## AGENDA

### BOARD OF DIRECTORS

Thursday 27 July 2017 at 9am in the RED Centre, Tickhill Road Hospital, Doncaster DN4 8QN

<table>
<thead>
<tr>
<th>No</th>
<th>Time</th>
<th>Item</th>
<th>Lead</th>
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<tbody>
<tr>
<td>1</td>
<td>9.00</td>
<td>Welcome</td>
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</table>
| 2  | 9.05 | Apologies for Absence  
• Dr Deb Wildgoose, Director of Nursing and Quality – who will be represented by Wendy Joseph; and  
• Richard Banks, Director of Health Informatics) | LP | |
| 3  | 9.05 | Declarations of Interest | | A |
| 4  | 9.05 | Doncaster Care Group - Early patient outcomes from transformation (presentations by Jo McDonough, Doncaster Care Group Director) | DS | Pres. |
| 5  | 9.30 | Minutes of the Board of Directors held in public on 22 December 2016 | LP | B |
| 6  | 9.30 | Matters Arising and Follow up action list | LP | C |
| 7  | 9.30 | Chairman’s Report and Council of Governors update | | D |
| 8  | 9.30 | Chief Executive's Report | KSi | E |
| 9  | 9.40 | STP update | KSi | F |
| 10 | 9.45 | Doncaster PLACE Plan – Implementation Update  
Presentation by Anthony Fitzgerald, Chief of Strategy and Delivery, NHS Doncaster CCG and Jo McDonough, Doncaster Care Group Director) | KSi | G |
| 11 | 9.55 | Report from the Quality Committee | AP / WJ | H |
| 12 | 9.55 | Annual Reports 2016/17  
• Safeguarding  
• Infection Prevention and Control | WJ | I |
| 13 | 9.55 | Medical Revalidation | NA | J |

### BREAK

### STRATEGY

#### 10.15

<table>
<thead>
<tr>
<th>Item</th>
<th>Lead</th>
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</table>
| Doncaster PLACE Plan – Implementation Update  
Presentation by Anthony Fitzgerald, Chief of Strategy and Delivery, NHS Doncaster CCG and Jo McDonough, Doncaster Care Group Director) | KSi |

### QUALITY

#### 10.40

<table>
<thead>
<tr>
<th>Item</th>
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<tbody>
<tr>
<td>Report from the Quality Committee</td>
<td>AP / WJ</td>
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</table>
| Annual Reports 2016/17  
• Safeguarding  
• Infection Prevention and Control | WJ |
| Medical Revalidation | NA |

### FINANCE

#### 10.40

<table>
<thead>
<tr>
<th>Item</th>
<th>Lead</th>
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<tbody>
<tr>
<td>Report from the Finance, Performance and Informatics Committee (FPIC)</td>
<td>TS / SH</td>
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</table>
| Doncaster Care Group – Performance Overview  
(presentation by Jo McDonough, Doncaster Care Group Director) | DS |

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**RDaSH leading the way with care**
## GOVERNANCE

<table>
<thead>
<tr>
<th>No</th>
<th>Time</th>
<th>Item</th>
<th>Lead</th>
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<tbody>
<tr>
<td>16</td>
<td>6</td>
<td>Board Assurance Framework 2017/18 - Overview</td>
<td>PG</td>
<td>L</td>
</tr>
<tr>
<td>17</td>
<td></td>
<td>Extreme Risks</td>
<td>PG</td>
<td>M</td>
</tr>
<tr>
<td>18</td>
<td></td>
<td>Annual Report and Accounts 2016/17</td>
<td>PG</td>
<td>N</td>
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<tr>
<td>19</td>
<td></td>
<td>Any Other Business (to be notified in advance to the Chair)</td>
<td>LP</td>
<td>Verbal</td>
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<tr>
<td>20</td>
<td></td>
<td>Public questions *</td>
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<tr>
<td>21</td>
<td></td>
<td>Chair to resolve that because publicity would be prejudicial to the public interest by reason of the confidential nature of the business to be transacted, the public and press be excluded from the meeting.</td>
<td>LP</td>
<td>Verbal</td>
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</table>

**PUBLIC QUESTIONS:**
The Board welcomes questions from members of the public at the appointed time during the agenda and offers the following guidance.

- Questions at the meeting should relate to papers being presented on the day
- Members of the public and Governors are very much welcome to raise questions at any other time, on any other matter, through the office of the Chair and Chief Executive or other contact points
- There is no need for questions to be submitted in advance, although this may mean that it is not always possible to provide an answer at the meeting. In that case, the questioner’s contact details will be requested for response.
- Questions will be taken in rotation, to ensure those wishing to raise questions have equal opportunity, within the limited time available

Next meeting:
Thursday 31 August 2017 at 9am – RED Centre, Tickhill Road Hospital, Doncaster, DN4 8QN
# ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

<table>
<thead>
<tr>
<th>Committee Name</th>
<th>Board of Directors</th>
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<tbody>
<tr>
<td>Agenda Item</td>
<td>A</td>
</tr>
<tr>
<td>Date</td>
<td>27 July 2017</td>
</tr>
<tr>
<td>Title of Paper</td>
<td>Declarations of Interest</td>
</tr>
<tr>
<td>Action Required</td>
<td>Decision, Assurance, Information ✓</td>
</tr>
<tr>
<td>Prepared by</td>
<td>Philip Gowl, Board Secretary/Director of Corporate Assurance</td>
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<tr>
<td>Presented by</td>
<td>Lawson Pater, Chairman</td>
</tr>
<tr>
<td>Delivery against</td>
<td>Strategic Goal(s)</td>
</tr>
<tr>
<td>Financial/Budget</td>
<td>No financial implications</td>
</tr>
<tr>
<td>Equality &amp; Diversity</td>
<td>No E&amp;D implications – the requirement to make declarations is applicable to all Directors.</td>
</tr>
<tr>
<td>Previously Presented to</td>
<td>N/A</td>
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</table>

### Background / Key Points / Outcome

1. The Board of Directors to note the Register of Interests and to consider any conflicts of interest arising from the agenda items.

2. The Register is presented as attached and Directors are asked to confirm at the meeting that this register is accurate.

Declarations are made to the Board Secretary as they arise, recorded on the public register and formally reported to the Board of Directors at the next meeting. To ensure openness and transparency during Trust business, the Register has, from September 2012, been included in the papers that are considered by the Board of Directors each month. Updates are shown in **bold**.
<table>
<thead>
<tr>
<th>Name / Position</th>
<th>Interests Declared</th>
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</table>
| Lawson Pater Chairman           | • Trustee of Doncaster Community Arts, a registered charity  
• Trust Associate Manager at RDaSH                                                                                                                     |
| James Marr Non-Executive Director| • Managing Trustee of the Barton and Brigg Methodist Circuit  
• Daughter is a Pharmacist with Boots in Scunthorpe.  
• Volunteer Manager at Brigg Job Club  
• Trust Associate Manager at RDaSH                                                                                                                   |
| Kathryn Smart Non-Executive Director | • Independent member of the Doncaster Metropolitan Borough Council Audit Committee  
• Independent Audit Committee member of a social housing provider (ACIS, based in Gainsborough)  
• Court Secretary for Foresters Friendly Society (Sheffield court) (from Jan 2017)  
• Director of Flourish (from Jan 2017)  
• Trust Associate Manager (TAM) - RDaSH  
• Volunteer member of the Friends of Town Fields (charity)  
• Volunteer at Town Fields Primary School (charity) (from Jan 2017)                                                                                     |
| Tim Shaw Non-Executive Director  | • Trust Associate Manager at RDaSH  
• Chair of Doncaster Business for the Community                                                                                                            |
| Alison Pearson Non-Executive Director | • Husband’s daughter works at Doncaster Rape Crisis and Sexual Abuse Counselling Service  
• Chair of Stillington Village Institute  
• Trustee for the Two Ridings Community Foundation  
• Independent Member of the Parole Board  
• Trust Associate Manager at RDaSH                                                                                                                     |
| Dawn Leese, Non-Executive Director | • Daughter works for Price Waterhouse Coopers (PWC) (the Trust’s previous external audit providers) – her role does not involve work within the NHS sector.  
• Occasional consultancy work for NHSE Central Midlands (March 2017 / July 2017) - no conflict with RDaSH duties.                                                                                           |
| Justin Shannahan, Non-Executive Director | • Head of Finance Strategy and Processes, Derbyshire County Cricket Club  
• Ad hoc consulting work for GLG (Gerson Lehrman Group, Inc.)                                                                                              |
| Kathryn Singh, Chief Executive   | • Husband is Chair of Derbyshire Community Health Services NHS FT  
• Husband is MD of PMS Consulting Ltd (provides consultancy support to NHS organisations and individuals)                                                                                                    |
<p>| Dr Nav Ahluwalia, Executive Medical Director | • Chair Y&amp;H RO/Appraisal Leads network                                                                                                                      |</p>
<table>
<thead>
<tr>
<th>Name</th>
<th>Role</th>
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| Richard Banks, **Director of Health Informatics** | Research Lead for the South Yorkshire Specialist Higher Trainees in Psychiatry  
Member of the Y&H National Clinical Excellence Awards Committee  
RCPsych Trent Division Regional Representative in Addictions  
RCPsych Trent Division Regional Representative for Workforce  
RCPsych Membership CASC (Clinical Examination): member of Examination panel, run examination circuits, train new examiners |
| Steve Hackett, **Executive Director of Finance and Performance** | Nil  
Director of Flourish Enterprises Community Interest Company |
| Rosie Johnson, **Executive Director Workforce and Organisational Development** | Nil  
Director of Flourish Enterprises Community Interest Company |
| Deborah Smith, **Chief Operating Officer** | Nil  
Director of Flourish Enterprises Community Interest Company |
| Dr Deb Wildgoose, **Executive Director of Nursing and Quality** | Nil  
School Governor of South Axholme Academy  
Son is a volunteer within Flourish Enterprises Community Interest Company |
| Philip Gowland, **Board Secretary/Director of Corporate Assurance** | Nil  
Partner is employed by RDaSH as a Membership & Engagement Facilitator (working in Nursing & Quality Directorate) |
<table>
<thead>
<tr>
<th>Committee Name</th>
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<tbody>
<tr>
<td>Agenda Item</td>
<td>B</td>
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<tr>
<td>Date</td>
<td>27 July 2017</td>
</tr>
<tr>
<td>Title of Paper</td>
<td>Minutes from the public Board of Directors meeting held on 29 June 2017</td>
</tr>
<tr>
<td>Action Required</td>
<td>Decision</td>
</tr>
<tr>
<td>Prepared by</td>
<td>Paula Donald, PA to Director of Health Informatics</td>
</tr>
<tr>
<td>Presented by</td>
<td>Lawson Pater, Chairman</td>
</tr>
<tr>
<td>Delivery against</td>
<td>Strategic Goal(s) All</td>
</tr>
<tr>
<td>Financial/Budget</td>
<td>The financial implications of the matters discussed are recorded as appropriate in the minutes and are within the original supporting paper.</td>
</tr>
<tr>
<td>Equality &amp; Diversity</td>
<td>The Equality and Diversity implications of the matters discussed are recorded as appropriate in the minutes and are within the original supporting paper.</td>
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<tr>
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<tr>
<td>Background / Key Points / Outcome</td>
<td>The Board of Directors is asked to consider whether the attached minutes are a true record of the Board of Directors meeting held in public on 29 June 2017. The Chairman will sign a copy of the ratified minutes.</td>
</tr>
</tbody>
</table>
Mr Pater opened the meeting, welcoming everyone and explaining the format of the meeting. Mr Pater welcomed Mr Hackett to his first meeting of the Board of Directors.

APOLOGIES FOR ABSENCE

Apologies had been received from Mrs Singh and Mrs Smart.
### DECLARATIONS OF INTEREST

The Register of Interests of the Board of Directors was noted.

There were no conflicts of interest declared for any of the agenda items at the meeting today.

The Board of Directors received and noted the Register of Interest report.

### PATIENT STORY

A young carer attended the Board meeting to share the story of her role as a young carer for her mum who has mental health issues and substance misuse problems. The young carer wanted to share her story to raise awareness to the challenges of young carers especially those who care for people using RDaSH services.

Mr Pater offered, on behalf of the Board, his thanks and appreciation to the young carer.

Mrs Watkinson promoted the family MOT (Moving on Together) programme which is a joint partnership between RDaSH, Aspire and Doncaster MBC that works with families to acknowledge the effects on young carers. This is a relatively new initiative that comprises an 8 week programme which gives the young person a voice and works with families individually or as a group to share their experiences.

Mrs Watkinson said it was difficult to quantify how many children were in the position of being a carer for a parent or older family member and Mrs Prewett added that one of the biggest problems in identifying young carers is because they do not see themselves as a carer. Mrs Watkinson reported that RDaSH was currently developing the roles of carer champions within the Trust's services.

### STANDING ITEMS

The minutes were agreed as an accurate record of the meeting.

Mr Shannahan referred to 81A/17 ICT Strategy and noted the need to link this to other work programmes, but there is the need to clarify what the Trust aimed to achieve. He felt that a much wider discussion was required and Dr Wildgoose suggested that it should also be considered from a quality perspective. Mr Pater agreed there was further work to do from a strategic and timeline point of view and that a wider debate would be held during the Board development session on the afternoon of 29/06/17.
<table>
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<tr>
<th><strong>ACTION</strong></th>
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<tr>
<td>Mr Shannahan referred to the second paragraph under the Informatics section of item 83A/17 regarding the data sets and he felt that a need to capture the distinction and differences. Mr Banks had met with Deloitte to discuss data supply chain. Mr Hackett stated that there was a need to make sure the right information was provided to the Commissioners and the Trust’s own teams.</td>
</tr>
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</table>

### 94A/17 MATTERS ARISING AND FOLLOW UP ACTION LIST

The previously circulated paper informed the Board of Directors of the completed action and progress update. The following was discussed further:

- **Item 30A/17 Guardian of Safe Working hours Quarterly Report**
  It was noted that the report would be discussed further under agenda item 15 Paper L presented by Dr Ahluwalia.

- **Item 83A/17 FPIC Informatics**
  It was agreed that the status for this item should be amber.

### 95A/17 CHAIRMAN’S REPORT AND COUNCIL OF GOVERNORS UPDATE

Mr Pater’s activities at the Trust were detailed in the paper and in particular he highlighted patient story feedback from the Partnership meeting with Doncaster Cancer Detection Trust, evidencing outcome improvements from working across organisational boundaries, sharing RDASH palliative care skills more widely and suggested these stories were shared with the Board.

It was also noted that Doncaster Care Group were hosting an event on 6 July at St Catherine’s House to showcase their services and to share how they are starting to transform and integrate with other services for the benefit of the patients. It will give staff the opportunity to learn more about what the Care Group does and also see the benefits of transformation.

Mr Pater also highlighted the North Regional Mental Health and Learning Disability (NHS Improvement) event in Leeds on 23/06/17. The aim of the event was to support the continuing improvement of mental health and learning disability services across the North by bringing together many of the key individuals and teams responsible for the management, delivery and improvement of these services.

Mr Pater also highlighted a presentation by Professor Louis Appleby who champions suicide prevention at a national level and the emphasis which was given to those committing suicide that had been assessed as low risk, with many suicides taking place in the three days following discharge. Dr Ahluwalia reported that the vast majority of the patients seen by the Trust will be ‘low risk’. Mr Pater highlighted that it demonstrates the challenges we face.

Mr Pater reported that Alex Sangster (Lead Governor) and Jim Marr (NED/SID) had recently participated in the PDR (Performance Development Review) of the Chair.

The Board of Directors received and noted the Chairman’s Report.
The Chief Executive's Report was presented by Miss Johnson in the absence of Mrs Singh.

Although it was not included in the Chief Executive’s Report, Miss Johnson referred to the publication of a Serious Case Review by North East Lincolnshire Safeguarding Board in which RDaSH was referred to and that had previously been reported to the Board of Directors.

Miss Johnson referred to Listening into Action (LiA) and confirmed that the Year 2 work commenced in April 2017 with the aim of spreading the LiA way of working throughout all the operational services and to have specific focus upon safe and caring services. It was noted that LiA would be showcased at the Trust Nursing Conference on 30 June 2017.

Miss Graham referred to the Appendix to the Chief Executive’s Report which provided a high level summary of the LiA journey and achievements since the last LiA update paper presented to the Board of Directors in February 2017 as well as insights into the LiA Year 2 progress.

Mrs Leese expressed an interest in the launch of the leadership development session. Miss Smith reported that it went very well, and feedback from managers was positive around the approach, with interest in how plans are developed in the future. There was dual focus regarding looking to develop our leadership skills. It was noted that there was a need to concentrate on operational services first in terms of transformation, with consideration of how to measure our workforce’s views on a quarterly basis rather than yearly.

Mr Marr referred to a positive presentation at the Unity Steering Group around data and how reports are written. He queried the levels of understanding about the potential of IT and how to put it to best use. Miss Johnson indicated that leaders needed to be clear and honest in terms of where they need additional support and sessions will be held to look at their responsibilities which will feed into a training needs analysis. She confirmed that work had started to look at areas where senior leaders have skills such as project management and they need to evidence how to demonstrate the skills.

Dr Ahluwalia queried whether there was a basic understanding of data for by managers and Mr Pater asked how best to progress and agree thresholds as certain individuals would be expected to have certain skills. In response, Mr Banks referred to the Information Management Strategic Vision which described how the Trust would engage with staff to produce a more ‘information led’ organisation.

Mr Mohammad Ramzan joined the meeting at 9.58am.

The Board of Directors received and noted the Chief Executive’s Report.

The South Yorkshire and Bassetlaw STP Collaborative Partnership Board minutes from the meeting on 12 May 2017 were presented for information.
The Board of Directors noted the South Yorkshire and Bassetlaw STP Collaborative Partnership Board minutes from the meeting held on 12 May 2017.

Miss Johnson referred to the South Yorkshire and Bassetlaw Memorandum of Understanding. She highlighted on Page 5, section 1.1 that stated “it is not a plan or a legal contract” and 1.2 which stated “it does not replace the legal framework or responsibilities of our statutory organisations”. The change in terminology from STP to ACS (Accountable Care System) was also noted.

Mr Shaw expressed his preference for track changed versions and he highlighted some points in the document which were noted for feedback to the author.

Mr Pater observed that there were no pending changes to legislation, however, he acknowledged there may be changes in the future and any implications for the Trust would be discussed openly by the Board and with the Council of Governors. From a personal perspective, he noted the fundamental benefits for service users and patients of working together better across organisations.

Mrs Leese referred to the last paragraph of the covering letter and sought confirmation on the outcome required of the Board. Miss Johnson replied that it was to support the direction of travel and a formal ‘signing’ would likely follow.

Mr Shannahan referred to the key milestones on page 12 and whilst he provided his support to the direction of travel, he was concerned that the ambition evident in the timescales was not achievable.

Mr Hackett stated that to maintain the direction of travel, the Trust and others needed to support the delivery of the milestones as presented. Miss Smith expressed her support to Mr Hackett’s statement.

Mr Shaw reminded the Board that the document was seeking to deliver the 5 year forward view for mental health and is an enabler to take the diverse organisations of the area along that route. Going forward, there must be clarity on the scope of any delegations from individual organisations. The end result has to be an improvement in the health outcomes both mental and physical health and within associated funding. Mr Shaw concluded that he was comfortable moving forward but stressed the need to understand any delegation of power or authority from the Trust.

Mrs Pearson confirmed that she was comfortable in supporting the MOU as a direction and it was in our best interest to be involved moving forward.

Mr Marr was comfortable with the document and although he was clear on the scope of what was being discussed, the outcomes for patients were important.

Dr Wildgoose was supportive around the comments that Mr Hackett and Miss Smith had made.

Dr Ahluwalia was concerned about the opportunity for public scrutiny and whilst he thought the document was more than just a direction of travel, he offered his support.

Mrs Leese added that it was the right thing to do and the Board should support it in terms of partnership working.
Mr Banks provided his support and added there was uncertainty at present about how this would impact on in-flight patch based initiatives.

Mr Pater concluded that the Board was supportive of the direction of travel, although there was concern around the timelines and key dates in section 6 and concerns around accessibility and transparency of the plan for members of the public.

The Board of Directors provided its support to the direction of travel as set out in the final version of the MOU.

**98A/17 BOARD DECLARATIONS – ANNUAL PLANNING**

The declarations included in the report presented to the Board by Mr Gowland in relation to the Corporate Governance Statement and Certification on Training of Governors was discussed around the table. Mr Shannahan asked if the Governors were supportive and Mr Gowland replied that we have been working with the Council of Governors over the last 12 months to identify their needs and they have called for access to the National Programme. Mr Pater expressed concern that the Governing body had not been directly asked for their views of the declaration. As a result, a discussion was needed outside the meeting.

The Board supported the statements subject to the discussion with Governors.

The meeting adjourned for 15 minute break.

Following a short break in the meeting, Mr Pater confirmed that he had taken the opportunity to discuss with the Lead Governor the matter further and had received assurance that the Governors were supportive of the position as outlined in the declaration and therefore the Board of Directors certified the Corporate Governance Statement and the Certification on Training for Governors.

**99A/17 STRATEGIC DIRECTION**

Mr Gowland explained that this was presented following agreement in the private session in May 2017 so that the staff, public and others were aware. Mr Shannahan commented that the statements are well worded. Mr Gowland reported that the Board Assurance Framework (BAF) will drive the management of risks and that a discussion had been held at the Executive Management Team (EMT) meeting that would lead to a wider discussion at the Board of Directors Development Session in July. Mr Shannahan sought confirmation about the business plan deployment to ensure that there was clarity about what was expected and how the Board of Directors could monitor progress. He stated he would like to be involved in the development of such. Mr Marr stated he would also like to be involved. Miss Johnson suggested that a further discussion was held at EMT to agree the next steps.

The Board received and noted the Strategic Direction paper.

**100A/17 FREEDOM TO SPEAK UP (FTSU) GUARDIAN SIX MONTH UPDATE**

Miss Graham explained that the purpose of this paper was to provide an update on the Trust’s Freedom to Speak Up Guardian’s actions and activities since the last Board update presented in December 2016.

The report also provided a brief overview of cases reported to the FTSU.
Guardian’s office between January and June 2017.

Additionally the paper provided details concerning developments from the National FTSU Guardian’s office and CQC inspections in relation to the FTSU implementation in Trusts.

The Board noted the updated paper and the progress nationally.

QUALITY

101A/17 REPORT FROM THE QUALITY COMMITTEE

Mrs Pearson highlighted the key areas, assurances, risks and gaps further to the last meeting of the Quality Committee held on 8th June 2017. The following salient points were discussed:

Highlights

- The Patient and Public Engagement (PPEE) Dashboard for Quarter 4 2016/17 was reviewed.
- A detailed update of the Workforce Strategy 2016-2021 was received.

Assurances

- The Safe Staffing report identified there were three (0.02%) ‘red’ rated shifts on inpatient wards in April (using local reporting v occupancy and acuity criteria). Seven wards were rated as ‘red’ on the national reporting framework relating to fill rates of qualified staff, with additional non-qualified staff brought in to enhance staffing levels. Sick absence and the seven IR1s submitted within April related to staffing, were reviewed at the clinical staffing review group and appropriate contingency plans were found to have been put in place. The Trust staffing levels were reported as safe for the month of April, but specific action is required following the review of the IR1s for New Beginnings and Skelbrooke Ward.

The Board of Directors noted the update from the Quality Committee.

102A/17 PPEE QUARTERLY UPDATE

Dr Wildgoose referred to the Patient and Public Engagement and Experience (PPEE) Strategy which had identified a number of evaluation approaches and the paper provided qualitative feedback to the Board since the last update in March 2017.

Mr Shannahan referred to the 40 open actions and asked if these were a concern. Dr Wildgoose replied that there was no reason for concern as it is a 2 year programme and the progress against each continued to be monitored.

It was agreed that the risk rating of each PPEE strand should be made clear with specific focus on establishing a consistent set of criteria for Red, Amber and Green for this and other similar reports. Ensuring that expected completion dates were realistic and achievable was also stressed as important.

The Board noted the content of the report.

103A/17 GUARDIAN OF SAFE WORKING HOURS QUARTERLY REPORT

Mr Marr referred to page 2 of the paper where it stated that the Guardian of Safe Working has the authority to levy a fine against the employing authority, should it
be considered in breach of the agreed work schedule. Dr Ahluwalia revealed that it is inevitable that fines would be imposed (on NHS trusts) and Miss Johnson confirmed they are written into the National Guidelines. She commented that the Trust has been required to monitor the Junior Doctor number of working hours per week and had always been compliant.

Mr Marr referred to page 1 of the paper and with reference to the exception report data he questioned whether exceptions were reported via IR1. Dr Ahluwalia and Miss Johnson described the monitoring system, noting the limitations of what is a manual, paper-based system. Mr Marr queried how the Trust was monitoring all staff not just clinical staff. Miss Johnson responded that e-rostering was in place for staff in several areas and also for bank staff and periodically reports from payroll are produced to highlight any potential excessive working hours from other staff. Where any issues are identified, the matter is taken up with the appropriate manager. Miss Smith confirmed that this is also discussed operationally in the Organisational Management Meeting (OMM) and in local Care Group meetings.

Mrs Pearson referred to the manual system in place and asked if it was therefore at the discretion of the Junior Doctor if issues were reported and whether there may be under reporting out of good will. Dr Ahluwalia stated the Trust needed to know about any deviation of safe working practices and the relevant staff were encouraged to ensure this was the case.

Mr Shaw suggested the reference to imposition of fines was considered by a committee of the Board of Directors. It was agreed that this would be discussed at EMT from an oversight perspective.

Mrs Pearson suggested the paper should be presented to the Quality Committee in future prior to discussion at the Board of Directors.

FINANCE PERFORMANCE AND INFORMATICS

104A/17 FINANCE PERFORMANCE & INFORMATICS COMMITTEE (FPIC)

Mr Hackett highlighted the following salient points from the Finance, Performance and Informatics Committee (FPIC) held on 22nd June 2017:

Assurances
- The financial position as at month 2 for the financial year 2017/18. A surplus before technical adjustments of £0.492m above the plan (control total) of £0.472m. A cash balance of £27.3m against a target of £26.5m. Capital expenditure of £0.812m against a target plan of £0.382m and a charitable funds balance of £2.9m.
- The committee received a report detailing the current position in relation to the NHS Improvement Single Oversight Framework performance targets. The report gave assurance that the Trust was achieving all the current requirements.
- The committee received a report outlining the assurance requirements for the submission of the reference costs for the Trust. The committee were asked to review the assurances provided, and it agreed that to the best of its knowledge, the Trust would submit its combined cost collection in line with NHS Improvement requirements.

Risks
- Performance against the agency cap
  The figure for May 2017 is 22% below the target
There is an additional medical target of £391.2k which will provide an additional challenge.

The Trust has spent £0.72m on agency expenditure to May 2017, which is 3.6% of the pay bill.

- **PMO Report**
  The committee received an update report on the PMO process following recent considerations at the Executive Management Team.

- **Other Information**
  The committee received a comprehensive overview of the Doncaster Care Group which included a SWOT analysis and assurance on the Finance, Quality, Performance and Workforce within the Care Group. The committee recommended that each Care Group should present an overview of their position to the Board of Directors.

Miss Smith reported ongoing discussions with Doncaster CCG and Rotherham CCG regarding an ADHD service.

Mr Shaw stated that steps are in place to meet efficiencies through the PMO and there would be a further debate at a later session. Mr Hackett stressed that this was an area of focus and the management of the non-recurrent gap was vital.

Mr Banks updated on the security patch regime following the recent worldwide cyber attacks. This would be an area of greater work and he would continue to update FPIC.

Following the Grenfell Tower incident Mr Hackett reported that additional assurance had been sought both internally and by external bodies. Following an initial review and submissions the Trust was deemed as a low priority Trust. Local risk assessments have been undertaken and guidance and procedures reiterated across the Trust.

With reference to Appendix 1 of the report and in response to a question from Mr Shannahan, Mr Hackett confirmed the variation in income was ‘real’ income, over and above the planned income. Mr Shannahan suggested the finance report featured more on the income and expenditure position and any changes to both, as opposed to the report starting at the ‘bottom line’ position.

**The Board agreed to receive regular presentations from the Care Groups.**

**The Board noted the update from FPIC and the assurance provided in relation to Cyber Security and NHSMail2 migration.**

**105A/17 REPORT FROM THE CHAIR OF THE CHARITABLE FUNDS COMMITTEE**

Mr Pater thanked Mr Marr for his contribution to the Charitable Funds Committee and noted Mr Shannahan would be the Chair of the Committee in future.

Mr Marr highlighted the following salient points from the meeting held on 24th May 2017:

- In total the Trust currently holds £2.9m in Charitable Funds.

- The committee received the performance data from Investec (CFC investment managers) that detailed returns of 11.76% from 31st March 2016 to 31st March 2017 compared to a return benchmark of 19.37% (the basic indices FTSE WMA Conservative). The return was considered by the committee to be reflective of the current risk appetite for investment.

- The significance of the Hospice (58%) and Older Peoples (33%) funds within the total funds represents a risk that the remaining general fund (9%)
of the total) is proportionately small and therefore the Committee is to review the structure of the funds given the Transformation Project taking place at the Trust.

The Board noted the update from the Charitable Funds Committee on 24 May 2017 including the confirmation of minor changes to the Terms of Reference.

### GOVERNANCE

<table>
<thead>
<tr>
<th>106A/17</th>
<th>RISK REGISTER UPDATE REPORT</th>
</tr>
</thead>
<tbody>
<tr>
<td>The report provided an overview of the two extreme operational risks as at 20th June 2017 which had both been presented to the respective lead committee in April, May and June 2017. It was noted that the financial risk was a matter of great focus for Mr Hackett going forward and both risks remain under close scrutiny.</td>
<td></td>
</tr>
</tbody>
</table>

The Board of Directors noted the Risk Register Update Report.

<table>
<thead>
<tr>
<th>107A/17</th>
<th>AUDIT COMMITTEE ANNUAL REPORT</th>
</tr>
</thead>
<tbody>
<tr>
<td>In Mrs Smart’s absence, Mr Gowland presented the Annual Report of the Audit Committee which provided assurance to the Board that the Committee had discharged its responsibilities in line with the terms of reference and to provide an overview of the work of the Audit Committee over the period.</td>
<td></td>
</tr>
</tbody>
</table>

The Board noted the Audit Committee Annual Report.

<table>
<thead>
<tr>
<th>108A/17</th>
<th>ANY OTHER BUSINESS</th>
</tr>
</thead>
<tbody>
<tr>
<td>There was no other business on this occasion.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>109A/17</th>
<th>PUBLIC QUESTIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mr Carter referred to the terminology used around the STPs and suggested that the authors should use a clear and simple language which members of the public can understand.</td>
<td></td>
</tr>
</tbody>
</table>

Mr Fox raised a question around the Charitable Funds Committee and asked who the Trustees are and whether they are paid additionally. Mr Marr responded that the Trust is the corporate Trustee and he confirmed that Directors do not receive any additional pay for fulfilling this role.

Mr Fox asked what the £2.9m charitable funds balance could be invested in and what guidelines were in place. Mr Marr agreed to email a copy of the guidelines to Mr Fox but noted that there are restrictions on their use usually linked to the instructions of the donor.

Mr Carter remarked that he had been inspired by the Patient Story today and asked if there was any way of getting an update on the links being developed between Aspire and Mental Health. Miss Smith explained what the Trust has done in terms of transformation and how teams can work together and have less boundaries and restrictions. Dr Ahluwalia noted the current benefit in this regard from the Trust providing both mental health and drug and alcohol services, but he noted this wasn’t common nationally, with many drug and alcohol services now managed by third sector organisations.

JM
After listening to the Patient Story, Mr Sangster felt that more care was needed for young people. Miss Smith revealed that there was related work underway as part of clinical services review.

In terms of the MOU, Mr Sangster could not identify a role for the Governors. Mr Pater replied that he would be attending the first meeting of the Governance and Assurance Group in relation to STP and he would be taking the views of the Governors with him as part of the process.

Mr Fox enquired about the support for the Wheelchair Charter. Miss Smith replied that the Wheelchair Services would be taking this forward.

Mr Fox queried the need or ability to sell assets. Mr Hackett confirmed there was no need to whilst the Trust remained financially sound.

Miss Smith responded to Mr Fox’s question about Transformation and explained that it was making the work more efficient and supporting the organisational change. Mr Hackett commented that every member of staff needs to contribute to transformation and to improve patient care, improve the service we deliver and it is not just about saving money.

Mr Pater thanked all for their attendance and read the following statement as the Board of Directors meeting moved to private session. “To resolve that because publicity would be prejudicial to the public interest by reason of the confidential nature of the business to be transacted, the public and press be excluded from the meeting.”

**DATE, TIME AND VENUE OF NEXT MEETING**

Thursday 27th July 2017 at 9.00am at St Catherine’s House, Woodfield Park, Doncaster DN4 8QN.
The statements below provide assurance that the actions have been completed and/or or provide an update on the progress to date.

**Follow up actions from the Board of Directors meetings held in Public on 25 May 2017**

<table>
<thead>
<tr>
<th>Minute</th>
<th>Item</th>
<th>Lead Director</th>
<th>Progress</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>74A/17</td>
<td>MATTERS ARISING AND FOLLOW UP ACTION LIST</td>
<td>PG</td>
<td>Stephen Davies, Chief Pharmacist attended the Governor Information and Discussion group meeting (July 2017) and presented on medication errors, their reporting and investigation work – including the verification and moderation processes that are used to ensure the reporting is robust and accurate - and which are fundamentally the reason why external audit did not consider there to be an appropriate audit trail in place to audit.</td>
<td>Green</td>
</tr>
</tbody>
</table>

**Follow up actions from the Board of Directors meetings held in Public on 29 June 2017**

<table>
<thead>
<tr>
<th>Minute</th>
<th>Item</th>
<th>Lead Director</th>
<th>Progress</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>93A/17</td>
<td>Minutes of the previous meeting</td>
<td>LP</td>
<td>The links between work programmes and the delivery against the Trust’s strategy / business plan will be discussed during the next session for the Board on the development of the forward strategy.</td>
<td>Amber</td>
</tr>
<tr>
<td>99A/17</td>
<td>Strategic Direction</td>
<td>RJ</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reference</td>
<td>Agenda Item</td>
<td>Description</td>
<td>Action</td>
<td>Status</td>
</tr>
<tr>
<td>-----------</td>
<td>-------------</td>
<td>-------------</td>
<td>--------</td>
<td>--------</td>
</tr>
<tr>
<td>101A/17</td>
<td>12</td>
<td>Report from the Quality Committee</td>
<td>DW</td>
<td>Action complete</td>
</tr>
<tr>
<td>102A/17</td>
<td>12</td>
<td>PPEE Quarterly Update</td>
<td>DW / RJ</td>
<td>Action started but not complete</td>
</tr>
<tr>
<td>103A/17</td>
<td>12</td>
<td>Guardian of Safe Working Hours Quarterly Report</td>
<td>NA</td>
<td>Action outstanding</td>
</tr>
<tr>
<td>109A/17</td>
<td>12</td>
<td>Public Questions</td>
<td>JM</td>
<td>Action complete</td>
</tr>
</tbody>
</table>

**Key to ‘Status’ column:**
- Green: Action complete
- Amber: Action started but not complete
- Red: Action outstanding

*Report from the Quality Committee*
The Safeguarding annual report has been deferred and will be presented to the next Board of Director’s meeting.

*PPEE Quarterly Update*
Agreement to review the action plans referred to in the paper.
A common approach to RAG ratings was suggested

*Guardian of Safe Working Hours Quarterly Report*
The issue of potential fines was to be discussed by EMT

*Public Questions*
The parameters and rules around the use of charitable funds was queried. Guidance was to be shared with the requestor.

*Board Secretary*
The Board Secretary has sent information to the requestor regarding the parameters within which the charitable funds must be spent and offered a further discussion if necessary.
<table>
<thead>
<tr>
<th>Committee Name</th>
<th>Board of Directors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Agenda Item</td>
<td>D</td>
</tr>
<tr>
<td>Title of Paper</td>
<td>Chairman’s Report</td>
</tr>
<tr>
<td>Action Required</td>
<td>Decision</td>
</tr>
</tbody>
</table>
| Prepared by | Lawson Pater, Chairman  
Philip Gowland, Board Secretary / Director of Corporate Assurance  
Diane Jeavons, Personal Assistant |
| Presented by | Lawson Pater, Chairman |
| Delivery against | Strategic Goal(s) | 1  
2  
4  
5  
Strategic Risk(s) | 1.4  
2.1  
4.2  
CQC Domain | WL |
| Financial/Budget | There are occasional costs associated with attendance at some of the events recorded in the report (for example conference fees). |
| Equality & Diversity | N/A |
| Previously Presented to | N/A |
| Background / Key Points / Outcome | The Board of Directors is asked to receive and note the Chairman’s Report including the report of NED activities and the Council of Governor’s update, which includes details of 13 newly elected Governors.  
Of the newly elected Governors only 3 have previously served in this role with the Trust. All new Governors will benefit from an improved induction programme developed in collaboration with existing governors. |
Chairman’s Report to the Board of Directors

This report includes background notes indicating the rationale for the various activities undertaken by the Chair since the last meeting, which include the following attendances and engagements, in addition to regular meetings with the Chief Executive and other Trust staff.

RDASH
- One to one meetings with 11 of the new governors
- Doncaster Care Group showcase day
- LiA Deaf Project meeting
- Opening of the Wellbean coffee lounge
- Governor Information and Discussion Group
- Non-Executive Director meeting
- One to one meetings with Non-Executive Directors
- Quality circle – New Beginnings
- Sandfield House Garden Party

I attend board committees and other meetings to contribute to Trust decision making and to observe their operation and contribution to the effectiveness of Trust Governance systems. I take the opportunity to visit services and internal events to engage with and learn from patients, staff and other stakeholders.

EXTERNAL
- Chair of Doncaster Clinical Commissioning Group
- St John’s Hospice partnership meeting with Doncaster Cancer Detection Trust
- South Yorkshire and Bassetlaw Accountable Care System (previously known as the STP) – Oversight and Assurance Group

The purpose my engagement with external organisations is to promote partnership working, to learn from service users and their representatives, to act as an ambassador for the Trust, assist in building strong relationships, and facilitate the resolution of problems and development of opportunity.

Non-Executive Director activities

Non-Executives have ensured representation at Board Committee meetings throughout the month. In addition, over the last month the Non-Executives attended:

- Nursing Conference (Mrs Pearson, Mrs Leese, Mr Shannhan)
- Doncaster Care Group showcase day (Mrs Pearson, Mrs Smart, Mr Shannhan, Mr Shaw)
- Quality committee (Mrs Pearson, Mrs Leese, Mr Marr)
- Freedom to Speak Up meeting (Mrs Pearson, Mrs Smart)
- NED meeting (Mrs Pearson, Mrs Leese, Mrs Smart, Mr Shannhan, Mr Marr)
- Mental Health Act training (Mrs Leese)
- Opening of the Wellbean coffee shop (Mrs Smart)
- Unity benefits realisation meeting (Mr Shannhan)
- Finance, Performance and Information Committee (Mr Shannhan)
- Charitable Funds Committee (Mr Marr, Mr Shannhan)
- Project Management Office meeting with Executive Director of Finance and Performance (Mr Shannhan)
- Meetings with the Executive Director of Finance and Performance and the Executive Director of Workforce and OD meeting (Mr Shaw)
- Mental Health Act hearings (Mr Shaw, Mr Marr)
- TAMS Forum (Mr Shaw)
- Estates Consultants meeting (Mr Shaw)
- Meeting with the Chairman (Mrs Leese, Mr Marr)
- Meeting with the Director of Corporate Governance/Board Secretary (Mrs Leese)
- Unity Steering Group (Mr Marr)
- St John’s Hospice partnership meeting with Doncaster Cancer Detection Trust (Mr Marr)
- Meeting with the Director of Health Informatics and Ian Shaw regarding the Unity Project (Mr Marr)
- IG training for Trust Associate Managers (Mr Marr)
- Governor Information Discussion Group (Mr Marr)

**Council of Governors**
Following the recent elections it is pleasing to announce that a number of governors have been re-elected and that I am able to welcome a number of new governors to the Trust. The table below provides details of all current governors (recent changes are marked in bold.)

