committee and Governors to let her know if there were any particular areas they felt QEC should consider in more detail.

Meeting Reflections / What to improve

It had been a good meeting. The Committee particularly welcomed the work of

the Medical Director to improve the approach to clinic risks and the involvement of the Divisional Director (DD) and Associate Director of Nursing. The Committee would consider giving future DD presentations more time on the agenda. The Committee reflected on how the deep dive reports were presented; it was felt that slides could be more self-explanatory, and this would be fed back. The committee would consider giving non-committee members a couple of minutes to introduce their reports. In future any late papers would be added to the end of the pdf pack or send round as a standalone document.

19/02/56 Time and date of next meeting:

19/02/57 Regular Bi-Monthly Meeting

Date: 24 April 2019
Time: 2pm
Venue: Boardroom, DRI

Signed:……. **…….**

Linn Phipps **Date**

Board of Directors – Work-plan
(Updated 25/04/19)

	SRO/Author	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Regular Reports for Assurance													
Finance Report	*DoF*	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Performance Report	*COO (DP&OD/MD/DNMAHPs)*	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Thematic P&OD Report	*DP&OD*	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Executive Team Objectives	*TBS / Execs*	~~Q3~~	Q3		Q4						Q1/Q2		
ICS Update	*CE*	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
BAF/CRR Quarterly	*TBS*	✓			✓			✓			✓		
Report from Guardian for Safe Working (QTRLY)	*DP&OD*		✓	✓ Annual Report		✓			✓			✓	
Estates & Facilities Report (Quarterly)		✓			✓			✓			✓		
Regular Reports for Information													
Presentations *(arranged by Chair/TBS)*	*Various*	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Chief Executives Report	*CE/TBS*	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Chair & NEDs' Report	*Chair/TBS*	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Board Committee Assurance Logs	*F&P*	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
	QEC		✓		✓		✓		✓		✓		✓
	ARC			✓		✓		✓		✓		✓	
Minutes *(to Board after approval)*													
Finance & Performance Committee	*CGO*	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Quality & Effectiveness Committee	*CGO*		✓			✓		✓		✓		✓	
Audit & Risk Committee	*CGO*			✓			✓		✓	✓		✓	
Management Board	*CGO*	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Fred & Ann Green Legacy Advisory Group	*CGO*		✓										

	SRO/Author	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Charitable Fund Committee	*TBS*	~~✓~~	✓	✓			✓				✓		
Reports for Approval/Decision													
Minutes	*TBS*	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Budget Setting / Business Planning / Annual Plan	*DoF/DS&T*			✓ P2									
Annual Financial Accounts 2018/19 (April or May)	*DoF*				✓?	✓?							
NHSI Plan	*DoF/DS&T*			✓									
Staff Survey Improvement Plan (?P1/P2)	*DP&OD*		✓										
Staff Survey Results	*DP&OD*			✓									
Staff Survey Action Plan	*DP&OD*				✓								
Annual Report	*TBS*				Draft	✓							
Quality Account	*DNMAHPs Deputies Comms*				Draft	✓							
Standing Orders, SFI's, *standards of business conduct* and powers reserved for the Board *reviewed by ARC in march '19)*	*TBS/DOF*			✓									
"ISA 260" *(considered by ARC in May '19)*	*DoF*					✓							
Winter Plan	*COO*									✓			
BoD Work Plan	*CE/TBS*		✓										
Review ToRs	*TBS*		✓										
CCG Contracts	*DoF*			✓									
Reference Costs *(Date TBC)*	*DoF*												
Procurement Update – *KS to check with R Somerset (Date TBC)*	*DoF*												
Other Annual / Ad Hoc Reports													
EU Exit			✓										
Car Parking and Security Contract (approve)	*DF&E*		✓										

	SRO/Author	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Mixed Sex Accommodation *Kate to Check*	*DNMAHPs ??*												
Bassetlaw Place Plan Update	*CE*	✓						✓					
Meetings Dates for Information													
Finance & Performance		22/1	25/2	22/3	23/4	20/5	21/6	23/7	20/8	20/9	22/10	22/11	16/12
Quality & Effectiveness Committee			20/2		24/4		27/7		21/8		23/10		05/12
Audit & Risk Committee			19/3			23/5 or 28/5		26/7		17/9		19/11	
Council of Governors		30/1			11/4			25/7			30/10		
Annual Members Meeting										26/9			