<table>
<thead>
<tr>
<th>Constituency / Partner Organisation</th>
<th>Governor</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Public</strong></td>
<td></td>
</tr>
<tr>
<td>Doncaster</td>
<td>Richard Rimmington</td>
</tr>
<tr>
<td></td>
<td>John Carter</td>
</tr>
<tr>
<td></td>
<td>Allyson Vuli</td>
</tr>
<tr>
<td></td>
<td><strong>Helen Ward</strong></td>
</tr>
<tr>
<td>Rotherham</td>
<td>Alex Sangster</td>
</tr>
<tr>
<td></td>
<td>Ian Fairbank</td>
</tr>
<tr>
<td></td>
<td>Gary Cooper</td>
</tr>
<tr>
<td></td>
<td>Mohammed Ramzan</td>
</tr>
<tr>
<td>North Lincolnshire</td>
<td>Christine O’Sullivan</td>
</tr>
<tr>
<td></td>
<td>Roni Wilson</td>
</tr>
<tr>
<td>North East Lincolnshire</td>
<td><strong>George Baker</strong></td>
</tr>
<tr>
<td>Rest of England</td>
<td>Vacant</td>
</tr>
<tr>
<td><strong>Service User</strong></td>
<td></td>
</tr>
<tr>
<td>Mental Health</td>
<td>Melissa March</td>
</tr>
<tr>
<td></td>
<td><strong>Peter Vargas</strong></td>
</tr>
<tr>
<td></td>
<td>Rebecca Parkin</td>
</tr>
<tr>
<td>Learning Disability</td>
<td><strong>Peter Barr</strong></td>
</tr>
<tr>
<td>Specialist Services</td>
<td>Sue Hodgson</td>
</tr>
<tr>
<td>Community Services</td>
<td><strong>Brendan Fox</strong></td>
</tr>
<tr>
<td></td>
<td>Vacant</td>
</tr>
<tr>
<td><strong>Carer</strong></td>
<td></td>
</tr>
<tr>
<td>Mental Health</td>
<td><strong>Karen Biddle</strong></td>
</tr>
<tr>
<td></td>
<td>Adam Foster</td>
</tr>
<tr>
<td></td>
<td>Eileen Harrington</td>
</tr>
<tr>
<td>Learning Disability</td>
<td>Vacant</td>
</tr>
<tr>
<td>Specialist Services</td>
<td><strong>Chris Grice</strong></td>
</tr>
<tr>
<td>Community Services</td>
<td>Maggie McAndrews</td>
</tr>
<tr>
<td></td>
<td><strong>Joan Cox</strong></td>
</tr>
<tr>
<td><strong>Staff</strong></td>
<td></td>
</tr>
<tr>
<td>Nursing</td>
<td>Vacant</td>
</tr>
<tr>
<td>Allied Health Professionals/Psychology</td>
<td>Amy Chambers</td>
</tr>
<tr>
<td>Community Nursing</td>
<td>TBC</td>
</tr>
<tr>
<td>Medical/Pharmacy</td>
<td>Dr Alison Davies</td>
</tr>
<tr>
<td>Social Care</td>
<td><strong>Simon Mills</strong></td>
</tr>
<tr>
<td>Non Clinical</td>
<td>Sue Sparks</td>
</tr>
</tbody>
</table>

**Nominated/Partner Governors**
- Doncaster MBC: Karen Johnson
- Rotherham MBC: Cllr Eve Rose
- North Lincolnshire Council: Vacant
- University: Dr Heidi Cheung
- Community Voluntary Sector: Vacant
In the last month Governors have again been active in many areas of the Trust with attendance at events such as the Nursing Conference, Well-Bean Lounge opening, Doncaster Care group Showcase, and members Drop in sessions. In addition, the Governors held their quarterly Information and Discussion Group meeting this month and as well as discussing a number of current issues, feeding back to the Trust from their own experiences and engagement with members, they also received a presentation from Stephen Davies, Chief Pharmacist on the way the Trust manages medication errors and also from Kathryn Singh, Chief executive on the recent developments within the Sustainability and Transformation Partnership/Accountable Care System.
The Chief Executive’s Report provides the Board with information about policy, legislative and developmental issues and changes that affect the Trust and local initiatives across the Trust in the last month.

Further information can be gained from the relevant lead director. This month’s report contains the following:

- RDaSH News
- National / Regional Update
- RDaSH Summary Information
  - Media coverage
  - Freedom of Information (FOI) Requests
We held our inaugural Nursing Conference on the 30 June 2017 which was entitled: *Nursing into the Future: Learning and Preparing*. This conference combined national presentations concerning care improvements with our RDaSH LiA teams ‘passing on’ their outcomes via conducting specific workshops, providing journey posters and hosting market stalls.

This event was attended by nearly 250 people including: RDaSH staff from different professions, local universities, leaders from neighbouring Trusts, commissioners, students of varying professions and apprentices. Key note speakers at our event were: Dr Ruth May (NHSi), Corinne Harvey (Public Health England) and Kath Evans & Lorraine Wolfenden (NHS England). In each of the speaker’s speeches they recognised the improvement work our RDaSH LiA teams have been working on in the last 6 months including specifically: nutrition work, patient engagement and coproduction work, falls reduction work and education pathways.

Alongside of the conference we held a specific breakfast session with Ruth May which provided an opportunity for key nurses and AHPs to have a question and answer informal meeting with Ruth. This was invaluable in engaging with Ruth and her national work and identifying key areas for some joint work. As part of the conference we had a recruitment stall and were able to start the recruitment process for a number of students and nurses to the Trust.

Feedback has been obtained from attendees demonstrating:

- 100% of attendees rated the conference 4-5/5
- 100% of attendees explained that they felt that the conference was a positive use of their time.
- 94% of attendees stated that listening to the local and national speakers will help them improve the patient care they provide.
- 96% of attendees rated the conference market stalls 4-5/5
- 100% of attendees provided feedback that they feel that such a conference should be provided yearly.

Quotes from some people who attended on the day were:

- “The conference was an excellent day that allowed for networking and provided excellent examples of good practice” (University Lecturer)
- “It has been pleasant for me as a student to attend the event as it gave me a broader picture of what to expect when I qualify my degree.” (Student Nurse)
- “Energised and inspired by developments across services from LiA projects – good ideas to share” (RDASH AHP)
- “Positive, proud, informed, innovative” (Nurse RDASH)
- “Encouraged by work being done in Trust and ethos” (Nurse in neighbouring NHS Trust)
The success of this conference and feedback will be shared across the Trust through short videos being produced and material from the event being shared at other smaller professional network events.

**LiA Update**

After providing the extended summary of our second 20 LiA teams in my last board report I am happy to share with you that our operational leaders have now taken LiA to the next level ensuring LiA is used to focus service change in every part of our patient facing service. What this means is that we have 22 Teams, with missions focussed upon increasing patient safety, who have now started their journey within all of the care groups. Many of them have set up their Big Conversations and have their clinical and professional leads on board. They will be reporting their leadership progress and results via our Leadership Development Forum and I will provide an update within my report as we progress.

As you are aware we have just repeated our staff Pulse Check, and we now have the first set of results which we can share. I am happy to report that 921 of our staff responded to our Pulse Check and as well as providing their opinion they have provided 1200 separate comments related to ways in which we could change to improve our staff services.

The response to our Pulse Check was slightly lower than in 2016 and there is a variation in terms of how people have responded to each of the question, however when we compare this to the national average of Pulse Checks taken by the Optimise service, which factor in over 80,000 respondent’s, our results ranges are still very positive in comparison, please see the graphs and tables below for details:

Graph: demonstrating RDASH Pulse Check response in July 2017 compared with national pulse check scores gained from over 80,000 staff:-

<table>
<thead>
<tr>
<th>LiA Pulse Check Questions</th>
<th>RDASH July '17</th>
<th>National Results</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. I feel happy and supported in my team / department / service</td>
<td>59%</td>
<td>50.2%</td>
</tr>
<tr>
<td>2. Organisational culture encourages me to contribute to changes that affect my team / department / service</td>
<td>48%</td>
<td>31.3%</td>
</tr>
<tr>
<td>3. Managers and leaders seek my views about how we can improve our services</td>
<td>46%</td>
<td>31.1%</td>
</tr>
<tr>
<td>4. Day to day issues and frustrations that get in our way are quickly identified and resolved</td>
<td>34%</td>
<td>17.3%</td>
</tr>
<tr>
<td>5. I feel that our organisations communicates clearly with our staff about its priorities and goals</td>
<td>40%</td>
<td>29.1%</td>
</tr>
<tr>
<td>6. I believe that we are providing high quality services to our patients / service users</td>
<td>67%</td>
<td>46.4%</td>
</tr>
<tr>
<td>7. I feel valued for the contribution I make and the work I do</td>
<td>51%</td>
<td>28.2%</td>
</tr>
<tr>
<td>8. I would recommend our organisation to my family and friends</td>
<td>56%</td>
<td>51.3%</td>
</tr>
<tr>
<td>9. I understand how my role contributes to the wider organisational vision</td>
<td>62%</td>
<td>47.9%</td>
</tr>
<tr>
<td>10. communication between senior management and staff is effective</td>
<td>38%</td>
<td>21.9%</td>
</tr>
<tr>
<td>11. I feel that the quality and safety of patient care is our organisations top priority</td>
<td>63%</td>
<td>50.4%</td>
</tr>
<tr>
<td>Question</td>
<td>Percent</td>
<td>Rating</td>
</tr>
<tr>
<td>------------------------------------------------------------------------</td>
<td>---------</td>
<td>--------</td>
</tr>
<tr>
<td>12. I feel able to prioritise patient care over other work.</td>
<td>54%</td>
<td>43.6%</td>
</tr>
<tr>
<td>13. Our organisational structures and processes support and enable me to do my job well</td>
<td>40%</td>
<td>26.2%</td>
</tr>
<tr>
<td>14. Our work environment, facilities and systems enable me to do my job well</td>
<td>41%</td>
<td>27.7%</td>
</tr>
<tr>
<td>15. This organisation supports me to develop and grow in my role.</td>
<td>48%</td>
<td>31.7%</td>
</tr>
</tbody>
</table>

Despite our continued good results compared with the national average, we know we need to do better to ensure that RDaSH provides the best services for our patients and carers and is a place where our staff choose to work and would advocate their family and friends are cared for. For this reason we will be breaking down our Pulse Check results in order to analyse our variance between our last Pulse Check, the variance between different teams and also the variation in staff groups considered alongside of our transformation process.

We also aim to use our Pulse Check results in developing our staff engagement strategy, organisational development strategy and also retention strategy over the next 12 months.

**NHSi Staff Retention**

NHSi have developed a national programme for improving retention across the NHS, and we are really pleased that RDaSH are included in the first cohort of work. The programme was launched in June 2017 with two master classes, where examples of good retention strategies were discussed. The retention programme is set to run until 2020 and is focussed upon firstly stabilising leaver rates, which are acknowledged as rising throughout the NHS and then reducing leaver rates as the programme progresses.

The retention programme is targeted upon the non-medical staff workforce and emphasis is placed upon it being clinically led, meaning that NHSi’s central workforce team will provide direct support to trusts whose leaver rates are higher than the mean rate within the regional trust peer group. The aim of the support is to reduce the variation in leaver rates across trusts.

RDaSH have been placed in a comparison group of 15 other mental health trusts. We currently rank 9th out of 15 in our turnover rate within this peer group. The lowest turnover rate recorded in our peer group is 7% and the highest is 17%. Although our RDaSH overall turnover rate has been gradually reducing from 13.9% in 2014 to 12.6% in 2016, we are higher than our peer group whose 2016 average was 11%.

Our focus of the Year 2 LiA schedule concerns improving within the domains of "safe" and "caring". What the research tells us is organisations with high turnover rates have higher patient safety incidents. Research also shows that high turnover rates are also linked with increased financial pressures and also increased recruitment difficulties. Using an LiA approach to our focussed retention work over the next year will enable us to target our staff wellbeing work, and enhance our recruitment and retention strategies building on the work our LiA enabler team commenced in 2016. Alongside of our internal teams we have been allocated an NHSi Buddy, Professor Mark Radford, who will be working with us to help develop our approaches towards staff retention and recruitment over the next 12 months.

**Health and Work Champions National Pilot**

The Trust is taking part in a national pilot to support people to return to work. The Health and Work Champions’ pilot programme, which has been developed by the Royal College of Occupational Therapists and Public Health England, uses peer-to-peer staff training delivered through Health and Work Champions to encourage staff to discuss employment with their patients as part of their care plan. The Trust is one of the first NHS Trusts to take part in a national pilot programme to support people with illness, injury or disability to remain in or return to work.

The pilot aims to change the culture in the NHS so that work is seen as an important part of patient care and to offer advice or onward referral to employment support services to patients who need help to remain in or return to work. Evidence shows that being in work is good for health and wellbeing. As well as giving people a sense of pride, identity and personal achievement, those in employment tend to enjoy happier and healthier lives and, with the right support, many people will recover from illness more quickly by returning to work.
WellBean Coffee Lounge

On Friday 7 July 2017 the WellBean coffee lounge was opened on the Tickhill Road Site in Doncaster. Patients on the recovery pathway, volunteers and peer support workers now have access to vital work experience and grow in confidence to help them into work or education thanks to the newly revamped coffee shop. Guests included the Civic Mayor of Doncaster Cllr George Derx and his wife Pauline. The WellBean project was led by Aspire Drug and Alcohol Service and Flourish Enterprises.

Visitors to the WellBean Coffee Lounge can also enjoy a range of barista style coffees and speciality teas.

NHSi Mental Health observations and engagement collaborative

NHSi have commenced a Mental Health observations and engagement collaborative. The aim of the 6 month improvement programme is to deliver an improved experience for the most vulnerable hospital in-patients whilst also seeking to measure, monitor and reduce the cost of care. The Trust is one of 24 Trusts nationally taking part in the collaborative.

Led by the Deputy Director of Quality Improvement, the Trust will have a small project team made up of clinicians, performance and finance leads and covers Doncaster and Rotherham services. The team will attend four collaborative events through the 6 months and will receive visits from the NHS Improvement national team.

Highlights from the month of July

- Service visit to Great Oaks in Scunthorpe
- Service visit to Ferns Ward at the Woodlands in Rotherham
- Meeting of the South Yorkshire & Bassetlaw Accountable Care System – Oversight and Assurance Group
- Meeting with the Chief Executive of North Lincolnshire Council
- Meeting of the Joint Local Negotiating Committee
- Executive to Executive meeting with Doncaster Children’s Services Trust
- Attendance at the Governor Information and Discussion Group
- Doncaster Chief Executive Provider meeting
- Joint meeting with the Chief Executives of Doncaster and Bassetlaw NHS Foundation Trust and Doncaster Clinical Commissioning Group
- Rotherham Place Plan Board meeting
- Meeting of the South Yorkshire & Bassetlaw Sustainability and Transformation Collaborative Partnership Board
- Joint Working Mental Health STP Event
- Meeting of the South Yorkshire & Bassetlaw Mental Health and Learning Disabilities workstream
National Publications and Guidance

Listed below are the key publications and guidance issued in the last month which are received within the Executive Management Team and incorporated / referred to in the ongoing relevant pieces of work at the Trust.

1. The State Of The NHS Provider Sector

In early July, NHS Providers published their report *The State Of The NHS Provider Sector*. The report provides a valuable update on how the provider sector is performing, identifying the challenges faced and the support needed over the course of this parliament. It combines analysis and commentary, published data and the views of 158 chairs and chief executives from 125 trusts that responded to their survey in April. The centrepiece of the report is mental health. This is a critical area of care for the NHS, working in collaboration with a range of other public services, as well as now being a growing concern for the wider society.


2. Suicide by Children and Young People

Manchester University carried out a National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (NCISH). The study was carried out to find the common themes in the lives of young people who die by suicide. They wanted to identify possible sources of stress and to examine the role of support services. They collected information on 922 suicides by people aged under 25 in England and Wales during 2014 and 2015. The information came from investigations by official bodies, mainly from coroners, who take evidence from families and professionals.

[http://research.bmh.manchester.ac.uk/cmhs/research/centreforsuicideprevention/nci/reports/cyp_2017_report.pdf](http://research.bmh.manchester.ac.uk/cmhs/research/centreforsuicideprevention/nci/reports/cyp_2017_report.pdf)

3. Drug Strategy

On 14 July 2017 the Government released their Drug Strategy. The 2017 Drug Strategy builds on the approach of the 2010 Strategy, recognising that while progress has been made, there is a need to go further to respond to the evolving threats and challenges that continue to emerge from drug misuse, including changing drugs markets, changing patterns of use and an ageing and more ill group of people who need support to recover.

The aim of the Strategy will be to expand the two overarching aims of the 2010 Strategy - to reduce illicit drug use and increase the rates recovering from their dependence - by introducing a raft of new measures, including addressing both the frequency and type of drug used, and segmenting our recovery data to facilitate even greater ambition for particular user groups.


4. NHS Resolution Annual Report and Accounts 2016/17

The NHS Resolution annual report and accounts 2016/17 was published on 14 July 2017. NHS Resolution is the new name for the NHS Litigation Authority. At the same time they also published their 5 year strategy: Delivering fair resolution and learning from harm.

Both documents are available through the links below.


5. Cyber Security

The NHS Confederation reports that every NHS board in England will be required to designate an executive board member responsible for data and cyber security, under government plans to bolster data security and increase cyber resilience across the health and care sector.

The move forms part of a new requirement for chief executives to issue an annual ‘statement of resilience’ detailing the action their organisation is taking to meet the ten data security standards recommended in Dame Fiona Caldicott’s review into data security, consent and opt-outs. Your data: Better security, better choice, better care, the government’s response to the Caldicott review and Care Quality Commission’s (CQC) review into data security, states:

“To ensure that the standards are being prioritised and implemented, in summer 2017, NHS Improvement will publish a new ‘statement of requirements’ which will clarify required action for local organisations, which chief executive officers must respond to with an annual ‘statement of resilience’, confirming essential action has been taken. “This will include the requirement for each organisation to have a named executive board member responsible for data and cyber security.” The measure follows the global WannaCry cyber security incident which affected NHS organisations in May 2017. The responsible Director will be Richard Banks, Director of Health Informatics


6. The state of care in mental health services 2014 – 2017

The CQC have completed their programme, which started in 2014, of comprehensive inspections of all specialist mental health services in England. The landscape of specialist mental health care in England is complex – care is provided by both mental health NHS trusts and independent mental health providers. As at 31 May 2017, they have rated services provided by 54 NHS trusts and 221 independent mental health locations.


7. Quality Improvement in Mental Health

The Kings Fund published their report on quality improvement in mental health. This report explores the potential opportunities arising from the application of quality improvement approaches in the mental health sector and identifies relevant learning from organisations that have already adopted these approaches.

Media Coverage – 12 June – 17 July 2017
Press releases, statements, interviews arranged and information supplied to the press: 35
Taken up: 35
Plus tweets and Facebook messages: 114
Positive press hits – minimum of 38
Factual press hits: 2
Negative press hits: 19 negative reports (1 x fraud case and 18 x coverage of Hull trial)
Twitter positive: 661 (up to 3.7.17)
Twitter impression: 35,347 (up to 3.7.17)
Facebook reach 30,699 (up to 3.7.17)

Press release – Great Get Together at New Beginnings (Aspire Drug & Alcohol)
Press release – Mexbrough fundraiser to challenge the stigma of mental health (AMH)
Press release – Massive response to teddy bear appeal (Hospice)
Press release – All about the Health Bus for Learning Disability Week (LD)
Press release – Donation to young people’s project (Know the score/Childrens)
Press release – BoD Meeting June (Corporate)
Press release – Balby community turns out for Great Get Together (Aspire Drug & Alcohol)
Press release - Cheers! Marking National Carers’ Week (DCIS A)
Press release – Rainbow of colours on Doncaster wards (DCIS – A)
Statement prepared and issued to NE Lincolnshire Council regarding services we offer for people with addiction to drink – Grimsby Telegraph enquiry
Press release: All the fun of the fair at the Woodlands (Rotherham/OPMH)
Press release – Seaside theme for summer fair (Flourish)
Statement – IAPT figures Rotherham (AMH)
Statement – IAPT figuresse North Lincolnshire (via CCG) AMH
Press release: End of life care team praised (Woodfield 24)
Statement: re Court case (fraud)
Statement – Paranormal night allegations (Flourish)
Media invitation for interview – Aspire conference
Press release - Have a go at yoga and help the hospice
Trial in Hull – Coverage (AMH)
Press release - RDaSH is taking part in a national pilot to support people to return to work
Look North scoping interview re: Fentanyl with Stuart Green with a view to doing a potential interview
Press release – Summer fair (Flourish)
Press release – Stress control classes in Rotherham (AMH)
Facebook & Twitter - Feeling #stressed? Need our support? Find our more here: http://aq.be/201f92 #rotherhamiswonderful
Press release – Carers invited to have me time (Hospice)
Press release – Getting ready for the Recovery Games
Sine FM – Like to do ‘My Time’ show with Neil Firbank to promote Aspire and the games
Press release - World Breastfeeding Week to be celebrated in Doncaster (Childrens)
Media – Doncopolitan want to do a big feature in their next issue on the Recovery Games
Press release – Joint with Macmillan (led on the release) support from our Living Well Centre
Press release – Bloomin amazing donation (Flourish/hospice) F & T - Thank you to @Flourish_Ent for their fantastic £500 donation - full info @ http://bit.ly/2vc6lMU #doncasterisgreat
Hospice diary date – Trax FM events page
News release – Official opening of WellBean Coffee Lounge
Media enquary – HallamFM re: Home Office news release on new drug strategy to safeguard vulnerable and stop substance misuse (Stuart Green to do recorded radio interview)
Press release: Nursing conference success (Corporate)
DSDaily email included Recovery Games
Coverage – Magazine Community Practitioner article by Tracey Long, health visitor
Statement: Hull trail statement BBC Look North (Folarin.Sagaya@bbc.co.uk)
Trax FM– hospice dragon boat team
Freedom of Information (FoI) Requests – 16 June – 16 July 2017

- FOI 1648 – Questions regarding the Trust’s provision of Older People’s Mental Health Services and our career pathways for OPMH staff
- FOI 1649 – Request for approximate costs of accessing crisis team services and admission to a psychiatric unit
- FOI 1650 – Request for the number of under-25 mental health inpatient admissions from 2015 to present
- FOI 1651 – Questions on consultancy metrics relating to HR and Learning and Development
- FOI 1652 – Questions around our eating disorder service provision and specialist staff employed
- FOI 1653 – Request for the Trust’s 2016 agency spend for all non-clinical, non-medical agency staff
- FOI 1654 – Request for the number of under-25 mental health inpatient admissions from 2015 to present
- FOI 1655 – Questions around the Trust’s energy initiatives and carbon reduction target
- FOI 1656 – Request for the number of deaths that have occurred under general anaesthetic for dental procedures
- FOI 1657 – Questions around the Trust’s use of diagnostic services from external providers outside the UK
- FOI 1658 – Request for the number of OPMH inpatients in 2016 who were discharged between 22:00 and 06:00 hours
- FOI 1659 – Questions around the Trust’s use of routine enquiry relating to sexual violence or abuse
- FOI 1660 – Request for dispensing information relating to schizophrenia medication used by the Trust (follow-up to FOI 1637)
- FOI 1661 – Request for a copy of the Trust’s patient information leaflet relating to outpatient hysterectomy/biopsy
- FOI 1662 – Request for the number and cost of eye injections carried out by the Trust from Jan 2016 to May 2017
- FOI 1663 – Request for the Trust’s agency spend on cardiology locums from May 2016 to present
- FOI 1664 – Questions around the Trust’s use of diagnostic services from external providers outside the UK
- FOI 1665 – Request for confirmation that the names/roles match up for the executive team
- FOI 1666 – Request for number of cancelled operations in the Trust since 2012
- FOI 1667 – Questions about the impact on the Trust of the recent WannaCry ransomware attack
- FOI 1668 – Questions around assaults recorded within the Trust
- FOI 1669 – Questions around motor fleet insurance
- FOI 1670 – Questions around the Trust’s spending on medical IT
- FOI 1671 – Questions around the Trust’s Non-Emergency Patient Transport Services (NEPTS)
- FOI 1672 – Questions around anticoagulation services
- FOI 1673 – Questions around decontamination of inpatient units
- FOI 1674 – Questions around the Trust’s data on anticoagulation services
- FOI 1675 – Questions around the Trust’s data on anticoagulation services
- FOI 1676 – Request for number and percentage of private contractors on staff in the Trust since 2012
- FOI 1677 – Request for the number and percentage of private contractors on staff in the Trust since 2012
- FOI 1678 – Request for the number and percentage of Trust beds used by private patients since 2012
- FOI 1679 – Request for the number of cancelled operations in the Trust since 2012
- FOI 1680 – Request for the number of cancelled operations in the Trust since 2012
- FOI 1681 – Request for the number of cancelled operations in the Trust since 2012
- FOI 1682 – Questions around the Trust’s Non-Emergency Patient Transport Services (NEPTS)
- FOI 1683 – Questions around decontamination of inpatient units
- FOI 1684 – Questions around the Trust’s Non-Emergency Patient Transport Services (NEPTS)
- FOI 1685 – Questions around the Trust’s PFI contracts
- FOI 1686 – Questions around the Trust’s agency spend on medical locums/AHPs

Kathryn Singh, Chief Executive
July 2017
<table>
<thead>
<tr>
<th>Committee Name</th>
<th>Board of Directors</th>
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</thead>
<tbody>
<tr>
<td>Agenda Item</td>
<td>F</td>
</tr>
<tr>
<td>Date</td>
<td>27 July 2017</td>
</tr>
<tr>
<td>Title of Paper</td>
<td>Sustainability and Transformation Plan (STP) Update:</td>
</tr>
<tr>
<td></td>
<td>• South Yorkshire and Bassetlaw (SYB) Collaborative Partnership Board Minutes</td>
</tr>
<tr>
<td>Action Required</td>
<td>Decision ✓ Assurance ✓ Information ✓</td>
</tr>
<tr>
<td>Prepared by</td>
<td>Philip Gowland, Board Secretary / Director of Corporate Assurance</td>
</tr>
<tr>
<td>Presented by</td>
<td>Kathryn Singh, Chief Executive</td>
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<tr>
<td>Delivery against</td>
<td>Strategic Goal(s) All Strategic Risk(s) 3.2 4.2 CQC Domain W</td>
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<tr>
<td>Financial/Budget</td>
<td>The SY&amp;B STP has triple aims:</td>
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<tr>
<td></td>
<td>• Closing the health and well-being gap</td>
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<td>• Driving Transformation to close the care and quality gap</td>
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<tr>
<td></td>
<td>• Closing the finance and efficiency gap</td>
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<td>Equality &amp; Diversity</td>
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<td>Presented to</td>
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<tr>
<td>Background / Key Points / Outcome</td>
<td>Please find attached the ratified minutes of the SYB STP Collaborative Partnership Board, held on 9 June 2017.</td>
</tr>
<tr>
<td>Minute reference</td>
<td>Item</td>
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<tr>
<td>59/17</td>
<td>Minutes of the previous meeting held 12 May 2017</td>
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<tr>
<td></td>
<td>The following amendment was required at 49/17 (delete last two</td>
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<tr>
<td></td>
<td>paragraphs and insert:</td>
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<tr>
<td></td>
<td>The Chair advised members that the Cancer Alliance Board agreed a</td>
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<td>shared inter provider transfer (IPT) policy at the May Cancer</td>
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<td>Alliance Board meeting and has advised the Collaborative Partnership</td>
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<td>Board at this meeting that the policy had been signed off and was</td>
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<td></td>
<td>ready to be sent out to partners. After discussion members agreed</td>
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<td>that the Clinical Reference Group would finalise any outstanding</td>
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<td>clinical issues within 6 weeks, which will need to be agreed to</td>
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<td>ensure we are able to successfully operationalise the policy.</td>
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<td>Add Richard Jenkins to the list of those present.</td>
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<tr>
<td>61/17</td>
<td>National Update</td>
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<td></td>
<td>Members agreed that SYB STP should continue to progress our plans</td>
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<td></td>
<td>and work together as an ACS.</td>
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<tr>
<td>62/17</td>
<td>SYB MOU</td>
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<tr>
<td></td>
<td>South Yorkshire and Bassetlaw Memorandum Of Understanding</td>
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<td></td>
<td>Will Cleary-Gray agreed to circulate a revised draft next week when</td>
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<td>all comments had been received.</td>
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<td>In order that members had another opportunity to review the draft SYB</td>
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<td>MOU following changes members agreed that the turnaround of the</td>
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<td>document should be within 48 hours of it being circulated. To enable</td>
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<td></td>
<td>the final draft to be circulated to local governance by Friday, 23rd</td>
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<td>June 2017.</td>
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<tr>
<td>63/17</td>
<td>Finance Update</td>
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<td>Will Cleary-Gray requested members to provide any written comments</td>
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<td></td>
<td>they may have regarding the finance update direct to Jeremy Cook</td>
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<td></td>
<td>and he would duly respond and address them.</td>
</tr>
<tr>
<td>Reference</td>
<td>Agenda Item</td>
</tr>
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</tbody>
</table>
| 64/17     | Development of a Single Accountability Framework | After discussion, members endorsed:  
- the establishment of a short-life working group to draw up the framework, with representatives drawn from the STP executive, STP cancer, urgent and emergency care and mental health programme plus one place, NHS England and NHS Improvement (local and national)  
- Alison Knowles to Chair the group with support from Andrew Morgan and their respective teams.  

Greg Fell and Richard Jenkins volunteered their help to Alison Knowles regarding the Single Accountability Framework. |
|           | AK          |            |
|           | AK & AM     |            |
|           | GF & RJ     |            |
| 65/17     | Summary update to the Collaborative Partnership Board |  
- Sharon Kemp from RMBC has had a conversation with Will Cleary-Gray about having a regular item on the Collaborative Partnership Board agenda for discussion and feedback that reflects the full breadth of Local Authority and partners' work. Sharon Kemp will be bringing back a proposal for members' consideration on how this might look.  

Lesley Smith added that as part of the National Accountable Care System Development programme there are currently 3 ACSs participating in the Population Health Management which is a huge theme and has lots of different elements. Lesley Smith stated a small team may be required to engage in this on behalf of SYB STP and requested members to flag up with her who they feel should be approached to be in the team. |
|           | SK          |            |
|           | LS          |            |
| 66/17     | Health Inequalities |  
The presentations accompanying the report will be circulated after this meeting.  

The Chair noted that a pocket of work relating to the stratification of health care to enable aspirations to be delivered was required and we should work through this as a system. Therefore, we should schedule in scorecard discussions and invest time for this subject. |
|           | JA          |            |
|           | WC-G        |            |
| 67/17     | SCR/STP Health Led IPS Employment Service |  
The Chair confirmed he will be happy to meet with Kevan Taylor and the combined authorities will have direct discussions regarding this initiative. |
South Yorkshire and Bassetlaw Sustainability and Transformation Partnership

Collaborative Partnership Board

Minutes of the meeting of 9 June 2017,
The Boardroom, 722 Prince of Wales Road, Sheffield, S9 4EU

<table>
<thead>
<tr>
<th>Name</th>
<th>Organisation</th>
<th>Designation</th>
<th>Present</th>
<th>Apologies</th>
<th>Deputy for</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sir Andrew Cash</td>
<td>South Yorkshire and Bassetlaw STP</td>
<td>STP Lead/Chair and CEO, Sheffield Teaching Hospitals NHS FT</td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adrian Berry</td>
<td>South West Yorkshire Partnership NHS FT</td>
<td>Deputy Chief Executive</td>
<td>✓</td>
<td></td>
<td>Rob Webster CEO</td>
</tr>
<tr>
<td>Adrian England</td>
<td>Healthwatch Barnsley</td>
<td>Chair</td>
<td></td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Ainsley Macdonnell,</td>
<td>Nottinghamshire County Council</td>
<td>Service Director</td>
<td>✓</td>
<td></td>
<td>Anthony May CEO</td>
</tr>
<tr>
<td>Alison Knowles</td>
<td>Locality Director North of England,</td>
<td>NHS England</td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ben Jackson</td>
<td>Academic Unit of Primary Medical Care, Sheffield University</td>
<td>Senior Clinical Teacher</td>
<td>✓</td>
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<tr>
<td>Brian Hughes</td>
<td>NHS Sheffield Clinical Commissioning Group</td>
<td>Director of Commissioning</td>
<td>✓</td>
<td></td>
<td>Maddy Ruff</td>
</tr>
<tr>
<td>Catherine Burn</td>
<td>Voluntary Action Representative</td>
<td></td>
<td>✓</td>
<td></td>
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<tr>
<td>Chris Edwards</td>
<td>NHS Rotherham Clinical Commissioning Group</td>
<td>Accountable Officer</td>
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<tr>
<td>Des Breen</td>
<td>Working Together Partnership Vanguard</td>
<td>Medical Director</td>
<td>✓</td>
<td></td>
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</tr>
<tr>
<td>Greg Fell</td>
<td>Sheffield City Council</td>
<td>Director of Public Health</td>
<td>✓</td>
<td></td>
<td>John Mothersole CEO</td>
</tr>
<tr>
<td>Frances Cunning</td>
<td>Public Health England</td>
<td>Deputy Director of Health and Wellbeing</td>
<td>✓</td>
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<tr>
<td>Helen Stevens</td>
<td>South Yorkshire and Bassetlaw STP</td>
<td>Assc. Director of Comms &amp; Engagement</td>
<td>✓</td>
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<tr>
<td>Idris Griffiths</td>
<td>NHS Bassetlaw Clinical Commissioning Group</td>
<td>Interim Accountable Officer</td>
<td>✓</td>
<td></td>
<td></td>
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<tr>
<td>Jackie Pederson</td>
<td>NHS Doncaster Clinical Commissioning Group</td>
<td>Accountable Officer,</td>
<td>✓</td>
<td></td>
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<tr>
<td>Jane Anthony</td>
<td>South Yorkshire and Bassetlaw STP</td>
<td>Corp Admin, Exec PA, Business Mgr</td>
<td>✓</td>
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</tr>
<tr>
<td>Janette Watkins</td>
<td>Working Together Partnership Vanguard</td>
<td>Director</td>
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<td></td>
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<tr>
<td>Jeremy Cook</td>
<td>South Yorkshire and Bassetlaw STP</td>
<td>Interim Director of Finance</td>
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<td></td>
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</tr>
<tr>
<td>John Mothersole</td>
<td>Sheffield City Council</td>
<td>Chief Executive</td>
<td>✓</td>
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</tr>
<tr>
<td>John Somers</td>
<td>Sheffield Children’s Hospital NHS Foundation Trust</td>
<td>Chief Executive</td>
<td>✓</td>
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<tr>
<td>Julia Burrows</td>
<td>Barnsley Council</td>
<td>Director of Public Health</td>
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<tr>
<td>Julia Newton</td>
<td>Sheffield Clinical</td>
<td>Chief Finance Officer</td>
<td>✓</td>
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</tbody>
</table>
Welcome and introductions

The Chair welcomed members and noted apologies for absence.

The Chair reminded members that the Collaborative Partnership Board meeting is for Chief Executives or Accountable Officers to attend in person as representatives of their respective organisations. As SYB STP moves forward, its governance will be increased to...
ensure accountability and Chief Executives and Accountable Officers will be expected to attend rather than sending a deputy.

### 59/17 Minutes of the previous meeting held 12 May 2017

The following amendment was required at 49/17 (delete last two paragraphs and insert:

The Chair advised members that the Cancer Alliance Board agreed a shared inter provider transfer (IPT) policy at the May Cancer Alliance Board meeting and has advised the Collaborative Partnership Board at this meeting that the policy had been signed off and was ready to be sent out to partners. After discussion members agreed that the Clinical Reference Group would finalise any outstanding clinical issues within 6 weeks, which will need to be agreed to ensure we are able to successfully operationalise the policy.

Add Richard Jenkins to the list of those present.

Subject to the above amendments the minutes of the meeting were accepted as a true and accurate record and would be published.

### JA

### 60/17 Matters arising

All matters arising would be picked up as part of the agenda.

### 61/17 National Update

The Chair noted the position emerging from the national election this morning.

The Chair added that there would likely be a clear message for STPs coming out of the annual conference next week. At a local level he felt that partners were in a strong position to continue with plans.

Members made the following comments:

- Within the current political climate there are numerous scenarios that could emerge. It is right that we carry on as planned.
- Partners needed to consider risk over the next period.
- Doing nothing is not an option and therefore we should continue our direction of travel.
- The vision of agencies working together in a coherent way cannot be disputed.

Members agreed that SYB STP should continue to progress our plans and work together as an Accountable Care System (ACS). The Chair added we believe that with careful design we can plan our way ahead for communities and patients in a sustainable way.

### ALL

### 62/17 SYB MOU

**South Yorkshire and Bassetlaw Memorandum Of Understanding**

Will Cleary-Gray updated members on the progress of the Memorandum of Understanding (MoU). The revised SYB MoU document was not circulated due to comments still coming in from local Boards, Governing Bodies and Councils and with feedback still awaited from one or two partners.
Will Cleary-Gray added that the document has been shared with the Centre and regions and has been received positively. Members were reminded a package of support to take forward the STP ambitions would follow signing of the MOU.

The Chair added that there was a helpful minute from last month’s meeting where Will Cleary-Gray stated ‘The MoU is not a legal contract, nor does it serve to replace the legal framework or responsibilities of our statutory organisations. It is an agreement that sets out the framework within which our partner organisations will come together to establish how we will develop as an Accountable Care System.’.

Will Cleary-Gray agreed to circulate a revised draft next week when all comments had been received.

In order that members had another opportunity to review the draft SYB MOU following changes members agreed that the turnaround of the document should be within 48 hours of it being circulated. To enable the final draft to be circulated to local governance by Friday, 23rd June 2017. Therefore, if any member observed that their feedback was not addressed they had the opportunity to flag this up.

The Collaborative Partnership Board noted the Memorandum of Understanding.

### Finance update

The finance update was considered.

Will Cleary-Gray requested members to provide any written comments they may have regarding the finance update direct to Jeremy Cook and he would duly respond and address them.

### Development of a Single Accountability Framework

Alison Knowles, Locality Director, NHS England presented the paper which set out how South Yorkshire & Bassetlaw could work with the regional and national teams in NHS England and NHS Improvement to shape a new regulatory relationship and establish a Single Accountable Framework.

Alison Knowles highlighted the proposed ways of working and the outline structure for the Single Accountability Framework that was identified in the paper. Members were also informed that the MOU commits to having such a framework in shadow form from October 2017 and this would require agreement from the Collaborative Partnership Board in September 2017.

Alison Knowles invited comments and welcomed volunteers to join the working group.

Alison Knowles responded to members comments as follows:

- Care Quality Commission (CQC) is not involved at the moment but we need them to be drawn into this as they are aligned nationally.
- There are national teams progressing this work and we are able to help shape national thinking.
Aiming to be innovative regarding clinical engagement, looking to engage clinicians and also patients into this framework.

Members made the additional comments:
- The scorecard core targets for all England should blend with local targets.
- Wider consideration should be given to the targets (e.g. not just hospitals).
- We have an opportunity to be innovative and organise our architecture to change and not just use our existing frameworks.
- Recognise we are responsible for our own organisations and that there is scope to support each other.
- The system should have ownership of any health differentials, there should be no health inequalities across the system.

After discussion, members endorsed:
- the proposed way forward,
- the establishment of a short-life working group to draw up the framework, with representatives drawn from the STP executive, STP cancer, urgent and emergency care and mental health programme plus one place, NHS England and NHS Improvement (local and national)
- Alison Knowles to Chair the group with support from Andrew Morgan and their respective teams.

Greg Fell and Richard Jenkins volunteered their help to Alison Knowles regarding the Single Accountability Framework.

The Chair thanked Alison Knowles and looked forward to the Single Accountability Framework coming back to a future Collaborative Partnership Board meeting.

65/17 Summary update to the Collaborative Partnership Board

Lesley Smith informed members that the identified Accountable Care Systems have been asked to get involved at a national level in establishing a set of priorities. As a result of this request SYB STP is leading on a number of areas e.g. urgent care and primary care. As a result SYB STP will get access to additional support regarding oversight and assurance.

Will Cleary-Gray updated members as follows:
- Sharon Kemp from RMBC has had a conversation with Will Cleary-Gray about having a regular item on the Collaborative Partnership Board agenda for discussion and feedback that reflects the full breadth of Local Authority and partners’ work. Sharon Kemp will be bringing back a proposal for members’ consideration on how this might look.

- NHS England is aligning staff to aid delivery in key areas. SYB STP has received additional support from NHS England regarding finance and engagement. The programme is looking to gain additional support in other areas e.g. for the single accountable framework, planning and programme
management. Alignment of staff is taking place at pace and this is very helpful to SYB STP.

- NHS England has given full assurance on Children’s Non Specialised Surgery and Anaesthesia and this project will progress to Joint Committee of Clinical Commissioning Groups (JCCC) at the end of June for endorsement. The Hyper Acute Stroke (HASU) and needs more work and therefore will not proceed to JCCC in June. Our challenge is to work through in a mature way to find a solution. Will Cleary-Gray added that the earliest a decision on HASU could be reached in early autumn.

- Due to pre-election period guidance the work for the Hospital Services Review (HSR) has been delayed. However this can now be progressed and some key appointments have been made to support this work:
  - Chris Welsh has been appointed as the independent review director and clinical lead.
  - Sir Jonathan Michael is engaged to provide peer support to Chris Welsh and review team.
  - Alexandra Norrish is engaged as the Programme Director and will phasing in work in June and full time in August.
  - SYB STP is about to appointment a consultancy to support the work.
  - All elements of the Hospital Services Review will be in place shortly.

Helen Stevens informed members that communications for the HSR review is in hand. She is working on the HSR Communications Plan which is just one element of the STP. Helen Stevens reminded colleagues of the importance of the work happening in local communities and that all communications would reflect the whole picture.

The Chair added that the HSR launch will be in 4-6 weeks’ time and we will utilise this time to ensure everything is clear and is in place.

The Chair invited Louise Barnett to give members a verbal update of the Urgent and Emergency Care Workstream.

Her update items included:
  - performance and the STP agenda;
  - a prevention stream being in place to help people stay healthy at home;
  - mapping what is happening in the system;
  - a show and tell to better understand ‘place’;
  - Crystallising the workstream to ensure there is no duplication;
  - A recent workstream visit to the 111 and 999 service and discussion regarding the 111 contract.

The Chair thanked Louise Barnett for her update.
The Chair invited Richard Jenkins and Idris Griffiths to give members a verbal update of the Elective and Diagnostic Services.

Richard Jenkins and Idris Griffiths update items included:

- The existing Radiology and Pathology outpatients and looking at organisations and their different approaches across the patch. This is an opportunity to share best practice and in June organisations will come together at an event to communicate strategies and technologies regarding delivery. The event is scheduled for 30th June at the New York Stadium in Rotherham and will include patients and the public.
- Another area the group is looking at is endoscopy.
- The workstream will be reviewing the NHS England Elective Care Delivery Plan.

The Chair thanked Richard Jenkins and Idris Griffiths for their update.

Lesley Smith added that as part of the National Accountable Care System Development programme there are currently 3 ACSs participating in the Population Health Management which is a huge theme and has lots of different elements. Lesley Smith stated a small team may be required to engage in this on behalf of SYB STP and requested members to flag up with her who they feel should be approached to be in the team.

The Collaborative Partnership Board received the report and welcomed the written and verbal updates provided from each of the STP workstreams and they would use these to inform local discussions.

### 66/17 Health Inequalities

The Chair welcomed Greg Fell, Sheffield City Council Director of Public Health to give his report on Health Inequalities to the meeting.

Greg Fell informed members that the report was written with co-authors Ian Cameron and Steve Pintus. The paper summarised the output of a DPH/PHE sponsored workshop on health inequalities and the role of STP in addressing this.