Minutes of the meeting of the Board of Directors
Held on Tuesday 26 March 2019
In the Fred & 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
	Cindy Storer	Acting Deputy Director of Nursing, Midwifery and AHP for *Moira Hardy*
	Sheena McDonnell	Non-executive Director
	Richard Parker	Chief Executive
	Pat Drake	Non-executive Director
	Linn Phipps	Non-executive Director
	David Purdue	Chief Operating Officer
	Jon Sargeant	Director of Finance
	Sewa Singh	Medical Director
	Kath Smart	Non-executive Director
In attendance:	Marie Purdue	Director of Strategy and Transformation
	Emma Shaheen	Head of Communications and Engagement
	Kate Sullivan	Corporate Governance Officer
	Clive Tattley	Governor Observer *(part)*
	Peter Abell	Governor Observer

ACTION

Welcome and apologies for absence

19/3/1 Apologies were received on behalf of Moira Hardy, Director of Nursing Midwifery & Allied Health Professionals, Neil Rhodes, Non-executive Director and Gareth Jones, Trust Board Secretary. The Chair welcomed Emma Shaheen back to the Trust after a period of Maternity leave and Peter Abell who was observing the meeting. There had been some criticism from some Governors about the acoustics of various meetings they observed; The Chair reminded the Board of its commitment to make meetings accessible and asked that members speak clearly.

Declarations of Interest

19/3/2 No interests were declared in the business of the public session of the meeting.

Matters Arising and Actions from the previous minutes

19/3/3 The list of actions from previous meetings were noted and updated.

19/1/65 – Refresh of Board Committee Terms of Reference (ToRs) in respect of Health & Safety: The Trust Board Secretary had met with the Chair of The Audit & Risk Committee. An update would be brought to a future meeting.

19/1/82 – Hospital Cancellation Rates – numbers of patients, as well as percentages to be provided: Data had been circulated to NEDs and would be included in future performance reports.

18/2/9 – Deep Dive of staff mandatory training to be emailed to the Board in March: It was noted that the action related specifically to Information Governance (IG) Training.

19/2/42 – Scenario reports on EU exit had been shared with the Board. The Chief Operating Officer (COO) gave assurance that the Trust had declared to NHS Improvement (NHSI) that it was compliant with the requirement to ensure that all senior management teams, the Board and CCGs had been through the scenarios. The COO provided details of a new daily reporting requirement to NHSI in respect of EU Exit and this was briefly discussed.

19/2/54 – Target date to amended from May 2019 to June 2019

19/2/55 – Metrics for care of children to be included in future reports; progress had been made and some information had been included in the performance report included in the papers. The Medical Director gave assurance that work was ongoing to increase the level of metrics in coming months.

Presentation slot – NHS Improvement QI Update and Breakthrough Objectives for 2019/20

19/3/4 The Board considered a presentation from Marie Purdue, Director of Strategy and Transformation. Marie updated the Board on work to align the improvement programme aims with the Strategic Direction such that the Trusts' Vision became ***The safest Trust in England, outstanding in all we do*** and a more detailed version of the previous vision to become the mission; ***As an acute teaching Hospital Trust, a leading partner in health and social care across South Yorkshire and Bassetlaw, we will work with our patients partners and the public to maintain and improve the delivery of high quality integrated care***. The Board endorsed this proposal noting the proposed strategic deployment mechanisms. The key aim of strategic deployment was to ensure everyone knew how they contributed towards the vision. The agreed definition of Quality Improvement was also noted - *"working together using methods, tools, data measurement, curiosity and an open mindset to improve healthcare".*

19/3/5 The remainder of the presentation focussed on how the Trust had translated the 5-year strategic objectives, the '*True North Objectives'*, in to specific objectives that everyone in the organisation could relate to and help deliver. Below the True North Objectives sat the *Breakthrough Objectives* that the Trust aimed to deliver within the first year. The True North and breakthrough objectives would be the golden thread through everything the Trust did to help us prioritise resources and assure partners.

True North Objectives:

- Achieved and maintained CQC outstanding
- 100% of staff know how they contribute to the vision
- In top 10% for staff and patient feedback
- Trust in recurrent surplus

Breakthrough Objectives (Archive in 1 year)

- Achieve CQC good

- Level 1 of QI rollout (train 40 practice coaches and 30 Kata coaches)
- Higher than average for staff and patient feedback
- Achieve Control Total

19/3/6 The Board discussed how the True North and Breakthrough Objectives linked to Board Committees and examples of how they might translate in to Divisional / Departmental objectives and how they could be made relevant in terms of individual objectives. The Board also considered how the objectives could be measured and noted that at a recent Governor Appointments and Remuneration Committee meeting, to consider the appraisal and objective setting process for the Chair and NEDs, Governors had endorsed this framework for setting their objectives. In response to a query from Kath Smart about how the objectives could be made relevant for non-clinical and non-patient-facing staff, the Board were assured that the Trust was working on this.

19/3/7 The Board noted that achieving the Strategic Direction depended on engaging everyone in quality improvement (Qi). An overview was provided of the process for working with divisions and corporate directorates to achieve outputs linked to the True North and Breakthrough Objectives and examples of Qi work along with an overview of Qi plans for 2019/20 were shared. It was important to ensure the Trust used examples that were relevant to all staff groups and this was noted.

19/3/8 The Board NOTED the presentation and ENDORSED aligning the improvement programme aims with the Strategic Direction and the proposed changes to the Trust's Vision and Mission.

Use of Trust Seal

19/3/9 The use of the Trust Seal for the entry 105 in the Seal Register was APPROVED.

Standing Orders, Standing Financial Instructions and Standards of Business Conduct

19/3/10 The Board noted that the Standing Financial Instructions, Standing Orders and Scheme of Delegation had been reviewed and updated in line with best practice and up to date practices in the Trust. A summary of these changes were set out in the covering report. This paper had been considered by the Audit & Risk Committee (ARC) on 19th March 2019, and it was recommended for approval by that Committee.

19/3/11 The Board APPROVED the updated documents subject to being made gender neutral. **JS/GJ**

19/3/12 Reports for Assurance

Finance Report - 28 February 2019

19/3/13 The Board considered a report of the Director of Finance that set out the Financial Position at Month 11(February 2019) which was a favourable variance against plan of £855k before PSF funding and a favourable variance against forecast of £644k in month. The cumulative position to the end of month 11 was a £21.7m deficit before PSF Funding, which was £1,455k favourable to plan (£2,334k adverse to plan including PSF) and £1,452k favourable to forecast.

19/3/14 The Trust now expected to deliver its control total at year end, and this was welcomed. This was a result of; the improved position against forecast and plan (especially in income), following final discussions with Doncaster CCG who were funding any undelivered CQUINs monies and delivery of the waiting list recovery plan, the funding agreed from the ICS and reduced spend on agency in February by more than forecast. The Trust's key remaining risk was the delivery of the Waiting List recovery plan, which attracted incentive payments of c.£2.4m, which was yet to be included in the Trust's position.

19/3/15 In response to a question from Linn Phipps, an update on the terms of the waiting list incentive payments was provided along with how performance was progressing; at the time of the meeting the Trust was on track to deliver the waiting list size target; the key challenge was delivery of RTT performance; this was being monitored monthly through F&P and would be discussed further under the performance report.

19/3/16 The Board NOTED:

- The Trust's deficit for month 11 (February 2019) was £224k, which was a favourable variance against plan of £855k before PSF. This was a favourable variance against forecast of £644k in month. The cumulative position to the end of month 11 was a £21.7m deficit before PSF, which was £1,455k favourable to plan (£2,334k adverse to plan including PSF) and £1,452k favourable to forecast.
- The achievement with regards to the Cost Improvement Programme.
- The improved financial position and that the Trust was forecasting to deliver its control total at year end subject to delivery of the Waiting List position.
- The risks set out in the paper.

19/3/17 Thematic People & Organisational Development Report - Terms and conditions update

19/3/18 The Board considered the report of the Director of People & Organisational Development that provided an update to the Board on the Agenda for Change pay deal which was introduced in 2018. These changes could be categorised under the below headings;

- Three year pay deal
- Band 1 to Band 2 transition
- Pay Progression
- Amendments to Agenda for Change terms and conditions.