Greg Fell picked out the three key points from the workshop being:

- Health inequalities are not a public health issue, they are a system issue.
- We must have real genuine prioritisation of primary care.
- Agree and enact a principle of a disproportionate offer and resourcing.

The presentations accompanying the report will be circulated after this meeting.

Gregg Fell added:

- If we continue as we have always done we will not make much progress to address health inequalities.
- GP funding is fairly equal in £ per head but this formula does not reflect need.
- There are social complexities to consider.
- There is evidence that health inequalities can be addressed through primary care.

The Chair noted that a pocket of work relating to the stratification of health care to enable aspirations to be delivered was required and we should work through this as a system. Therefore, we should schedule in discussions and invest time for this subject.

Collaborative Partnership Board members thanked Greg Fell for attending this meeting and presenting this report.

67/17  **SCR/STP Health Led IPS Employment Service**

Kevan Taylor informed the Collaborative Partnership Board that Sheffield City Region (SCR) Health-Led Employment Trial and Collaborative Health Partnership is a potential significant investment to obtain jobs. Employment is one of the key determinants of health. Part of this subject is how we form relationships with ourselves and with Local Authorities.

The Chair welcomed Andrea Fitzgerald, Senior Programme Manager Employment, Sheffield City Region, and Fiona Goudie, Clinical Director - Strategic Partnerships Sheffield Health & Social Care NHS Foundation Trust to the meeting to give their presentation on this subject.

At this point that the meeting had a short 10 minute recess due to the building being evacuated for an unexpected fire drill.

The meeting resumed and Andrea Fitzgerald and Fiona Goudie continued their presentation.

Kevan Taylor informed the Collaborative Partnership Board that the project is using Sheffield CCG infrastructure regarding procurement. Additional support is required from GP practices and he will obtain this outside this meeting.

The Chair confirmed he will be happy to meet with Kevan Taylor and the combined authorities will have direct discussions regarding this initiative.

Helen Stevens offered her help and assistance to Andrea Fitzgerald and Fiona Goudie regarding the communications mechanism into this programme.

The Chair thanked Andrea Fitzgerald and Fiona Goudie for attendance and presentation at this meeting.

68/17  **Any Other Business**

There was no other business brought before the meeting.
<table>
<thead>
<tr>
<th>69/17</th>
<th>Date and Time of Next Meeting</th>
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<tbody>
<tr>
<td></td>
<td>The next meeting will take place on 14th July 2017 at 9.30am to 11.30am.</td>
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</tbody>
</table>
## Background / Key Points / Outcome

In 2016 Health and Social Care organisations across Doncaster developed the Doncaster Place Plan. The joint vision was that:

> Care and support will be tailored to community strengths to help Doncaster residents maximise their independence, health and wellbeing. Doncaster residents will have access to excellent community and hospital based services when needed.

The Doncaster Place Plan was approved by NHS Doncaster CCG Governing Body in October 2016 and the Board of Directors at RDaSH also received a presentation on the Place Plan at that time.

In January 2017 Health & Social Care partners appointed Ernst & Young as a strategic partner to facilitate implementation of the Place Plan. The attached report is the phase 1 assessment of the Health and Social Care partnerships ability to implement the Place Plan. It includes an assessment of readiness state across 6 key areas, and describes the key areas of focus for Phase 2 of implementation.

The key summary areas from the review are included in the attached chart.

The report attached aims to:

- Set out where Doncaster is in terms of its readiness for the next phase of delivery
- Set out practical steps and key considerations for phase 1 and Phase 2 and the journey to accountable care
- Set out the approach to the phase 2 work
- Technical skills required through the journey to accountable care
- Focus for the next seven weeks and an outline plan for the future

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### Board of Directors

<table>
<thead>
<tr>
<th>Agenda Item</th>
<th>Date</th>
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<tr>
<td>G</td>
<td>27 July 2017</td>
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<table>
<thead>
<tr>
<th>Title of Paper</th>
<th>Action Required</th>
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<tbody>
<tr>
<td>Doncaster Place Plan – Implementation Update</td>
<td>Decision</td>
</tr>
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<table>
<thead>
<tr>
<th>Prepared by</th>
<th>Presented by</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ernst &amp; Young (Doncaster Place Plan Strategic Partner)</td>
<td>Anthony Fitzgerald, Chief of strategy and Deliver, NHS Doncaster CCG and Jo McDonough, Doncaster Care Group Director</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Delivery against</th>
<th>Financial/Budget</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strategic Goal(s)</td>
<td>Page 17 of the report refers to the Financial implications</td>
</tr>
<tr>
<td>Strategic Risk(s)</td>
<td>There are references within the report to improved equality of access to services</td>
</tr>
<tr>
<td>CQC Domain</td>
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</table>

### Doncaster CCG Governing Body Board meeting 15 June 2017
There will be a presentation of the report and its main conclusions at the meeting led by Anthony Fitzgerald, Chief of Strategy and Delivery, NHS Doncaster CCG in conjunction with Jo McDonough, RDaSH Doncaster Care Group Director.

The Board of Directors is asked to note the phase 1 state of assessment and the recommendations and work programme for phase 2 of implementation.
What did we find in Phase 1?
The assessment focused on some key areas that we believe are the 'get it rights' for taking this forward

<table>
<thead>
<tr>
<th>What do we need to get right?</th>
<th>What are we doing well?</th>
<th>What do we need to focus on?</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Leadership</td>
<td>• There is strong commitment to the proposals and an eagerness to progress</td>
<td>• Strengthened system leadership is needed and a clearer understanding of Doncaster’s role within South Yorkshire &amp; Bassetlaw</td>
</tr>
<tr>
<td>2. Culture</td>
<td>• There is a culture of honesty and transparency</td>
<td>• There is a need to develop a common language and continue to build understanding and trust</td>
</tr>
<tr>
<td>3. Governance</td>
<td>• There has been strong engagement with regards to governance processes</td>
<td>• Strengthened processes are required to drive the programme forward effectively</td>
</tr>
<tr>
<td>4. Services</td>
<td>• There is a clear direction of travel and view on what should be included</td>
<td>• Benefit and working frameworks need agreement</td>
</tr>
<tr>
<td>5. Finance</td>
<td>• Strong relationships and a willingness to share information in a transparent way</td>
<td>• There is a need to devise a collaborative approach on group accounting</td>
</tr>
<tr>
<td>6. Operational and Commercial</td>
<td>• There is good alignment of plans and ambitions</td>
<td>• There is a need to form a collaborative approach and refinement of focus</td>
</tr>
</tbody>
</table>

What are we doing now?

- **Setting up a programme approach:** to develop a project management office meaning better coordination, transparent reporting and more streamlined robust governance to support rapid decision making.
- **Energising and evidencing the Case for integration:** by ensuring the benefits for the local health and social care economy for each change are clearly described and aligned to neighbourhood needs.
- **Working out some of the technical arrangements to deliver new services:** developing the appropriate operating model for the integrated services in 6 defined areas of opportunity (for example the type of contract we need).
- **Planning our approach to leadership development:** developing programme to support system leaders who work closer together
- **Looking at how best to communicate & engage:** to develop a collective voice and make sure the answers are coproduced
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1. Executive Summary

1. Executive Summary
2. Introduction & Context
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## Executive Summary

### Context and Purpose:
The Doncaster Health and Social Care Economy has significant challenges with regards to its local population in terms of social economics, life expectancy and growing financial pressures on the system. System leaders within Doncaster have recognised the need to modernise and improve services for residents through greater integration via a place based accountable care system.

### Headline Assessment:

<table>
<thead>
<tr>
<th>Leadership</th>
<th>All leaders demonstrate commitment to the direction of travel</th>
<th>Further progress needed on leadership across the system and individuals</th>
</tr>
</thead>
<tbody>
<tr>
<td>Commercial</td>
<td>Commissioners are engaged with new go to market specifications</td>
<td>Refinement of how and what will be done</td>
</tr>
<tr>
<td>Finance</td>
<td>Joint forums have been held and a shared vision is being developed</td>
<td>Defining the financial envelope and practicalities of group accounting</td>
</tr>
<tr>
<td>Programme architecture</td>
<td>The need for strong Programme management is understood</td>
<td>Programme set up and mobilisation</td>
</tr>
<tr>
<td>Case for Implementation</td>
<td>A case for Implementation has been developed, particularly for intermediate care</td>
<td>This needs to be further developed, especially outside of intermediate care and complex lives</td>
</tr>
<tr>
<td>Finance</td>
<td>Shared understanding of the collective financial problem</td>
<td>Better understanding of the scale of the future scope</td>
</tr>
<tr>
<td>Neighbourhoods</td>
<td>It has been agreed a Neighbourhood model would be the start of the journey to Accountable Care</td>
<td>Defining the scope and models</td>
</tr>
<tr>
<td>Communications and Engagement</td>
<td>It is understood their exists a need for a uniform and transparent communications and engagement strategy</td>
<td>Defining the methods and mobilising a joint team</td>
</tr>
</tbody>
</table>

### Approach:
The Cohorts have been devolved into 17 area’s of opportunity which have been aggregated up to a tiered approach. The 3 tiers are;

**Strategic** - which will drive the design of the Neighbourhood Model, taking a system wide approach. **Operational** - where an integrated approach will complement the design and inform the development of the Neighbourhood Model (5 high priority immediate areas have been agreed; Intermediate Care, Complex Lives, Starting Well, Starting Well, Children – Edge of Care)

### Functional -
Quick wins; which will progress & facilitate closer working relationships, streamline processes, patient & financial benefits which aid in culture change.

### Five key workstreams for phase 2:
The five workstreams for phase 2 are: (These are explored further within this report) **1. Programme Set Up** 2. Case for Implementation & service model. 3. Operating framework 4. Leadership Development 5. Communications and Engagement.
2. Introduction & Context

1. Executive Summary
2. Introduction & Context
3. Current State Assessment
4. Good Practice Examples
5. Programme Scope/Operating Framework
6. Workstreams
7. Implementation Planning
Introduction & Context

Introduction

Doncaster is one of the 20% most deprived areas in England. c. 24% (13,300) of children live in low income families. Life expectancy for both men and women is lower than the England average and the health of people in Doncaster is generally worse than the England average. The Monitor BCF 2014 cost model, applied to the current spend profile across age groups, coupled with the impact of population growth means Doncaster will need to find an additional £61m to meet the needs of the population by 2018 unless action is taken.

What is the ambition for health and care services in Doncaster?

Even without the imminent demographic and financial challenge, system leaders have recognised the need to modernise and improve services for residents. Over the summer of 2016, leaders set out a vision for health and care that drives:

- Improved health and wellbeing outcomes
- A focus on prevention
- A better experience of care
- Better value for money by optimising the what we do and the way we work

How will it be different and better?

Doncaster spends over £500m annually on health and social care services. Changing the system perspective to view this as the Doncaster £, sets the context for the challenge we are trying to address through this work.

How can we most effectively spend our collective resources to improve outcomes for the local population?

This question formed the basis for the development of the Doncaster Place plan – an approach that has been developed jointly and approved through each participating bodies governance process.

It sets out a set of proposed changes to the system that will, if progressed effectively have a profound impact on how all stakeholders experience the system.

Residents: Will have a more seamless experience of care, will be able to access care closer to home, will be supported to understand, maximise and grow their strengths and assets in relation to improving outcomes and will be more informed, involved and responsible for their health and wellbeing.

Workforce: Will have more opportunities to work across organisational boundaries, creating new and exciting career paths, spending increased time with the people they are supporting, engaging more in designing the services they deliver and are supported to innovate and collaborate.

Providers: Are supported to collaborate to drive improved outcomes, can have a more open conversation with commissioners regarding viability, are more engaged in the development and deliver of new services and are party to the development of the commercial strategies that will govern new contracting arrangements to ensure flexibility is inbuilt.

Commissioners: Are able to engage with providers in a more streamlined governance arrangement that supports system commissioning. Simplified commissioning processes and increase market management capability. An opportunity to evolve insight and intelligence capability.
Introduction & Context

Context for this report

Doncaster’s place plan set out an ambitious plan for making the change described.

Considerable work and commitment has been shown by all involved to get to this point. The jointly approved plan sets the direction for all involved and as well as addressing local priorities is in line with national drivers such as the Five Year Forward View Update.

Achievements of note:

► The establishment of three cohorts to focus on:
  - Early intervention and prevention
  - Intermediate Health and Social Health
  - Enablement and Recovery

Since the development of the place plan South Yorkshire and Bassetlaw STP has been identified as an exemplar. This provides Doncaster with a unique opportunity to build on its progressive place plan work to really define the local way of working and be a leading light within the STP footprint for accountable care locally delivered.

Community Led Support

Community Led Support is focused on implementing a fundamental change to the customer journey, building community capacity and resilience, early intervention and prevention work, introducing a three conversation model for customer contact, reshaping the front door, developing community hubs and supporting reconfiguration of a number of teams and culture change in social care staff.

Doncaster has already embarked on the development of a community led support model through raising awareness of a community led approach, starting to redesign the front door, the development of the 3 different “conversations” and the creation of innovation sites and community hubs aimed at diverting people away from social care and towards community based support mechanisms.

The Team Doncaster Partnership board oversees four thematic partnerships that direct activity to where it is needed the most. Each theme board is responsible for delivering a section of the Borough Strategy - a key document that sets out an aspirational vision for improvements to the quality of life for Doncaster’s residents.
EY has been commissioned as the Doncaster Place Plan strategic partner. As part of the initiation of this relationship, this report sets out a maturity assessment that identified the key strengths and areas of focus for the local economy to achieve its ambition. The key findings are summarised below;

### Purpose of this report

The health and care economy jointly specified and commissioned EY as their strategic partner to achieve three key ambitions:

1. To test readiness
2. To develop a practical plan to move forward
3. To provide technical skills as required through the journey

---

**Scope and Navigation**

The scope of this report is to provide maturity assessment, a scope and approach for phase 2 of Doncaster’s place plan implementation. This includes a proposed programme scope, architecture and outline workplan. It also sets out the key activities required in the next seven weeks to progress mobilising the programme at pace and generate further buy in from the range of stakeholders engaged in the process.

This document is not intended to be a case for change/case for action for the programme. It is a management product to initiate further activity and convene a greater level of focus and rigour to drive forward the ambitions set out by all partners.

### Timeline of this work

This report has been in development between February and April 2017.

### Approach:

- Data collection and validation
- Define initial list of areas for opportunity
- Opportunity scoping
- Challenges sessions with task and finish group
- Prioritisation
- Review maturity assessment recommendations
- Design programme scope
- Define additional mobilisation activity
- Test phase 2 approach with HSC transformation group
- Consolidate phase 2 scope and approach report
Report Navigation:

The scope of this report is to provide a current state assessment and to set out the detailed scope or approach for phase 2.

**Section 3. Current state assessment:** This section sets out the current baseline and assess the readiness for change.

**Section 4. Good practice examples:** This section sets out national examples of health and social care integration.

**Section 5. Programme scope:** This section sets out a logic flow of choices the programme will need to navigate across services, commissioning approach and contracting models.

**Section 6. Work streams:** This section sets out the workstreams within the programme that will enable the system to deliver.

**Section 7. Implementation plan:** This section sets out the high level route map for the programme over the next 9 months.
3. Current State Assessment

1. Executive Summary
2. Introduction & Context
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4. Good Practice Examples
5. Programme Scope/Operating Framework
6. Workstreams
7. Implementation Planning
Introduction and analysis of case for Implementation

Introduction

Doncaster is seeking to engage in a change programme of a significant size and complexity - and one which is vital to get right for its residents. There are a key set of success factors which a programme such as this needs to consider to increase the chance of success.

Case for Implementation analysis

<table>
<thead>
<tr>
<th>What is currently not working? What needs to change?</th>
<th>What is the Doncaster ambition?</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Population Segmentation &amp; Needs</strong></td>
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</tr>
<tr>
<td>There has been recognition, both locally and nationally, that there is not a “one-size fits all” approach that can cater for the needs of the population. Currently in Doncaster, there is a fragmented approach to delivering health and social services, which is leading to a care and quality gap across Doncaster. As a result, health is not improving as quickly as the rest of the UK, with significantly reduced life expectancy in the most deprived areas of Doncaster.</td>
<td>To improve the health and wellbeing and quality of care of Doncaster residents, a cohort model has been adopted with the aim of creating community resilience and maximising existing strengths. This will enable residents to stay at home and will also aid in the re-ablement of patients coming out of hospital. In addition to the three cohorts, Doncaster has been split into four neighbourhoods in order to tailor services in each of the geographic areas. This will allow the adoption of a universal and universal plus care model – the majority of services within each neighbourhood will be the same, with some services focussed locally where appropriate.</td>
</tr>
<tr>
<td><strong>Finance</strong></td>
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<tr>
<td>With the increasing cost of provision of care and constrained public resources there is an expected financial gap of £139.5m by 2021. There is currently no pooling of budgets, so services are often commissioned by the CCG or council without an understanding of what the other commissioner is doing. This is leading to duplication of effort and ineffective use of the money available in Doncaster.</td>
<td>The place plan has been developed to help close ~£60m of the expected financial gap. This will require initial investment to implement changes within the neighbourhoods, but once the services and ways of working are running there should be a significant reduction in hospital admission and length of stay through a focus on prevention and re-ablement.</td>
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</table>
## Overview of the Case for Implementation

<table>
<thead>
<tr>
<th>What is currently not working? What needs to change?</th>
<th>What is the Doncaster ambition?</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>National Direction of Travel</strong></td>
<td>The NHS has developed STPs to address the problem of increasing demand and reduced budget. In line with the national direction of travel Doncaster has signed up to the South Yorkshire &amp; Bassetlaw sustainability and transformation partnership. This partnership supplements rather than replaces the accountabilities of individual organisations. Doncaster has been selected as an exemplar so must ensure the place plan aligns with the wider STP and demonstrates the benefits of integrated care. There also needs to be consideration of how the STP boards will be formed with senior leaders from across health economies.</td>
</tr>
<tr>
<td>The NHS is struggling to respond to rising demand for its services and its senior leaders are increasingly concerned about service provision. The King’s Fund Quarterly Review published in March reported that 63% of trust finance directors and 56% of CCG finance directors believe that care in their local area has deteriorated over the past year.</td>
<td></td>
</tr>
<tr>
<td><strong>Current Issues in Baseline</strong></td>
<td>Through several discussions with providers and commissioners there appears to be a shared vision to improve the service provided to Doncaster residents. The six building blocks are discussed in this report and linked to the strengths and Area of focus for both commissioners and providers.</td>
</tr>
<tr>
<td>This report looks at six of the building blocks required to implement the place plan. These include: leadership, culture, governance, services, finance and operational &amp; commercial environment.</td>
<td></td>
</tr>
<tr>
<td><strong>Sustainability</strong></td>
<td>The vision for sustainable and effective integrated care is shared across Doncaster and the wider STP – the implementation of this vision must now be agreed by partners.</td>
</tr>
<tr>
<td>If Doncaster continues along the current path there will be a large financial gap and workforce shortage leading to unsustainable provision of services. It’s vital that Doncaster and the wider partnership find new ways of working that make better use of the money available and develop plans to create future leaders.</td>
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Leadership - Headlines

**Definition**

Leadership describes both leadership of the individual organisations involved in the Doncaster Place Plan and also System Leadership. System Leadership describes the leadership over all the organisations and individuals within the Doncaster Place Plan. Leadership includes setting a clear vision, sharing that convincingly, delivering against it and managing conflicting interests.

**Doncaster Strengths**

- Demonstrating commitment in the room to moving forward together
- Demonstrating positive working relationships in shared forums
- Formation of the GP Federation
- Keenness to engage with staff and residents but need narrative to support

**Doncaster Area of Focus**

- How to operate as system leaders to progress detailed work
- Connectivity with levels within organisations on this agenda
- Clarifying role within STP and each other roles within the place plan

**Leading Practice Pointers**

- Clear & Consistent leadership at both organisational and system level recognised by all involved
- SRO in place with recognised authority
- Clear links back to each statutory organisation’s board/decision-making structures
- Clarity on STP inter-dependencies

**Evidence**

- A System Leadership Maturity Framework was developed, based on the main stages of effective partnerships (preparing, partnering, delivering and learning) as well as integrating aspects of the ‘Stepping up to the Place’ assessment. This was used as the basis for interviews with key stakeholders.
- All leaders are in slightly different places, despite some clear strengths in a shared commitment, with a marked difference between providers and commissioners.
- Commissioning – there is currently some joint commissioning through the Better Care Fund and a strong shared vision.
- Providers - each organisations leadership team’s lead their own organisation and workforce.
- System leadership – there is currently limited system leadership in place.
- More detailed information is found at appendix I.
Culture - Headlines

**Definition**
Culture describes the customs, beliefs and behaviours across those individuals and organisations delivering the Doncaster Place Plan. It includes the language, trust and ways of working together.

**Doncaster Strengths**
- Level of honesty that has developed over past three months on readiness and understanding
- Senior leaders spend lots of time talking and working together

**Leading Practice Pointers**
- Blended culture where both commissioners (local authority & CCG) speak similar language and respect each others distinct & complementary roles
- Similar mature relationships amongst providers based on mutual respect between all parties and understanding of the unique strengths of each to the system

**Doncaster Area of Focus**
- Developing a Common Language
- Need to engage frontlines further to be part of the design
- Find barriers
- Conversation and action not always linked

**Evidence**
- The leadership readiness assessment, along with observations during phase 1 showed that there were some differences in culture across and among providers and commissioners.
- Examples of mismatches with language include understanding of models such as ACP.
- There are also differing levels of tolerance of risk, although these have yet to be fully tested.
- Some stakeholders are more ready to engage in the process than others. For example, commissioners tend to be more aligned with each other than providers. There is a particular issue with GPs being able to fully engage in the process, given that the Federation is emerging as an organisation. A shared understanding of the role of the Acute trust in out of hospital care is a problem. As is the potential conflict for the Children’s Trust in terms of their position of being commissioned by the Secretary of State for Education directly.
Governance - Headlines

**Definition**

Governance refers to both the Governance of the final state of the Doncaster Place Plan (e.g. the services which will be commissioned) and also the Governance to get there - i.e. the programme to deliver this.

**Doncaster Strengths**

- Leaders are relatively engaged in governance processes
- Keenness to participate in strategic decision making and place shaping

**Leading Practice Pointers**

- Clear governance which promotes timely and considered decision making at all levels: system, organisational, project
- Clarity on migration required from plan development to service delivery phases
- Delegated authority to joint arrangement which support integrated action with a clear scope and terms of reference

**Doncaster Area of Focus**

- Relationships between individual bodies, collective decision making, HWWB board
- Ownership is unclear
- Missing the ‘engine’ - require a more detailed programme plan that is actively managed to make this happen

**Evidence**

- Despite engaged and extensive governance arrangements the routes to decision making are unclear with those arrangements which are advisory vs decision making unclear.
- Senior leaders are spending significant time on governance arrangements, however this does not translate into on the ground action to move the place plan forward. For example, there is a lack of effective programme management to drive decisions through to action.
- Further information in found at appendix II.
Services - Headlines

<table>
<thead>
<tr>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>The services describe what will be done (and how that will be different to what is currently available in Doncaster). These are built on the opportunities for Doncaster and relate back to the Cohorts described in the Doncaster Place Plan.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Doncaster Strengths</th>
</tr>
</thead>
<tbody>
<tr>
<td>✅ Begun to identify the areas of opportunity that have buy in across commissioners and providers</td>
</tr>
<tr>
<td>✅ Aligned neighbourhoods but not using them</td>
</tr>
<tr>
<td>✅ Aligned view on the focus on prevention and EI</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Leading Practice Pointers</th>
</tr>
</thead>
<tbody>
<tr>
<td>✅ Services clearly defined and linked to populations and their needs</td>
</tr>
<tr>
<td>✅ Service scope and specifications which drive an outcome focused approach and system commissioning</td>
</tr>
<tr>
<td>✅ Integrated pathways</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Doncaster Area of Focus</th>
</tr>
</thead>
<tbody>
<tr>
<td>✅ Not always clear on the cohorts ambition and definition</td>
</tr>
<tr>
<td>✅ Require some structuring and prioritisation of activity</td>
</tr>
<tr>
<td>✅ Lack of clarity on the scope of the place plan</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Evidence</th>
</tr>
</thead>
<tbody>
<tr>
<td>✅ There is some agreement regarding the key areas of opportunity. However it has not been possible to get data from the council on some of these areas, which will need to be addressed before moving forward with the next phase of work.</td>
</tr>
<tr>
<td>✅ The link between cohorts and services is not clear with some difficulty in fully defining cohorts at this stage.</td>
</tr>
<tr>
<td>✅ Further information on defining the cohorts and areas of opportunities can be found in the phase 2 report.</td>
</tr>
</tbody>
</table>
## Finance - Headlines

<table>
<thead>
<tr>
<th>Definition</th>
<th>Leading Practice Pointers</th>
</tr>
</thead>
</table>
| The financial quantum which commissioners will commit to the Doncaster Place Plan (which may be phased over several years) and the financial mechanisms by which this will be shared and governed. | ð‘ Collective and individual financial positions understood and respected  
ð‘ Range of mechanisms for financing integrated services understood and employed  
ð‘ Group accounts used to track collective action  
ð‘ Risk sharing supporting a common financial strategy |

<table>
<thead>
<tr>
<th>Doncaster Strengths</th>
<th>Doncaster Area of Focus</th>
</tr>
</thead>
</table>
| ð‘ Good relationships – built on trust and transparency e.g. BCF  
ð‘ Shared understanding of the collective financial problem and “conflict” caused  
ð‘ Information sharing  
ð‘ Established transformation plans within organisations with solid evidence base | ð‘ No Group approach to accounting  
ð‘ Lack of sense of scale of investment required  
ð‘ Availability of information  
ð‘ Measurement of impact and benefits tracking needs to be stronger to show the progress |

## Evidence

| ð‘ There is a lack of transparency across stakeholders regarding their shared financial position – although all have agreed the shared approach.  
ð‘ Commissioners, due to their existing relationships around joint commissioning are more open to sharing financial information with each other, but there have been difficulties in getting information from the council (thought to be due to process rather than intent). Providers are more distrustful of an open book approach and have not always seen a compelling case for why they should do this.  
ð‘ There is an issue with the sovereignty of GPs as independent businesses – while GPs are more likely to speak as one when planning future services, the separate approaches are more evident when the finances are being discussed. |
## Operational & Commercial Environment - Headlines

### Definition
The market, workforce and commissioning environment which will support the Doncaster Place Plan.

### Leading Practice Pointers
- Operational & commercial environment understood and shaped as appropriate
- Workforce plan which supports and promotes new roles and skills
- Consideration of new ways of working for operational managers

### Doncaster Strengths
- Recognition that the form needs to be around something that works
- Relative alignment on plans for integrated commissioning
- Understand that we need to define where we focus efforts and when

### Doncaster Area of focus
- Principles to agree risk/benefit share prior to joint working
- Some fundamental misunderstandings about the principles
- Confusion on the proposed provider ‘form’ Lack of discussions on form have resulted in confusion
- Ability of the Children’s Trust to join a new form
- Ability of GPs to speak as one

### Evidence
- Transformation plans – there are a range of transformation plans & programmes across all commissioner and provider organisations. Some of these are in line with the Place Plan but most are about efficiencies or improving the current state, rather than being truly transformational. This potentially adds up to a lot of change, which needs to be better managed.
- Workforce – the total workforce likely to be impacted by this change is somewhere in the region of 8,500 WTE, although it is impossible to make a full assessment at this stage due to lack of detail around scope of future services - see appendix IV for more details.
The Stakeholder Landscape

Introduction

The effective delivery of the Place Plan will be highly dependent on the successful interaction of a wide range of stakeholders form the public, private, voluntary and community sectors.

This section looks specifically at the strategic stakeholder environment for the Place Plan, providing an introduction to the key strategic level partners involved, and specific stakeholder interests, priorities and current pressures.

The implementation of the Place Plan will need to operate flexibly within this context, adding value and taking full account of the issues and incentives all partners bring to the table.

There is already a relatively complex change environment in play both overall across the Borough and within individual partners organisations.

This is laced with ambition and a strong shared sense of the need for Doncaster to continue its economic and public service recovery by working together in partnership.

An outline of existing transformational plans and the details is highlighted in this section.

Key Questions and Next Steps

As we enter the next stage of focus on specific opportunity areas, we will need to establish if the current plans for each stakeholder align with this.

We need to ensure that the current transformation plans and programmes do not duplicate or double count potential benefits.

We need to clearly audit the current plans to ensure that we understand the co-dependencies and inter-relationships.
The Team Doncaster Strategic Partnership has agreed the framework of a four year reform programme called Doncaster Growing Together.

This is focused on achieving economic and social growth, and developing a laser like focus on a relatively small number of key reform priorities and new partnership delivery models.

These reforms are grouped into four broad policy priority areas:-
- Caring
- Working
- Learning
- Living

The Place Plan focus on integration of Health and Social Care is the delivery process for the ‘Doncaster Caring’ policy priority.

The Place Plan will also benefit from and contribute to reforms in the other three policy priority areas.

Work is currently under way to define the detail of the specific reforms across the policy priority areas.

There is close coordination and tracking to ensure that this fully incorporates and aligns with the emerging focus of the Place Plan.
Stakeholder Analysis

NHS Doncaster Clinical Commissioning Group

△ Purpose: The CCG is the strategic commissioning body for Health Care in Doncaster. It has a commissioning budget of just under £500m.

△ Current/planned reforms: The CCG currently have 11 delivery plans:

- Planned care, Mental Health, Cancer, Community & End of Life, Children’s Intermediate Care, Urgent Care, Primary Care, Medicines Management, Learning Disability and, Dementia

- Most of the above are planned collectively with the Council.

- These reforms are at differing levels of maturity

Doncaster Metropolitan Borough Council

△ Purpose: DMBC is the Local Authority, providing Democratic political leadership including a directly elected Mayor.

△ The Council both commissions and provides a range of social care services for adults and children – now led collectively by an interim ‘People’ Director. It also commissions supported and specialist housing and manages the ALMO relationship with St Leger Homes and Leisure/healthy lifestyles provision through Doncaster Community Leisure Trust. A range of wider functions also impact on the Place Plan, including housing developments and economic development.

△ The statutory Director of Public Health is part of the DMBC Senior Leadership Team, and Public Health commissioning and development is embedded within the Local Authority.

△ Key strategic priorities/pressures: The key challenge for DMBC is to continue to lead and deliver economic and social progress in light of continued budget constraints. The next four years sees a further £70m budget reduction which will needs to be managed through new delivery models and a shift to prevention and demand reduction and citizen contribution.

△ Current/planned reforms:

- DMBC is leading and engaged in delivery of a range of Strategic reform programmes, covered in Growing Doncaster Together (previous slide)

- This includes a major Adult Health and Well Being Programme and Education and skills and inclusion reforms
Rotherham, Doncaster & South Humber NHS Foundation Trust (RDaSH)

- **Purpose:** RDaSH is the Community Health Provider Trust covering Doncaster as part of a wider footprint

- **Current/planned reforms:**
  
  RDaSH currently have a range of improvement projects which fall into the following headings:
  
  - Transforming Service
  - Corporate Review
  - Estates (over 200 buildings to rationalise)
  - Agile Working (hot desking and electronic devices)
  - Unity (Electronic Records)
  - Information Management

  Each project has a project lead and a report is produced to show project progress monthly. This monthly report is sent to the Senior Leadership Team and then the Board for review.

St Leger Homes Doncaster

**Purpose:**

- SLHD is the Arms Length Management Organisation (ALMO) set up to manage the DMBC Housing stock. It also has the statutory duty for discharging the Homelessness duty.

**Key strategic priorities/pressures:**

- National housing and welfare reform policies are placing social housing under significant pressure. In particular, the rise of homelessness and rough sleeping are major concerns and pressures on resources. St Leger has a key priority to shape and respond to the need for appropriate accommodation to enable frail, elderly and disabled people to remain at home for longer, and to provide suitable accommodation options for vulnerable young people, particularly care leavers.

Fylde Coast Medical Services

**Purpose:**

- FCMS deliver 3 unplanned care services in Doncaster. These are:
  
  - Urgent Care Centre and GP out of hours service
  - Emergency Practitioner Service
  - 12 hour Primary Care Centre
Stakeholder Analysis

Doncaster & Bassetlaw Teaching Hospitals NHS Foundation Trust

- Purpose: DBH is the major acute NHS Trust covering the population of Doncaster

- Key strategic priorities/pressures: The Trust has recently been focussed on turnaround measures and is currently in the process of updating it’s strategic direction.

Current/planned reforms:
- DBH are currently working on updating the strategic direction and the following 4 themes are the current draft proposals:
  - Optimise Elective Capability
  - Maximise capacity for emergency and specialist care
  - Increase self care and community care (prevention)
  - Develop Partnership working

- These are currently emerging themes but appear to be consistent with the goals of the Place Plan.

Doncaster Local Medical Committee/GP Federations

- Purpose:
  - The LMC represents over 40 GP practices across Doncaster. In early 2017, Doncaster developed a GP Federation to cover it’s locality.

Doncaster Children’s Services Trust

- Purpose: DCST was created in 2015 as a result of Government direction in Children’s services in Doncaster. Its services are commissioned by DMBC and the Trust has a line of accountability directly to the Department for Education

- Key strategic priorities/pressures: The Trust’s operational priorities are:
  - Safeguarding the most vulnerable
  - Reducing domestic abuse
  - Supporting children in care and care leavers
  - Reducing child sexual exploitation
  - Making sure people get support when problems start, and before they become really serious (Early Help)

- DCST has an immediate priority to achieve at least a ‘good’ rating in an OFSTED inspection in Autumn
## 4. Good Practice Examples

|----------------------|---------------------------|-----------------------------|--------------------------|---------------------------------------|---------------|---------------------------|

Implementation of the Doncaster Place Plan
Good practice summary

Areas of national practice considered:

Doncaster wants to base its development of the Place Plan on examples of good practice where these exist. These examples have been selected as those which are most relevant to Doncaster’s situation and based on the aspirations of the Health and Care Economy as a whole.

This does not seek to be an exhaustive list of every scheme but does aim to set out some of the key themes Doncaster should be considering based on an emerging evidence base:

- Population health and prevention
- Early intervention at all ages
- Out of hospital care interventions
- Accountable care options

Population Health and Prevention

Greater Manchester Health and Care Partnership launched their ‘Taking charge’ programme. A fundamentally different approach to engaging citizens in improving their health and wellbeing.

The approach focused how to create a positive shift in the whole population of GM health, a slightly different approach to delivering only targeted programmes to those in the ‘poor outcomes’ categories. This was underpinned by the evidence that linked improved health to improved economic prosperity.

This regional approach improving population health is delivered in tandem with local offers focused on more targeted prevention.

The approach had some key elements:

1. Understand ‘What mattered to people’ – using genuine customer insight to understand peoples ambitions and barriers to improving their health
2. Getting people engaged in a conversation about health – raising the profile of its importance
3. Using a number of different media, including staff, which had the knock on impact of triggering broader healthy living conversations with residents
4. Generating insight that challenges perceptions on ‘norms’ and also informed the more considered commissioning and resource allocation of ‘Public Health’ programmes

Further information can be found on the taking charge microsite: https://takingchargetogether.org.uk/

Relevance for Doncaster:

1. Building this type of engagement and insight capability into the new integrated commissioning function
2. Utilising the engagement approach in the design of the neighbourhood model
3. Opportunity to look at improving population health through this approach, with a potential link to Early Intervention and prevention cohort
4. Engaging in a conversation with the STP footprint to identify if the approach to population health could be scaled up
5. Opportunity to und
Good practice summary

Early intervention at all ages

There are a number of models for Early Intervention across the country, varying across age groups. Within this section we will explore:

- Predictive analytics
- Integrated family support
- Support for SEN and LD across the life course
- Assistive technology

Predictive analytics:

Predictive analytics can be used to identifying children, young people and families early before needs escalate. A number of London Boroughs are exploring the use of this capability to support Early Identification and Early Help, through the London Ventures programme. The approach will focus on using data more intelligently to:

- Improve the early identification of children most at risk of maltreatment
- Provide a risk profile of the most vulnerable families
- Ensure the service offer within the complex level of need is focused on those most in need
- Support continuous improvement through redesign and innovation to change how services are delivered
- Support smarter commissioning that is proven to be effective, improving the role of partners to collaboratively build and improve the Early Help offer
- Support the development of demand management strategies and approaches

Relevance for Doncaster

This is about working with partners to share data to proactively identify children with a number of risk factors and where EIEH support could be provided to prevent needs from escalating. This will involve sharing data amongst partners to view the child and family as one unit and ensure key indicators are picked up. The move to integrated commissioning and provider collaboration creates a positive platform for a more data driven approach to intervention that supports the targeting of activity and resource.

Integrated family support

A number of areas are beginning to develop fully integrated offers for Early intervention. The focus has been to create a holistic offer across Health, Public Health and Social Care, with a view to potentially moving to a place based approach that incorporated access to relevant adult services. The offer would bring universal services, case management and targeted interventions together to build on the learning from the Troubled Families evaluation.
Good practice summary

Integrated Family support

Notable examples include:

**East Sussex:** 0-5 offer has been integrated across public health and children' services (Children Centres and Health Visitors), creating additional health checks pre-5 years old and encouraging volunteers and community groups to take over running some of the previous 'drop in' services – allowing the Health Visitors to be more focused on specific outcomes. This has been described in further detail below.

**Surrey County Council and Hammersmith and Fulham:** Creation of integrated family hubs. Combining a number of existing services into a locality offer Universal, Targeted and targeted plus) that is accessed via self referral, outreach as a result of predictive analytics early identification, MASH, Edge of Care team. There is the intention to extend some adult services interventions being present in the hubs.

**Wolverhampton:** Think Family A service that support families at risk to access appropriate adult and public health services

Relevance to Doncaster:

In Doncaster, c.8 Integrated Early help Hubs have been established that provide a strong platform for evolving a place based approach to early intervention. It would be an opportune time to review progress on these and identify further benefits from expanding the approach.

**Life Course management of SEN/ Learning Disabilities**

Learning Disabilities and SEN is an acknowledged high cost area, particularly for the local authority with a combined spend of c.£28m. Research also suggests that GP registration amongst people with LD is poor and they experience worse health outcomes that the rest of the population. Moving to an all age service is a solution a number of authorities have looked at. However there are some key lines of enquiry within this that are of particular interest:

SEN: Work in Barnet and the Tri-borough identified that the statement process (now replaced by EHCP but with the same issues) created an adversarial relationship with parents, and engagement with medical professionals resulted in referrals for significantly higher packages that were actually required or requested by the family. The interventions being considered are twofold: Review the referral process to facilitate access to Early Help more readily at two year checks, or through children centres and school nursing and; provide access to some low level therapy services and equipment/ technology straight away (pre plan) to try and prevent a EHCP referral (where appropriate) and needs escalating.
Transitions: Encourage and incentivise informal carers to care for longer and helping families lead a normal life, such as supporting ownership through equity release schemes or mortgage/rent support and other utilities support (for example council tax exemptions) in exchange for informal care.

Relevance for Doncaster:
Doncaster have identified LD as a strategic area of priority. Given the high spend in this area, a move to a neighbourhood model and the move to integrated commissioning. There is potential to review the end to end approach, changing the conversation with services users regarding the local offer within the context set by the Place plan case for change.

Assistive Technology:
East Thames Housing association and Wigan council are looking at pioneering approaches with the use of modern assistive technology. A combination of room sensors, communication devices, online command devices, video keys etc are been used to significantly reduce the cost of waking nights, sleeping nights, avoid residential care and more generally support people to live independently, as well as provide additional customer insight for both commissioning and predictive analytics. Key to the approach is a different way of working with Extracare, supported living, flexi care and homecare. Savings of £2-3m on care packages have been identified.

Relevance for Doncaster:
Integrated commission and the move towards a new way of developing customer insight and predictive analytics – coupled with a assets led, neighbourhood delivered approach could add an innovative angle to this established form of prevention.

Through the development of the accountable care system, there is a potential to work with providers early on this agenda and increase the pace of benefit realisation.

Out of hospital support
The key aspects of an integrated out of hospital model have been articulated as part of the place plan. Some schemes to consider as part of this development are:

- A holistic intermediate care approach that links access and capacity for both step up and step down support, this should include rapid access packages and have clear link with community based re-ablement
- Residential health care – linked to a new model for nursing care that incorporates primary care and support more effectively and utilises community capacity across the nursing bed base
- Integrated, risk based case management led by primary care and linked into neighbourhood teams
- Exploring community access to consultant – potential using technology to overcome some of the logistical challenges that can increase costs – evolution of the virtual ward
- Loaning falls equipment to care homes to reduce admissions and to generate provider buy in to the use of technology
- Workforce remodelling to create sustainability in the health and care workforce by creating alternative career pathways and forming closer links with higher education entities

Some of the supporting case studies for these initiatives are outlined in appendix 2.
Good practice summary

Relevance for Doncaster:

Work on intermediate care is already underway and will form a core focus of the next phase. As part of the wider neighbourhood redesign and to complement the staff engagement approach, the discussion regarding workforce should be prominent once the case for Implementation has been refreshed. Collaboration on CHC has also been identified as a priority, coupled with the formation of the GP federation, this could provide a new opportunity to refresh the approach in this area of out of hospital care.

Accountable Care:

A common understanding of accountable care is essential, and has been an integral part of the discussion among both commissioners and providers in this work.

Key features of accountable care v. the NHS status quo

► Contracts are let for population cohorts not care settings
► Contracts incentivise outcomes rather than measures
► Integration is fundamental to achieving successful outcomes
► Providers are accountable achieving outcomes

Accountable care has reduced costs in the US modestly to start with (1-2%) but savings may increase over time. Commercial ACO arrangement delivered 6.8% lower spending and net savings by year four (Song et al 2014). For integrated care, a Powel Davies 2006 review, suggested only 18% of interventions impacted favourably on cost. EY/Rand Europe (2012) evaluation of integrated care pilots showed overall significant saving of 9% in hospital costs where case management implemented (driven by reductions in outpatients and elective admissions). But the early results from MCP/PACS encouraging (1-2% lower growth in UPA) (Next Steps on 5YFV).