It also provided an update to pension contributions in respect of both the NHS Pension scheme and the alternative NEST pension scheme for those staff ineligible to join the NHS pension scheme.

Some of the changes were quite complex and some staff had already raised a number of queries about how the changes would affect them. The Trust was working with the communications team on some easy to understand briefings to be shared through a range of communications channels.

19/3/19 In respect of the abolishment of Band 1, and in order to progress the transition of staff from Band 1 to Band 2, current Band 1 job descriptions were being revised if there was no existing Band 2 job description for staff to move into. This was a voluntary transition for staff, but it was anticipated that the majority of staff would choose to transition with support if required and details of how that would work were provided and discussed in detail. In response to several questions it was clarified that the transition would mean a change in role with the aim of upskilling staff and examples were provided.

19/3/20 The Board noted that from April 2020 staff would no longer automatically progress annually though the pay points within a band; a set of criteria that all staff would need to meet was being agreed. The Board considered how this might impact on the future recruitment of staff in the context of alignment of this approach across the ICS; it was clarified that this was being discussed at ISC level.

19/3/21 The Chair expressed a wish for the Trust to aspire to signing up to the Real Living Wage and this was discussed; although at this time the Trust (in line with the national Agenda for Change pay rates) could match the real living wage but could not commit to keeping up with future increases due to the links to national pay deals. During the discussion it was agreed to set an aspiration to the pay the real living wage and to raise this with the ICS / discuss the matter at PLACE level. **KB**

19/3/22 The Board NOTED the update and next steps.

Performance Report at 28 February 2019

19/3/23 The Board considered a report of the Chief Operating Officer, Medical Director, Director of Nursing, Midwifery and Allied Health Professionals and Director of People and Organisational Development that set out the operational and workforce performance at month 10, 2018/19.

19/3/24 Performance against key metrics included:

- Cancer targets – The 62-day performance achieved the 85% standard, coming in at 85.4%.
- Four-hour access – The Trust achieved 91.6% against the national standard of 95% which was 12th best nationally.
- RTT – The Trust performed slightly below contract target, reaching 87.5%
- HSMR – The Trust's rolling 12-month HSMR remained better than expected at 92.
- C.Diff – Below (better than) the year to date trajectory, the same period the previous year and the national trajectory.
- Appraisal rate – The Trust's appraisal completion rate remained static at 78.85% - The Trust was preparing for the 2019/20 round of appraisals. Appraisal paperwork had been updated to reflect changes to objective setting. It was noted that all Executive Director appraisals had been completed
- SET training – 81.31% compliance rate for Statutory and Essential Training (SET)

- Sickness absence – Year-to-date figure at 4.43%

19/3/25 The Board noted that this month's reports included quality metrics for Children and Young People, and this was welcomed; going forward the Trust would expand on this range of metrics and would work to include more soft intelligence. Commenting on this, Pat Drake shared feedback from a Maternity Clinical Governance meeting she had attended; she had been encouraged to observe that they were using the Quality Dashboard and benchmarking data. The report also included details of additional reporting requirements for NHS Improvement in respect of performance and of proposed changes to the 4hr access including the rationale for and proposed value of the changes; these were set out in detail in the report and the Chief Operating Officer provided further background information.

19/3/26 62 Day Cancer Performance - Key issues remained around complex pathways and shared breaches. Reflecting on this Pat Drake raised a question about tertiary care referrals going to Sheffield, it was noted that the Chair had previously enquired about this and the matter was discussed; The Trust was looking at review of tertiary care undertaken in Manchester to see what learning could be taken from this.

19/3/27 Cancelled Operations – Pat Drake noted that it had been reported at F&P that a significant proportion of cancellations had been due to High Dependency Unit (HDU) capacity and staffing issues; It had been agreed for the Finance & Performance Committee to receive more granular information on this in future reports.

19/3/28 Hospital Acquired Pressure Ulcers (HAPUs) – Following a question from Kath Smart, the Board were assured there were no implications should the Trust not achieve the target trajectory because this was a local quality standard. Although it was disappointing not to have achieved a further year-on-year reduction in HAPUs, the Board were reminded of the significant improvement in this quality standard over several consecutive years and that this was within the context of increased emergency activity. The Trust remained committed to achieving further improvements. Cindy Storer provided an update on work to share learning with staff and on how HAPUs were reported and this was discussed in detail. In response to a query from Pat Drake it was noted that there had not been any grade 4 HAPUs for a significant period of time.

19/3/29 Sheena McDonnell welcomed the improvement in complaints resolution performance; reflecting on the report she felt it would be useful to capture how many complaints were upheld. **CS**

19/3/30 Following a question from Pat Drake about whether or not levels of advanced care needs had impacted on skill mix on wards, or given rise to any staffing issues, an overview of the process and tools used to assess acuity and dependency needs of patients and how this linked to workforce plans was provided. The Trust had been undertaking periodic reviews for several years and this had given a picture over time that had enabled better assessment of workforce needs.

19/3/31 The Board were advised that the Trust's had won Best Team at the NHS Employers National Flu Awards the previous day; The team had vaccinated 70% of staff in 21 days. The Board congratulated the team for their hard work to achieve this.

19/3/32 Statutory & Essential Training (SET) – it was agreed that more progress needed to be made to improve the compliance rate which had remained static at around 81%. A Deep Dive was scheduled for the next Workforce, Education & Research Committee (WERC) meeting to look in to this in more depth. An overview of the areas of key concern (those with the lowest compliance rates) was provided. The Board discussed the links between SET and Appraisal compliance rates and the Trusts ambition to achieve a CQC rating of Outstanding, what learning could be taken from Trusts that had achieved CQC outstanding as well as from organisations outside the NHS and whether enough was being done at the current time to improve performance. The Board was assured that this was a key area of focus for the Trust and the Director of People & Organisational Development shared details of work to improve the appraisal process and achieve the Trusts ambition of beyond 90%. She also provided an update on work with education leads and Divisions to better understand what was preventing staff from completing SET; this would be reported through QEC. During further discussion it was agreed for Sheena McDonnell, Kath Smart and Karen Barnard to meet to consider what could be learned from other organisations and think about a more focussed piece of work to bring to a future meeting. **KB/SM. KS**

19/3/33 Board DISCUSSED and NOTED the report.

Staff Survey

19/3/34 The Board considered the report of the Director of People & Organisational Development on the results of the 2018 Staff Survey. The Trust's True North statement stated that the Trust aimed to be in the top 10% of Trusts for staff satisfaction in the next 5 years. The results from the 2018 staff survey had been shared widely with leadership teams in order that they could develop their own action plans. The results had been captured into themes; equality, diversity & inclusion, health & wellbeing, immediate managers, morale, quality of appraisals, quality of care, safe environment – bullying & harassment, safe environment – violence, safety culture and staff engagement. The paper provided the Trust wide summary with those of each division and directorate. In addition, the staff engagement questions were provided. The paper detailed the proposed actions to be taken, timescales and the KPIs to be monitored. The Trust would continue to utilise the pulse check data which was being obtained through the Quality Improvement (Qi) programmes of work such as ED, Antenatal, Trauma & orthopaedics. These pulse check questions would be made available to all areas who may be undertaking service improvement pieces of work. Regular feedback on progress against the action plan would be reported to QEC and divisional/directorate action plans would be monitored through visual management boards and the performance accountability framework.

19/3/35 There had been an increase in response rate of 5% to 54% which is above the acute sector average by 10%. The response rate by division/directorate ranged from 46% within the Division of Medicine to 94% within Finance and Procurement.

19/3/36 The report was discussed in detail with particular focus on those areas that had declined in comparison to the previous year, the staff engagement scores, the Trust Wide Action plan (included in the paper) and the development of divisional/directorate action plans. The Trusts results were above average in respect

of equality, diversity & inclusion and safe environment – bullying & harassment. Each theme had either remained static or improved apart from health and wellbeing which had declined by 0.1 with the question relating to whether staff felt the Trust took positive action on health and wellbeing reducing by 5% points; it was noted that this was disappointing. Members of the Board were reminded that the Trust had recently been awarded Nottinghamshire Council's platinum health at work award, therefore Divisions would be encouraged to explore this question with their staff to understand how the Trust could demonstrate that their health and wellbeing is important to us and to ensure we are directing our attention to those areas which are having an impact on staff.