Interventions that worked included GP access to specialists, ambulance triage, nursing/care home support, end of life care in community, remote monitoring of some LTCs, support for self care. In terms of scale smaller hospitals fared better on spending and readmission rates in the US and larger independent physician groups had lower spending and better quality than small. A stronger primary care orientation led to lower spending and fewer readmissions (McWilliams et al 2013). From a patient point of view accountable care has had positive results in terms of access and feeling informed but there were some negative impacts seen in the ICPs on involvement.
**Good practice summary**

**Live examples:**

Although there is limited evidence from the UK, a number of areas are now seeking to implement accountable care arrangements:

### Northumbria CCG and Northumbria Healthcare

- A primary and acute systems vanguard that is seeking to develop an ACO with agreed outcomes for a population of 330k
- The ACO would involve mental health and social care services
- Initial work involved the transformation of urgent and emergency care via the Northumbria Specialist Emergency Care Hospital
- Key to its development is the creation of primary care hubs and seven-day services in primary care

### Manchester City CCGs

- Seeking to procure a local care organisation based on the MCP model
- The ACO would include some local authority services and children’s services
- The work is also aligned to the city’s Single Hospital Service and the potential to integrate the city’s three CCGs.

### Tameside Care Together

- ACO led from the previous acute trust
- All DGH and community services currently integrated
- Adults social work and commissioning of community services will be transferred within next 12 months
- Joint Cx/C of CCG and Council, single commissioning budget but managed through 3 main arrangements (e.g. ST5 and aligned budget)
- Contract in development, performance levers key points of discussion at present

### Dudley

- Seeking to procure an accountable care organisation based on the MCP model
- Focusing on three key areas: Integrated Care, Planned Care and Urgency and Emergency Care
- Within these areas services to be covered include primary care, A&E, ambulatory care and out-patients
- The MCP will create a series of integrated MDTs across physical and mental health and the voluntary sector

**Relevance for Doncaster**

The Place plan set a direction of travel towards accountable care and a provider partnership approach. Within this there will be a number of choices to make. Some of these approaches can be tested in specific services, for example intermediate care. However it is key that the discussion regarding form more broadly aligns to the scope of the neighbourhood model. Other considerations locally:

- **Primary Care and non NHS providers:** Contracting model needs to be cognisant of business viability – for example independent providers and GPs will have different working capital requirements. This must be considered to maintain buy in and sustainability

- **Acute providers:** may need to develop new skills in commissioning community services if they become responsible in the selected model. Also required to develop and establish local care networks and potentially shift their operating model to accommodate. This may impact on estates utilisation and will need to be modelled in the context of the service requirements

- **Mental Health providers:** Interface with secondary mental health services

- **Commissioners:** Work is required to define what services are required at a local level and the resulting requirements of and implications for providers. It is also essential this conversation happens in the context of commissioning at an STP level, that may drive quality improvements and economies of scale.

Doncaster has the opportunity to define its agenda and it’s local scope. This should be an immediate action for phase 2.
Results from Phase One

The key recommendations concluded from the current state assessment are outlined below. These are discussed in more detail in the Phase Two Scope Report document.

<table>
<thead>
<tr>
<th>Recommendation</th>
<th>What needs to be done?</th>
<th>Why does it need to be done?</th>
</tr>
</thead>
</table>
| 1. Set up Programme Architecture      | Set up the onward development of implementing the Place Plan as a programme with updated governance, PMO and workstreams | Ñ Governance and decision making unclear  
Ñ Increase traction to move decisions into action |
| 2. Update the Case for Integration    | The case for Integration needs to be revised / updated to make it more compelling and enable better communication with stakeholders | Ñ Leadership & culture – Key tool for leaders for comms.  
Ñ Support and give permission to extend sharing of financial information |
| 3. Service Re-design                  | Services need to be re-designed at the strategic, operational and functional level    | Ñ Need to clarify scope of neighbourhoods  
Ñ Need to take forward area of opportunity with consideration to future model for neighbourhoods  
Ñ Need to prioritise implementation approach |
| 4. Leadership Development             | The right leadership behaviours and skills are required at a system and individual level to drive change | Ñ Need to support system leaders to work together  
Ñ Need to build further confidence in staff engagement  
Ñ Building resilience and succession into system to lead change |
| 5. Operating Framework Development    | The options for the Accountable Care System need to be appraised and a Target Operating Model developed. | Ñ Clarify the contracting model  
Ñ Develop common language for Accountable Care System  
Ñ Develop working arrangement that support delivery of services in scope |
| 6. Communications & Engagement        | The vast number of stakeholders and staff involved need to be brought along on the journey | Ñ Support leaders to talk confidently about the direction of travel, the vision and the practical implication  
Ñ Identify a more innovative way of engaging in the future design |
5. Programme Scope/Operating Framework
Programme Scope Introduction

Introduction
The Doncaster Place Plan set out the ambition to move towards accountable care. Current practice and evidence relating to implementing this model was outlined in the phase 1 maturity assessment. This section is focused on the scope of work required to move to an Accountable Care System based on the Neighbourhood model.

What is accountable care?

<table>
<thead>
<tr>
<th>Type</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accountable Care</td>
<td>The alignment of incentives, budgets and decision making to promote greater co-ordination of and integration by providers of health and social care provision for a defined population. Focus on health as well as services.</td>
</tr>
<tr>
<td>Accountable Care System</td>
<td>An evolved version of an STP, with system partners taking collective responsibility for resources and population health, and having the ability to create their own decision making and governance structures, and agree accountable performance contracts with NHS.E/I</td>
</tr>
<tr>
<td>Accountable Care Organisation</td>
<td>A provider-led organisation (integrated or networked); delivering accountable care to a defined population, holding financial risk through a global budget (±/risk gain share arrangements) and required to deliver improved outcomes and quality</td>
</tr>
</tbody>
</table>

Key features of accountable care v status quo
- Contracts incentivise outcomes and integration rather than operational measures
- Integration is fundamental to achieving successful outcomes
- Providers are accountable for driving integration and achieving outcomes

Based on our experience, to deliver improved outcomes through a move toward accountable care, there are four key choices the system needs to work through. Once these decisions have been worked through, the supporting operating framework will need to be developed to sustain the systems new operating model.

The approach to this section has been developed and considered the outputs from the Maturity Assessment and Current State Assessment undertaken during the work in Phase One.

For choice 1, the Doncaster neighbourhoods are identified and aligned. This means the focus is now on the scope of services delivered at a neighbourhood, which must be decided in the context of the evolving STP and regional commissioning approach. In addition, there is a need to demonstrate some quick wins, agree the prioritisation and accelerate delivery to produce benefits and test the approach to system commissioning and contracting. This has been addressed through the identification of 17 areas of opportunity and the prioritisation of 3 to move forward on through the summer, developing the contracting model. In the subsequent pages, we have outlined the programme scope across these choices, and the operating framework in further detail.
Choice One - Population

Introduction
Accountable care has some key features which are fundamentally different from current NHS contracting and delivery.

Below we have outlined and explored the findings from the phase one Maturity Assessment of how commissioners intend to contract for the local population of Doncaster.

Population Choice
The phase one maturity assessment reflected on the 3 cohorts (Prevention & Early help, Intermediate Health & Social Care and Enablement & Recovery) of the local population with a remit of improving Health and Social care across the Doncaster region. In order to deliver the ambition of accountable care for the Doncaster population, it was mutually agreed that this would be delivered via a neighbourhood model and these cohorts would need to be refined and defined so that immediate focus and change implementation steps could be drawn out.

Population Health
There is a recognition that within the system design a focus on improving population outcomes whilst delivering financial sustainability is required. This mean changing the approach to population health and moving to what matters to people as opposed to what is the matter with people.

Neighbourhoods
Whilst the neighbourhoods have been agreed in principle there are further considerations:
Ñ does Primary care align with Neighbourhoods
Ñ will universal care and universal care plus be offered in the neighbourhoods,
Ñ are the hubs physical or virtual in nature,
Ñ what are the care provisions required for the different neighbourhood

What will be different
The neighbourhood model should be supported by localised, system commissioning. This means service design being support by insight, and analysis of the ambitions, outcomes and needs of the different localities. This will allow for greater targeted resource in the right area at the right time; which will result in qualitative benefits for residents and reduced demand on inappropriate secondary service demand, furthermore a move to a more enhanced preventative health and care system which builds strength and resilience within the community setting.

Next Steps
Ñ Needs analysis of neighbourhoods to identify likely volumes and nature of services based on current model
Ñ Customer insight approach proposal developed to define outcomes and support system delivery and service redesign
Choice Two - Delivery Systems and Services

Introduction

Engagement with stakeholders at the joint commissioner and providers sessions highlighted that the development of integrated pathways is the most important element of redesigning the service.

The development of the neighbourhood model is a high priority for all Partners and as part of the scoping and design, all of the areas for opportunity will be evolved further. The model will develop integrated pathways for the other services set out in the context of the case for change and broader system redesign.

Relevant findings in the maturity assessment:

- Neighbourhoods have been agreed but the scope of services provided at this level has not. Work is required to define the scope, in the context of both the STP and the wider Council services.
- The scope of neighbourhoods may initially be ring-fenced to ‘health and care’ but should be able to expand to other relevant areas in line with the Team Doncaster approach.
- The Cohorts from the Doncaster Place Plan are wide ranging and cover a multitude of Departments and Services – this system wide approach is critical to the ambition and vision, but does not provide the required immediate focus to implement the change.
- There is an appetite to ‘get on with it’ and test the model, as well as move forward on some quick wins.

How have we addressed the findings in the way we move forward?

To support the system to make progress, a tiered approach to service design has been developed with the task and finish group, built on the identified Areas of Opportunity.

The tiers include

- Strategic: The development of the end to end service model at a neighbourhood level. A life course approach; How they will be delivered and how they will define the TOM.
- Operational: Specific services or groups of services that can be progressed how to test the wider model and approach, deliver quicker wins and generate pace and momentum to support the strategic approach.
- Functional: Common functions provided by all/most of partners where there are clear synergies and opportunities to drive better ways of working together.

Within the strategic tier, Learning Disabilities, Mental Health, Primary Care (excl. GMS) and CHC have been identified as key areas of focus to evolve the service design. LD due to the high life course cost of this user group and the current disjointed approach. Mental Health due to the interrelationship with pressure on other areas of the system where MH may not be the presenting need but is the underlying cause. Primary Care because of the fundamental role it plays in the success of a community based model and reducing pressure on acute services. CHC due to the opportunity to align activity and streamline processes. On the subsequent pages, a summary of the operational and functional areas of opportunity described. A full description of each opportunity is included in Appendix I.

Next Steps

- Refresh the case for Integration and confirm the scope of neighbourhoods in the context of the STP
- Prioritise operational areas to test the model
- Set up the Design Groups to take the activity forwards
- Mobilise activity on the functional areas
- Agree insight approach on development of neighbourhood model
Introduction

The Strategic Workstream will drive the design of the Neighbourhood Model, taking a system wide approach to reflect the ambition and vision of the partners. The Neighbourhood approach is intrinsic in the way delivery systems and services will be designed and commissioned.

Some of the agreed Areas of Opportunity will be critical to the Neighbourhood Model Design Work during Phase Two as they will be used to inform the development.

Key Features

The Neighbourhood Model for Doncaster is built around the communities within it, representing a holistic integrated approach to service delivery; specifically to:

- **Support people and families to support themselves** - This means investing in low level support to reduce the demand on high end care. It also requires staff to identify at risk group, intervene early and build resilience through enhancing a person or families own skills to manage their condition/situation.
- **Deliver a better resident experience** through more seamless care delivery. This means fewer referrals and hands offs, better continuity of care across different services and making every contact count.
- **Drive quality, accountability** for statutory responsibilities and delivery of outcomes and ensure the involvement of individuals in service design.
- **Provide a different configuration of services** , building on what works well already, to ensure the right care is delivered, in the right place at the right time.
- **Deliver the necessary cost efficiencies** without compromising care and support.

High Level Descriptions

**Learning Disabilities**: Delivery of the core principles of Building the Right Support in Communities of People with a Learning Disability and / or ASD. Enhancing community provision for people with learning disabilities and prevent people from going into crisis and support people to live as independently as possible

**Mental Health**: People with mental health problems will have sustained recovery, have access to information and peer support in order to maintain their wellbeing. People with a mental health problems will enjoy good physical health and emotional wellbeing.

**Primary Care (excl. GMS)**: Primary Care is fundamental to the Neighbourhood Model and will be engaged to deliver on the commitments in the Place Plan. The newly established GP Federation will build on the engagement and Areas or Opportunity will be impacted by the role of Primary Care in the wider system.

**Continuing Health Care** - A co-ordinated approach to CHC will ensure that decisions are always made in the best interests of the individual and not related to budget ownership. Co-ordinated market management will ensure that the most competitive price is procured each time. Consistency of paperwork, reviews, process and decisions will reduce waste, lost time and duplication of effort.

**Neighbourhood Profiles**

The development of the Neighbourhood Profiles will be critical to the new delivery model; to ensure that services are commissioned to reflect neighbourhood need where relevant as this can be different to Doncaster wide need in some instances.
## Operational work-stream

### Introduction

The work over the previous three months has identified a number of priority areas for commissioners and providers.

In addition to the Strategic work-stream there are a number of operational areas where an integrated approach will complement the design and inform the development of the Neighbourhood model.

Six of the areas on the table opposite have been categorised as “high priority” due to them being more ready/more urgent and can be progressed faster.

These areas will be used to test the emerging operating model and the operating arrangements; involving a good range of providers to test the design of the contracting model/s required to deliver the services.

The six agreed areas of immediate focus are:

- Urgent & Emergency Care (developed specification exists, contracting model to be determined)
- Complex Lives
- Intermediate Care
- Starting Well (1001 days)
- Vulnerable Adolescents (Tier 4 Specialist Services)
- Dermatology

### Area of Opportunity

<table>
<thead>
<tr>
<th>Area of Opportunity</th>
<th>Where does this find efficiency / enable redesign?</th>
</tr>
</thead>
</table>
| Urgent & Emergency Care                  | • This will reduce costs by moving patients into more appropriate services  
• Reduction inappropriate patients hitting the core bed base |
The areas below can be progressed and will facilitate closer working relationships across organisations, streamlined processes for end users and possible financial benefits which will all contribute to the change in culture required to deliver on the integrated working. The additional Areas of Opportunity on Community Led Support and Single Point of Access will be integral to the design and delivery of the Neighbourhood Model – integrating Neighbourhood Pathways to achieve the outcomes for the residents of Doncaster.

<table>
<thead>
<tr>
<th>Why?</th>
<th>What?</th>
<th>What needs to happen Next?</th>
<th>How &amp; When?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Common function, multiple approaches.</td>
<td>Develop common approach, paperwork procedures etc. to reduce duplication and costs and increase quality</td>
<td>Conduct a mapping exercise in order to understand; what/where services are offered, maturity of services with regards to integration and the scale of the opportunity</td>
<td>Identify lead organisation and project manager (Suggest Local Authority and Children’s Trust) Agree scope, objectives, deliverables and timelines Identify approval required for changes Work should begin in May</td>
</tr>
<tr>
<td>Unnecessary costs/cross charging/under utilisation.</td>
<td>Rationalisation and use of assets could realise efficiencies</td>
<td>Develop baseline of current estates Agree policy re charging Id quick wins</td>
<td>Develop baseline of current estates Agree policy re charging Id quick wins</td>
</tr>
<tr>
<td>Local people, community groups can all work together much more effectively</td>
<td>Keeping people within their own community and helping them to remain independent</td>
<td>Develop Community assets and resilience Staff will have more flexibility and freedom to innovate leading to increased morale</td>
<td>Develop Community assets and resilience Staff will have more flexibility and freedom to innovate leading to increased morale</td>
</tr>
<tr>
<td>The current entry points to services are fragmented and difficult to navigate</td>
<td>Streamline access through integration of current SPAs and/or creation of new</td>
<td>Detailed population trends of service users aligned to neighbourhoods to be produced</td>
<td>Governance Arrangements to be put in place</td>
</tr>
</tbody>
</table>

**Infection Control**

**Safeguarding**

**Estates**

**Community Led Support**

**Single Point Of Access**
Choice Three - Commissioning Role

Introduction

This element of scope is to define the approach to Commissioning within the Doncaster Place plan and to support the Accountable Care System.

Currently the commissioning activity takes place separately within the CCG and DMBC.

Within the Council there are three separate teams, these are; Adults, Children's and Public Health.

These teams are supported by a central strategy and performance unit, responsible for the development of management intelligence and other corporate functions such as finance who also support other aspects of the council.

The CCG is a single commissioning unit, with strategic and operational commissioning functions, contract management, finance and performance and analytics capability.

Some services are jointly commissioned, governed within the Better Care Fund.

Direction of travel

There is a shared ambition between the council and CCG to move towards integrated commissioning. This model will evolve over the next 9 months, initially taking a system commissioning approach to the areas of opportunity and subsequently leading to a fully integrated model.

Required activity

Wave 1:

- Develop a joint committee with delegated responsibility to commission the services outlined in the area of opportunity
- Define the budget in scope and the specification for services
- Agree the investment model
- Resource the management activity required for the contract (potentially as a programme role)
- Begin provider engagement to implement the services
- Agree performance/contract management approach and responsibilities

Commissioning redesign

- Scope and value of commissioning fund (inc STP link)
- Governance arrangements and relationship statutory commissioning bodies
- Team structure and sizing
- Hosting arrangements and transition plan
- Combined commissioning strategy
- Estates plan
- Aligned Finances and mechanisms e.g. Section 75, Pooled Budgets, etc.
- Driving a more innovative approach to customer insight and engagement as part of the new function

Next steps

- Specifications and system commissioning approach for prioritised area of opportunity
- Set up joint committee for these services
- Outline proposals for broader redesign
- Proposal developed for customer insight approach
Choice Four - Provider Role

Introduction

There are currently 6 main providers in Doncaster:

- Doncaster Children’s Trust
- Doncaster and Bassetlaw Hospital
- Rotherham, Doncaster and South Humber FT
- FCMS
- Doncaster Council
- Primary Care Doncaster

In addition, there are number of private and 3rd sector providers (for example homecare) that support service delivery across the health and care economy.

Direction of travel:

The place plan set out a direction of travel towards an accountable care system. To deliver this, work will be undertaken to define the structure that will drive the required changes. There are four broad contracting options available to providers to come together.

The early discussions in the Doncaster Transformation Group have shown a preference for “Alliance Contracting” in the short term. As the scope of services subject to a system commissioning approach increases - this may be revisited to achieve further benefits.

The agreed work-streams to accelerate delivery involve some early work on three agreed Opportunity Areas - these are:

- Intermediate Care
- Complex Lives
- Vulnerable Adolescents

Next steps

- Establish provider forum
  Providers need to agree how they are going to work collectively and what delegated authority/decision making powers the provider forum will have
- Develop specifications for three areas
  Work with providers to develop service delivery model, contracting relationships between providers
- Performance metrics
- Funding flows, financial forecast and investment model
- Viability assessment and risks
Operating Framework

Introduction:

To support the move to an accountable care system, there are a number of additional principles and practicalities that need to be established. This is the operating framework, that defines and supports the relationship between all parties in the delivery of improved outcomes in a more financially sustainable way.

These are:

- **Strategic Leadership**
  This will define the relationship between system leaders and their collective role in shaping the place plan and interacting with STP.

  Why: It is essential the relationship between commissioners and providers does not become transactional.

  How: The governance arrangements set up for the programme and for the future accountable care system will need to incorporate this ‘function’. For example this could include a review of the Health and Wellbeing Board at a strategic level and a stronger role for the HSC transformation group. It should also include the development of capability in system leadership as a group.

- **Commercial Strategy**
  This will define commercial principles and approach that will govern the accountable care system. Taking a system commissioning approach will have implications for how commissioners ‘go to market’ and how the market is managed.

  Why: Asking providers to operate in a more collaborative and transparent way must be supported by some assurances from Commissioners with regards to how services will be commissioned. Equally, integration can result in a contracted market, limiting options for commissioners should performance be sub-optimal.

  How: Decisions will be required on: What services are competed and which ones are a co-designed and collaborative. For example, we may collaborate on the design and implementation of intermediate care services, part of this specification may be for the accountable care partnerships of providers to be responsible for commissioning homecare. This element of the service may still be subject to competition, but that competition may be run by the ACP. This approach will require engagement with all procurement functions to ensure legally compliant process are developed will be part of this. In addition, in a system where retendering services become less tenable due to a contracted market, agreements and contractual levers need to be developed and mutually agreed with providers to ensure commissioners have the ability to incentivise and sensibly penalise poor performance.

- **Financial Strategy**
  Accountable Care has significant implications for activity and how it is costed and rewarded.

  Why: We need to understand how services will be funded, how savings will be realised, how benefits might be reinvested into prevention and demand management initiatives.
**Operating Framework**

### Financial Strategy

**Why cont.** We also need to understand how this is then disseminated across the system, between commissioning organisations, between providers and between both. Benefits for providers include the combined resources available to help manage the cost base more effectively and provide a more innovative and person centred response. It also means the incentive to invest in prevention, early identification and intervention and care delivery in alternative settings to reduce the demand on higher tier services. Benefits for commissioners include a risk sharing partnership with the provider. The integrated contract for aspects of care, with a base budget and outcome based incentives and penalties removes the perverse incentives currently created by the market.

**How:**

<table>
<thead>
<tr>
<th>Cost modelling</th>
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<tbody>
<tr>
<td>Detailed data on treatment costs which allow robust, clinically meaningful forecasts of how costs are impacted by demographic changes and new care models</td>
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</table>

<table>
<thead>
<tr>
<th>Integrated financial plans</th>
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</thead>
<tbody>
<tr>
<td>Models which truly integrate the financial forecasts of organisations within a system</td>
</tr>
</tbody>
</table>

### Next steps

- Programme and accountable care system
  - Develop joint governance arrangements for place shaping – HWWB, CEX group and Transformation Group to be reviewed
  - Design system leadership development programme

### Areas of opportunity

- Develop working principles for commercial strategy
- Financial baseline validated for areas of opportunity
- Agree financial strategy, required savings, reinvestment proposals, monitoring approach
- Develop financial model for contracts
- Develop commercial strategy

### Broader financial strategy (medium term activity)

- Review opportunity to take group accounting approach follow scope definition for neighbourhoods and STP
- Agree approach to assessing provider impact and viability as scope of accountable care contracts increases
## 6. Workstreams

Designing the Workstreams

This section describes the workstreams required for phase 2 of the Doncaster Place Plan. These workstreams are based on the findings from the Phase 1 maturity assessment and are designed to help accelerated progress towards improved outcomes and financial sustainability through integrated pathways and an accountable care system:

1. **Set up Programme Architecture**
   - Governance and decision making unclear
   - Increase traction to move decisions into action

2. **Update the Case for Integration**
   - Leadership & culture – Key tool for leaders for comms.
   - Support and give permission to extend sharing of financial information
   - Need to clarify scope of neighbourhoods
   - Need to take forward area of opportunity with consideration to future model for neighbourhoods
   - Need to prioritise implementation approach

3. **Delivery System and Service redesign**
   - Need to support system leaders to work together
   - Need to build further confidence in staff engagement
   - Building resilience and succession into system to lead change
   - Clarify the contracting model
   - Develop common language for Accountable Care System
   - Develop working arrangement that support delivery of services in scope

4. **Leadership Development**
   - The right leadership behaviours and skills are required at a system and individual level to drive change
   - Support leaders to talk confidently about the direction of travel, the vision and the practical implication
   - Identify a more innovative way of engaging in the future design

5. **Operating Framework Development**
   - The options for the Accountable Care System need to be appraised and a Target Operating Model developed.

6. **Communications & Engagement**
   - The vast number of stakeholders and staff involved need to be brought along on the journey
   - Identify a more innovative way of engaging in the future design
Workstream Definitions: Set Up Programme Architecture

Purpose:

The purpose of the workstream is to design the programme architecture and programme management approach.

What does good look like?

1. Clear programme structure and delivery framework
2. Reporting approach that assists key system leaders in decision making/ taking action at key gateways and on resources, risks and dependencies
3. Engage existing projects and work-streams to avoid duplication, manage dependencies align activity
4. Develop, implement and support the establishment and use of effective programme management to generate pace
5. Provide on-going assurance on successful delivery of the programme and benefits – making sure thing get done and get done right
6. Provides resources to the projects we say are important
7. Has clear governances that both within the programme and within the system (e.g what decisions can be taken where)

How will this be done?

We will use the framework set out to the right to design the programme architecture, using existing tools etc where possible. This includes:

- Developing a PMO and reporting approach
- Developing a programme plan
- Case for Implementation
- Communication

Not in scope for this workstream:

- Case for Implementation
- Communication

Immediate next steps:

- Design and establish PMO
- Identify resources
- Review Governance
Workstream Definitions: Case For Integration and Delivery System/Service Design

Purpose:

This workstream will focus on refreshing the case for Implementation and the longer term design of the neighbourhood model/commissioning organisation.

What does a good case for Implementation look like?

- What is the landscape within which Doncaster Health and Wellbeing is operating? Describes the events that have shaped the current environment (FYFV, Devo, STP, resident expectations)
- Why Change? What are we trying to achieve by this? What do we want to do better and why? What is not working well currently?
- Where do we want to achieve together?
  - For who? (What are the cohorts/ population)
  - Doing what? (What is the scope)
  - How? (How will we commission? How will we contract? How could providers respond?)
  - Why? (What is the evidence)
  - When? (Roadmap)
- What if we did nothing? What are the risks we need to manage if we do something?
- What are the potential benefits? Highlights the financial gap, describes the benefit themes and where they would be realised? Describe the necessity to identify a suitable mutual investment model (e.g. Capitation)
- How will we know it has worked? (Success measures from the perspectives of all our key stakeholders)

How will we do this?

Case for Implementation:

- Review the place plan and phase 1 material and develop an initial draft in line with the above
- Review and input into STP level commissioning proposals
- Utilise the task and finish group session to review and refresh
- Finalise drafts and approve draft with HSC transformation group

System Delivery & Service redesign:

- Agree scope of services in neighbourhood hub
- Agree outcomes and ambition
- Service specifications
- Using customer led insight approach to evolve and evaluate
- Provider engagement to design service model
- Estates baselining

Commissioning redesign:

- Baseline information
- Develop integration principles/ budgets in scope
- Transitional joint delegated governance established
- Design functions and agree hosting arrangements
- Transition plan

Immediate activity:

- Refresh case for Implementation and approve with HSCTG
- Estates baselining (strategic estates group)
- Commissioning baseline, principles and governance
Workstream definitions: Leadership Development

**Purpose:**

This work-stream will focus on the leadership that is in place across the health and social care system from two aspects – system leadership to drive the required change and individual leadership to provide personal coaching to drive confidence and the right behaviours to support the system change.

**What does good look like?**

A jointly established, co-designed set of approaches, rules, behaviours and working practices at a system and individual level.

**How do we do it?**

- Define the meaning of system leadership in Doncaster - Agreeing the system leadership ‘operating rules and principles’. Finalising the system leadership programme & narrative. Testing the principles & framework
- System styles and ways of working: Developing the leadership framework -Understanding the similarities and differences across the System Leadership Group. Getting the best out of the System Group. Managing any potential shadow side of system working
- Testing the system: Working through the emergent operating model, via soft systems simulations, to test how the system leadership framework and ways of working react under points of pressure and opportunity. Refinement of the operating model and system leadership framework as a result
- Distributed leadership development: Ensuring that the system rules and leadership framework is effective at supporting a distributed model of leadership throughout the system. Developing effective system networks of planning & delivery
- Developing resilience: Developing system leadership resilience for the longer term; Resolving system challenges; Succession and ‘social movement’ planning for the longer term

**Immediate next steps**

- Develop the detailed plan for this workstream in the context of the revised case for Implementation and results from the operating framework testing
Workstream Definitions: Operating Framework

**Purpose:**
This work stream will focus on the development of the operating model for integrated services

**What does good look like?**
The key decisions have been set out in the scope section of this report. Working with all partners in the system, the operating framework will be established using an agile approach. This means developing and testing it using the areas of opportunity, whilst being cognisant of the broader neighbourhood model redesign in flight. The learning from these ‘test’ areas will be built used to evolve the approach at a system level.

Three areas have been selected to accelerate over the next seven weeks, it is anticipated a second wave will the progress over the summer. The project manager for this workstream will also support providers in the progression of work on some of the functional quick wins.

**How will we do this?**
For each area of opportunity
- Establish a specification, outcomes, activity etc.
- Establish budgets and contributors
- Develop service model with providers – design groups
- Develop cost and benefit model
- Develop draft contract
- Develop provider alliance agreements
- Agree monitoring approach
- Papers submitted to joint delegated governance arrangements

**Areas of opportunity for May/June focus**
- Intermediate care
- Starting Well (0 to 5yrs)
- Urgent & Emergency Care
- Children on Edge of Care
- Complex lives
- Vulnerable adolescents

**Immediate next steps**
For the above areas:
- Develop/ Review specification
- Work with providers to establish service model and understand organisations involved
- Develop contracting principles
- Establish financial baseline and savings required
Workstream Definitions: Communications & Engagement

**Purpose:**

The purpose of this workstream is to coordinate communications in relation to the evolving case for Implementation. It should also develop the engagement approach for the neighbourhood system delivery and service redesign.

**What does good look like?**

The Doncaster Place Plan is fundamentally about working together locally to achieve the best health and social care for Doncaster communities. Communicating and engaging with our local population is vital to delivering this vision. It is critical that all stakeholders are truly involved in this work. There has been lots of communication around the Doncaster Place Plan in various forms and mediums. However, the Phase One current state assessment highlighted there still exists an inconsistency of understanding across stakeholders. It is essential that we deliver clear messages which staff and residents can easily understand. Greater Manchester have had significant success with their Taking Charge programme, a large scale engagement activity relating to population level health. It is proposed that this approach is reviewed and incorporated into the system delivery and service redesign approach to the neighbourhood model.

- Good broadcasting: Clear and consistent messages that are tailored to the audience
- Good engagement: Generating genuine insight and acting on it together to reshape services

**How do we do it?**

- Stakeholder analysis
- Develop case for Implementation engagement pack in a number of different format to support broader consultation

**Immediate next steps**

- Agree dissemination strategy for case for Implementation
- Clever together proposals

with staff and users

- Develop proposal with Clever Together to establish approach to insight in neighbourhood model development
- Develop communication and engagement strategy in partnership with system leaders that is linked to the system delivery and service redesign activity
- Detailed communication plan
# 7. Implementation Planning

|----------------------|--------------------------|-----------------------------|--------------------------|----------------------------------------|---------------|---------------------------|

Implementation of the Doncaster Place Plan
Deliverable descriptions

**Introduction**

This section sets out:

- **Key deliverables from EY required in the next seven weeks (Phase 2a)** to maintain pace in the progression of the place plan and to meet your deadline for the Chief Executives Meeting on the 16th June.
- **Supporting activity and a timeline for the next seven weeks** key deliverables that will be produced in the “immediate activity. A high-level description of each is outlined below. These will be prepared in advance of the Chief Executives Meeting.
- **A high-level milestone plan for the next nine months** to progress the place plan, aligned to the define programme workstream.

Once the PMO is established and a programme manager assign, a detailed programme plan will be developed as part of the programme set up workstream.

**Deliverables for Phase 2a:**

**WORKSTREAM: PROGRAMME SET UP**

PMO and programme management approach:

- **Agree projects within remit of PMO**
- **Determine programme team required incl. PM/PMO together with any additional resources required**
- **Identify project leads**
- **Determine reporting arrangements**

**WORKSTREAM: CASE FOR INTEGRATION & SYSTEM REDESIGN**

- **Refreshed case for integration**—in line with the deliverable structure set out in the workstream description
- **Clear scope for strategic opportunities**
- **Proposals for joint delegated commissioning governance and a plan of activity for designing integrated commissioning**

**WORKSTREAM: OPERATING FRAMEWORK**

- **Project charters for the agreed Operational Areas of Opportunity that shows timelines and activity required to go live**
- **Progress on delivery with agreed sign off points as set out in the Project Charters**

**WORKSTREAM: LEADERSHIP DEVELOPMENT**

- **Detailed implementation plan for the leadership programme**

**WORKSTREAM: COMMUNICATION AND ENGAGEMENT**

- **Approved Executive Summary with dissemination plan**
- **PMO set up to manage ongoing communication and engagement**

Implementation of the Doncaster Place Plan
Immediate activity plan

The agreed areas of focus for the next seven weeks of activity are on the creation of the infrastructure to support the five agreed work-streams – with the outputs required for the Chief Executives Meeting on the 16th June. A high level plan of activity is presented below, together with indicative milestone dates.

<table>
<thead>
<tr>
<th>Workstreams</th>
<th>Wk 1 w/c 1st May</th>
<th>Wk 2 w/c 8th May</th>
<th>Wk 3 w/c 15th May</th>
<th>Wk 4 w/c 22nd May</th>
<th>Wk 5 w/c 29th May</th>
<th>Wk 6 w/c 5th June</th>
<th>Wk 7 w/c 12th June</th>
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<tbody>
<tr>
<td>Operating Framework Development</td>
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<td>Case for Integration &amp; Service Design</td>
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<td>Programme Set Up</td>
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<td>Leadership Development</td>
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<td>Communications &amp; Engagement</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Key Meetings</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

- **Operating Framework Development**
  - Project Charters agreed for the Operational Areas of Opportunity
  - Progress on Delivery with agreed sign off points
  - Updated Case for Integration

- **Case for Integration & Service Design**
  - Refreshed Case for Integration
  - Writing Documentation
  - Further work to define scope for Strategic Opportunities
  - Proposals for Joint Delegated Commissioning

- **Programme Set Up**
  - Agree projects within remit of PMO
  - Determine reporting arrangements
  - Determine Programme Team

- **Leadership Development**
  - Detailed Implementation Plan for Leadership Programme

- **Communications & Engagement**
  - Approved Executive Summary with dissemination plan
  - PMO set up to manage ongoing communications and engagement

- **Key Meetings**
  - Weekly Progress Call
  - Weekly Progress Call
  - Weekly Progress Call
  - Output required for CX Meeting on 16th June
Implementation planning

We have outlined below a milestone plan for the next 9 months – this is an indicative plan based on the key work-streams we have identified.
Leadership

Objective
The Doncaster Place Plan and the requisite partnership arrangements that need to be in place to deliver it, require a very different approach to the planning and delivering of health and care services, than has previously been in place. As part of the diagnostic for Phase 1, we carried out a maturity assessment of the system leadership, to shape and design this new approach. This was for two purposes. The first was to inform the areas of system leadership inquiry. The second was to shape the support and framework for the next phase.

Method
We carried out semi-structured interviews with the senior leaders (CEO/Chief Officer/Lead Director) across the main commissioning and provision organisations of Doncaster. We also observed the first sets of commissioner and provider only meetings.

System Leadership Maturity Framework
The interviews and the observations were informed by a framework of partnership readiness shown right. This is based on the main stages of effective partnerships (preparing, partnering, delivering and learning) as well as integrating aspects of the ‘Stepping up to the Place’ assessment, developed by the Local Government Association and the NHS Confederation for joint collaborations around place based change.

Early Assessment
Presented next are the early findings from the assessment process on the first two stages of the partnership readiness (preparing and partnering). This is provided in terms of the respective groups – commissioners and providers and then we present the next steps and issues for the integrated system going forward.
## Leadership

<table>
<thead>
<tr>
<th>System Leadership Component 1: Preparing for Change</th>
<th>Commissioners</th>
<th>Providers</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>System Ambition/Vision/Values</strong></td>
<td>There is a strong vision in place across the CCG and the Local Authority to guide the Doncaster Place Plan. Commissioners are very active in developing the focus and momentum across the Place. There are some subtle differences in culture, philosophy and ways of working across the Council and the CCG, which need more clarity and exploration to shape the strong joint commissioning partnership.</td>
<td>There has been good sign up to the vision of the Doncaster Place Plan across Providers. Not all providers are in the same place, but this may be a facet of the ‘cohort’ focus – e.g. leading with intermediate care. Overall, providers are not as developed in their grasp of the changes in opportunity and role than perhaps they need to be and this is a focus for attention. There were some views that the DPP and its approach could also be bolder in its ambition. This was not to suggest it should be over-reaching, but that a bolder approach may support different levels of change across the system.</td>
</tr>
<tr>
<td><strong>Relationship between Leaders</strong></td>
<td>There are good working relationships across the senior commissioner leadership team. There is commitment to a stronger and joint way of working. This needs further development of what this practically means in terms of the leadership requirements and commitments to deliver joint working, alongside single commissioning responsibility.</td>
<td>There are more providers and therefore, by default, relationships are more complex. Some of the provider group have been involved from the inception of the DPP. As a result, they show good levels of commitment. Some provider leaders are newer to the initiative and need a bit more time. It is to be noted that there is not a dedicated provider forum across Doncaster. This may be something that would help the strengthening of the provider network going forward. The provider group also includes members of children’s services provision, who feel it is important to shape the system leadership offer, but who, do not immediately see a requirement, in terms of the priority services which will be tested through the joint commissioning arrangements, which are adult services.</td>
</tr>
<tr>
<td><strong>Representation</strong></td>
<td>The commissioners have led a good degree of the preparatory work. There has been high levels of commitment from the senior team. Senior staff have been available to author and develop joint thinking and plans. There has been good consistency across the group.</td>
<td>The representation across the Provider group has been more mixed. Some of this is to do with the roles and order (i.e. the commissioning vision shaped different partnership models), some is to do with personnel changes in the group since the planning sessions. Finally, some of this is to do with better understanding of the prize of collaboration.</td>
</tr>
<tr>
<td><strong>Shared Accountability</strong></td>
<td>There appears to be very high levels of commitment to making the joint commissioning arrangements work. The Council is clear that it has to do things differently to make its financial savings, but also to deliver differently for the Doncaster citizen. Likewise, the CCG has shown strong commitment to sharing joint accountability. What this means in operational practice, needs now to be clearly mapped and tested, alongside the service models.</td>
<td>The Provider group are, perhaps understandably, in a slightly different place to their commissioning colleagues. There is a desire from the providers for a much clearer articulation of the strategic direction of the DPP and an understanding of the outcomes – i.e. what needs to be different. This also potentially includes a stronger and practical articulation of the provider model – i.e. there is an expectation of greater degrees of collaboration, innovation and system leadership across the provider group.</td>
</tr>
</tbody>
</table>
Leadership

<table>
<thead>
<tr>
<th>System Leadership Component 2: Partnering for Change</th>
<th>Commissioners</th>
<th>Providers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Citizen Focus</td>
<td>There is a strong and shared focus on the driver the Doncaster Place Plan being the Doncaster resident and locality groups. There are undoubtedly, as elsewhere in the country, differences in how health and Local Authority organisations view needs and solutions (the former rooted in medical model and the latter, rooted around a social/economic model of intervention). This provides a comprehensive approach to a system-wide and a systematic approach. It is important that both approaches are combined and that leaders (and organisation’s) focus is around the cohort groups and not the organisations.</td>
<td>It was felt that this ‘unit of currency’ needs to be more strongly developed within the provider group. Not to suggest that providers do not consider the needs of Doncaster citizens and/or patients, but rather that the default currency hitherto has been the service model, contract threshold etc. For the system going forward, there needs to be stronger locality-based and person centred modelling and challenge, to shape services to needs and more upstream challenges, than fit residents to services, as is more the case at the moment. This will require development of more sophisticated locality intelligence systems.</td>
</tr>
</tbody>
</table>

Operational Model:
- System Leadership
- Service

System Leadership:
Although the vision and ambition across the joint commissioning group is strong, what this means in practical terms, still needs further focus and development. There are stretching principles in place, but these need rigorous testing in terms of what they may mean for different operational scenarios and how different ‘system polarities’ which might play out over the development of the partnership (discussed in the next section) and how these might be handled. This would help to confirm the ‘rules of engagement’, to cover leadership behaviours, as well as system actions.

Service Model:
It was reported that the interplay between the system leadership, or ‘architecture’ of the partnership and how the new commissioned services were tested against the model needed to be strongly and clearly connected, as both were largely interdependent. The system leadership model should and needs to create a strong partnership template for joint commissioning, across a range of services, beyond the immediate priorities.

System Leadership:
It is fair to say the the provider network does not yet, as a collective, recognise itself as part of the Doncaster system leadership. As reported, there are pockets of good vision and commitment, but this is not yet matched with a clear understanding and commitment to a system leadership model with commissioning colleagues, or with other providers. Providers need to develop their system leadership framework as a group and then combine with the commissioners, where relevant. Having a practical focus should support this, but is not a replacement from understanding how the partnership model or network will practically work.

Service Model:
Providers wanted to have a much more practical approach to how joint working would be delivered in the future. There is a clear desire that commissioners set out their vision of the destination (i.e. what will be different as a result of the intervention) and the individual outcomes. Providers wanted to have freedom to innovate and collaborate. There was consensus that they did not want commissioners to micro manage them or service innovation. There was also recognition amongst providers that there is still not good enough understanding across the group of their respective service offers and strengths. This is a priority focus, as it prevents early and easy identification of where they might collaborate, or partner, or simply deliver as part of a commissioned service/pathway.
## Leadership

### System Leadership Component 2: Partnering for Change

#### Roles & Responsibilities

The commissioners need to work through in a little more detail their levels of work and responsibility—i.e.:

A. What will continue to be done by health
B. What will be done through the joint commissioning arrangement
C. What will continue to be done by the LA

There is a desire, over time, that more activity will be directed through the joint arrangements. Although both groups commission, there are still perhaps subtle and obvious differences in the approach. As greater strides are taken to a partnership approach, it is important to explore those similarities and differences.

What roles and responsibilities the providers will take (as per each commissioned service or areas) is at this point less clear. It was felt that with a clearer steer on the direction, providers would benefit from more time to work through delivery solutions, for each service, clarifying how roles and responsibilities would be managed.

#### Attitude to Risk

It is not yet clear what the risk tolerances are across the group. This is often different across partnerships (of any form) and is an important area to discuss and more clearly specify, as part of the operational model. Differences can be appropriately tolerated, if they are shared and transparent. Difficulties are introduced in new partnerships, where these factors are less visible and/or one partner assumes, for example, that the attitude to risk is the same across the partnership.

Risk is referred to here in its broadest sense—role of the partnership, future direction, financial and organisational.

The same is true of the provider network, although their ability to discuss and set this out is more dependent upon having a practical service model and/or example to work through. However, it is clear and understood that only if providers are willing to share risk, up to agreed tolerances, will different and required service solutions be developed for the people of Doncaster.

#### Decision-Making & Governance

It is recognised that although all Boards and decision making bodies of the respective commissioning groups have signed off the DPP in principle, more work needs to be done to take NEDs and Local Authority Members through the process, to ensure buy-in and importantly, to support the appropriate management of governance arrangements, which may not, in the first instance, be as flexible in supporting different and joint arrangements, as required.

This was mirrored by provider respondents. There is a recognition that organisational governance constraints and/or requirements could be used as a blocker of progress, if the system leadership and operational model are not correct, or are not fully owned by system leaders.
Leadership

Other Issues Raised as part of the Maturity Assessment

<table>
<thead>
<tr>
<th>A Programme Approach</th>
<th>Many respondents identified that the strength of the partnership will grow on the basis of its ability to deliver real and measurable change. There is a fine balance to be struck across the system leadership group and their respective teams of setting out and refining the plan and the rules of engagement, with delivery and reflection. There was strong agreement that high level principles have been established and now adopting a disciplined programme approach to the initiative will strengthen it. This required a clear plan, with timescales and milestones, as well as regular review and learning points. Learning through the doing the DPP seemed to be a strong preference. This of course needs consistent understanding and management of how any of the system polarities, or issues, will be handled. There was also strong and similar views expressed that once the framework was established, that leaders needed to hold their nerve and not go back upon plans, behaviours, or agreements that had already been made. This is obviously not simply a matter of having a strong programme approach, but also of growing trust and commitment to the group, rather than to the individual institutions. This cannot be forced, but must grow. Undoubtedly, having clear parameters will support this nascent collaboration. Some respondents highlighted pace. This was more in terms of needing to keep momentum and managing chunks of delivery and action, with appropriate points of reflection. Because the arrangements will be appropriately tested through cohort and service groups, there is some apprehension that some provider partners attention will wane.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Joining the Strategic Dots</td>
<td>It was felt that as part of the further development of the DPP, there needed to be closer attention to how the programmes of work fitted within the wider regional and local context, particularly in terms of the South Yorkshire &amp; Bassetlaw Strategic Transformation Plan, but also local initiatives such as DN 21 and local transformation plans. It was recognised that the local issues are probably easier to handle.</td>
</tr>
<tr>
<td>Developing the Compelling Narrative &amp; Engagement</td>
<td>There are good levels of engagement and representation from senior leaders across the health and care economy. This is vital at the planning and partnering stage. However, it was recognised that part of the test of the new relationships and ways of working will be its ability to engage and direct next tiers of commissioning and provider organisations. More attention needs to be given in this first phase, to develop a compelling and consistent narrative around the plan, to support understanding and wider engagement – to deliver the vision.</td>
</tr>
<tr>
<td>Organisational Development</td>
<td>Likewise, this may require, in time, support to both commissioning and provider organisations to change ways of planning, delivering and working to move to a different model of partnership across Doncaster. This will require attention to shaping joint culture, skills, competencies and mind-sets. Although this is not an immediate priority, it needs some consideration early in the process, so that partners organisations are ready, confident and capable to deliver changes</td>
</tr>
</tbody>
</table>
Leadership

Next Steps
As the work on the service model develops, there needs to be connected and parallel development on the specification of the operating model for the system leadership group - as commissioners, as providers and finally, as a connected system. To do this, it would be useful to work through a number of scenarios, and/or ‘system polarities’ attached to practical services to test and develop the system response. Some of these are represented below, from discussion so far. This will help set clear rules of engagement, which are practical, but which also shape a system leadership framework, or concordat.

Example System ‘Polarities’

- Competition
- Collaboration
- Stasis
- Innovation
- Low Risk
- High Risk
- Organisation
- System
- Service
- Outcome
- Transaction
- Transformation

X Insert Next Workshop Views?
Play back the programme of sole commissioner – so provider and joint commissioner/provider workshops 1.
Appendix II - Governance
The current governance of the Doncaster Place Plan was mapped through conversations with Stakeholders from the CCG and DMBC. The intention was to understand the current Steering and Working groups of the Doncaster Place Plan in addition to all governance in place for the programme i.e. Decision making forums, Escalation points, Roles and Responsibilities of Groups/Boards, etc.

The designated chains of governance illustrated from these conversations can be observed below:
Observations:
The current governance of the Doncaster Place Plan is not fit for purpose this is due to the following factors:

- There is no formalised Steering Group – A steering group for a programme as large as this is essential to ultimately design the strategic vision of the programme and ensure risks & issues are discussed and resolved in a timely manner. Currently the Health & Social Care System Transformation Governance Group is the steering group however this group has no delegated responsibility or authority.

- There is no formalised Working Group – A working group is essential for a programme as large as this to formulae work products and drive the programme forward in addition to highlighting potential risks & issues for resolution/escalation. Currently the Task and Finish group is the working group however this is not a formal channel of governance in addition the group has no delegated responsibility or authority.

- There is no formalised Joint commissioning group with delegated authority to design the function of the Doncaster Place Plan – A joint forum to discuss the proposed function of commissioning is not in place which is a potential barrier for formalised plans being designed by an authorised authority.

- There is no formalised Joint provider group with delegated authority to design the form of the joint commissioned services – A joint forum for the proposed form of services is not in place this could be a potential barrier as no forum exists to discuss the method in which services will be delivered by providers who are in partnership. Proposed plans currently need to be signed off by multiple organisational boards which could lead to delays and challenges in decision making which could impact programme timelines and delivery.

Recommendations
In order for the Doncaster Place Plan to have a robust governance process the following governance arrangements should be formalised:

- Steering group for the Doncaster Place Plan
- Working group for the Doncaster Place Plan
- Joint Commissioning group for the Doncaster Place Plan
- Joint Provider group for the Doncaster Place Plan
- Both statutory and local reporting also need to be considered in terms of who compiles which report and what governance arrangements review them.
Appendix III - Workforce As Is
Workforce Headcount

- This following information sets the scene for understanding the current workforce across all partners which will support the aims of the Place Plan.

- Most pay costs typically relate to direct pay costs and do not include ‘on costs’. Typically an uplift of around 25% to 30% is used to include ‘on-costs’. Where FTEs has been used this is clearly stated.

- It is important to note that the Place Plan looks at the future state whilst this looks as a snapshot of the current workforce figures.

- The services impacted by the Place Plan are not well defined so a mapping exercise needs to occur to allow us to understand which of the current workforce relates to the future Place Plan vision.

Rotherham, Doncaster & South Humber NHS Foundation Trust

Rdash are now arranged over 4 Care Groupings:
- Doncaster
- Rotherham
- North Lincolnshire
- Children’s

The Place Plan focusses only on the Doncaster Care Group and the Doncaster residents within the Children’s Care Group. It has not been possible to identify the Doncaster element of Children’s Care Group.
Within the Doncaster Care Group there are 2 teams. Service 1 is involved in the delivery of services whilst Service 2 is involved in access and locality.

Service 1 includes around 720.21 WTE staff the following service groupings:
- Rehabilitation – 72.77 WTEs
- Drug and Alcohol – 111.76 WTEs
- Specialist Palliative – 106.15 WTEs
- Intermediate Care & Frailty – 118.86 WTEs
- Forensic – 123.64 WTEs
- Learning Disability – 193.13 WTEs

Service 2 includes around 773.32 WTEs and includes the following groupings:
- Mental Health Rehabilitation – 72.53 WTEs
- Acute All Age Mental Health – 130.51 WTEs
- Access and Liaison – 118.10 WTEs
- Rapid Response – 102 WTEs
- North Locality – 82.17 WTEs
- Central Locality – 110.37 WTEs
- East Locality – 84.80 WTEs
- South Locality – 74.41 WTEs

In total the Doncaster Care Group has around 1,493.53 WTEs and has £58.5m Direct Pay Costs. Service 1 contributes £28.8m to this figure and Service 2 contributes £29.7m.

The outstanding information is around the overheads for management costs and the Doncaster element of the Children’s Care group.
NHS Doncaster Clinical Commissioning Group

- The CCG employs 166.81 WTEs with a total direct pay cost of £6,258,482.
- These figures do not include a number of services which the CCG outsources. The outsourced services include:
  - Payroll
  - HR Shared Services
  - Occupational Health
  - Health and Safety
  - Legal Advice
- Costs for the services above are not included in the workforce figures.
- The CCG workforce is split by the following groupings:

<table>
<thead>
<tr>
<th>Staff Grouping</th>
<th>WTEs</th>
<th>Total Direct Pay Costs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Corporate Services</td>
<td>15.24</td>
<td>£409,958</td>
</tr>
<tr>
<td>Finance and Contracting</td>
<td>19.97</td>
<td>£708,641</td>
</tr>
<tr>
<td>Governing Body</td>
<td>9.45</td>
<td>£878,224</td>
</tr>
<tr>
<td>Primary Care</td>
<td>3.79</td>
<td>£135,258</td>
</tr>
<tr>
<td>Quality and Patient Safety</td>
<td>89.45</td>
<td>£2,895,859</td>
</tr>
<tr>
<td>Senior Management Team</td>
<td>3.0</td>
<td>£251,752</td>
</tr>
<tr>
<td>Strategy and Delivery</td>
<td>25.91</td>
<td>£978,790</td>
</tr>
</tbody>
</table>

Doncaster Local Medical Committee

There are 43 GP Practices across Doncaster with approximately 140 GPs. The map below shows the distribution across the 4 localities.

The LMC currently represent the GP Practices within Doncaster. We do not have access to their workforce figures.
The following data has been culled from EY’s previous work with the Council ‘Annex 1 – Baseline FINAL’.

Need to confirm if this includes all services covered by the Place Plan and to exclude any beyond the Place Plan and include any above the original EY work.

Current services (excluding Public Health) are forecast to spend £133m per annum gross (£90.5m net). Around 940 FTE are currently in post, with an additional 100+ vacancies.

This information is based on 2016/7 budget (including recharges) and data from the HR system.

Services continue to predominantly focus on delivery - Two thirds of FTE effort is aligned to service delivery - key areas are specialist care (~240 FTE), Home Care (124 FTE), Community Safety (117 FTE) and Libraries and Culture (64 FTE).

This is the breakdown of services and WTEs:

<table>
<thead>
<tr>
<th>Assistant Director</th>
<th>Head of Service</th>
<th>Gross Cost</th>
<th>Net Cost</th>
<th>FTE</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>ADULTS SOCIAL CARE</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>25,292,300</td>
<td>17,402,000</td>
<td>573.33</td>
<td></td>
</tr>
<tr>
<td>Care Management</td>
<td>7,947,200</td>
<td>7,402,700</td>
<td>140.70</td>
<td></td>
</tr>
<tr>
<td>Community Provision</td>
<td>6,017,500</td>
<td>5,134,600</td>
<td>192.55</td>
<td></td>
</tr>
<tr>
<td>DEFUNCT SERVICES</td>
<td>3,340</td>
<td>3,340</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Directorate Management</td>
<td>26,600</td>
<td>26,600</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Specialist Care</td>
<td>10,067,600</td>
<td>8,494,800</td>
<td>250.60</td>
<td></td>
</tr>
<tr>
<td><strong>COMMUNITIES</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>14,773,600</td>
<td>9,476,800</td>
<td>247.40</td>
<td></td>
</tr>
<tr>
<td>Communities</td>
<td>5,668,100</td>
<td>3,468,500</td>
<td>89.20</td>
<td></td>
</tr>
<tr>
<td>Community Safety</td>
<td>3,629,700</td>
<td>1,628,200</td>
<td>63.27</td>
<td></td>
</tr>
<tr>
<td>Leisure &amp; Culture</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td></td>
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<tr>
<td>Libraries &amp; Culture</td>
<td>5,206,100</td>
<td>4,377,400</td>
<td>90.05</td>
<td></td>
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<tr>
<td>Translation Services</td>
<td>259,480</td>
<td>190</td>
<td>3.33</td>
<td></td>
</tr>
<tr>
<td>Improving Families</td>
<td>20</td>
<td>20</td>
<td>2.00</td>
<td></td>
</tr>
<tr>
<td><strong>DIRECTOR OF ADULT SERVICES</strong></td>
<td>187,056</td>
<td>187,056</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td><strong>MODERNISATION &amp; COMMISSIONING</strong></td>
<td>19,907,400</td>
<td>12,846,600</td>
<td>41.3</td>
<td></td>
</tr>
<tr>
<td>Commissioning &amp; Contracts</td>
<td>88,488,000</td>
<td>60,121,600</td>
<td>19.47</td>
<td></td>
</tr>
<tr>
<td>Modernisation &amp; Improvement</td>
<td>1,030,700</td>
<td>1,030,700</td>
<td>15.77</td>
<td></td>
</tr>
<tr>
<td>Safeguarding Adults</td>
<td>343,500</td>
<td>343,500</td>
<td>5.33</td>
<td></td>
</tr>
<tr>
<td><strong>PUBLIC HEALTH</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>20,309,700</td>
<td>12,548,800</td>
<td>27.22</td>
<td></td>
</tr>
<tr>
<td>Commissioning</td>
<td>10,038,320</td>
<td>10,038,320</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Public Health</td>
<td>1,043,800</td>
<td>1,043,800</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Well Programmes</td>
<td>9,173,800</td>
<td>9,173,800</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td><strong>Other (Unallocated)</strong></td>
<td>0</td>
<td>0</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td><strong>Grand Total</strong></td>
<td>152,090,260</td>
<td>90,126,060</td>
<td>947.38</td>
<td></td>
</tr>
</tbody>
</table>

FTE allocated according to operating model area:

- Contact: 1%
- Community: 6%
- Assessment: 9%
- Delivery: 14%
- Strategic Core: 70%
Workforce

Doncaster & Bassetlaw Teaching Hospitals NHS Foundation Trust

- We were not able to gather information but have found the following numbers from the Trust’s website.
- Total staff employed as at 31 March 2015 (excl. bank and locum) are 6,638 (5,486.29 FTEs)

<table>
<thead>
<tr>
<th>FTEs</th>
<th>Headcount</th>
<th>FTEs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical Support</td>
<td>1,277</td>
<td>1,049</td>
</tr>
<tr>
<td>Other Healthcare professionals</td>
<td>726</td>
<td>643</td>
</tr>
<tr>
<td>Medical and Dental</td>
<td>503</td>
<td>480</td>
</tr>
<tr>
<td>Nursing and Midwifery</td>
<td>1,889</td>
<td>1,620</td>
</tr>
<tr>
<td>Non clinical (Administrative &amp; Clinical and estates &amp; ancillary)</td>
<td>2,243</td>
<td>1,620</td>
</tr>
<tr>
<td>Total</td>
<td>6,638</td>
<td>5,486</td>
</tr>
</tbody>
</table>

Doncaster Children’s Services Trust

- No data received as yet but from Business Plan 2016-19, the following numbers have been sourced

<table>
<thead>
<tr>
<th>Grouping (FTEs)</th>
<th>Doncaster Council</th>
<th>Department for Education</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Operational</td>
<td>428.4</td>
<td></td>
<td>428.4</td>
</tr>
<tr>
<td>Support</td>
<td>110.0</td>
<td>27.5</td>
<td>137.5</td>
</tr>
<tr>
<td>Total</td>
<td>538.4</td>
<td>27.5</td>
<td>565.9</td>
</tr>
</tbody>
</table>

- Total pay costs of £20,406,000 in 16/17
Fylde Coast Medical Services

► According to the figures provided by FCMS, the Doncaster services have an average of 99 staff.
► This figure includes around 45 substantive non clinical staff and 20 substantive clinical staff.
► In addition, the service typically uses 21 Agency GPs and 13 Agency Nurses/ECPs.
► We do not have the total pay costs associated with these numbers.

Next Steps

► Where gaps exist, it would be useful to complete the picture of total staff and pay costs across all providers and commissioners.
► In Phase 2, these figures will need to be broken down for the priority ‘areas of opportunity’.
► As the future operating model and scope of services become clear, it will be necessary to assess the skills and capabilities across all groups and to evaluate these against future needs.
Appendix IV - Shared Transformation Plans
# CCG & Council Shared Transformation Plans:
## Adult Health and Well Being Project
### Complex Dependencies Project

<table>
<thead>
<tr>
<th>Project</th>
<th>Cohort</th>
<th>Scope / vision</th>
<th>Capabilities / changes</th>
<th>Focus area</th>
<th>Stage of development</th>
<th>Timescale</th>
<th>Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Adult Health &amp; Wellbeing</strong></td>
<td>C - delivered in localities</td>
<td>The Vision ‘People are able to look after their own health and wellbeing, but know that support is always available from us and the community’.</td>
<td>Project 1: Customer Journey Project 2: Community Led Support Project 3: Transforming Commissioning Project 4: Digital and Technology Project 5: Performance Management and Continuous Improvement Project 6: Alternative Service Delivery Models Project 7: Health and Social Care Integration</td>
<td>Population: Adults Neighbourhood: all</td>
<td>There are current immediate business improvement projects that are linked to this programme and delivering at this point in time. The Transformation Programme itself commences on 1st April 2017. It has a fully agreed business case and plan and is on track to deliver.</td>
<td>The Programme will be in place between 2017 and 2022. Key milestones are mainly financial at this stage though operational milestones are being developed within the process of producing individual project PIDs. Financial savings milestones are as follows - 2017/18 £4.3m 2018/19 £4.6m 2019/20 £3.2m 2020/21 £1.7m 2021/22 £900K. Total for the programme equals £14.6m.</td>
<td>More people on direct payments More people every month having meaningful conversations in their own communities 50% reduction in people accessing our front door Individual budgets are now our preferred model of choice Up to 30 community hubs 80% of people will use IAG or self serve Over 200 more older people given the support they need to live at home More than 60 adults of working age with a disability living independently Fewer staff Integrated commissioning with CCG Shared NHS and social care data Through ASDMs new companies formed – Domestic Abuse, Day Opportunities, Libraries Savings: 2017/18 £4.3M 2018/19 £4.6M 2019/20 £3.2M 2020/21 £1.7M 2021/22 £900K Total programme net savings £14.6M (all reflected in the MTFF)</td>
</tr>
<tr>
<td><strong>Complex Dependenc es</strong></td>
<td>A - delivered in localities</td>
<td>Engage directly and build trusting relationships with people with complex needs in a variety of settings Develop a multi-disciplinary team with a common theory of practice Development of asset-based approaches to build on individuals’ existing relationships and skills and enabling them to take actions Improving outcomes for people with complex needs Reduce demand</td>
<td>Population: 53 identified individuals Neighbourhood:</td>
<td>Definition phase</td>
<td>Development of assertive outreach and engagement team - Jan - Mar 2016 Prototype in central locality - tbc Evaluation of prototype - tbc Roll out of new delivery model - tbc</td>
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</tr>
</tbody>
</table>
### Early Help Project

#### Cohort A - delivered in localities

- **Scope / vision**: "To prevent and intervene early with children, young people and families experiencing problems in order to prevent escalation of problems. This will deal with root causes, providing support at an early age and an early stage of problems emerging. We will do this by taking a whole family approach and intervening in a co-ordinated way."

- **Capabilities / changes**:
  - Reduction of Assets - Children's and Youth Centres
  - Strategic Youth Alliance Development of Children's Voice and Advocacy
  - Development of Early Help Strategic Partnership
  - Starting Well Family Hubs
  - Transfer of Family Support Workers to DCST - by 31.3.2017
  - Roll out of Outcomes Star - by 31.3.2017 and then BAU
  - Data and systems

- **Focus area**:
  - Population: 0-19 year olds
  - Neighbourhood: all Doncaster

- **Stage of development**:

- **Timescale**:
  - Current strategy runs from 2015-2018 - this is currently being reviewed by the Strategic EH Partnership Group
  - Y1 2016/17 - Focus on Social Care pathway
  - Y2 2017/18 - increase quality of Early Help Partnership support; align other public sector Early Help provision (e.g. Local Transformation Programme, Children and Young peoples plan); launch and embed the family hub integrated model; Improve Information, Advice and Guidance; generate contributions from partners through evidencing the value of Early Help; embed implementation of Outcomes Star
  - Y3 2018/19 fully embed locality integrated working

- **Benefits**:
  - All families supported through universal services at the earliest opportunity
  - Resilience in families
  - Reduction in referrals to specialist services
  - Sustainable youth offer

### Learning Disability (CCG)

#### C-Doncaster wide

- **Scope / vision**: Delivery of the core principles of Building the Right Support in Communities of People with a Learning Disability and / or ASD

- **Capabilities / changes**:
  - Deliver Transforming Care Partnership plans with local government partners, enhancing community provision for people with learning disabilities and / or autism
  - Prevent people from going into crisis, support people to live as independently as possible in the community and prevention of the need for out of areas placements. Reduce cost pressures on spend for our of area placements

- **Focus area**:
  - Population- all ages with LD, full spectrum but transforming care around specific pathways. NB gap re autism and ADHD
  - Place Plan Cohort: Across all: Cohort A: Prevention & Early Help; Cohort B : Integrated Intermediate Health & Social Care; Cohort C: Enablement and Recovery
  - Neighbourhood or geographical area (includes footprints wider than Doncaster): Doncaster, Sheffield, N Lincs, Rotherham; LA work only Doncaster population

- **Stage of development**:
  - Live- early 2016

- **Timescale**:
  - From April 2017 - Key Actions:
    - Reduce out of area placements – step down from locked rehabilitation
    - Development of Enhanced Community Team
    - Enhanced primary care support for people with a learning disability including annual health check
    - Implement intermediate care model – step down and step-up crisis management
    - Enhancement acute liaison services

- **Benefits**:
  - Reduce inpatient bed capacity by March 2019 to 10-15 CCG commissioned beds per million population, and 20-25 in NHS England commissioned beds per million population
  - Improve access to healthcare for people with learning disability so that by 2020 75% of people on a GP register are receiving an annual health check.
  - Reduce premature mortality by improving access to health services, education and training of staff, and by making necessary reasonable adjustments for people with a learning disability
  - Remodelled provision of step down/up services supported by an enhanced community service focusing on patient case management and supporting individual need. This will deliver patient care within the local community and within the least intensive setting by ensuring timely intervention, identification of preventative care, avoidance of out of area care. Resourced through remodelling of existing commissioned inpatient and community capacity to provide timely and efficient patient interventions.
## CCG & Council Shared Transformation Plans: Mental Health Project

| Cohort                     | Scope / vision                                                                 | Capabilities / changes                                                                 | Focus area                                                                                      | Stage of development                                                                 | Timescale                                                                                             | Benefits                                                                                                                                                                                                 |
|----------------------------|--------------------------------------------------------------------------------|----------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------|
| C- delivered locally       | People with mental health problems will have sustained recovery, have access to information and peer support in order to maintain their wellbeing. People with a mental health problems will enjoy good physical health and emotional wellbeing. Primary Care and Secondary Care services will be responsive and supportive to those who experience mental ill health and they will have a positive experience and outcome. | Population-all age MH although children’s been developed a little separately; facing 4 neighbourhood areas. Place Plan Cohort: All cohorts: Cohort A: Prevention & Early Help; Cohort B: Integrated Intermediate Health & Social Care; Cohort C: Enablement and Recovery Neighbourhood or geographical area (include footprints wider than Doncaster): 4 neighbourhoods | Live-commenced at different time but 15/16 for 5 year forward view; except MH liaison which not yet underway | From April 2017 - Key Actions: • Implementation of Single Point of Access for all age mental Health services; • Development of collaborative pathways to deliver physical health for people with severe and enduring mental health problems; • Development of community based model to improve perinatal mental health; • Modernise the adult mental health acute care and home treatment pathway • Progress development of Early intervention in psychosis services • Deliver IAPT Plus and start the development of IAPT to include employment advisors improving access to employment opportunities • Develop the IAPT pathway to include joint care management of people with long term conditions • Core 24/ MH liaison development • Transferring stable patients back to primary care inc training at practice level by RDASH consultant and locally developed algorithm to support. Annual health check – will be further local tools developed to support • Comms both to staff/ primary care and out to general public • Bringing OOA patients back from locked rehabilitation and children also done (tripartite funding) | • Reduce suicide rates by 10%, against 16/17 baseline and understand significant events alongside suicides • Ensure delivery of MH access and quality standards incl 24/7 access to community crisis teams, home treatment teams, and MH liaison services in acute hospitals; • Reduction in A&E attendances due to improved access to crisis prevention and crisis support services; • Reduction in A&E attendances of people who are supported to better manage their Long Term Condition • 50% reduction in avoidable A&E attendances by frequent flyers (£10,10) • Expand capacity so that 53% of people begin a NICE recommended package of care within two weeks of referral; • Additional psychological therapies, so that at least 19% with anxiety and depression access treatment through integration with Primary Care; • Increase access to individual placement support for people with severe mental illness in secondary care by 25% by April 2019, against 17/18 baseline. • Increase baseline spend on MH services to deliver MH Investment Standard; • Eliminate out of area placements for non-specialist acute care by 2020/21. |
### Intermediate Care Project

#### CCG & Council Shared Transformation Plans:

<table>
<thead>
<tr>
<th>Cohort</th>
<th>Scope / vision</th>
<th>Capabilities / changes</th>
<th>Focus area</th>
<th>Stage of development</th>
<th>Timescale</th>
<th>Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td>B - Doncaster wide</td>
<td>Intermediate Care will be simpler and more responsive. There will be fewer teams and less hand-offs along the intermediate care pathway. Intermediate Care will do more to maintain people at home and prevent admissions and A&amp;E attendances as well as stepping people down from hospital as early as possible. Intermediate Care will be part of the local neighbourhood model to ensure continuity of care, maintenance of social networks and will build on existing community assets. The majority of Intermediate care services will be in the community, to support people in their own bed with less bed based intermediate care services. The Intermediate Care workforce will be able to respond to physical, mental health and social care needs in an integrated way.</td>
<td>Population-all adults, not condition specific, no exclusions but tends to be older frail people and very old ie 85 plus. Place Plan Cohort: Cohort A: Prevention &amp; Early Help; Cohort B : Integrated Intermediate Health &amp; Social Care; Cohort C: Enablement and Recovery</td>
<td>Neighbourhood or geographical area (include footprints wider than Doncaster): whole of Doncaster; some elements could be delivered through neighbourhoods</td>
<td>November 2016- April 2017</td>
<td>1. Test and refine delivery model by implementing and evaluating a series of discrete projects with providers 2. Undertake skills audit and agree workforce development plan 3. Further engagement with patients, carers and the public to develop the model 4. Complete financial and activity modelling 5. Continue to develop appropriate joint commissioning and provision model 6. Identify any procurement processes required and plan accordingly. (Intention is to work with current providers to develop existing services) 7. Develop a joint dashboard for intermediate care</td>
<td>Maintenance or improvement in reported patient experience of intermediate care services. More service users are supported to maintain their independence, live at home and in the community as long as possible. A greater proportion of people feel supported to manage their long term condition(s). More service users will be enabled to reach their goals and maintain connections with their home and community environments. More responsive to step up referrals. Reduced A&amp;E attendances for people aged 75 and over (or limited growth). Reduced emergency admissions for people aged 75 and over (or limited growth). Proposal = Year 1 x% Year 2: x% TBC. Reduced ambulance conveyance to A&amp;E for people aged 75 and over Proposal 5% reduction initially - linked to YAS pathfinder target, increasing to x%. Reduced Delayed Transfers of Care. More people remaining at home following discharge from an acute bed. Fewer admissions to Intermediate Care beds, less intermediate care beds. Reduce bed base by 50% initially. Increase in community based intermediate care activity (linked to reduction in bed based activity) Reduce A&amp;E attendances by a cost of - not yet quantified Reduced emergency admission episodes by - not yet quantified. Reduction in excess bed days - not quantified. Reduced A&amp;E attendances - refer to Urgent &amp; Emergency Care Plan. Reduced conveyance to A&amp;E - refer to Urgent &amp; Emergency Care Plan. Implement new service model within or under existing financial envelope for intermediate care. Reduction in social care costs: Admissions into long term care are reduced. Reduction in level of on-going care needed as a result of reablement</td>
</tr>
</tbody>
</table>
## CCG & Council Shared Transformation Plans:
### Primary Care Project

<table>
<thead>
<tr>
<th>Cohort</th>
<th>Scope / vision</th>
<th>Capabilities / changes</th>
<th>Focus area</th>
<th>Stage of development</th>
<th>Timescale</th>
<th>Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td>A - delivered in localities</td>
<td>Patients of all ages will be able to access a range of primary care in different settings, dependent on clinical need. Greater focus on health promotion, prevention, early diagnosis and interventions via the Keeping People Well pillar specification.</td>
<td>Timely access to the right skilled clinician.</td>
<td>Population- all age groups (responsive, extended) but 2 pillars focussed on complex frail 2% (the proactive pillar) keeping well pillar (18-40 that have multiple risk factors not already on a disease register).</td>
<td>Conceptual- responsive or Defined- keeping well and extended (PC committee and engagement group all received) or Live-proactive pillar</td>
<td>Quality Implementation of the Quality Assurance Framework and Primary Care Dashboard to support general practice delivering good quality care. Launch with general practice December 2016, initial intelligence gathering and dialogue to take place Jan-June 2017. Investment National resilience, sustainability and transformation support programmes for GP Practices (Dec 2016 – March 2018). Investment in the Primary Care Strategy Model including the specifications for the Proactive Coordinated Primary Care Service, Extended Primary Care Service, Keeping People Well Service and Responsive Primary Care Service (from April 2017). Workforce Ring-fenced funding via CCG towards training for receptionists in active signposting and upskilling clerical staff to manage correspondence (Dec 2016 – March 2019). Practice Manager Development Programme. Second wave of the clinical pharmacist in practice scheme. Investment into the General Practice Nurse Development Strategy. Workload Releasing Time for Care programme Support practice EOIs by June 2017, &amp; implementation of the 10 high impact actions thereafter. Implement Productive General Practice programme in Doncaster April – June 2017. Support uptake of GP Improvement Leader Programme. Support update of Practice Manager Development Programme (national scheme). October 16 – April 18 Practice Infrastructure Capital investment in estates and technology infrastructure, Cohort 1 practice by March 2017, Cohort 2 by March 2019. Extra investment to support practices to adopt online consultation. Implementation of the national specification from April 2017.</td>
<td></td>
</tr>
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</table>
**CCG & Council Shared Transformation Plans:**

### Stronger Families Project

**Well North Project**

<table>
<thead>
<tr>
<th>Project</th>
<th>Cohort</th>
<th>Scope / vision</th>
<th>Capabilities / changes</th>
<th>Focus area</th>
<th>Stage of development</th>
<th>Timescale</th>
<th>Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stronger Families</td>
<td>A - Doncaster wide</td>
<td>To transform services to reduce dependence on high cost and often long term services, through the use of targeted and personal support to those families in greatest need, working with them in a whole family approach, bringing together the right services at the right time and as early as possible.</td>
<td>Population: agreed cohort of 2920 families. Neighbourhood: all Doncaster.</td>
<td>The national Troubled Families Families Programme, known locally as Stronger Families commenced in its first phase in April 2012, following the success of that phase Doncaster became eligible for the expanded programme which commenced in April 2015 and has a 5 year lifespan. Assessment against the national programmes maturity model is that Doncaster is 'developing' we have a targeted number of families to engage and to support to achieve successful outcomes by the end of the 5 years.</td>
<td>Expended Programme (5 Years) commencing April 2015. Milestones can be defined in the profiled targets for the numbers of families that Doncaster intends to work with, and in respect of transformational changes against the National Maturity Model.</td>
<td>Doncaster has agreed to work with 2950 families (minimum) across the life of the programme, and achieving successful outcomes will be measured by either, moving a family member off out of work benefits and into work, or, the whole families has sustained and significant improvements across all of their identified issues. Transformational change is to reduce the long term demand and dependency on services and improve efficiency across the partnership. Through the development of enhanced ways of working, interventions have become much more evidence based, and we can show that interventions with families work. This has a number of benefits including more value for money, more effective outcomes for families, less duplication and greater efficiencies for services.</td>
<td></td>
</tr>
<tr>
<td>Well North</td>
<td>A - Local delivery</td>
<td>Address health inequalities to improve the health of the poorest fastest, increase resilience at individual, household and community levels, reduce worklessness and increase enterprise.</td>
<td>Well Doncaster is delivering a number of distinct action plans; environment and green space, community assets, community leadership, work and enterprise, arts &amp; culture and invisible people. Research and evaluation cuts across these.</td>
<td>Neighbourhood: Denaby.</td>
<td>Delivering</td>
<td>Start date April 2015. Budget profiled to 2020/21</td>
<td>Reducing demand on unplanned healthcare (number of A&amp;E attendances and emergency admissions), reducing demand on adult social care (long term residential placements), reducing the number of people claiming out-of-work benefits (JSA, ESA, IB) and increasing self-employment. Well Doncaster is a principle-based intervention working to a holistic model to create connected and healthy communities. Long term outcomes are to reduce demand on unplanned healthcare, reduce demand on long term social care and reduce out of work benefits. However the programme has not estimated or committed to specific measureable benefits.</td>
</tr>
</tbody>
</table>
Appendix V - References
### Good practice examples for out of hospital services (1 of 4)

<table>
<thead>
<tr>
<th>Service</th>
<th>Description</th>
<th>Qualitative Benefit</th>
<th>Evidence</th>
<th>Financial Benefit</th>
</tr>
</thead>
</table>
| **Bed based intermediate care** | ▶ Smoother access to intermediate care via access function  
▶ Aiming to reduce the length of stay by harnessing the role of home based intermediate care and the community treatment teams.  
▶ Clinical oversight provided by the integrated geriatricians service | ▶ Supported, smoother transition from hospital  
▶ Additional step sideways capacity to support people to prevent a hospital admission | ▶ NHS benchmarking - The first National Audit of Intermediate Care | ▶ Avoiding admissions  
▶ Reduction in excess bed days  
▶ Reduction in attendance due to alternative settings |
| **Home based intermediate care** | ▶ Consolidating reablement and CARA into a single service that supports hospital discharge and provides a longer term intervention where required from urgent response | ▶ Supporting more people to remain at home with the right support  
▶ Prevention of residential care admissions | ▶ Bristol PCT and Bristol County Council – net savings of £3.6m | ▶ Joint impact of UT, UAR, HBIC and RAP  
▶ Admissions, attendances and bed days avoided |
| **Rapid Access Packages** | ▶ As part of the intermediate care, short term domiciliary care packages would be available in urgent situations and when there is no immediate rehabilitation potential. | ▶ Enabling timely access to short term domiciliary care provision to enable people to return/remain at home | ▶ Barking, Havering and Redbridge | ▶ Reduction in residential care admissions  
▶ Reduction in acute admission  
▶ Reduction in excess bed days |
| **Residential Healthcare Service** | ▶ A GP led service supporting care homes.  
▶ Delivers more proactive care  
▶ Focus on ensuring palliative care arrangements in place.  
▶ Up-skilling care home staff to have better health input.  
▶ Supported by Pharmacy undertaking medicine usage review and prescription services.  
▶ Supported by integrated community treatment team where needed  
▶ Provides own out of hours service  
▶ Provides medical cover for short term residential beds | ▶ Improved equality and access to health care for care home residents.  
▶ Reduction in medical needs requiring secondary care.  
▶ Improved end of life care.  
▶ Improved quality in care home provision | ▶ Improving care in residential care homes: a literature review (JRF, 2008) | ▶ Reduction in admissions  
▶ Potential to reshape continuing health care and commissioning of nursing placements  
▶ Supports hospital discharge |
<table>
<thead>
<tr>
<th>Service</th>
<th>Description</th>
<th>Qualitative Benefit</th>
<th>Evidence</th>
<th>Financial Benefit</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Hospital Transfer Team</strong></td>
<td>Increasing the efficacy of the health and social care hospital discharge team.</td>
<td>Support people to get back to home or a home based setting in a safe, efficient way.</td>
<td>NHS St Helens</td>
<td>Reduction in excess bed days</td>
</tr>
<tr>
<td></td>
<td>Increase use of discharge planning tools across all ward staff.</td>
<td>Better discharge planning</td>
<td>Cambridge University Hospital foundation trust</td>
<td>Reduction in readmissions</td>
</tr>
<tr>
<td></td>
<td>Development of hub and spoke model to up-skill ward staff in discharge planning.</td>
<td>Better access to step down options</td>
<td>NHS Camden – Reach Early Discharge Team</td>
<td></td>
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<tr>
<td></td>
<td>Critical friend role to clinical staff re appropriateness for discharge of clinically stable patients – risk management and enablement through better skilled staff</td>
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<tr>
<td><strong>Integrated locality teams</strong></td>
<td>Integrated health and social care staff</td>
<td>Co-ordinated health and social care support with the individual at the centre of the co-ordination of care</td>
<td>North West London Integrated Care Pilot: 6.6% reduction in non-elective admissions</td>
<td>Admissions, attendances and bed days avoided.</td>
</tr>
<tr>
<td></td>
<td>Reablement and homecare attached to team for clients referred from community</td>
<td>Proactive identification and management of risks to reduce escalation of needs</td>
<td>Cockermouth – prevention: £2.20 return for every £1</td>
<td>Reduction in need for unplanned care through better management of client holistic needs and quicker access to low level support to prevent escalation/exacerbation.</td>
</tr>
<tr>
<td></td>
<td>Expectation that for existing clients who require reablement their home carer is up-skilled to deliver</td>
<td>Efficiencies in working practice and better continuity of care</td>
<td>Community Budgets Health and Social Care expected 50% reduction in non contact time due to streamlined referral processes in Solihull.</td>
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<tr>
<td></td>
<td>Move to named carer model in homecare contracts</td>
<td>Better understanding of the person to be able to manage their conditions and support them to navigate the health and social care system</td>
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<td></td>
<td>Key worker model which can be utilised in urgent scenarios to support decision making</td>
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<tr>
<td><strong>Increasing the use of equipment</strong></td>
<td>Further investment in more equipment to target falls and preventing admissions to residential care</td>
<td>People are more independent and able to live in their own homes for longer</td>
<td>‘Interventions for the prevention of falls … meta-analysis “ BMJ 2004</td>
<td>Prevention of hospital admissions</td>
</tr>
<tr>
<td></td>
<td>Pharmacies provide non-complex items potentially reducing the cost of logistics as an additional benefit</td>
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<td></td>
<td>Prevention of residential care admissions</td>
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<td>Prevention of need for urgent response and intermediate care</td>
</tr>
<tr>
<td>Service</td>
<td>Description</td>
<td>Qualitative Benefit</td>
<td>Evidence</td>
<td>Financial Benefit Description</td>
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</table>
| **Triage**                          | ► Providing a single point of access to urgent community assessment and response.  
► Includes social care, nursing and specialist clinical support.  
► Acts as one of two access points to intermediate care. | ► Alternative call for help at home.  
► Provide care and support in the home in urgent situations.  
► Rapid assessment and access to professionals.  
► Liaison with key worker for existing cases to ensure holistic management and right response. | ► Bristol PCT and Bristol County Council – net savings of £3.6m  
► NHS Salford – Rapid Response Health and Social Care Crisis Team  
► South-east Essex Community Services | ► Supports attendance and admission avoidance through providing a home base alternative.  
► Avoids admission to residential care due to additional community cover for more at risk clients. |
| **Assessment and Response**         | ► Assesment and provision in urgent circumstances to identify most appropriate pathway of care for individual  
► Where needed will provide 1-2 days care to eliminate need for acute care.  
► Part of ‘access function’ and can allocate intermediate care where longer term support may be needed  
► Initiate crisis MH beds or facilitate access back to CMHT where needed | ► As above  
► Provide instant access medical and social cover in crisis situation to help person to remain at home where possible or identify a suitable solutions to support needs without escalating to acute  
► Support GPs to identify and deliver ambulatory care pathways as well as understand other service options for patient management | ► Royal National Orthopaedic Hospital NHS Trust/King’s College NHS FT Trust/Medihome – support for acute patients at home  
► King’s College Hospital NHS FT – Older Person’s Assessment Unit | ► As above |
| **Use of Integrated Case Management in primary care** | ► Proactive case finding of at risk clients including social risks such as isolation or depression  
► Supported by locality teams, with a coordination role of community matrons and the health improvement team  
► Locality teams members attached to GP practices to coordinate the relationship and increase visibility of support options  
► Bring resources together, identify cases and support case conferencing to plan next steps and signpost | ► Better communication  
► Co-ordinated case planning across primary care, health, and social care services.  
► Better management of conditions  
► Better continuity of care  
► Up-skilling of staff re different options available to support patients | ► Cockermouth: £2.20 return on every £1 invested.  
► Barking and Dagenham  
► North West London care pilots 6.6% reduction in admissions | ► Cost of locality teams has allocated resource to undertake coordination  
► The GP cost and benefit analysis is out of scope |
## Good practice examples for out of hospital services  (4 of 4)

<table>
<thead>
<tr>
<th>Service</th>
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<th>Evidence</th>
<th>Financial Benefit Description</th>
</tr>
</thead>
</table>
| Investment in Nursing Care/ Residential Care | ▶ Multi-Disciplinary Teams (MDTs)  
▶ Enhance nursing and therapies in care homes - especially for those with complex needs  
▶ Improvements in oral health, hydration, and nutrition  
▶ Improvement in end of life care  
▶ Promotion of mental health and wellbeing | ▶ Improved health outcomes  
▶ Enhanced satisfaction for residents  
▶ More efficient use of resources | ▶ Islington MDTs: 26% decrease in admission and 87 less bed days per month.  
▶ Worcestershire community nurse: 23.1% reduction in A&E attendances  
▶ Peterborough review: 27% reduction in admissions | ▶ Reduction in bed days  
▶ Reduction in admissions |
Appendix VI - One Page Templates for the Areas of Opportunity
Mental Health

**Case for Implementation**

- Parity of esteem – for mental health to have the same importance as physical
- Improve outcomes by improving community services
- Improve the experience of people using the services
- Improve the safety and effectiveness of services
- Develop preventative services to break the cycle of spending resources in reactive way.