19/3/37 The Board considered the areas identified for the Trust wide action plan; Non-executives endorsed the concise and focused presentation of the plan and the Board discussed possible approaches to be taken. Divisions and Directorates had been tasked with developing local action plans. They would also set up local staff engagement groups which would come together to meet with the Chief Executive; in response to a suggestion from Pat Drake it was agreed to consider developing some key principals for these groups to ensure focus and continuity of approach. Reflecting on the Trusts Due North objective of being in the Top 10% of Trusts for staff and patient feedback, Linn Phipps suggested setting some milestones to achieving this; the Trust was developing questions for the next Friends & Family Test and these would be monitored through QEC.

19/3/38 Sheena McDonnell highlighted how showing 'We Care' linked to living the values of the Trust and there was a useful discussion about how this this could be demonstrated, for example through better communication with staff and examples of how this had worked well through the staff Facebook page were highlighted. This led to discussion about staff perceptions of the availability of / how to access funding to improve staff environments; there needed to be improved messaging about how to access funding for example charitable funds. The Chair implored colleagues to ensure all Estates issues were logged and to arrive at work each day with a fresh pair of eyes; they after all were the keepers of the patient and staff experience.

19/3/39 The Board NOTED the paper for assurance.

CQC Update

19/3/40 The Board considered the report of the medical Director and Director of Nursing, Midwifery & Allied Health Professionals that provided a detailed update on the recently released CQC report following a focussed unannounced inspection of the urgent and emergency care services at Doncaster Royal Infirmary and Bassetlaw Hospitals on 27-29 November 2018. This inspection was to follow up on issues identified at the previous inspection in December 2017; the specific issues identified at that time were set out in the paper.

19/3/41 The paper detailed actions set out by the CQC that the Trust must take and actions the Trust should take, immediate steps taken by the Trust at the time of the inspection, and post Inspection to respond to the specific issues and further action the Trust intended to take to improve compliance with CQC standards ahead of future inspections. The paper also set out a number of improvements since the December

2017 Inspection that had been acknowledged by the CQC.

19/3/42 The Board noted the detailed action plan (appended to the report). The Medical Director provided an overview of the governance process for monitoring and tracking progress against the plan including escalation processes and plans to set up an electronic dashboard for CQC compliance; The Trust would work with all divisional CQC leads to ensure consistency with the action plans and supply of evidence. The Trust was organising a schedule of cross discipline mock CQC inspections and would welcome participation of Governors and NEDs. A list of dates would be circulated once available. **CS**

19/3/43 The Clinical Governance Teams were working hard to collect patient feedback and to collect staff feedback on clinical service delivery. There was a useful discussion about the importance of board member engagement with staff in the context of the Trusts ambition to achieve a CQC rating of outstanding. It was noted that Linn Phipps had now met with all clinical governance leads.

19/3/44 The report was discussed; The Board were assured by the detailed action plan and noted that it would be refreshed after the mock CQC inspections. Commenting on action plans, Alan Chan commended the level of actions already closed and was encouraged to hear about work to seek staff feedback on the new Emergency Department model.

19/3/45 The Board NOTED the report.

New case Assignment Definitions Clostridium Difficile Infections (CDI)

19/3/46 The Board considered a report of the Director of Nursing, Midwifery & Allied Health Professionals and the Director of Infection Prevention and Control that set out the new case assignments definitions to be introduced from 1st April 2019 on Healthcare Associated Infection recommended definitions used to attribute/apportion Clostridium Difficile Infections (CDI) to trusts. The paper showed the rate of CDI that would have been reported by the Trust in the year 2018/19 had the new definitions been in force and described action to be taken to support achievement of the objective to have no more than 44 CDI cases in 2019/20.

19/3/47 It was noted that while there was not expected to be any increase in the total number of cases, there would be a shift in number of cases that were assigned to the Trust; particularly as healthcare associated cases would include those with recent (last four weeks) hospitalisation. In response to a question from the Chair, the Board were assured that the Trust remained committed to keeping CDI rates as low as possible; key actions included a proactive and zero tolerance to the management of patients known to be positive for Clostridium difficile infection or carriers of Clostridium difficile showing symptoms, within the Trust and the wider communities.