**Context**

- People with mental health problems will have sustained recovery, have access to information and peer support in order to maintain their wellbeing. People with a mental health problems will enjoy good physical health and emotional wellbeing.
- Primary Care and Secondary Care services will be responsive and supportive to those who experience mental ill health and they will have a positive experience and outcome.

**Scope**

- Reduce suicide rates by 10% against 16/17 baseline and understand significant events alongside suicides. Ensure delivery of MH access and quality standards incl 24/7 access to community crisis teams, home treatment teams, and MH liaison services in acute hospitals.
- Reduction in A&E attendances; by improved access to crisis prevention and crisis support services in addition to enhanced support to better manage Long Term Condition. 50% reduction in avoidable A&E attendances by frequent flyers (£10, 10). Expand capacity so that 53% of people begin a NICE recommended package of care within two weeks of referral. Additional psychological therapies, so that at least 19% with anxiety and depression access treatment through integration with Primary Care. Increase access to individual placement support for people with severe mental illness in secondary care by 25% by April 2019, against 17/18 baseline. Increase baseline spend on MH services to deliver MH Investment Standard. Eliminate out of area placements for non-specialist acute care by 2020/21.

**Assumptions**

- This area is commissioned by both the CCG and Council and is defined by the following services:
  - Rdash contract, Notts Healthcare Trust Contract, Sheffield Care Trust Contract, Various Specialist Packages, Various S117 Packages, Rethink Contract, Alzheimer's Society, Adult Social Care (Council), Modernisation and Commissioning (Council), Public Health (Council)

**Finances and Activity**

<table>
<thead>
<tr>
<th>Area</th>
<th>Volume</th>
<th>Metric</th>
</tr>
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<tbody>
<tr>
<td>RDASH Contract</td>
<td>1,354,777</td>
<td>MH Cluster days / contacts</td>
</tr>
<tr>
<td>Notts Healthcare Trust Contract</td>
<td>9,773</td>
<td>MH Cluster days</td>
</tr>
<tr>
<td>Sheffield Care Trust Contract</td>
<td>1,797 / 114</td>
<td>MH Cluster days / contacts</td>
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<tr>
<td>Specialist Packages</td>
<td>n/a</td>
<td>Individual Care Packages with Regular Review Periods</td>
</tr>
<tr>
<td>S117 Packages</td>
<td>n/a</td>
<td>Individual Care Packages with Regular Review Periods</td>
</tr>
<tr>
<td>Rethink Contract</td>
<td>4 beds</td>
<td>Occupied Bed Days</td>
</tr>
<tr>
<td>Alzheimer's Society</td>
<td>n/a</td>
<td></td>
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</tbody>
</table>

- The services above equate to £43.1m of Council and CCG commissioning costs with the CCG making up 95% of the total.

**Approach / Next Steps**

- Detailed Scoping to be done with Key stakeholders
- Develop and agree approach for the long term framework
- Detailed project plan to be developed
- Design and embed governance for the programme of work
- Validate end user and financial benefits
- Scope Risk/Issues and interdependences
- Assess key enablers (i.e. Estates rational and I.T)
# Learning Disabilities

## Context
- Population - all ages with LD, full spectrum but transforming care around specific pathways. NB gap re autism and ADHD
- Place Plan Cohort: Across all: Cohort A: Prevention & Early Help; Cohort B: Integrated Intermediate Health & Social Care; Cohort C: Enablement and Recovery
- Neighbourhoods - All Neighbourhoods are included in addition to specialist services in the surrounding areas.

## Scope
- Delivery of the core principles of Building the Right Support in Communities of People with a Learning Disability and / or ASD.
- Deliver Transforming Care Partnership plans with local government partners, enhancing community provision for people with learning disabilities and /or autism.
- Prevent people from going into crisis, support people to live as independently as possible in the community and prevention of the need for out of areas placements.
- Reduce cost pressures on spend for out of area placements.

## Case for Implementation
- Reduce inpatient bed capacity by Mar 2019 to 10-15. CCG commissioned beds per million population, and 20-25 in NHSE commissioned beds per million population.
- Improve access to healthcare for people with L&D so that by 2020 75% of people on a GP register are receiving an annual health check.
- Reduce premature mortality by improving access to health services, education and training of staff.

## Assumptions
- This area is commissioned by both the CCG and Council and is defined by the following services:
  - Rdash contract
  - Various Specialist Packages
  - Various S117 Packages
  - Adult Social Care (Council)
  - Modernisation and Commissioning (Council)

## Approach / Next Steps
- Detailed Scoping to be done with Key stakeholders
- Develop and agree approach for the long term framework
- Detailed project plan to be developed
- Design and embed governance for the programme of work
- Validate end user and financial benefits
- Scope Risk/Issues and interdependences
- Assess key enablers (i.e. Estates rational and I.T)

## Finances and Activity

<table>
<thead>
<tr>
<th>Area</th>
<th>Volume</th>
<th>Metric</th>
<th>CCG 34%</th>
<th>Council 66%</th>
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</thead>
<tbody>
<tr>
<td>Rdash Contract</td>
<td>9,416 / 5 beds</td>
<td>Contacts / Occupied Beddays</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Specialist Packages</td>
<td>n/a</td>
<td>Individual Care Packages with Regular Review Periods</td>
<td></td>
<td></td>
</tr>
<tr>
<td>S117 Packages</td>
<td>n/a</td>
<td>Individual Care Packages with Regular Review Periods</td>
<td></td>
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</tbody>
</table>

- The services above equate to £27.5m of CCG and Council commissioning costs.
- The Council contributes 66% of this total and the CCG contributes 34%.
Primary Care (Excluding GMS & PMS)

Context
- Patients of all ages will be able to access a range of primary care in different settings, dependent on clinical need.
- Patients able to make informed decisions about their healthcare and their independence is supported.
- Patients identified for coordinated care will receive regular multidisciplinary reviews by a team involving health and care professionals with the necessary skills to address their needs.

Scope
- Greater focus on health promotion, prevention, early diagnosis and interventions via the Keeping People Well pillar specification Timely access to the right skilled clinician.
- Patient care does not suffer as it moves between different services Access to primary care services will be timely. Primary Care will become more stable with working at scale and the establishment of accountable care organisations. Improved interoperability and integration between computer systems in primary care, the community and secondary care.
- Identification of 2% most vulnerable and complex patients. Practice to proactively treat and coordinate care of this cohort of patients.
- Confirmation of named professional and their respective caseloads
- Patients on the proactive coordinated care register will have a single care plan that will be shared with all professionals involved in their care.
- Patients will feel more empowered and motivated to take responsibility for their health and wellbeing.

Case for Implementation
- Slow development of general practice collaboration and working at scale
- Lack of focus and incentive on prevention and early detection
- Shortage in skill mix and workforce
- Variation of business models within practices
- Increased workload in primary care
- Increase in workload due to shift of services between secondary and primary care
- Lack of understanding regarding estates and infrastructure across Doncaster Practices

Finances and Activity

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<tr>
<th>Area</th>
<th>Volume</th>
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Approach / Next Steps
- Implementation of the Quality Assurance Framework and Primary Care Dashboard to support general practice delivering good quality care. Launch with general practice December 2016, initial intelligence gathering and dialogue to take place Jan - June 2017.
- Investment in the Primary Care Strategy Model including the specifications for the Proactive Coordinated Primary Care Service, Extended Primary Care Service, Keeping People Well Service and Responsive Primary Care Service (from April 2017).
- Releasing Time for Care programme Support practice EOIs by June 2017, & Implementation of the 10 high impact actions thereafter. Implement Productive General Practice programme in Doncaster April - June 2017.
- Support uptake of GP Improvement Leader Programme.
- Support update of Practice Manager Development Programme (national scheme)
**Urgent & Emergency Care**

**Context**
- A number of urgent care services were re-commissioned in Doncaster during 2015.
- These services are primarily those that are directly accessed by patients as their first step when seeking urgent care through choice and include: The Doncaster Same Day Health Centre; the Urgent Care Centre and the Front Door Assessment and Signposting Services at DRI.

**Scope**
- These services are currently provided by 2 different providers
- It has been recognised by the local System Resilience Group that this may be an area to test out an Accountable Care Partnership approach due to the interdependencies between the services.
- This area is commissioned by the CCG only and is defined by the following services:
  - Accident and Emergency (A&E) across DBTH NHS FT
  - Front Door Assessment and Signposting Service (FDASS) at DBTH NHS FT
  - Urgent Care Centre (UCC) provided by FCMS
  - Same Day Health Centre (SDHC) provided by FCMS
  - Emergency Care Practitioner Service (ECPS) provided by FCMS

**Case for Implementation**
- Providing better support for people and their families to self-care.
- Helping people who need urgent care to get the right advice in the right place, first time.
- Ensuring that adults and children with more serious or life threatening emergency needs receive treatment in centres with the right facilities
- Connecting all urgent and emergency care services together so the overall physical and mental health and social care system becomes more than just the sum of its parts.

**Finances and Activity**

<table>
<thead>
<tr>
<th>Area</th>
<th>Volume</th>
<th>Metric</th>
</tr>
</thead>
<tbody>
<tr>
<td>A&amp;E</td>
<td>81,000</td>
<td>Attendances</td>
</tr>
<tr>
<td>FDASS</td>
<td>98,000</td>
<td>Attendance</td>
</tr>
<tr>
<td>UCC</td>
<td>70,350 / 34,650</td>
<td>Triage/Contacts</td>
</tr>
<tr>
<td>SDHC</td>
<td>14,000</td>
<td>Contacts</td>
</tr>
<tr>
<td>ECPS</td>
<td>1,650 / 4,884</td>
<td>Consultations/Contacts</td>
</tr>
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</table>

**Finance**
- The services below equate to £15.2m of commissioning costs.

**Assumptions**
- This area currently excludes non elective admissions to DBTH NHS FT

**Approach / Next Steps**
- An Accountable Care Partnership type approach would support the inherent interdependencies between the services from both a service delivery and a performance perspective.
- Need to understand demand by locality to map demand to services
- Need to develop preventative measures
Intermediate Care

**Context**
- Intermediate Care will be simpler and more responsive.
- There will be fewer teams and less hand offs along the intermediate care pathway.
- Intermediate Care will do more to maintain people at home and prevent admissions and A&E attendances as well as stepping people down from hospital as early as possible.

**Scope**
- The majority of Intermediate care services will be in the community, to support people in their own bed with less bed based intermediate care services.
- This area is defined by the following services:
  - Mexborough Montagu Hospital - General Rehab at Doncaster and Bassetlaw (commissioned by the CCG)
  - Hawthorn and Hazel Wards at Rdash (commissioned by the CCG)
  - Unplanned nursing at Rdash (commissioned jointly)
  - Short Term Enablement Programmes (Steps) (commissioned by the Council)
  - Social Care Enablement Programme - Positive Steps (commissioned by the Council)
  - RAPT (Rapid Assessment Programme Team) (commissioned by the Council)
  - Integrated Discharge Teams (IDT) (commissioned by the Council)
  - Home from Hospital (commissioned by the Council)

**Case for Implementation**
- Maintenance or improvement in reported patient experience of intermediate care services.
- More service users are supported to maintain their independence, live at home and in the community as long as possible.
- Reduced A&E attendances for people aged 75 and over (or limited growth).
- Reduced Delayed Transfers of Care.
- More people remaining at home following discharge from an acute bed.
- Reduce bed base by 50% initially.

**Finances and Activity**

<table>
<thead>
<tr>
<th>Area</th>
<th>Volume</th>
<th>Metric</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assessment Teams</td>
<td>2 hospital based assessment teams</td>
<td>IDT RAPT</td>
</tr>
<tr>
<td>Bed Based Services</td>
<td>Four bed based units (approx 100 Intermediate care beds)</td>
<td>Hazel and Hawthorn Fred &amp; Ann Green Rehab Positive Steps</td>
</tr>
<tr>
<td>Hospital Based Services</td>
<td>2 Community teams have a combined case-load of over 200.</td>
<td>CICT STEPs ECPs (Some elements commissioned as part of urgent care)</td>
</tr>
</tbody>
</table>

- The current Intermediate Care service costs around £17.6m

**Assumptions**
- This project is developed and outputs need to be carefully measured

**Approach / Next Steps**
- Move from focus on early discharge onto a focus on admission prevention
- Monitor KPIs to ensure that this project is delivering as expected
- Need to develop both admission avoidance schemes and preventative admission measures
Starting Well (1001 Days)

Please Note: The Draft below focuses on Starting Well and the scope as agreed with stakeholders has shifted emphasis to Starting Well 1001 Days. Version 2 of this template is now being produced in line with the agreed scope change.

Context

- This is about ensuring that all children across Doncaster have the opportunity to a good start in life.
- It is about developing support so that our children have the best possible opportunity to thrive.
- It is about offering appropriate support to families and children at the right time.

Scope

- To prevent and intervene early with children, young people and families experiencing problems in order to prevent escalation of problems.
- This will deal with root causes, providing support at an early age and an early stage of problems emerging.
- We will do this by taking a whole family approach and intervening in a coordinated way. This will mean look at areas such as:
  - Smoke free homes
  - Breastfeeding
  - Diet & healthy start vitamins
  - Safe sleeping
  - Maternal mental health
  - Stop smoking in pregnancy
  - Immunisation uptake
  - Illnesses

Case for Implementation

- All families supported through universal services at the earliest opportunity.
- Resilience in families.
- Reduction in referrals to specialist services.
- Sustainable youth offer
- Healthier children who will develop into health adults
- Breaking the cycle of poor health and social outcomes by intervening early

Assumptions

- Limited to children aged 0 to 5 years old
- Focussed on those most at risk to break the cycle of life long dependency on health and social care services

Finances and Activity

<table>
<thead>
<tr>
<th>Area</th>
<th>Volume</th>
<th>Metric</th>
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</tbody>
</table>

Approach / Next Steps

- Detailed Scoping to be done with Key stakeholders
- Develop and agree approach for the long term framework
- Detailed project plan to be developed
- Design and embed governance for the programme of work
- Validate end user and financial benefits
- Scope Risk/Issues and interdependences
Continuing Healthcare (CHC)

Context
- Currently DCCG and DMBC hold separate budgets for CHC with decisions made over who pays for the individual care package.
- In addition, care packages are procured separately so the overall market for CHC need and dependency is not managed collectively.
- Both organisations face significant financial challenges and will review CHC spend to assess the opportunity to reduce spend.

Scope
- To improve and standardise systems and processes.
- Ensure eligibility review checks and target review checks are met for all patients.
- Integrated administration and clinicians to avoid delay and contact “hand-off”.
- Develop and implement a caseload management framework together with a standard operating procedure.
- Implement an escalation protocol to avoid cancellations of assessments.
- Deliver a workforce development programme for all staff involved to ensure consistency of approach and shared understanding.
- Communicated relentlessly with all staff.
- Closely performance manage progress with revised, cleansed data.

Case for Implementation
- A co-ordinated approach to CHC will ensure that decisions are always made in the best interests of the individual and not related to budget ownership.
- Co-ordinated market management will ensure that the most competitive price is procured each time.
- Consistency of paperwork, reviews, process and decisions will reduce waste, lost time and duplication of effort.

Finances and Activity

<table>
<thead>
<tr>
<th>Area</th>
<th>Volume</th>
<th>Metric</th>
</tr>
</thead>
<tbody>
<tr>
<td>Various</td>
<td>n/a</td>
<td>Individual Care Packages with Regular Review Periods</td>
</tr>
</tbody>
</table>

- The CCG costs for CHC are £34.1m.

Assumptions
- This area is commissioned by both the Council and the CCG and is defined by the following services (Currently data is available for CCG only):
  - Continuing Healthcare Fully Funded
  - Continuing Healthcare - Jointly Funded DMBC
  - Personal Health Budgets - Fully Funded
  - Children & Young People Continuing Health Care
  - Personal Health Budgets - Jointly Funded DMBC
  - Fully Funded Nursing Care

Approach / Next Steps
- Agree the financial position from DCCG and DMBC, crucially understanding the savings earmarked for this area and the level of risk this poses.
- Benchmark current performance with peers to understand how delivery could change.
- Agree the new service delivery model to drive the required change.
**Dermatology**

**Context**
- Dermatology services are currently provided in both primary and secondary care settings.
- It has been recognised in Doncaster that there is significant potential for a greater level of service to be provided within neighbourhoods, on a more equitable basis, by primary care.

**Scope**
- The scope of this project will be around reducing the beds, outpatient attendances, outpatient procedures and excluded drugs from the acute setting and moving this activity to the community settings, where it is safe to do so.
- It will be about using Telederm more extensively to ensure that community settings can deliver dermatology services in a safe way.

**Case for Implementation**
- Patients will be able to access services more locally with less travel and less waiting time.
- Referrals to secondary care would reduce, enabling secondary care to focus on the more specialist roles required.
- Acute costs would reduce.

**Finances and Activity**
- The current Dermatology service costs around £2.1m

<table>
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<tr>
<td>Inpatient</td>
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<tr>
<td>Outpatient Attendances</td>
<td>18,900</td>
<td>PbR</td>
</tr>
<tr>
<td>Outpatient Procedures</td>
<td>3,700</td>
<td>PbR</td>
</tr>
<tr>
<td>Excluded Drugs</td>
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<td>Quantity Dispensed</td>
</tr>
<tr>
<td>Telederm</td>
<td>No target</td>
<td>Assessments</td>
</tr>
</tbody>
</table>

**Assumptions**
- This area is commissioned by CCG only and is defined by the following services:
  - Inpatients at DBTH NHS FT
  - Outpatient Attendances at DBTH NHS FT
  - Outpatient Procedures at DBTH NHS FT
  - Excluded Drugs at DBTH NHS FT
  - Telederm at the Mole Clinic
  - GP Minor Surgery?

**Approach / Next Steps**
- Detailed Scoping to be done with Key stakeholders
- Develop and agree approach for the long term framework
- Detailed project plan to be developed
- Design and embed governance for the programme of work
- Validate end user and financial benefits
- Scope Risk/Issues and inter dependences
Vulnerable Adolescents (Tier 4 Specialist Services)

Please Note: The Draft below focuses on Vulnerable Adolescents and the scope as agreed with stakeholders has shifted to Vulnerable Adolescents - Tier 4 Specialist Services. Version 2 of this templates is now being produced in line with the agreed scope change.

**Context**
- It is often the case that young people struggle during adolescence.
- This is the age when life paths can be determined.
- This is exacerbated for those who’ve grown up around dysfunction, substance abuse, crime or domestic violence.

**Scope**
- These young people face distinctive challenges and, too often, poor prospects in education and employment.
- Robust, tailored, wide-ranging support is needed to challenge these issues.

**Case for Implementation**
- Reduce adolescents transitioning into adults dependent on support.
- Develop co-ordinated support which can steer adolescents away from a lifetime of support.
- Improve outcomes for adolescents.

**Finances and Activity**

<table>
<thead>
<tr>
<th>Area</th>
<th>Volume</th>
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</tbody>
</table>

**Assumptions**
- xxxx

**Approach / Next Steps**
- Define exactly who is included within the project scope and develop a clear understanding on how we will deliver these principles.
- Detailed Scoping to be done with Key stakeholders.
- Develop and agree approach for the long term framework.
- Detailed project plan to be developed.
- Design and embed governance for the programme of work.
- Validate end user and financial benefits.
- Scope Risk/Issues and interdependences.
Complex Lives

### Case for Implementation

- This is a low volume high cost cohort of people who experience very chaotic lifestyles, and have often experienced trauma in earlier life.
- The cohort also has a major impact on place, and in particular the town centre which is a major priority for Team Doncaster.
- The response to the issue requires a highly integrated relationship between police, investment and practice from homelessness/supported housing, drug and alcohol and mental health services and the criminal justice system.

#### Shared accountability for this cohort between organisations is crucial.

- Establish joint commissioning group for this area of opportunity asap
- Soft test of first stage joint commissioning and collaboration in delivery for intensive support workers and navigator case coordinators (as minimum between St Leger, RDaSH, DMBC)
- Soft joint commissioning of homelessness service reforms
- Develop and agree approach for the wider roll out/long term framework
- Detailed project plan to be developed
- Design and embed governance for the programme of work
- Validate detailed end user and financial benefits
- Scope Risks/Issues and interdependences

### Scope

- The scope and specifics of a new delivery model has been developed through a prototype phase since November 2016. The key components are:
  - Assertive outreach and engagement delivered in a multi agency approach
  - Integrated case planning and delivery of accommodation wrap around support with personalised pathways - supporting people over time to recover and stay well
  - Key Workers for complex and less complex cases to provide the focal point for case coordination and ongoing support - the consistent point of contact for a person and their empowered champion in co-defining their outcomes
  - 'Housing First' - the commissioning and development of housing support services to enable stability of accommodation with built in wrap around support
  - An Outcomes Framework includes familiar Key Performance Indicators.
  - One Shared System - A shared access and case management system enables pooling of intelligence and effective case management act from a person-centred perspective.

### Context

- This cohort includes some of the most vulnerable people living within Doncaster.
- The complex relationship and interdependencies between homelessness, drug and alcohol addiction, mental health problems, domestic abuse, violence, begging, offending behaviours requires integrated investment and delivery, with an increasing focus on prevention.
- This is one of two Team Doncaster prototypes for new delivery models (with town centre), and is one of the two pilot activities listed in the Place Plan (with intermediate care).

### Finances and Activity

<table>
<thead>
<tr>
<th>Area</th>
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<th>Metric</th>
</tr>
</thead>
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<tr>
<td>Housing</td>
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<tr>
<td>Drugs/alcohol</td>
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<tr>
<td>Mental health</td>
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<tr>
<td>Offending behaviour</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Care leavers</td>
<td></td>
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</tbody>
</table>

- A range of current commissioning activity currently focuses directly or in part on this cohort. This includes:
  - Homelessness commissioning managed by DMBC Adults and delivery by St Leger Homes
  - Drugs and Alcohol commissioning by Public Health and delivered by RDaSH (via third parties in some cases)
  - Mental health provision commissioned by the CCG and delivered by RDaSH.
  - Social Care and mental health social work funded and delivered by DMBC
  - Support for care leavers provided by DCST, commissioned by DMBC, with accountability lines to DFE
  - Support for offenders commissioned by Home Office/Police and Crime Commissioner/Probation and delivered by the Community Rehabilitation Company
  - Other services contribute indirectly

### Assumptions

- There is a strong partnership commitment to produce a highly integrated response
- A new delivery model requires a joint strategic approach between commissioners across DMBC, Public Health and the CCG, with scope to extend to criminal justice commissioners
- It requires a collaborative delivery model between DMBC, St Leger, RDaSH, South Yorkshire Police, DCST, DBH & criminal justice agencies
- The development of an accountable care model will be managed in stages
- This is an area where community/peer led support is vital

### Approach / Next Steps

- Establish joint commissioning group for this area of opportunity asap
- Soft test of first stage joint commissioning and collaboration in delivery for intensive support workers and navigator case coordinators (as minimum between St Leger, RDaSH, DMBC)
- Soft joint commissioning of homelessness service reforms
- Develop and agree approach for the wider roll out/long term framework
- Detailed project plan to be developed
- Design and embed governance for the programme of work
- Validate detailed end user and financial benefits
- Scope Risks/Issues and interdependences
Please Note: This is currently a draft version that will be finalised with key stakeholders in the w/c 2nd May

Context
- There is clear evidence of the need for services to support young people thought to be ‘on the edge of care,’
- The aim is to prevent the need for them to enter care in the first place or to rapidly return them to their families if they do enter care.
- Attention to services to support children and young people thought to be at risk of care or accommodation is imperative.

Scope
- Create co-ordinated packages of care to break the cycle of support required during childhood, adolescence and adulthood

Case for Implementation
- Reduce the cycle of reliance on state support to deal with vulnerable young people.
- Prevent the number of children entering care.
- Reduce the length of time spent in care.
- Intervene early to support families to prevent long term residential care where possible,

Finances and Activity

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<tr>
<th>Area</th>
<th>Volume</th>
<th>Metric</th>
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</tbody>
</table>

Assumptions
- Need to define age group this project will focus on

Approach / Next Steps
- Define exactly who is included within the project scope and develop a clear understanding on how we will deliver these principles
- Detailed Scoping to be done with Key stakeholders
- Develop and agree approach for the long term framework
- Detailed project plan to be developed
- Design and embed governance for the programme of work
- Validate end user and financial benefits
- Scope Risk/Issues and interdependences
Domestic Abuse

Context
- The national agenda has moved from a risk led approach, to an approach which now also prioritises prevention and early intervention.
- It seeks to meet the needs of the whole family earlier and in so doing reduce the risk of escalation and serious harm in the longer term.

Scope
- The Vision for Domestic Violence in Doncaster is where domestic violence and abuse is recognised as unacceptable, and people live safe and happy lives free from abuse. Anyone experiencing domestic abuse, whether being abused, being the abuser, or witnessing abuse, has access to the support they need at the time they need it, to be safe and recover, or address their own behaviour.
- Estimates for Doncaster show for high risk cases to MARAC the cost to services for adults is over £12m and will exceed this by the year 2020 if the rate continues or increases.
- Earlier intervention could reduce High Risk case costs by £4m if services assess need earlier and intervene.
- The overall wider public cost of domestic abuse in all cases for Doncaster is estimated to be over £110 million.

Case for Implementation
- Domestic and sexual abuse has been a key priority for the Safer Stronger Doncaster Partnership (SSDP) since 2010.
- The numbers of high risk cases referred are well above the average against both regional and national figures and SafeLives benchmark.
- The number of children affected has increased to over 800 in each of the last 2 years.
- Although there has been a reduction of cases over the period the percentage of repeat cases remain higher than regional and national figures.

Finances and Activity

Doncaster Domestic Violence Incidents

Source – Doncaster Domestic Abuse Strategy

Approach / Next Steps
- To improve the use of the collective intelligence through:
  - effective use of data,
  - To continue to listen to staff working with families and in the community and also,
  - To hear what victims (adults and children) and perpetrators tell us.
- This will allow us to focus on achieving our key outcomes:
- The current strategy (2016 to 2020) identifies three key outcomes:
  - Outcome 1: Communities and families no longer accept or experience domestic abuse.
  - Outcome 2: Families who are vulnerable to or experience domestic abuse are identified earlier and receive effective support to stay safe; reduce repeat victimisation and recover.
  - Outcome 3: People who use abusive behaviour are challenged and provided with effective support to change.
# Infection Control

## Context
- Multiple Infection control services across the organisational partners which have scope to be integrated, reduce cost and improve quality of service through best practice and knowledge sharing.
- Infection Control is deemed to be an area which could integrate quickly in addition to a test area that could help produce ‘lessons learnt’ documentation.
- Estimated 300,000 patients a year acquire healthcare associate infections.

## Scope
- To aid in the reduction of infections rates across organisations which delay recovery and adversely affect quality of life for the Doncaster Population.
- Enabler to: prevent people dying prematurely, positive experience of care and protection from avoidable harm.
- Standardised quality of care across all care settings.
- A more coordinated, person-centre approach which aims to deliver high quality care for all which prevents and or controls infection proactively.
- Where possible leverage economies of scale to reduce costs.
- Flex workforce to appropriate areas of need to ensure best practice is shared and embedded.

## Case for Implementation
- To reduce and proactively control infection rates across partnership organisations with a robust strategy that has a focus on continuous improvement.
- To better utilise multi-agency working and surveillance systems to enhance patient experience and reduce delayed recovery.
- To standardise and embed best practice across partners to ensure we leverage knowledge sharing in addition to reducing cost.

## Assumptions
- All partner organisations compile with NICE guidance.
- All partner organisations have a similarly developed Infection Control service.
- Infection Control Services are not outsourced.

## Finances and Activity

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## Approach / Next Steps
- Rapid current state assessment of all Infection control services.
- Baseline data to be validated and signed off.
- SRO to be assigned.
- Project team to be defined.
- PID production.
- Governance arrangement made and documented.
- Project team mobilisation.
- Project Management approach implemented for the programme.
# Safeguarding

## Context
- Safeguarding is protecting vulnerable adults or children from abuse or neglect.
- It means making sure people are supported to get good access to healthcare and stay well.
- Across Doncaster, each partner needs to consider safeguarding and this issue is currently dealt with individually by each partner.
- The aim is to remove this duplication and develop a shared safeguarding function.

## Scope
- This project will be limited to the following partners:
  - Doncaster & Bassetlaw Teaching Hospitals NHS Foundation Trust
  - Doncaster Children’s Services Trust
  - Doncaster LMC and Federations
  - Doncaster Metropolitan Borough Council
  - Fylde Coast Medical Services
  - NHS Doncaster Clinical Commissioning Group
  - Rotherham, Doncaster & South Humber NHS Foundation Trust

## Case for Implementation
- Remove duplicated services
- Provide a centralised service which promotes a consistent approach across the whole of Doncaster
- Reduce the overall cost of the current fragmented service
- Develop robust safeguarding measures will not only protect vulnerable adults and children but will also enhance the confidence of staff, volunteers, parents/carers and the general public.

## Finances and Activity

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## Assumptions
- Benefits will be maximised if all partners participate in this project and agree to it’s fundamental purpose.

## Approach / Next Steps
- Understand the current cost, activity and workforce for each partner currently associated with safeguarding
- Develop and agree a future state
- Detailed Scoping to be done with Key stakeholders
- Develop and agree approach for the long term framework
- Detailed project plan to be developed
- Design and embed governance for the programme of work
- Validate end user and financial benefits
- Scope Risk/Issues and interdependences
Estate is a key enabler for services across Doncaster
 Currently estates is managed by each individual stakeholder with only limited sharing of estates to deliver services
 Some partners may have old estates which is over utilised and others may have new estate which is underutilised
 This project is about exploring the possibilities across Doncaster to use estate effectively across all partners

Focus must be on understanding the age and utilisation of current estate across all partners. This must be linked to ownership and current usage (ie freeholds leased to third parties etc.). This will allow a picture which will allow a Doncaster wide strategy for estates across all partners.
 This project will, crucially, need to map current estates and future clinical need.
 Care must be taken as the future state may lead to a greater requirement for services within neighbourhoods and reduce the requirements for centrally held estate.
 Opportunities may exist to share estates across partners, dispose of excess estates and use the current estate more effectively

Arrangement will need to be discussed around sharing any proceeds for disposals of estates and/or investment in estates
 Arrangements will need to be agreed for the potential of sharing estate and splitting costs
 Partners will need to agree to share information on estates data

Detailed Scoping to be done with Key stakeholders
 Develop and agree approach for the long term framework
 Detailed project plan to be developed
 Design and embed governance for the programme of work
 Validate end user and financial benefits
 Scope Risk/Issues and interdependences

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Community Led Support

**Context**
- Local people, community groups and local partners can all work together much more effectively with a common aim.
- Health and social care professionals are integrated joined up - at a community level.
- The system/process works swiftly and responsively and is proportionate to people's needs and circumstances.
- The focus is on getting upstream - early intervention and prevention.

**Scope**
- This project is aimed at keeping people within their own community and helping them to remain independent and in control of their own lives. It is about people accessing advice, information and lower level support to stop issues from escalating and building individual, community and family resilience and capacity. At its core is a re-ablement and enablement approach. It will, therefore, contribute significantly to the 5 BCF indicators:
  - Reducing Non-Elective Admissions
  - Reducing Delayed Transfers of Care
  - Reducing Residential Admissions (65 years + only)
  - Increasing the assistive technology installations aged 65+
  - Proportion of older people (65 years +) who were still at home 91 days after discharge from hospital into re-ablement/rehabilitation services.

**Case for Implementation**
- We cannot afford to do nothing, from both a financial perspective but also we are not yet achieving the best outcomes for people.
- For example, in Doncaster we admit more people per 1000 population into residential care than England and Yorkshire and Humber.
- We have a lower take up of Direct Payments, indicating both a lack of choice and control and an over reliance on statutory provision.

**Context**
- Local people, community groups and local partners can all work together much more effectively with a common aim.
- Health and social care professionals are integrated joined up - at a community level.
- The system/process works swiftly and responsively and is proportionate to people's needs and circumstances.
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**Scope**
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  - Increasing the assistive technology installations aged 65+
  - Proportion of older people (65 years +) who were still at home 91 days after discharge from hospital into re-ablement/rehabilitation services.

**Assumptions**
- Health and Social Care staff have the appropriate support to work together at a community level.

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**Approach / Next Steps**
- Develop Community assets and resilience will be developed in each locality.
- Staff across agencies will have more flexibility and freedom to innovate leading to increased staff morale and motivation.
- Expectations will be managed more effectively within the neighbourhoods.
- Test out a more integrated service and community offer within localities to enhance the future models of care.
Single Point Of Access

Context
- The current entry points to services are fragmented and difficult to navigate for service users
- Currently there are 29 different single points of access (SPA) available (23 community based, 3 bed based and 3 hospital based)
- 17 of the 29 are classed as gateways
- 86% of SPA’s are for adults
- 38% offer a service at point of contact

Scope
- Streamline the existing access to service through integration of current SPAs and/or creation of new gateways
- Ensure that all organisations have a consistent approach, which will help residents to navigate through the care systems
- Assess the benefits of having SPAs located in one hub or dispersed across Doncaster
- Effective service driven by a clear definition of the function of SPA, leading to increased user satisfaction
- Reduce the duplication of unnecessary services and gateways in order to lower costs

Case for Implementation
- Services are over complicated, difficult to navigate and not efficient
- Currently not enough home based services exist to respond at times of crisis which could help people maintain independency
- Approximately 50% of over 75’s admitted to hospital could potentially be support at home with different Intermediate care services
- Integration of Health and Social Care within SPA could support patients with independency and offered enhanced services which have both qualitative and financial benefits to patients and organisations

Finances and Activity

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Assumptions
- There could be a reduction in administration costs
- Reduction in inappropriate use of secondary care services
- Higher User satisfaction will be achieved

Approach / Next Steps
- Detailed baseline and PID to be signed off by SRO
- Detailed population trends of service users aligned to neighbourhoods to be produced
- Governance Arrangements to be put in place
- Mobilisation of project team
- Pilots to be set up and ran in defined areas
- Programme to be managed with project management tools and techniques
**Committee Name**: Board of Directors

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**Title of Paper**: Report from the Quality Committee – July 2017

**Action Required**

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**Prepared by**: Dr Deborah Wildgoose, Director of Nursing and Quality

**Presented by**: Alison Pearson, Non-Executive Director

**Delivery against**

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**Financial/Budget**

Financial implications are considered as part of the individual actions.

**Equality & Diversity**

The Quality Committee whilst undertaking its purpose considers matters relating to equality and diversity. All relevant issues are identified through supporting documents, therefore no additional areas are highlighted through this report.

**Previously Presented to**

Not applicable.

**Background / Key Points / Outcome**

The last meeting of the Quality Committee was held on 13 July 2017.

A summary of discussion and key highlights, assurances, risks and gaps are detailed in the attached paper.

Key areas identified are:

- Safeguarding Annual Report for 2016/17
- Safer staffing
- Patient Safety, Sign up to Safety, Smoke Detectors and Serious Incident Dashboard for Quarter 4 2016/17
- Suicide Analysis 2010 to 2017

The Board of Directors is asked to note the update from the Quality Committee on 13 July 2017.
Report from the Quality Committee

Held on 13 July 2017

Alison Pearson
Non-Executive Director
Chair, Quality Committee

Dr Deborah Wildgoose
Director of Nursing and Quality

July 2017
1. Introduction
This paper is a summary report that captures key messages from the meeting of the Trust Quality Committee (QC) held on 13 July 2017 and is framed around:
- Highlights and opportunities
- Assurance
- Gaps
- Risks

2. Highlights and Opportunities
- 100% of the 2016/17 CQUIN was achieved resulting in £2.8m income for the Trust.
- A Suicide Analysis 2010 to 2017 was presented to the Quality Committee. In that period there were 95 suicides, each one was analysed. Initial findings show a higher incidence in males between the ages of 45 to 64 with antecedents/issues related to Drugs and Alcohol, lack of employment, concerns about finance, employment and relationship breakdown. Further work is on-going to better understand the data including by protected characteristics, in-patient suicides or those within 7 days of discharge and benchmarks against other National data. Of note were an increasing number of suicides in the Rotherham area. Key learning will be used to raise awareness of increased risk parameters. Further work will inform Sign Up to Safety, pathway development, team integration and the strategic direction for Suicides prevention. The analysis will be shared with external partners, including Rotherham Public Health (Suicide Prevention Strategy Lead).
- Patient Safety, Sign up to Safety, Smoke Detectors and Serious Incident Dashboard for Quarter 4 2016/17 was reviewed. It was agreed that additional information is required to provide assurance particularly for Serious Incidents reviews and lessons learnt, and Medicine related incidents. The following items were of note:
  - Total number of incidents reported in Quarter 1 (Q1) was 2324 this year compared to 2831 in Q1 2016/17, with 95% classed as Minor (minimal harm) or lower.
  - 40 Central Alert System (CAS) safety alerts were evaluated and actioned as required in Q1.
  - 40 SIs were reported in Q1 2017/18 compared to 53 SIs Q1 in 2016/17, which is a 25% decrease. However, 30 SI this year are proceeding to a full investigation, which is an increase of 15% compared to Q1 in 2016/17. Further analysis requested on understanding the increasing trend.
  - 35 complaints were received in Q1 2017/18 compared to 40 in 2016-17, which is a 12.5% reduction. Only Doncaster Care Group shows a year on year increase by 5 to 18 complaints. Patient Care remains the highest cause of complaints.
  - Safeguarding processes in place to ensure all IR1s are reviewed and directed according to need.
  - There has been 10 Infection Prevention and Control audits in Q1 2017/18 with action plans being monitored. Level of incidents remains low.
  - There is reducing trend in overall falls and falls causing harm, year on year.
  - The incidence of restraint decreased from 270 in Q1 2016/17 to 152 in Q1 2017/18. Use of Seclusion in Q1 has increased by 7 to 40 incidents in 2017/18 although over the last year shows a reducing trend.
  - Pressure ulcers continue to reduce with only 2 that were classed as avoidable in Q1 (same as Q1 2016/17).
  - Overall trend in medicines related incidents and errors has increased 20% over the last year, although the trend in harmful incidents remains very low with 5 over the year and none in the last 3 months.
- The draft Smoke Detectors format and escalation process was outlined to the Quality Committee. It was proposed that further work take place to ensure alignment with the Quality at a Glance activity using a systems approach.
- Agency spend at month 2 is £204k under NHS Improvement (NHSI) ceiling target.
- A corporate Policy Panel has been established to oversee the ratification of HR, OD and other non-clinical corporate policies.
- The Guardian of Safe Working Hours quarterly update was received. Five exception reports were noted. A Junior Doctors Forum has also been established and is well attended. There is a plan in place to deal with any concerns raised.
• A verbal update on the Nursing Strategy was received outlining development options. A further update will be provided to the Quality Committee in December 2017.
• Verbal updates provided on complex serious incidents.
• Work on staff retention is to commence with attendance at an NHSI event in July 2017. The Quality Committee requested information on the current position and oversight going forwards.

3. Assurances
• The Safeguarding Annual Report 2016/17 was presented to the Quality Committee. This included highlighting progress made over the year on a number of safeguarding initiatives, and demonstrating compliance to the statutory reporting requirements for Safeguarding Children and Adults.
• A paper detailing Medical Revalidation 2016/17 was received confirming that RDaSH Medical Director (Responsible Officer) has complied with the requirements, and quality assured 20% of the appraisals.
• The Serious Incident report for June 2017 was reviewed. There have been 12 new serious incidents logged (2 of which were pressure ulcers). The number of SI's has increased by 5 on the same month last year and up 4 in the quarter when compared to Q1 2016/17. Information provided to demonstrate investigation, extraction of learning and tracking of actions by Care Group.
• The Safeguarding Quarterly update provided a comprehensive overview of all activity underway within the Trust, and with Local Authorities. Overall marginal increase in training compliance noted with plans to drive improvement in place.
• An Internal Audit (360 Assurance) report on Staff Engagement Listening into Action was received. Significant Assurance was provided and one low level risk identified.
• An Internal Audit (360 Assurance) report on Workforce Strategy and Planning was received. Significant Assurance was provided with 2 medium and 1 low level risk identified.
• The annual Quality Surveillance self-declaration for Amber Lodge was submitted to the national specialised commissioning team and feedback is awaited.
• A paper confirming that the monitoring equipment for physical health is maintained and audited was presented in support of the Care Quality Commission (CQC) ‘Should Do’ action plan.
• Mandatory and statutory training compliance has been maintained at 89.47%. The compliance for induction training within one month of joining the Trusts stands at 98.35%.

4. Gaps
• The Six monthly detailed review of staffing, due July 2017, has been deferred by one month to enable completion of a detailed staffing review of each inpatient ward to be undertaken.
• The Annual Report 2016/17 for Accountable Officer for Controlled Drugs has not yet been presented.
• Sign up to Safety 2015-18 has been reviewed but the paper to the Quality Committee has been delayed following amendments requested by EMT. To be presented to the Quality Committee in August.
• The Mortality quarterly report deferred to the September 2017 Quality Committee (to enable Medical Director to present).
• Medicines management report deferred to the August 2017 Quality Committee.
• The level of completion of the Personal development reviews (PDRs) remains at 75%. Managers and staff continue to be reminded to complete their PDRs.
• Fire Safety training compliance is currently at 77%. EMT to review fire safety process and determine whether persons in control (PIC) training is up to date.

5. Risks
• There are currently no “Extreme” risks aligned to the Quality Committee. The EPR (Unity) extreme risk (H12/16) is being monitored by FPIC but was noted by the Quality Committee due to potential quality impact.
• Safeguarding Adults and Children level 3 training shows that the challenge of driving up compliance remains for all Care Groups. The Quality Committee requested clarification on date by which required level of compliance will be achieved.
The level of Sick absence was 5.2% in May 2017 (note Apr 5.1%, Mar 5.1%, Feb 5.7%, Jan 6.3%), cumulative 5.2% against the Trust target of 4.8%. Existing policies will continue to be rigorously pursued.

The following areas have been identified for risk assessment and action:
  o Safe Staffing - 10 Red rated shifts on inpatient wards in May 2017, as opposed to 7 in April (using local reporting v. occupancy & acuity criteria). There was a significant increase in the number of red rated shifts on Skelbrooke ward in Doncaster from 2 in April to 9 in May, due to unplanned care given off site (Doncaster Royal Infirmary) as well as patient acuity and dependence. Discussion highlighted issues with AMH wards and the staffing of 136 suites, capacity issues on nights and during periods of seclusion leading to staffing levels that are too low which is of concern to the QC.
  o The Quality Committee has requested a review of the current risks and mitigations associated with the Adult Mental Health (AMH) services. A high proportion of incidents are not closed within 10 working days and narrative is often insufficient. Only 6 of the 22 (27%) Serious Incident reports were submitted to Commissioners within the required 60 days in Q1. The Quality Committee was informed that additional capacity will be in place to support the SI process by the end of Q3 2017-18.
  o A range of issues have been identified in relation to the capacity to provide, analyse and act on quality and safety data within the organisation. The executive team agreed to review the risks associated with this and the action required to mitigate.

6. Clinical Policies, Standard Operating Procedures and Patient Group Directions Approved by Sub-Committees
The Quality Committee noted that the last meeting of the Quality and Safety Sub-Committee (QSSC) held on 3 July 2017 was not quorate. Therefore the clinical policies, standard operating procedures and other documents needing approval were circulated electronically after the meeting. The following members of the QSSC responded to provide quoracy for the decisions taken:

- Dr Deborah Wildgoose, Director of Nursing and Quality
- Wendy Joseph, Deputy Director of Nursing and Quality
- Rachel Millard, Associate Nurse Director, Rotherham Care Group
- Julie Lodge, Associate Nurse Director for Children’s Care Group
- Dr Raymond Travers, Associate Medical Director
- Dianne Graham, Rotherham Care Group Director
- Andrew Houston, Pharmacist

Policies (and others) approved:

- 2017 Road Fuel Emergency Plan
- Consent to examination and treatment policy
- Management of seclusion and segregation policy
- Patient Information Policy
- Clinical audit policy
- Verification of expected death policy
- Copying letters to service users policy
- PGD for the Administration of Sodium Chloride 0.9% Injection as a Flush
- PGD for the Administration of Heparin Sodium to Line Lock a Vascular Access Device
- PGD for Vaccinations and Immunisations
- SOP – Vaccination and Immunisation of School Aged Children within Schools and Community Settings
- Non-Medical Prescribing Policy
Policies approved for removal:
- Incident reporting (Sapphire Lodge)
- Procedure for responding to patient opinion postings
- Central alerting system
- PGD for the Supply and Administration of Hepatitis Vaccines within the Trust Community Drug and Alcohol Services
- PGD – Pertussis in Pregnancy

Extensions to the following policies approved:
- Children Visiting Inpatient Areas Policy – extension for 3 months until October 2017
- Clinical risk assessments and management policy – extension for 6 months until December 2017
- Supportive observation – care of inpatient identified as posing a significant risk to themselves or others policy - 3 month extension until September 2017

The following were NOT approved:
- Service Access and Waiting Times Policy
- Policies for removal:
  - Management of service users who have, or are at risk of disengaging with adult community mental health services policy
  - Priority treatment of ex-service personnel (armed forces veterans) policy
  - Disengagement - children and young people who did not attend policy
  - Engagement and discharge of clients referred to and in contact with drug and alcohol services policy
  - Managing did not attends, no access visits and cancellations for Doncaster community integrated services (adult pathways)

7. Recommendation
The Board of Directors is asked to note the update from the Quality Committee held on 13 July 2107.
### Safeguarding Annual Report 2016/17

#### Background / Key Points / Outcome

The Safeguarding Annual Report 2016/17 is attached for the Board of Directors’ information. This is the first time a combined report has been written to highlight the work done by both the Safeguarding Adults and Safeguarding Children’s Teams.

This annual report was presented to the Quality Committee at its meeting on 13 July 2017, where it was agreed that it be presented to the Board of Directors for information.

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<td>Prepared by</td>
<td>Julie Lodge, Associate Nurse Director, Children’s Care Group</td>
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<td>Dr Deborah Wildgoose, Executive Director of Nursing and Quality</td>
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<td>Wendy Joseph, Deputy Director of Nursing and Quality</td>
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<td>Equality &amp; Diversity</td>
<td>The safeguarding and promoting the welfare of children and vulnerable adults is clearly laid out as a statutory duty of all NHS trusts, a child or adult’s right to be protected is in no way influenced by their ethnicity, religion or culture. It is however acknowledged that there groups within the communities RDaSH work with that are particularly vulnerable to abuse and exploitation. The vulnerabilities of these group is reflected in the way the safeguarding service is delivered and how RDaSH staff are supported, trained and supervised in relation to safeguarding and promoting the welfare of children and vulnerable people. These considerations are inherent in the attached Annual Report.</td>
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<td>Following the Board of Directors, the Annual Report will be shared with key partners and published on the Trust public website.</td>
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Safeguarding Annual Report - 2016/17

May 2017
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Introduction

“Another busy and productive year”

Welcome to the Rotherham, Doncaster and South Humberside 2016/17 Safeguarding Annual Report, the first combined Safeguarding Children’s and Adults report.

This annual report summarises the work undertaken across the Trust and demonstrates to the Trust Board, external agencies and the wider community how RDaSH discharges its statutory duties in relation to:

- Safeguarding Adults at risk in line with the Care Act 2014
- The Mental Capacity Act (2005) and Deprivation of Liberty Safeguards amendment in 2007
- Safeguarding Children in line with Section 11 of the Children Act (1984, 2004) and Working Together to Safeguard Children (2015). All staff have a statutory responsibility to safeguard and protect the children and families who access our care.

Definitions

Safeguarding Adults - An adult is an individual aged 18 years or over
- The Safeguarding duties apply to an adult who has needs for care and support (whether or not the local authority is meeting any of those needs) and…
- Is experiencing, or at risk of, abuse or neglect and…
- As a result of those care and support needs is unable to protect themselves from either the risk of, or the experience of abuse or neglect

Safeguarding Children – A child is an individual who has not reached their 18th birthday. The Children Act (1989, 2004) states that the welfare of the child is paramount and that all practitioners are required to protect children, prevent the impairment of health and development and to ensure they are provided safe and effective care in order to fulfil their potential.

Named and Designated Doctors – Named and Designated professionals have specific roles and responsibilities for Safeguarding Children, as described in intercollegiate Safeguarding Competencies 2014. All NHS Trusts must have a named Doctor and Nurse for Safeguarding, who will provide advice and expertise for fellow professionals and promote good practice within their organisation.

Safeguarding Children and Adults at Risk - In order to achieve this the Trust works closely with a wide range of agencies, carers and the wider community to ensure that the whole range of services provided have regard to the duty to protect human rights, safeguard against abuse, neglect, poor practice and ensure each person is treated with dignity and respect. There is always a balance between a person’s rights and choices and the need to protect those at risk is acknowledged. As a consequence both of the teams within the Trust work in an increasingly complex and multi-layered safeguarding environment.

All safeguarding work undertaken by the Safeguarding Children’s and Adults Team is underpinned by the Trust values of providing services that are:

- Passionate
- Reliable
- Caring and safe
- Empowering and supportive staff
- Open, transparent and valued
- Progressive
In addition, all safeguarding developments and initiatives are aligned to the Trust’s strategic goals:

- Continuously improve service quality (safety, effectiveness and patient experience) for our service users and carers
- Nurture the talent, commitment and ideas of our staff in order to deliver excellent services
- Ensure value for money and increased organisational efficiency whilst maintaining quality
- Adapt and deliver services to meet agreed commissioned needs through enhanced multi-agency partnerships
- Maintain excellent performance, governance and a strong market position, and improve further our reputation for quality

Safeguarding is a fundamental component of all the care provided by the Trust. RDaSH acknowledges and appreciates that safeguarding children and adults is everybody’s responsibility and that regardless of what position we hold in the trust we all have a duty to protect those accessing our services from abuse and harm.

**Safeguarding Team Structure**

[Diagram showing the structure of the safeguarding team, including names and roles of team members.]
Background

Safeguarding continues to have a high national priority. The wider context of safeguarding continues to grow and change in response to the findings of large scale inquiries such as the Lampard investigation into Jimmy Savile, Winterbourne View, The Francis Report, The Rotherham Child Sexual Exploitation (CSE) Enquiry and legislation such as the Care Act 2014.

This has led to greater scrutiny of safeguarding arrangements across the Trust and the on-going challenge of embedding recommendations/requirements into frontline practice, policies and procedures.

The document Safeguarding Vulnerable People in the NHS – Accountability Framework was refreshed in July 2015 by NHS England. It states that all health providers are required to have effective arrangements in place to safeguard children and adults at risk of abuse or neglect and to assure themselves, regulators and their commissioners that these are working. These arrangements include:

- Safe recruitment practices and arrangements for dealing with allegations against people who work with children or adults at risk as appropriate
- A suit of safeguarding policies
- Effective training of all staff commensurate with their role and in accordance with the intercollegiate competencies 2014
- Effective supervision arrangement for all staff working with children/families or adults at risk of abuse or neglect
- Effective arrangements for engaging and working in partnership with other agencies
- Identification of a named doctor and a named nurse
- Identification of a named lead for adult safeguarding and an MCA Lead
- Developing an organisational culture where all staff are aware of their personal responsibility to report concerns and to ensure that poor practice is identified and tackled.
- Policies, arrangements and records to ensure consent to care and treatment is obtained in line with legislation and guidance including the MCA 2005 and the Children Act 2004.

Key Achievements

During the past 12 months there has been significant progress made in promoting a “whole family approach to safeguarding”. The adults and children’s safeguarding teams are working collaboratively to promote a variety of safeguarding initiatives within the Trust

The Trust has an extended complement of safeguarding personnel:

- Nurse Consultant for Safeguarding Children
- Safeguarding Children Named Nurse and Lead Professionals
- Safeguarding Adult Lead Professionals
- Prevent Lead
- MCA & DoLS Lead
- Named Doctor for Safeguarding Children

Outcomes

The Trust can demonstrate its compliance in relation to its statutory requirements as regarding Safeguarding Children and Adults.
National safeguarding policy drivers

There continues to be a significant change across the safeguarding landscape, particularly with regard to safeguarding adult legislation and the consequent impact on multi-agency responsibilities and the workload of single agency safeguarding teams.

The Care Act 2014

The Act established a clear framework for how agencies should protect adults at risk of abuse and neglect. The Act put adult safeguarding on a statutory footing for the first time, embracing the principle that the “person knows best”. There is an emphasis on working with adults at risk of abuse and neglect to have greater control in their lives to both prevent it from happening, and to give meaningful options of dealing with it should it occur.

The six safeguarding principles that provide a foundation for achieving good outcomes for patients are being embedded into all areas of Adult Safeguarding training and policy development:

- **Principle 1 – Empowerment**
  Presumption of person led decisions and informed consent
- **Principle 2 – Protection**
  Support and representation for those in greatest need
- **Principle 3 – Prevention**
  It is better to take action before harm occurs
- **Principle 4 – Proportionality**
  Proportionate and least intrusive responses appropriate to the risk presented
- **Principle 5 – Partnerships**
  Local solutions through services working with their communities. Communities have a role in preventing, detecting and reporting neglect and abuse
• **Principle 6 – Accountability**
  Accountability and transparency in delivering safeguarding.

**Key Achievements**

- Trust policies and training packages have been amended and updated to reflect the changes in legislation.
- A “Making Safeguarding Personal” approach has been adopted within any safeguarding enquiry that has been undertaken during this period. There has been a commitment to moving enquiries away from being process driven to experience which fully involve the adult at risk or their carer/advocate as appropriate.

**Challenges**

- Ensuring that staff apply their training into practise and respond to safeguarding concerns in a personalised manner.

**Moving Forward**

- Each Care Group to ensure that all relevant staff attend mandatory training and promote Safeguarding practice which is person centred.
- Continue to work towards 90% compliance target for all Safeguarding training.
- To promote reflective practise in relation to safeguarding.

**Outcomes**

- The Trust can demonstrate its commitment to embedding personalised / person centred Safeguarding principles into practice.
- The Trust promotes responses which are responsive and proportionate. Risks are managed and harmful and abusive situations stopped / reduced to a safe level.

**Modern Slavery**

This includes Slavery, Servitude and forced or compulsory labour. A person commits an offence if:-

- The person holds another person in slavery or servitude and the circumstances are such that the person knows or ought to know that the other person is held in slavery or servitude, or
- The person requires another person to perform forced or compulsory labour and the circumstances are such that the person knows or ought to know that the other person is being required to perform forced or compulsory labour. Contemporary slavery takes various forms and affects people of all ages, gender and race. Adults who are enslaved are not always subject to human trafficking.

**Key Achievements**

A nominated Safeguarding Adults Lead Professional is now a member of the Humber Modern Slavery Partnership.

- A modern slavery training package has been devised. This was launched during Safeguarding Week and now appears as part of the Safeguarding Training Matrix for the Trust.
Challenges

- Reporting levels in relation to Modern Slavery within the areas that the Trust has a presence is currently low. Whilst it is unclear if this is an accurate reflection of the situation within the localities. It is important that all staff have an awareness of the issues and the mechanisms for reporting concerns.

Moving Forward

- For the nominated Safeguarding Adult Lead Professional to continue to work with other agencies to understand the emerging issues relating to Modern Slavery and to ensure that this information is shared widely within the Trust.

Self-Neglect

The Care Act 2014 certifies self-neglect as a safeguarding responsibility and defines self-neglect as covering a wide range of behaviours such as neglecting to care of one’s personal hygiene, health or surroundings and includes behaviour such as hoarding. Falling under the Safeguarding Policies and Procedures means that all safeguarding adult duties and responsibilities apply; however, a case of self-neglect may not always prompt an S42 Safeguarding Enquiry – an assessment of the intervention/support to be offered is made on a case by case basis.

Key Achievements

- A self-neglect training package has been devised and now appears as part of the safeguarding training matrix
- A member of the safeguarding team is currently part of the Doncaster Safeguarding Adults Board (DSAB) Sub Group which is developing a multi-agency self-neglect policy.

Challenges

- There is currently no Safeguarding Adults Board Self Neglect policy in any of the areas that the Trust has services, this has created challenges in respect of Multi-agency working to support those who present with these behaviours.

Moving Forward

- DSAB is currently working on a Self-Neglect Policy which when ratified will be adopted by the Doncaster Care Group. As an interim arrangement the principles within this document can be utilised within all Care Groups to ensure consistency in practice / approach until such times as the other two boards devise their own policy.

Lampard Report 2015

Following the publication of Kate Lampard’s report into lessons learnt in the aftermath of Jimmy Savile, there were 9 recommendations directly relating to NHS provider trusts arising out of the report. These addressed the key findings of the report which related to:

- Security and access arrangements, including celebrity and VIP access
- The role and management of volunteers
- Safeguarding assurance, capability, governance and training
- Raising complaints and concerns by staff and patients
- Fundraising and charity governance

An action plan and gaps analysis was produced considering the recommendations of the report. Oversight of this action plan has now been allocated to a Safeguarding Adult Lead Professional.
Key Achievements

• Significant work has been undertaken reviewing all of the recommendations and ensuring compliance and assurance within the action plan, elements of which were tested through an internal audit.
• Observance of due process and good governance.

Challenges

• Ensuring that continued compliance of the action plan remains a key priority on the Safeguarding landscape.

Moving Forward

• For compliance against the Trust action plan to be incorporated within the monthly Safeguarding dashboards.

Counter-Terrorism and Security Act 2015

The statutory guidance issued under Section 29 of the Counter-Terrorism and Security Act has several strands:

• **Pursue** – to disrupt terrorist activity and stop attacks
• **Prevent** – to stop people becoming or supporting violent extremists and build safer and stronger communities
• **Protect** – strengthening the UK’s infrastructure to stop or increase resilience to any possible attack
• **Prepare** – should an attack occur then ensure prompt response and lessen the impact of the attack.

NHS Trusts are now obliged to “have due regard to the need to prevent people from being drawn into terrorism” in accordance with the PREVENT duty outlined in Section 26 of the Act. For the Trust this has meant training staff so they know what “Prevent” is, and how to escalate concerns regarding people believed to be vulnerable. Key staff within the Trust have also had access to advanced training in relation to extreme ideology and extremism.

Key Achievements

• The Prevent responsibility is now aligned to a Safeguarding Adult Lead Professional role.
• The Lead for Prevent attends the Silver Prevent groups within each locality as well as attending the NHS England Steering Group.

Challenges

• The reporting of Prevent concerns continues to be low in all areas in which the Trust has a presence. During this reporting period there has been one referral and information shared.

Moving Forward

• For nominated representative to continue to participate in both Regional and Local Prevent groups and to cascade any new information to all staff within the Trust.
• For the Trust to continue to be compliant in relation to reporting Prevent activity to the respective Clinical Commissioning Groups (CCGs).
Child Sexual Abuse and Exploitation (CSE)

The issue of CSE has received high media coverage over the past few years. The Safeguarding Children’s Board for Rotherham, Doncaster, North and North East Lincolnshire each have CSE firmly established within their business plans. During 2016/17 the Trust has continued to information share in relation to Operation Stovewood. This is an Independent National Crime Agency led investigation of non-familial child sexual exploitation and abuse which is being conducted at the request of South Yorkshire Police following the publication of the Alexis Jay report.

Key Achievements

- CSE awareness raising is incorporated into each level of Safeguarding Children’s training and within the Modern Slavery training packages.
- All staff within the Trust’s Children’s Care Group have received mandatory training on how to identify CSE concerns.
- A specialist CSE Nurse from the Trust sits within the multi-agency CSE team and offers training support and day to day advice for RDaSH staff and those working in the Doncaster partnership.
- Staff from the Trust have been part of a multi-agency project to raise awareness of CSE and to encourage members of the public to do their part in helping to stamp it out. This included residents in the Doncaster area being asked to make a personal pledge on how they can help raise awareness of CSE by using the #HelpingHands on social media.

Challenges

- Maintaining the specialist CSE Nurse role during a period of service transformation.
- Providing assurance to Safeguarding Children Boards that RDaSH are identifying and referring CSE appropriately.

Moving Forward

- A recent ‘dip sample’ record audit identified that staff are recognising and responding appropriately to indicators of Child Sexual Exploitation. However, referral rates remain low and further work needs to be carried out to identify the narrative behind this.

Female Genital Mutilation (FGM)

As part of a worldwide effort to eliminate FGM, the Department of Health’s FGM Prevention Programme aims to improve the way in which the NHS responds to the health needs of girls and women who have had FGM, and to actively support prevention. It aims to support professionals to be confident when having discussions with women and girls, to record and share FGM information appropriately and to take the necessary action to safeguarding girls against risk.

An amendment to the Serious Crime Act 2015, introduced a new mandatory duty, it requires regulated health professionals to report ‘known’ cases of FGM in under 18 year olds. This includes if a professional is informed by a girl that an act of FGM has been carried out on her, or if they observe physical signs to show that an act of FGM has been carried out. The professional is required to report the case as soon as possible to the police via their 101 telephone number. Work around raising awareness will continue in the forthcoming year.

Key Achievements

- Information relating to FGM is embedded within the Domestic Abuse Policy.
- Safeguarding Lead Professionals have received enhanced training on FGM via the Department of Health
• Workshops on how to identify and report FGM have been delivered to Safeguarding Supervisors to cascade to their teams
• Information has been included within the Safeguarding Children newsletter and sent out electronically to all Trust staff as well as being posted on the Safeguarding Children intranet page.

Challenges
• To ensure that all RDaSH staff are aware of their mandatory duties to report known cases of FGM.

Moving Forward
• To devise and publicise and FGM protocol for the Trust that includes a clear line of reporting.
• To develop a training package to cascade to all staff

Mate/Hate Crime
There is no statutory definition of Mate Crime in UK Law. The term is generally understood to refer to the befriending of people, who are perceived by the ‘source of harm’ to be vulnerable, for the purpose of taking advantage of exploiting or abusing them. Mate Crime can strongly be associated, but not exclusively associated, with people with a learning disability or mental health condition.

Key Achievements
• Staff from the North Lincolnshire Learning Disability Team have begun developing a project in conjunction with Humberside Police to train staff in how to spot the signs of mate crime and offer advice on how to support people who are experiencing it.

Challenges
• The information in relation to Mate/Hate crime is not readily available in a format which is accessible by all those who may be affected by this form of abuse.

Moving Forward
• That the developments within North Lincolnshire are shared as widely as possible across the Trust.
• That user friendly mate/hate crime documents are developed for use across the Trust.

Outcomes
In relation to the national safeguarding policy drivers (pages 6-11) the Trust can demonstrate:
• Its commitment to training its staff and raising awareness into issues which may affect those who access its services.
• Its on-going commitment to multi-agency working to safeguard those who may be at risk of abuse or neglect
• Its commitment in and responding to high profile national issues and embedding learning into practice.
Inspections

All Providers of health care are required to be registered within Care Quality Commission (CQC). In order to be registered, providers must ensure that those who use the services are safeguarded and that staff are suitably skilled and supported. In April 2015 the CQC changed their regulation framework. Two regulations are now specific to safeguarding within the trust:

- **Regulation 12** – Safe Care and Treatment
- **Regulation 13** – Safeguarding Service users from abuse and improper treatment

Key Achievement

- Following a re-inspection by CQC the Trust received a revised rating of GOOD across the whole organisation. Every service within the organisation the domain of caring was rated GOOD.

Policy developments

Safeguarding is a rapidly changing and developing area of work – as such it is critical that, in order to demonstrate compliance and promote best practice, policies and procedures are revised and updated accordingly. Each of the four areas in which the Trust operates have its own overarching Local Safeguarding Adults Board (LSAB) and Local Safeguarding Children’s Board (LSCB) multi agency policy and procedures that support local practice. In addition the Trust has a range of policies that support staff in safeguarding children and adults at risk.

Key Achievements

- Over the past 12 months the following documents have been reviewed and refreshed in order to ensure compliance with their respective legislation:
  - Safeguarding Adults at Risk Policy
  - Safeguarding Children Policy
  - Safeguarding Children Supervision guidance
  - Prevent Guidance and guidance in respect of the Modern Slavery Act has been introduced.

Challenges

- Ensuring that the Trust policies relevant to Safeguarding remain updated in line with National and Regional guidance.

Moving Forward

- To develop a single Safeguarding gateway to access all children’s and adults safeguarding policies.
- To ensure new policies and guidance are developed in line with any new National and Regional guidance
- To review all policies to ensure they remain relevant and in date
Partnership working

The Trust recognises that safeguarding is most effectively delivered through strategic and organisational multi-agency arrangements, with partners working collaboratively to achieve a shared vision. The challenges of representation at the Safeguarding Boards for children and adults, and their associated sub-groups are recognised. Despite this the Trust is involved in a total of 6 Safeguarding Boards and associated sub-groups within Doncaster, Rotherham, North and North East Lincolnshire.

North Lincolnshire Safeguarding Adults Board

- **Communications Sub Group**
  - Julio Lodge, Lead Professional Safeguarding Adults

- **Training and Professional Development (six monthly)**
  - Lead Professional Safeguarding Adults

- **Performance and Quality**
  - Lead Professional Safeguarding Adults

- **SAR Panel**
  - Wendy Fisher, Associate Nurse Director for North Lincolnshire Care Group

North Lincolnshire Safeguarding Children’s Board

- **Early Help**
  - Julie Lodge, Associate Nurse Director for the Children’s Care Group

- **Serious Case Review Sub-Committee**
  - Julie Lodge, Associate Nurse Director for the Children’s Care Group

- **Performance and Quality**
  - Safeguarding Children Professional Lead

- **CSE**
  - Julie Lodge, Associate Nurse Director for the Children’s Care Group

- **Domestic Abuse Task and Finish Group**
  - Julie Lodge, Associate Nurse Director for the Children’s Care Group

Doncaster Safeguarding Adults Board

- **Prepare**
  - Lead Professional Safeguarding Adults

- **Workforce and Practice Sub-Group**
  - Lead Professional Safeguarding Adults

- **Business Co-ordination Group**
  - Lead Professional Safeguarding Adults

- **Making Safeguarding Personal**
  - Lead Professional Safeguarding Adults

- **Prepare**
  - Lead Professional Safeguarding Adults

- **Workforce and Practice Sub-Group**
  - Lead Professional Safeguarding Adults

- **Business Co-ordination Group**
  - Lead Professional Safeguarding Adults

- **Making Safeguarding Personal**
  - Lead Professional Safeguarding Adults
In order to promote more effective partnership working, a pilot project has been undertaken with a Safeguarding Adults Lead Professional co-locating within the Doncaster Safeguarding Adults Hub (Local Authority). There has been extremely positive feedback from all involved to such a level that a trial of the pilot is being undertaken in the Rotherham area (see Appendix 5 and 5a). In order to support the development of partnership working, the Safeguarding Leads continue to contribute to a variety of audits, task and finish groups including RLSCB Audit of Children and young people who go missing from homes or care.

- Self-neglect Policy Task and Finish Group.
Challenges

- The demand on a small team and its senior managers to maintain regular attendance and contribution to the Safeguarding Boards and their subgroups remains a challenge, but one that in spite of transformation and change of personnel has, in this year, been met.

Moving Forward

- For nominated personnel to continue to attend their respective boards and sub-groups.

Outcome

- The Trust can demonstrate that through partnership working we are engaged in promoting better safeguarding practices and outcomes for those involved with the Safeguarding processes.

Safeguarding adults activity

The Care Act 2014 introduced a new legal duty to investigate if an adult with care and support needs is exposed to risk or is at risk of abuse and neglect and is unable to protect themselves. This is contained in Section 42 of the Act and is referred to as a “Section 42 Enquiry”. The Care Act requires local authorities (or the Local Authority to cause others) to make proportionate enquiries where there is a concern about the possible abuse or neglect of an adult at risk. There has been a commitment to adopting a Making Safeguarding Personal approach to any Safeguarding Enquiry experience with an emphasis on the outcomes that the adult at risk (or their carer/advocate as appropriate) which to see as opposed to a process which had historically been “done to the person”.

The graph below identifies the geographical split and outcomes in relation to the 212 concerns which were received into the RDaSH Safeguarding Adults Team.
Data in relation to North Lincolnshire has only been centralised to the RDaSH Safeguarding Adults team since 1st November 2016. 32 cases remain open from, 2 of which are from 2014/15 and another 2 were raised during 2015/16.

The concerns raised have been in relation to a number of abuse types including financial, sexual and physical. There were 19 cases (5 in Rotherham, 14 in Doncaster) in which a member of RDaSH staff had been named as the Source of Harm. 17 have now been closed, the 2 remaining cases, 1 in Rotherham and 1 in Doncaster, are currently being explored as part of a Section 42 ongoing Enquiry.

In addition, all IR1’s and STEIS which are submitted are further scrutinised to determine whether there are any further safeguarding issues which need to be investigated. From October 2016, an information spreadsheet was developed to record IR1 reporting and analysis. Out of 122 IR1 received from the start of the spreadsheet 28 IR1s proceeded to a formal Safeguarding Section 42 Enquiry. 15 of these were in Doncaster, 8 in Rotherham and 5 in North Lincolnshire.

In regards to the STEIS reporting, out of the 63 STEIS received since October 2016, 6 proceeded to a formal Safeguarding Section 42 Enquiry, 3 in Doncaster, 2 in Rotherham and 1 in North Lincolnshire.

**Key Achievements**

- A Safeguarding Adults Dashboard is now completed on a monthly basis offering an overview of safeguarding activity within each Care Group.
- There is a greater presence of Safeguarding Adult Lead Professionals within service areas promoting a culture of early intervention/prevention and dialogue in safeguarding.

**Challenges**

- When Local Authorities “cause an enquiry to be made” the Trust has a legal duty to cooperate and conduct such enquiries. Processes could be improved in this area that clearly and precisely sets out the expectations of Trust staff.

**Moving Forward**

- To clarify with Local Authorities the process for “causing an enquiry to be made when Trust staff are asked to undertake a section 42 enquiry.
- To conduct routine audits of contact / advice calls and concerns submitted throughout the year to determine quality and threshold monitoring for Adult Safeguarding.

**Safeguarding children’s activity**

**Staff Contacts**

242 contacts were received from across the trust during the reporting period. These contacts resulted in a range of responses from the Safeguarding Children’s team including consultation over the phone, face to face supervision, attendance at complex or contentious case meetings and involvement in team and service meetings. The team aim to provide a responsive, timely and expert service to support colleagues in operational services in safeguarding children’s matters. There has been high levels of activity supporting staff in relation to the preparation of legal statements for case proceedings in the family courts.

**Child Deaths**

A total of 34 child deaths occurred during this reporting period, 23 were expected and 10 unexpected. All child deaths, whatever the cause, are reported and reviewed by the Child Death Overview Panels (CDOP) which have a statutory Junction as defined within the Children’s’ Act
(2004). Through a comprehensive multi-disciplinary review of child deaths, the CDOP aims to improve the understanding of how and why a child has died and uses the findings to take action to prevent future deaths and more generally to improve the health and safety of the children in the area. One of the unexpected deaths has progressed to a criminal investigation, none of these deaths have proceeded to a serious case review.

### Child Deaths (in Local Authority areas)

<table>
<thead>
<tr>
<th>Area</th>
<th>Number</th>
<th>Unexpected</th>
</tr>
</thead>
<tbody>
<tr>
<td>Doncaster</td>
<td>16</td>
<td>5</td>
</tr>
<tr>
<td>Rotherham</td>
<td>14</td>
<td>3</td>
</tr>
<tr>
<td>North Lincolnshire</td>
<td>4</td>
<td>2</td>
</tr>
</tbody>
</table>

### Meetings and Sub-Groups

As identified in section 6 of this report, the Safeguarding Children Lead Professionals have been active in representing the Trust on Local Safeguarding Children Boards and resulting sub-groups. They have been instrumental in supporting multi-agency audits of a variety of issues and have taken a number of individual case reviews.

The Doncaster team have worked with colleagues to develop a neglect strategy and assessment toolkit which has been shared with Trust staff.

Internally audits have been carried out on the impact of training and supervision compliance and application of the Trust’s policy on ‘children visiting the Trust’s in-patient areas’.

The team have been active in their support of colleagues in circumstances where children have been admitted to adult in-patient facilities.

### Themes from Safeguarding Children’s Annual Report 2015/16 and Progress to date

<table>
<thead>
<tr>
<th>Theme</th>
<th>Progress</th>
</tr>
</thead>
<tbody>
<tr>
<td>To review the training programme to ensure the content reflects local, regional and national priorities</td>
<td>Achieved</td>
</tr>
<tr>
<td>To complete audits on the impact of training and supervision on staff and their confidence and skill in their recognising and acting to keep children safe</td>
<td>Achieved</td>
</tr>
<tr>
<td>To complete a review in relation to the experience of children visiting inpatient units</td>
<td>Actioned awaiting rollout of action plan</td>
</tr>
<tr>
<td>To increase visibility and presence of the Safeguarding Children Team within the clinical and operational area</td>
<td>Achieved and on-going</td>
</tr>
</tbody>
</table>

### Key Achievements

- There is a greater visibility of safeguarding professionals at team meetings and within team bases and a 9 till 5 availability for telephone advice and support
- A Safeguarding awareness week was held in December 2016 which focussed on issues in modern day slavery, neglect and FGM
The Safeguarding Children Team was presented with the runner up award for Support Team of the year at the Trust awards ceremony.

Mental Capacity Act (MCA)/Deprivation of Liberty Safeguards (DOLS)

The MCA is one of the most significant pieces of law that directly applies to adults, carers, family members, health and social care and legal professions. The Act is primarily about people’s rights to make decisions and choices (even those that are considered to be unwise) and for decisions to be made in a person’s best interest if they lack the mental capacity to be able to make the decision themselves and the Trust is responsible for ensuring that staff are competent and confident in executing their responsibilities in relation to the MCA.

The Trust has developed an MCA improvement plan to ensure the Trust is fully compliant with the Act and meets its legal requirements associated with the Deprivation of Liberty Safeguards.

The Deprivation of Liberty Safeguards (DoLS) within the MCA provides a protective legal framework for those who are deprived of their liberty and not detained under the Mental Health Act.

<table>
<thead>
<tr>
<th>Deprivation of Liberty Safeguards – Requests for Authorisation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total number of requests</td>
</tr>
<tr>
<td>--------------------------</td>
</tr>
<tr>
<td>32</td>
</tr>
</tbody>
</table>

The Supreme Court judgement in relation to Deprivation of Liberty Safeguards (DoLS) widened and clarified the definition of deprivation of liberty. This has resulted in a significant increase in DoLS cases from hospitals and care homes. The judgement also widened the scope of DoLS to include adults living in the community regarding such cases to be put to the Court of Protection for decision making.

Key Achievements

- The Trust has a dedicated Mental Capacity Act Lead
- The Trust has developed an MCA Action Plan
- The Trust now has a Mental Capacity Act forum which brings together key professionals and offers and arena to share best practice, explore complex cases and be updated on developments at a regional and national level.
- The Trust has a comprehensive MCA training framework. The aim of the framework is to shift the focus of the MCA from issues just about capacity to a culture of care that serves to maximise a person’s capacity, support their decision making and advocate for them so that their voice is heard and when necessary make decisions in their best interests.

Challenges

- Concerns have been raised with the Supervisory Body in Doncaster regarding the delays in patients being assessed and the length of time it is taking to process the authorisation once recommended by the Best Interests Assessors.
- As reported in the Annual CQC report for 2015/16 local authorities continue to struggle to process the number of requests received within the statutory time frame of 21 days for a standard authorisation.
Moving Forward

- The Supervisory Body have informed the Trust that action is being taken to address the number of cases awaiting assessment and authorisation and that steps are being taken to commission an external agency for a period of 3 months to carry out the outstanding assessments.
- The Law Commission have undertaken a review of the DoLS safeguards and issued a report and draft amendment bill, this is awaiting ratification by parliament.

Training

Safeguarding Children’s, Adults and Mental Capacity Act training is a fundamental part of the Trust’s duty to safeguard and promote the welfare of children and adults at risk under Section 11 of the Children’s Act (2004), Working Together (2015) and the Care Act 2014. All staff need to be trained and competent to recognise potential indicators of abuse or neglect, know what to do about any concerns raised and fulfil their responsibilities in accordance with Local Safeguarding Children’s Boards (LSCB) and Safeguarding Adults Boards in Doncaster, Rotherham, North and north East Lincolnshire.

Staff have had an opportunity to attend sessions facilitated by the Safeguarding and MCA Lead Professionals as well as a variety of conferences and seminars commissioned by the various Local Safeguarding Children’s Boards and Safeguarding Adults Boards. In addition, bespoke training has been devised and delivered in response to specific issues identified in the various care groups.

Fig. 1 depicts the interface between the three strands of safeguarding training.

Fig 1. depicts the interface between the three strands of safeguarding training
Safeguarding Adults Training Compliance

<table>
<thead>
<tr>
<th>Care Group</th>
<th>Level 1</th>
<th>Level 2</th>
<th>Level 3</th>
<th>Level 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Doncaster</td>
<td>98.68%</td>
<td>72.25%</td>
<td>57.25%</td>
<td>N/A</td>
</tr>
<tr>
<td>Rotherham</td>
<td>99.02%</td>
<td>72.77%</td>
<td>65.41%</td>
<td>N/A</td>
</tr>
<tr>
<td>North Lincs</td>
<td>96.03%</td>
<td>73%</td>
<td>68.57%</td>
<td>N/A</td>
</tr>
<tr>
<td>Children’s</td>
<td>99.4%</td>
<td>60%</td>
<td>33%</td>
<td>N/A</td>
</tr>
<tr>
<td>Corporate</td>
<td>99.83%</td>
<td>100%</td>
<td>N/A</td>
<td>80%</td>
</tr>
</tbody>
</table>

Safeguarding Children’s Training Compliance
RDaSH has joined the South Yorkshire Working Together MAST Passport arrangements. This will enable a level of rationalisation and standardisation of training to take place bringing the RDaSH safeguarding training offer in line with health organisations across South Yorkshire.

Serious Case Reviews (SCR), Safeguarding Adults Reviews (SAR) and Domestic Homicide Reviews (DHR)

Serious Case Reviews (SCR)

There have been two serious case reviews published this year to which RDaSH staff contributed. In November 2016, Doncaster Safeguarding Children Board published their review into the death of child A. This review was completed between October 2014 and July 2015 but publication was delayed due to a criminal investigation and trial.

In January 2017 the North East Lincolnshire Safeguarding Children Board published a Serious Case review for Child T, a four year old who died in August 2013. Again, the publication was delayed due to criminal proceedings.

Safeguarding Adults Reviews (SAR)

The Care Act 2014 places statutory responsibility on Safeguarding Adults Boards to commission Safeguarding Adult Reviews. A SAR must be arranged when an adult in its area dies as a result of abuse or neglect, whether known or suspected and there is a concern that partner agencies could have worked more effectively to protect the adult. The purpose of a SAR is to learn lessons, review effectiveness of procedures and improve practice. The Trust has representation on the SAR Sub Group within each Care Group area. During this period the Trust has contributed to one Lessons Learnt Review (LLR).

Domestic Homicide Reviews (DHR)

Domestic Homicide Reviews (DHR’s) were established on a statutory basis under section 9 of the Domestic Violence, Crime and Victims Act (2004). This provision came into force in April 2011. A Domestic Homicide Review is a local multi-agency review of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by:
• A person to whom the perpetrator was related or with whom he/she was or has been in an intimate personal relationship, or
• A member of the same household as the perpetrator

DHR’s are held with the view to identifying the lessons to be learnt from the death.

During the reporting period, the Trust has been asked to contribute to 3 DHR’s (2 in Rotherham and 1 in Doncaster). These reviews are on-going and will be shared with relevant personnel in the Trust on publication.

Conclusion

The past 12 months have seen significant changes in the safeguarding agenda within the Trust, with particular emphasis on developing a holistic approach which encompasses “think family” and Making Safeguarding Personal. There is recognition that there is a need to continue to adopt a more integrated way of working between the Children’s and Adults Safeguarding Named Nurses/Lead Professionals and a requirement to adapt our style of working in order to respond to the ever complex challenges and issues which appear on the landscape.

This Annual Report has provided an overview into service developments, new initiatives and legislation which has had an impact on Safeguarding in the Trust during the reporting period. It is intended to provide a level of assurance that the Trust is fulfilling its statutory duties in respect of Safeguarding Children and Safeguarding Adults at risk. In addition, the report also includes a safeguarding work plan for 2017/18 highlighting the areas for development and compliance which are required by the Trust.

In conclusion, the underpinning message remains the same in that safeguarding is everybody’s responsibility regardless of the role that they hold within the Trust.
Safeguarding Super Hero awards 2016

The Safeguarding and Looked After Children’s Teams hosted their second Safeguarding Week with a number of events around the Trust.

Forming part of the week, the team also hosted an awards ceremony to celebrate our colleagues work and how they go above and beyond their duty in relation to Safeguarding. Staff had been invited to submit nominations for who they felt deserves the title of “Safeguarding superhero”

19 “Safeguarding Superheroes” were announced at the awards

<table>
<thead>
<tr>
<th>Award Winner</th>
<th>Care Group</th>
</tr>
</thead>
<tbody>
<tr>
<td>Belinda Clark-Vessey</td>
<td>North Lincolnshire</td>
</tr>
<tr>
<td>0-5 Health Visiting Team</td>
<td>Children’s</td>
</tr>
<tr>
<td>Ann Brown</td>
<td>Doncaster</td>
</tr>
<tr>
<td>CHAP Team</td>
<td>Children’s</td>
</tr>
<tr>
<td>Doncaster CAMHS</td>
<td>Children’s</td>
</tr>
<tr>
<td>Emma Jones</td>
<td>Doncaster</td>
</tr>
<tr>
<td>Looked After Children’s Team</td>
<td>Children’s</td>
</tr>
<tr>
<td>Nick Bedford, Sarah Gritton, Lynn Fitzwater (joint)</td>
<td>Children’s</td>
</tr>
<tr>
<td>Liz Rennocks</td>
<td>Children’s</td>
</tr>
<tr>
<td>Louise Burnett</td>
<td>North Lincolnshire</td>
</tr>
<tr>
<td>Roxanne Womack</td>
<td>Children’s</td>
</tr>
<tr>
<td>North Lincolnshire IAPT Team</td>
<td>North Lincolnshire</td>
</tr>
<tr>
<td>Martin Jones</td>
<td>North Lincolnshire</td>
</tr>
<tr>
<td>Lois Hindmarsh</td>
<td>North Lincolnshire</td>
</tr>
<tr>
<td>Jenny Gravestock</td>
<td>North Lincolnshire</td>
</tr>
<tr>
<td>Paul Stevens</td>
<td>Doncaster</td>
</tr>
<tr>
<td>Sharon Baxter</td>
<td>Children’s</td>
</tr>
<tr>
<td>Elaine Eggett</td>
<td>Children’s</td>
</tr>
<tr>
<td>Donna Fisher</td>
<td>Children’s</td>
</tr>
</tbody>
</table>

Safeguarding Annual Work Plan 2017/18

The safeguarding annual work plan is aligned to the work plans of the three Safeguarding Children Boards and the three Safeguarding Adult Boards. Work is taking place to identify the common themes and priorities which will influence the safeguarding work plan for RDaSH over the coming twelve months. The plan will include training delivery, audit and evaluation, CSE, modern slavery and the PREVENT agenda. It is anticipated there will be a number of additions to this already comprehensive list.
<table>
<thead>
<tr>
<th>Committee Name</th>
<th>Board of Directors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Agenda Item</td>
<td>I Date 27 July 2017</td>
</tr>
<tr>
<td>Title of Paper</td>
<td>Infection Prevention &amp; Control Annual Report 2016/17</td>
</tr>
<tr>
<td>Action Required</td>
<td>Decision Assurance Information x x</td>
</tr>
<tr>
<td>Prepared by</td>
<td>Infection Prevention and Control Team</td>
</tr>
<tr>
<td>Presented by</td>
<td>Wendy Joseph, Deputy Director of Nursing and Quality</td>
</tr>
<tr>
<td>Delivery against</td>
<td>Strategic Goal(s) 1 5 Strategic Risk(s) 1.1 1.3 1.5 5.1</td>
</tr>
<tr>
<td></td>
<td>CQC Domain S E R W</td>
</tr>
<tr>
<td>Financial/Budget</td>
<td>No impact</td>
</tr>
<tr>
<td>Equality &amp; Diversity</td>
<td>Through the course of the work of the infection, prevention and control team and operational services consideration is given to vulnerable groups and those with protected characteristics. This is inherent within the Annual Report and therefore no specific additional considerations are detailed within the report.</td>
</tr>
<tr>
<td>Previously Presented to</td>
<td>Quality Committee – 8 June 2017</td>
</tr>
<tr>
<td>Background / Key Points / Outcome</td>
<td>The Infection Prevention &amp; Control Annual Report 2016/17 is attached for the Board of Directors’ information.</td>
</tr>
<tr>
<td></td>
<td>This annual report was presented to the Quality Committee at its meeting on 8 June 2017, where it was agreed that it be presented to the Board of Directors for information.</td>
</tr>
<tr>
<td></td>
<td>The Board of Directors is asked to note the Infection Prevention &amp; Control Annual Report 2016/17.</td>
</tr>
<tr>
<td></td>
<td>Following the Board of Directors, the Annual Report will be shared with key partners and published on the Trust public website.</td>
</tr>
</tbody>
</table>
Infection Prevention and Control
Annual Report

2016/2017

Dr Deborah Wildgoose
Director of Nursing and Quality

Lisa Connor
Associate Nurse Director
Doncaster Care Group

Infection Prevention and Control Team

June 2017
Executive Summary

This report covers the period 1 April 2016 to 31 March 2017. The key points highlighted below are further explored within the main body of the report:

- The Trust has had 1 incident of Meticillin Sensitive Staphylococcus aureus (MSSA) bacteraemia
- The Trust has had 0 incidents of Meticillin Resistant Staphylococcus aureus (MRSA) bacteraemia
- The Trust has had 1 incident of Escherichia coli (E. coli) bacteraemia
- The Infection Prevention and Control Team (IPCT) have undertaken 10 post infection reviews (PIR) for Clostridium difficile infection (CDI)
- The Trust Infection Prevention and Control (IPC) audit programme continues to provide assurance on the effectiveness of the operational approach to IPC
- Compliance for Level 2 standard precaution training is 83.08%.