19/3/48 Following a question from Kath Smart, there was a brief discussion about the process for recording and learning from CDI route cause analysis; the Board were assured that the Trust carried out route cause analysis for all cases. A new procedure was to be piloted to attempt to monitor patients' positive in the community involving microbiologists and IPC practitioners. It was important to keep talking to Community

partners and to share learning with them learning from the Trusts experience of successfully reducing CDI rates.

19/3/49 The New case Assignment Definitions Clostridium Difficile Infections (CDI) Report was NOTED

Chairs Assurance Logs for Board Committee held 19 March 2019 and 22 March 2019

19/3/50 The Board considered a report of the chairs of Finance and Performance Committee and Audit and Risk Committee following their meetings on 19 March and 22 March 2019. In Neil Rhodes' absence, Pat Drake presented the report from Finance and Performance Committee.

19/3/51 In relation to oversight of the Sodexo contract Neil Rhodes had reported taking significant assurance from a walk-through of the catering service, accompanied by Mike Addenbrooke, public Governor and Vice Chair.

19/3/52 The Audit & Risk Committee had considered the report of Internal Audit on a review of Complaints; the report provided 'partial assurance with improvements required and this had been disappointing. Kath Smart shared some of the areas of concern identified in the report; a full action plan was being developed with divisional input and would be taken though the Patient Experience & Engagement Committee in March 2019.

19/3/53 Board NOTED the update.

Reports for Information

19/3/54 The following items were NOTED:

- Chair and NEDS' report
- Chief Executive's report
- Minutes of Management Board, 11 February 2019
- Minutes of Audit & Risk Committee, 22 November 2018
- Minutes of Charitable Funds Committee 25 January 2019

Items to Note

19/3/55 The following item was NOTED:

- Board of Directors Agenda Calendar

Minutes

19/3/56 The minutes of the meeting of the Board of Directors on 26 February 2019 were APPROVED as a correct record.

Any other business

19/3/57 There were no items of other business raised.

Governors questions regarding business of the meeting

19/3/58 Further to questions from Clive Tattley, it was clarified that if Governors identified an estates maintenance issue it should be escalated to the ward or department manager for the area. If an issue was on a non-identified or public area, for example the hospital main entrance, the matter should be escalated with the Trust Board Secretary's office who would escalate the matter on behalf of Governors.

19/3/59 Following a question from Clive Tattley, an update to the reported December 2018 rolling 12 Month HSMR position was provided; there had been an increase in crude mortality for January 2019 a key factor for this had been high levels of flu.

19/3/60 Peter Abell fed back on the NHS Providers Governor Regional Workshop he had attended including comments from Carolyn Jenkinson, CQC Head of Hospital Inspection, who had talked about how the Staff Survey fed into CQC Inspections for Well Led. He also fed back on work at Chesterfield Royal Hospital to increase their Staff Survey response rate to 72% and how they had adopted an approach that reported on progress to their Council of Governors using Non-Executive Directors. This was briefly discussed in the context of the Trusts True North Objectives and how the Trust planned to monitor progress to improve the staff survey response rate and staff survey results through the exiting committee governance structure.

19/3/61 Following a question from Peter Abell relating to the Hard Truths Nursing Workforce data for the Children & Families Division, in terms of some wards/departments flagging as 'red', the Board were reminded that a wide range of quality and workforce metrics were used to monitor the safety of these services and they were assured that none of these had flagged any safety issues. A number of examples were given along with an overview of escalation processes: it was noted that any area that flagged red for quality or workforce for 3 consecutive months, or for both quality and workforce in the same month, were escalated. There was a useful discussion about the Trusts aspirations for maternity services and how the Quality & Effectiveness Committee (QEC) was monitoring a number of aspects of children's and maternity services. Linn Phipps, Chair of QEC, noted that the Divisional Director for the Children & Families Divisions was due to present on his vision for quality to QEC in June 2019. She invited Peter, as a Governor Observer on that Committee, and the Board, to feed back to her any questions they wished her to raise.

Date and time of next meeting

19/3/62 9:15am on Tuesday 30 April 2019 in the Boardroom, Doncaster Royal Infirmary.

Exclusion of Press and Public

19/3/63 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