Introduction

IPC remains a high priority for Rotherham Doncaster and South Humber NHS Foundation Trust (RDaSH) and reducing health care associated infections (HCAI’s) remains high on the government’s safety agenda and in the general public’s expectations for quality of care. An increase in multi resistant organisms has prompted additional reporting and it is anticipated targets will be introduced for incidences of E.coli and MSSA blood stream infections.

Since 2008 there has been a legal requirement on the NHS and other health and social care organisations to implement the Health and Social Care Act 2008, and to meet the standards of the Code of Practice within the Act (DH, 2015). The prevention and management of HCAIs has also evolved to become an integral element of new NHS structures developed since the toolkit was first introduced.

Throughout 2016/17 there has been a considerable amount of work and activity carried out in relation to IPC and this report documents some of the activity undertaken.

The Chief Executive holds ultimate responsibility for providing effective IPC arrangements across the Trust, however this duty of care is delegated to the Director of Infection Prevention and Control (DIPC), this being the Director of Nursing and Quality. This report from the DIPC is the annual report to the Trust Board of Directors on HCIAs and the progress of the annual work plan. This report serves to provide assurance of the activities and mitigation of risks related to the prevention and control of these infections, and outlines how RDaSH has demonstrated compliance with the Health and Social Care Act 2008 and Care Quality Commission (CQC) Standards and highlights the continued excellent performance for IPC within the Trust.
Governance Arrangements

The key roles with regard to IPC have continued to be fulfilled throughout 2016/17. A dedicated team of three Senior Clinical Nurse Specialists and one Clinical Nurse Specialist was managed on a day to day basis by the Head of Nursing who reported directly to the Deputy Director of Nursing and Quality. In February an Associate Nurse Director (AND) for Doncaster Care Group was appointed, as part of their portfolio they provide line management of IPCT. In addition the AND line manages the Senior Clinical Nurse Specialist overseeing the Public Health contract.
Operational Approach

The team has continued to provide all Trust Localities with specialist advice and support through effective communication and fostering good relationships with modern matrons, service managers and staff. In 2016/17 the team have:

- Provided advice and support to staff in the management and care of patients with infections
- Continued to network and forge collaborative relationships at local, regional and national level to glean knowledge, information and ideas to promote within the Trust
- Supported the link nurse programme
- Promoted engagement with staff and patients
- Continued to regularly monitor IPC standards throughout the Trust
- Worked with ward staff to develop and implement action plans arising from audits and cleanliness walk rounds
- Actively contributed in the reporting process at IPC committee meetings
- Continued to review and improve training methods for the group work scenarios used for statutory training sessions
- Maintained good relationships with the Facilities and Estates team
Microbiology Arrangements

There have been no changes to the microbiology/infection control service agreements. This service is provided by the acute hospital trusts, The Rotherham Foundation Trust and Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust, who provide microbiology/infection control support for the 3 localities via the IPC Team (IPCT), including out of hours cover when necessary.

Social Media

Work has commenced on streamlining and improving the web page content. During this time information has been continually updated and expanded and this work stream will continue into 2017/18.

An IPCT twitter account was launched as another platform to inform staff of IPC initiatives.

Link Champions

There are approximately 80 IPC link champions across the organisation, including registered nurses, healthcare assistants, physiotherapists, podiatry staff, school nurses, occupational therapists, and staff from mental health services, registered care homes and drugs and alcohol services.

The link champions help create and maintain an environment which ensures the safety of patients, visitors and colleagues. They utilise their knowledge and skills to support compliance with national standards and help embed IPC theory into everyday practice.

Recognised by colleagues for their unique function and contribution, and with support from their managers, these link champion roles support patient safety strategies through the dissemination of knowledge and best practice in health care settings.

Link champions have been encouraged to undertake hand hygiene assessments annually and monthly/quarterly. This is to promote staff compliance with hand hygiene policy and procedure. This will continue into 2017/18 with the IPCT creating a database to collate this information for feedback through the Infection Control Committee.

The link champion profile was reviewed again and presented via the Infection Control Committee meetings. The IPCT maintained close contact with the link champions via clinical visits, one to one meetings and through the annual study day. In addition, drop in sessions were advertised at all 3 localities for staff and link champions to meet one of the team to discuss any IPC issues or concerns.

IPC Training

On 31st March 2017 Trust compliance with Level 1 Hand Hygiene training was 92.9%. On commencement of employment staff receive the hand hygiene leaflet and a link to the leaflet is sent via email annually to all staff in June.
Across the organisation Level 2 Standard Precaution compliance was 83.08%. This training is role specific and clinical staff that meet the criteria must complete the training every 3 years. Staff can attend a face to face session or complete an e-Learning package.

Specific training was requested around Norovirus and this was delivered in a timely manner.

<table>
<thead>
<tr>
<th></th>
<th>Required</th>
<th>Achieved</th>
<th>Compliance %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Children’s Care Group</td>
<td>289</td>
<td>232</td>
<td>80.28%</td>
</tr>
<tr>
<td>Corporate Division</td>
<td>217</td>
<td>205</td>
<td>94.47%</td>
</tr>
<tr>
<td>Doncaster Care Group</td>
<td>1127</td>
<td>927</td>
<td>82.25%</td>
</tr>
<tr>
<td>North Lincolnshire Care Group</td>
<td>154</td>
<td>128</td>
<td>83.12%</td>
</tr>
<tr>
<td>Rotherham Care Group</td>
<td>382</td>
<td>310</td>
<td>81.15%</td>
</tr>
<tr>
<td>Total Trust Compliance</td>
<td>2169</td>
<td>1802</td>
<td>83.08%</td>
</tr>
</tbody>
</table>

**IPC Policies**

To ensure compliance with the requirements of the Health & Social Care Act (2008) a new policy, Group 4 Hazard, Viral Haemorrhagic Fevers (VHF) has been produced. All IPC policies are up to date.

IPC information leaflets have been reviewed and updated where required.

Work has commenced on streamlining the suite of IPC policies. This work stream will continue into 2017/18.

**Going Viral**

During 2016/17, 5 editions of the Going Viral newsletter were published, and issued to staff via the daily email system. The newsletter is also available on the intranet.

Going Viral continues to provide updates to staff on key IPC topics including local, national and global issues, forthcoming conferences and training opportunities as well as information about antibiotic stewardship, sepsis, flu campaign updates and any changes to training requirements.

**Flu Campaign**

This year saw the team engage with the Flu Campaign for the first time. The team were keen to become involved in the roll out of the flu vaccinations for staff and participated by organising vaccination clinics, vaccinating staff and promoting the campaign during every day clinical activity as well as through newsletter releases and liaising with Communications. Several members attended community team meetings, conferences and manned the Health Bus to vaccinate as many front line staff as possible. This proactive approach helped the team to become the top vaccinators in the Trust and helped secure CQUIN funding for further investment into care services.
Domestic Monitoring Programme

Across the organisation 107 areas required monitoring. These included 21 in patient areas (wards) 33 clinical areas (out patients health centres etc.) and 53 non clinical areas (offices).

In the 12 month period from April 2016 to March 2017, 494 monitoring exercises were undertaken. Of these, 102 areas received full assurance, 375 areas received significant assurance and 17 areas received limited assurance. Action plans were developed and implemented in the areas that received limited assurance and the areas were re-audited after 2 weeks. Standards in these areas were raised and subsequently received significant assurance. When areas are re-audited following a limited assurance result, only the failed elements are re-audited. Any areas which have still not been addressed are then escalated to the Domestic Services Manager for further investigation and action.

Post Infection Reviews

The IPCT have continued to contribute to Doncaster Clinical Commissioning Group (DCCG) PIR meetings where the root cause for all Doncaster district wide MRSA bacteraemia and CDIs are discussed. Members consider if infection occurred through lapses in care, and if this is the case, an action plan is developed by the provider involved. Meetings are attended by one of the Senior Clinical Nurse Specialists and on occasions, Associate Nurse Director, to ensure decisions
relating to cases can be escalated if necessary. An overview of all RDaSH related cases are raised at the ICCM for assurance purposes.

**Healthcare Associated Infections (HCAI) Surveillance**

Surveillance has been identified as an important way to provide quality outcome indicators and identify key measures in order to reduce the burden of HCAIs. It also underpins policy development and informs education programmes. The IPCT undertake routine surveillance for MSSA bacteraemia, MRSA bacteraemia, E. coli bacteraemia and CDI.

There has been 1 case of E. coli bacteraemia in the community setting. The PIR concluded that were no lapses in care from the organisation which led to the infection.

There has been 1 case of MSSA bacteraemia in the community setting. No lapses in care were identified during the review process. There was 1 lesson to be learnt and this was shared appropriately with key staff.

There have been 0 cases of MRSA bacteraemia.

There have been 10 cases of CDI. The PIR process identified that there were no lapses in care for the organisation. Cases are attributed to NHS DCCG and apportioned to RDaSH if the Trust is the lead provider of care.

**Outbreaks**

An outbreak is defined as the occurrence of 2 or more related cases of the same infection, or where the number of infections is more than would normally be expected.

All of the outbreaks listed below were deemed to be minor as they were dealt with within existing routine arrangements. The IPCT compiled reports and good practice and lessons learnt were shared with key staff.

<table>
<thead>
<tr>
<th>Area</th>
<th>Infectious Agent</th>
<th>Date</th>
<th>Number of patients affected</th>
<th>Number of staff affected</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Glade</td>
<td>Norovirus</td>
<td>November 2016</td>
<td>9</td>
<td>3</td>
</tr>
<tr>
<td>Sandpiper</td>
<td>Norovirus</td>
<td>November 2016</td>
<td>5</td>
<td>3</td>
</tr>
<tr>
<td>Hazel Ward</td>
<td>Norovirus</td>
<td>December 2016</td>
<td>6</td>
<td>3</td>
</tr>
<tr>
<td>Hawthorne Ward</td>
<td>Norovirus</td>
<td>November 2016</td>
<td>13</td>
<td>14</td>
</tr>
<tr>
<td>Hawthorne Ward</td>
<td>Influenza A</td>
<td>February 2017</td>
<td>3</td>
<td>2</td>
</tr>
</tbody>
</table>

In November there was a cluster of patients with diarrhoea on Hazel Ward. No causative organism was identified from specimens sent.
World Health Organisation (WHO) Clean Your Hands Campaign

Every year on the 5th May the WHO campaigns to improve hand hygiene. This is a global initiative and RDaSH continue to promote the day through various activities raising awareness of the importance of hand hygiene in the fight against infection. On the 5th May 2016 members of the IPCT visited sites in Rotherham and Doncaster. A display was produced and hand hygiene assessments were carried out in the Food and Drink Café and at Woodlands. Staff participating in the event were given pens, notebooks and other free gifts which had been supplied free of charge by some of the Trust product suppliers. The hand hygiene assessments identified hand hygiene best practice and good hand washing techniques.

International Infection Control Week 16th – 22nd October 2016

Members of the IPCT visited a number of areas across the localities to promote the annual international awareness campaign.

The IPC team promoted Infection Control Week this year using the health bus. This year the focus was on respiratory illnesses. The information was displayed on the bus and throughout the organisation via the Link Champions. There were also opportunities to have the flu vaccination and complete a quiz with a prize draw.
Clinical Audit Programme

Inpatient Areas:

During 2016/17 the inpatient Link Champions completed an environmental and practices audit for their area. The IPCT visited the wards to validate the audit results. The IPCT supported the Link Champions and the Managers with the action plans.

Audit Results:

<table>
<thead>
<tr>
<th>Category:</th>
<th>Ward/Area:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outstanding</td>
<td>Amber Intensive Support Unit (ISU)</td>
</tr>
<tr>
<td></td>
<td>Hazel</td>
</tr>
<tr>
<td></td>
<td>Hawthorne</td>
</tr>
<tr>
<td></td>
<td>Goldcrest</td>
</tr>
<tr>
<td></td>
<td>Sandpiper</td>
</tr>
<tr>
<td></td>
<td>ECT Suite</td>
</tr>
<tr>
<td></td>
<td>Laurel</td>
</tr>
<tr>
<td></td>
<td>Jubilee</td>
</tr>
<tr>
<td></td>
<td>Emerald</td>
</tr>
<tr>
<td></td>
<td>New Beginnings</td>
</tr>
<tr>
<td></td>
<td>The Brambles</td>
</tr>
<tr>
<td>Good</td>
<td>Amber Rehabilitation and Recovery</td>
</tr>
<tr>
<td></td>
<td>St John's Hospice</td>
</tr>
<tr>
<td></td>
<td>Coniston</td>
</tr>
<tr>
<td></td>
<td>Kingfisher</td>
</tr>
<tr>
<td></td>
<td>Cusworth</td>
</tr>
<tr>
<td></td>
<td>Windermere</td>
</tr>
<tr>
<td></td>
<td>Glades</td>
</tr>
<tr>
<td></td>
<td>Coral</td>
</tr>
<tr>
<td></td>
<td>Skelbrooke</td>
</tr>
<tr>
<td></td>
<td>Brodsworth</td>
</tr>
<tr>
<td></td>
<td>Osprey</td>
</tr>
<tr>
<td>Requires Improvement</td>
<td>Magnolia</td>
</tr>
</tbody>
</table>

The ward requiring improvement has had additional support from the IPCT. The ward has implemented an improvement plan which includes IPC issues.
Themes and Trends:

<table>
<thead>
<tr>
<th>Good practices on some wards:</th>
<th>Practices needing improvement on some wards:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Link champions will contact IPC for advice</td>
<td>• Not all staff have access to alcohol hand gel at point of care</td>
</tr>
<tr>
<td>• Most documentation is up to date</td>
<td>• Lack of storage/cluttered store room</td>
</tr>
<tr>
<td>• Proactive link champion and ward manager</td>
<td>• Water and cleaning checklists not fully completed</td>
</tr>
<tr>
<td>• Training compliance is very good</td>
<td>• Discharge / terminal clean checklists are not always completed or signed</td>
</tr>
<tr>
<td>• Environmental cleanliness is very good</td>
<td>• No domestic schedules displayed</td>
</tr>
<tr>
<td>• Good systems and processes in place</td>
<td>• Small areas of environmental and furniture damage</td>
</tr>
<tr>
<td>• Good knowledge of IPC from staff members on the ward</td>
<td>• Sharps bins not labelled fully and temporary closure mechanism not in use</td>
</tr>
<tr>
<td>• Following the audit a link champion arranged a walk round with the matron and operational service manager to identify the issues</td>
<td>• Work required on staff knowledge regarding spillages of body fluids</td>
</tr>
<tr>
<td>• IPC issues are discussed at team meetings</td>
<td>• Some furniture is not impermeable</td>
</tr>
<tr>
<td>• Checklists are up to date</td>
<td>• Dust inside radiators and fans</td>
</tr>
<tr>
<td>• Positive IPC culture on the ward</td>
<td>• Small amount of paint work/plaster damage</td>
</tr>
<tr>
<td>• Regular walk rounds completed by ward manager</td>
<td>• No written evidence of IPC information on team meeting minutes</td>
</tr>
<tr>
<td>• Supportive manager that maintains good links with IPC team</td>
<td>• Curtains and blinds overdue for laundering</td>
</tr>
<tr>
<td>• Standards being met during a change of management and staff movement</td>
<td>• Poor knowledge of single use symbol</td>
</tr>
<tr>
<td></td>
<td>• All toiletries are not single patient use</td>
</tr>
<tr>
<td></td>
<td>• Failure to wear personal protective equipment appropriately</td>
</tr>
<tr>
<td></td>
<td>• There is sometimes no documented evidence in patients’ care plans that the Healthcare Associated Infection risk assessment form has been completed</td>
</tr>
<tr>
<td></td>
<td>• Not all staff are up to date with standard precautions training</td>
</tr>
<tr>
<td></td>
<td>• No HCAI risk assessment forms completed for some admissions</td>
</tr>
<tr>
<td></td>
<td>• Infrequent mattress checks</td>
</tr>
</tbody>
</table>

Issues identified have been addressed by the managers. Outstanding issues related to Estates have been escalated to the Head of Estates.
Community Premises Audit

An audit tool has been developed for community premises, which has been piloted with the Tissue Viability and Lymphodema Service. The plan for 2017/18 is for community premises to be audited, priority being clinics performing invasive procedures, e.g. phlebotomy.

IPC Practice Audits

An audit tool assessing staff practices has been developed. This looks at activities such as urinary catheters, Percutaneous Endoscopic Gastrostomies, basic principles of IPC and Intravenous insertion and/or management. The tool is being piloted with community nursing in Doncaster Care Group from April – July 2017 and after evaluation will be rolled out to all clinical teams.

Patient Led Assessments of the Care Environment (PLACE)

The 2016 Patient Led Assessments of the Care Environment (PLACE) were undertaken between February and May 2016.

The PLACE assessments were led by trained ‘Patient Assessors’ and included Governors, volunteers, in-patients and young people from the Princes Trust programme, and were facilitated by trained staff assessors from Facilities, Human Resources, Corporate Affairs, Voluntary Services (Hospice), and the IPCT.

The 2016 assessments focussed on six key themes:

- Cleanliness
- Food
- Privacy and Dignity
- Condition and Appearance
- Dementia
- Disability (new for 2016)

The results were nationally embargoed until the 10th August 2016 when the results for all service providers were published. In broad terms the Trust average results are above the national average for all areas with the exception of food and hydration which came just under the national average. Table 1 below refers average comparison with national average results.

<table>
<thead>
<tr>
<th>Cleanliness</th>
<th>Food and Hydration</th>
<th>Privacy and Dignity</th>
<th>Condition / Appearance</th>
<th>Dementia</th>
<th>Disability</th>
</tr>
</thead>
<tbody>
<tr>
<td>RDaSH average 2016</td>
<td>98.5%</td>
<td>86.7%</td>
<td>90.7%</td>
<td>96.2%</td>
<td>76.8%</td>
</tr>
<tr>
<td>National Average 2016</td>
<td>98.1%</td>
<td>88.2%</td>
<td>84.2%</td>
<td>93.4%</td>
<td>75.3%</td>
</tr>
<tr>
<td>Variation</td>
<td>+0.4%</td>
<td>-1.5%</td>
<td>+6.5%</td>
<td>+2.8%</td>
<td>+1.5%</td>
</tr>
</tbody>
</table>
The Trust’s 2015 v 2016 results comparisons are shown in table 2 below.

Table 2: RDaSH comparison of average results 2015 –v- 2016

<table>
<thead>
<tr>
<th></th>
<th>Cleanliness</th>
<th>Food</th>
<th>Privacy and Dignity</th>
<th>Condition / Appearance</th>
<th>Dementia</th>
<th>Disability</th>
</tr>
</thead>
<tbody>
<tr>
<td>RDaSH average 2015</td>
<td>94.7%</td>
<td>87.5%</td>
<td>92.2%</td>
<td>91.3%</td>
<td>76.1%</td>
<td>Not scored.</td>
</tr>
<tr>
<td>RDaSH Average 2016</td>
<td>98.5%</td>
<td>86.7%</td>
<td>90.7%</td>
<td>96.2%</td>
<td>76.8%</td>
<td>80%</td>
</tr>
<tr>
<td>Variation</td>
<td>+3.8%</td>
<td>-0.8%</td>
<td>-1.5%</td>
<td>+4.9%</td>
<td>+0.7%</td>
<td>n/a</td>
</tr>
</tbody>
</table>

A comparison of Trust results on a site by site basis of the 2015 and 2016 results is shown in table 3 below.

Table 3: RDaSH comparison of site results 2015 –v- 2016

<table>
<thead>
<tr>
<th></th>
<th>Cleanliness</th>
<th>Food &amp; Hydration</th>
<th>Privacy &amp; Dignity</th>
<th>Condition/App Perception</th>
<th>Dementia</th>
<th>Disability</th>
</tr>
</thead>
<tbody>
<tr>
<td>Woodlands</td>
<td>96.45%</td>
<td>98.63%</td>
<td>81.89%</td>
<td>78.22%</td>
<td>91.35%</td>
<td>91.46%</td>
</tr>
<tr>
<td>Emerald</td>
<td>85.86%</td>
<td>97.42%</td>
<td>0.00%</td>
<td>0.00%</td>
<td>88.41%</td>
<td>87.50%</td>
</tr>
<tr>
<td>TRH (DCIS)</td>
<td>95.38%</td>
<td>98.43%</td>
<td>81.63%</td>
<td>87.63%</td>
<td>83.43%</td>
<td>90.31%</td>
</tr>
<tr>
<td>St Caths</td>
<td>95.18%</td>
<td>90.77%</td>
<td>94.69%</td>
<td>89.96%</td>
<td>89.77%</td>
<td>96.19%</td>
</tr>
<tr>
<td>Great Oaks</td>
<td>95.38%</td>
<td>99.76%</td>
<td>88.98%</td>
<td>89.47%</td>
<td>100.0%</td>
<td>95.12%</td>
</tr>
<tr>
<td>Swallownest</td>
<td>91.82%</td>
<td>98.16%</td>
<td>87.05%</td>
<td>87.03%</td>
<td>90.00%</td>
<td>89.29%</td>
</tr>
<tr>
<td>Hospice</td>
<td>99.29%</td>
<td>98.71%</td>
<td>90.77%</td>
<td>94.91%</td>
<td>100.0%</td>
<td>92.31%</td>
</tr>
</tbody>
</table>

Water Safety

The Water Safety Group continues to meet bi-monthly at each Infection Prevention and Control Committee (IPCC) meeting with water safety as a standing agenda item. The function of the Water Safety Group is to provide a multi-disciplinary approach to assess and manage risks from water systems in the context of clinical risk to patients. During 2016 there have been concerns raised about water sampling results undertaken on Hazel ward which identified counts of Legionella colonies. A risk assessment was completed by the Estates Department and this identified no risk to patients as the sink was not in use. Work to replace oversized pipes was carried out and a replacement tap was installed which rectified the problem.

Emergency Preparedness

The IPCT have worked closely with the Emergency Planning Officer (EPO), contributing to a variety of Trust plans and procedures under Emergency Preparedness, Resilience and Response (EPRR).

Through working collaboratively with the EPO robust systems and processes have been developed to provide guidance to staff in the event of a CBRN/HAZMAT (Chemical, Biological, Radiological & Nuclear/Hazardous Material) incident.
Work has commenced on influenza planning. The aim is to ensure that staff have the knowledge and skills to work safely during a seasonal or pandemic flu incident. This is a large project and will be completed in 2017/18.

Infection Control Conference

The conference was arranged by the IPC Team.

On 21\textsuperscript{st} October 2016 the IPCT held their first conference at Castle Park Rugby Club in Doncaster. The conference was aimed at IPC link champions with spare places being offered to other Trust staff. Speakers included Dr Neil Wigglesworth, President, Infection Prevention Society, Dr Ken Agwuh, Consultant Microbiologist, Dr Lee Cutler, Consultant Nurse – Critical Care DBTHFT, Helen Jones, Hydrop Consultancy and Pixy Strazds, Lead Practitioner IPC Forensic Services Nottinghamshire. Topics included a personal perspective of flu and sepsis from Adele Joicey whose moving account of her experiences was one of the highlights of the day. Others included human factors, sepsis, antimicrobial stewardship, IPC in challenging environments and water safety.

Exhibitors included representatives from some of the companies the Trust procure products and services from. The link champions utilised the opportunity to obtain information and free goods from the exhibitors who kindly provided funds towards the refreshments provided on the day. Subject Matter Experts were also on hand at lunch time for delegates to view display boards, obtain information leaflets and ask questions. These experts included staff from the Continence team, Resuscitation Officer, IPC Care Homes, Hepatitis and TB Nursing teams.

During refreshment breaks and over lunch time flu vaccines were offered to all staff and members of the IPCT administered these vaccines.

The day was a great success and evaluations from delegates were overwhelmingly positive. As a result of this, a second conference has been planned for 2017.
Public Health Contract

IPC plays a fundamental part in improving the safety and quality of care provided to patients, clients and service users across the spectrum of adult health and social care.

In January 2015, following discussions with Public Health and Doncaster Clinical Commissioning Group (DCCG) it was agreed that IPC provision would be commissioned from RDaSH.

The primary focus of this Doncaster Metropolitan Borough Council (DMBC) commissioned service is to provide IPC expertise for residents of nursing and residential homes across Doncaster. Further scoping of wider community IPC requirements will also be undertaken.

National policies for the control of MRSA bacteraemia and CDI have improved IPC measures in the UK, with associated reductions nationally in HCAI infection rates. This service includes undertaking post infection reviews for CDI and MRSA bacteraemia with presentation at the PIR meeting held at DCCG.

On-going work is still required to maintain and improve these reductions and incidences of these and other HCAIs in line with current and future national guidance.

This service includes collaborative working with:

- DMBC Public Health Team
- NHS DCCG
- DMBC Contract Monitoring Team/CCG Overarching Care Home Strategy Group
- Public Health England (PHE) – South Yorkshire Health Protection Team
- DMBC Environmental Health Team
• Private nursing and residential home providers
• Microbiology and IPC teams at DBHFT and RDaSH

Annual Work Plan 2016/17

The Trust’s IPCC Work Plan and progress against it for the year 2016/17 are reflected across this annual report. The objectives and position at year end are summarised below:

<table>
<thead>
<tr>
<th>OBJECTIVE</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
</tr>
<tr>
<td>2</td>
</tr>
<tr>
<td>3</td>
</tr>
<tr>
<td>4</td>
</tr>
<tr>
<td>5</td>
</tr>
<tr>
<td>6</td>
</tr>
<tr>
<td>7</td>
</tr>
</tbody>
</table>

Annual Work Plan 2017/18

The Trusts IPC priorities for 2017/18 have been identified and the following objectives from the work plan:

<table>
<thead>
<tr>
<th>OBJECTIVE</th>
</tr>
</thead>
<tbody>
<tr>
<td>1a</td>
</tr>
<tr>
<td>1b</td>
</tr>
<tr>
<td>1c</td>
</tr>
<tr>
<td>2</td>
</tr>
</tbody>
</table>
### OBJECTIVE

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>3</td>
<td>Continue to monitor for alerts and new guidance on infection prevention and control (IPC) and implement changes to policies and guidelines.</td>
</tr>
<tr>
<td>4</td>
<td>Work in collaboration with partners to undertake and implement actions for post infection reviews (PIR).</td>
</tr>
<tr>
<td>5</td>
<td>Promote and support the link champion role and requirements for training/enhancing knowledge and skills.</td>
</tr>
<tr>
<td>6</td>
<td>Share evidence and quality and standards approach across all services.</td>
</tr>
<tr>
<td>7</td>
<td>Deliver IPC training and implement emergent best practice initiatives.</td>
</tr>
<tr>
<td>8</td>
<td>Promote IPC via campaigns, alerts, national, regional and international initiatives.</td>
</tr>
<tr>
<td>9</td>
<td>Scope business opportunities with partner organisations.</td>
</tr>
<tr>
<td>10</td>
<td>To support the Flu Campaign.</td>
</tr>
<tr>
<td>11</td>
<td>To support the Quality Review process.</td>
</tr>
<tr>
<td>12</td>
<td>To provide expert guidance and support to Care Groups during refurbishment and new build projects.</td>
</tr>
</tbody>
</table>

**Conclusion**

This report outlines the work that has been carried out in order to provide assurance that the Trust is meeting its IPC duties as defined by the Health and Social Care Act (2008) and in CQC Standards.

The IPCT has continued to implement a robust plan of IPC, in collaboration with clinical colleagues. This is evidenced by the small number of HCAIs occurring in 2017/18, including outbreaks.

Plans are in place with identified key priorities for 207/18. IPC remains a key priority for the Board of Directors and the Trust is committed to providing safe, effective, well led care.

The monitoring and governance arrangements which are in place will provide continued assurance to the Board of Directors.
Glossary

**Bacteraemia**
Bacteria in the bloodstream.

**Clostridium difficile (C. diff)**
Is an anaerobic bacterium that is present in the gut of up to 3% of healthy adults and 66% of infants. However, **Clostridium difficile** rarely causes problems in children or healthy adults, as it is kept in check by the normal bacterial population of the intestine.

**Escherichia coli (E-coli)**
Is the name of a bacteria that lives in the intestines.

**Healthcare associated infections (HCAIs)** are infections that occur:
As a direct result of treatment in, or contact with, a health or social care setting
As a direct result of healthcare delivery in the community
As a result of an infection originally acquired outside a healthcare setting (for example, in the community) and brought into a healthcare setting by patients, staff or visitors and transmitted to others within that setting (for example, Norovirus)

**IPC link champion**
Ward based or department level staff within the Trust who promote and support best practice in relation to IPC with a common goal of zero tolerance towards avoidable infections under the guidance of the Clinical Nurse Specialists.

**Microbiology**
The branch of science that deals with micro-organisms.

**Microorganisms**
A microscopic organism, especially a bacterium, virus, or fungus.

**MSSA - Meticillin Sensitive Staphylococcus aureus**
Is a common bacterium that lives harmlessly on the skin and nose of about a third of the population.

**MRSA - Meticillin Resistant Staphylococcus aureus**
Is a common form of staphylococcus aureus that has become resistant to some common antibiotics.
Medical Revalidation is underpinned by legislation: The Medical Profession (Responsible Officers) Regulations, 2010 as amended in 2013’ and ‘The General Medical Council (Licence to Practise and Revalidation) Regulations Order of Council 2012’

The Responsible Officer (RO) for Revalidation in RDaSH (this role is undertaken by the Medical Director) is expected to assure the Board that the Trust (the Designated Body) complies with the requirements for medical revalidation. The Chief Executive or the Chairperson is expected to sign a Statement of Compliance on behalf of the Trust after having considered the assurance.

The RO would like the Board of Directors to note the following main points within the Annual Revalidation (Medical) Board Report:

1. Out of a total of 55 doctors with a prescribed connection to RDaSH, 50 had a revalidation ready appraisal. Reasons for the 5 doctors not meeting this requirement are detailed on page 11 of the paper.

2. The RO was due to consider 8 doctors for revalidation recommendations in 2016-2017. He provided the GMC with 7 positive recommendations and 1 recommendation for deferral. All were accepted by the GMC.

3. The RO chairs the RDaSH Revalidation Support Team meetings approximately every quarter.

4. The RO is also the appraisal lead for RDaSH and provides personal
training to all new appraisers as well as an annual refresher meeting for existing appraisers. The Trust has 16 appraisers. All appraisers for doctors must be medical practitioners.

5. The RO personally audits approximately 20% of appraisals (12 for the 2016-2017 cycle) examining all documentation in detail and providing feedback to both appraisers and appraisees regarding quality.

6. For the second year in succession, the average time for completion of appraisals has been longer in the appraisal year than previously. Monitoring progress is very difficult for the Revalidation Support Team. The Trust has piloted a cloud based electronic system and is awaiting final feedback from doctors. However it is unlikely that the final feedback will be unanimously positive which means that the existing PDF based tool (the MAG) will be used in 2017-2018

7. **Since the paper was presented to Quality Committee on 13 July 2017:**

   - Following an audit of 12 appraisal files, doctors and appraisers have sent the RO some additional data which has allowed him to update the report on pages 12 and 13.
   - NHS England has reviewed the Annual Organisational Audit (AOA) regarding the annual appraisal of Trust doctors which RDaSH submitted at the start of June 2017. It stated in an email:

     "As we found everything to be satisfactory there is no action to be taken by us."

The Board of Directors is asked to note and consider the assurance provided in this paper.

The Chief Executive or the Chairperson is asked to consider whether the assurance provided within this report, and following open discussion at the Board of Directors, enables a decision to be reached as to whether the Statement of Compliance can be signed.
A Framework of Quality Assurance for Responsible Officers and Revalidation

Annex D - Annual Board Report Template
A template board report for use by designated bodies to monitor their organisation’s progress in implementing the Responsible Officer Regulations.

From June 2015

Gary Cooper, Project Manager Quality and Assurance, Professional Standards Team

16 June 2015

All Responsible Officers in England

Foundation Trust CEs, NHS Trust Board Chairs, Medical Appraisal Leads, CEs of Designated Bodies in England, NHS England Regional Directors, NHS England Directors of Commissioning Operations, All NHS England Employees, Directors of HR, NHS Trust CEs

A template board report for use by designated bodies to monitor their organisation’s progress in implementing the Responsible Officer Regulations.

The Medical Profession (Responsible Officers) Regulations, 2010 (as amended 2013) and the GMC (Licence to Practise and Revalidation) Regulations 2012


Designated Bodies to receive annual board reports on the implementation of revalidation and submit an annual statement of compliance to their higher level responsible officers.

From June 2015

england.revalidation-pmo@nhs.net

http://www.england.nhs.uk/revalidation/

This is a controlled document. Whilst this document may be printed, the electronic version posted on the intranet is the controlled copy. Any printed copies of this document are not controlled. As a controlled document, this document should not be saved onto local or network drives but should always be accessed from the intranet. NB: The National Health Service Commissioning Board was established on 1 October 2012 as an executive non-departmental public body. Since 1 April 2013, the National Health Service Commissioning Board has used the name NHS England for operational purposes.
Annual Board Report Template

Version number: 2.0

First published: 4 April 2014

Updated: 16 June 2015

Prepared by: Gary Cooper, Project Manager for Quality Assurance, NHS England

Classification: OFFICIAL
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1. Executive summary

Last year there were a total of 55 doctors with a prescribed connection to the Trust. Of these 50 had and completed a revalidation ready appraisal.

Revalidation recommendations were due for 8 doctors within this year and 7 positive recommendations were made within the prescribed period within the relevant time period. One recommendation was made for a deferral due to long-term sickness.

Timescales are tight in the appraisal cycle; for the second year the average time for appraisals to have been completed was longer than previous years. The current system does not allow easy monitoring of appraisal timescale adherence although a pilot of an electronic appraisal system is underway.

Resourcing the administrative inputs into appraisal and revalidation needs reviewing as it remains without dedicated funding.

2. Purpose of the Paper

Medical revalidation is the process through which the General Medical Council (GMC) confirms that a doctor’s license to practice will continue. Without a license to practice, a doctor may not prescribe medications and may not sign a number of statutory forms, including death certificates and Medical Recommendations under the Mental Health Act.

The purpose of revalidation is to provide assurance for patients and the public, employers and other healthcare professionals that licensed doctors are up to date and fit to practice. Revalidation is supported by a number of processes, including a strengthened form of medical appraisal that is based upon the doctor collecting and reflecting upon specified data about their performance, also known as ‘supporting information’.

The purposes of this paper are to:
- Update the Board on situation with regard to revalidation in the Trust
- Highlight emerging issues and risks
- Request the authority to sign off the Statement of Compliance for the higher level Responsible Officer

3. Background

Medical revalidation was launched in 2012 to strengthen the way that doctors are regulated, with the aim of improving the quality of care provided to patients, improving patient safety and increasing public trust and confidence in the medical system.

Provider organisations have a statutory duty to support their Responsible Officers in
discharging their duties under the Responsible Officer Regulations\textsuperscript{1} and it is expected that provider boards will oversee compliance by:

- monitoring the frequency and quality of medical appraisals in their organisations;
- checking there are effective systems in place for monitoring the conduct and performance of their doctors;
- confirming that feedback from patients and colleagues is sought periodically so that their views can inform the appraisal and revalidation process for their doctors; and
- Ensuring that appropriate pre-employment background checks (including pre-engagement for locums) are carried out to ensure that medical practitioners have qualifications and experience appropriate to the work performed.

4. Governance Arrangements

The Trust Responsible Officer (RO) is the Executive Medical Director who is managed by the Chief Executive and is professionally accountable to the GMC and to the Level 2 Responsible Officer in NHS England.

The implementation of revalidation has been monitored by reports to the Trust Revalidation Support Team, which is chaired by the Responsible Officer.

The list of prescribed connections held on the GMC Connect web-site is regularly checked against staff lists held on the Electronic Staff Records by a member of the Trust Revalidation Team who also received notifications of staff changes from the Medical Staffing Team in the Workforce Directorate.

The relevant policies are:-
- Medical Appraisal Policy
- Remediation and Responding to Concerns Guidance

5. Medical Appraisal

a. Appraisal and Revalidation Performance Data

Detailed activity levels of appraisal outputs in individual departments:

- Number of doctors: 55
- Number of completed appraisals: 50

\textsuperscript{1} The Medical Profession (Responsible Officers) Regulations, 2010 as amended in 2013’ and ‘The General Medical Council (Licence to Practise and Revalidation) Regulations Order of Council 2012’
Details of exceptions i.e. missed appraisals and reasons, incomplete appraisals etc. (See Annual Report Appendix A; Audit of all missed or incomplete appraisals audit)

b. Appraisers

- Number of appraisers: 16
- Further appraiser training support took place on the 9th June and 15th June 2017

The Trust Responsible Officer is also the ‘Appraisal Lead’. He personally delivers all new appraiser training so as to ensure that it is consistent and meets the required standard. The training materials used are ones that have been used at national training events facilitated by NHS England.

c. Quality Assurance

Outline of quality assurance processes:

In 2014-2015 the Responsible Officer personally examined the electronic document used to store all of the appraisal documentation for every doctor in the Trust:

- to provide assurance regarding the appraisal inputs: that the pre-appraisal declarations and supporting information provided is available and appropriate
- to provide assurance that the appraisal outputs: PDP, summary and sign offs are complete and to an appropriate standard
- To offer appraisers and appraises bespoke feedback.

In 2015-2016 he sampled around 20% of appraisals submitted.

For the individual appraiser

- In 2016-2017 the Responsible Officer examined 12 annual record of the appraisal documentation as a sample, ensuring that it was a different sample from the previous year.

For appraised doctors

- All are asked to complete a standard feedback form regarding their appraisal and the management of appraisal within the Trust, which is then discussed in the annual appraiser training.

For the organisation:

All complaints, SIs and IR1s involving medical staff are reviewed by the Medical Staffing Manager and discussed with the Responsible Officer

- Review of lessons learned from any complaints
• Review of lessons learned from any significant events

(See Annual Report Appendix B; Quality assurance audit of appraisal inputs and outputs)

d. **Access, Security and Confidentiality**

Access to appraisal folders confined to Appraisal Administrator, Medical Staffing Manager and the Responsible Officer (Medical Director).

Any patient identifiable information within the supporting information is redacted.

e. **Clinical governance**

Corporate data is used for individual doctors as a contribution to their supporting information. Information on Complaints, Serious incidents, IR1’s, CPD activity data and Sickness Absence are provided to individuals by the organisation for appraisal.

*Also see “Annual Report Template Appendix C; Audit of concerns about a doctor’s practice” as an example of what could be carried out.*

6. **Revalidation Recommendations**

The RO has a period of 120 days prior to the doctor’s revalidation date in which to make their recommendation to the GMC. There are only three possible recommendations: that the doctor is up to date and fit to practice (a positive recommendation), a request to defer the date of the recommendation (deferral request) a notification of the doctor’s non-engagement with revalidation (non-engagement notification).

In order to make a positive recommendation, the RO must be satisfied that the doctor has met the GMC’s requirements for revalidation, they have participated in systems and processes to support revalidation and they have collected the required supporting information for revalidation. The RO must also be able to confirm that there are no unaddressed concerns about the doctor’s fitness to practice.

A deferral request is a request made by the RO to ask the GMC to provide more time in which to submit a recommendation. Deferral requests can be made for doctors who are engaged in the systems and processes that support revalidation, but their required supporting information is incomplete, for example, because of prolonged sickness or other absence from work. A deferral request can also be made in connection with a doctor who is involved in an ongoing human resource or disciplinary process, the outcome of which will need to be considered in making the revalidation recommendation.

A doctor is not engaging in revalidation where, in the absence of reasonable circumstances, they are not participating in local processes and systems that support
revalidation or do not participate in the formal revalidation process. It is a matter for the RO’s judgement to determine what a “reasonable circumstance” may be and whether therefore to issue a notification of non-engagement.

In the last year, all revalidation recommendations were made on time and within the 120-day window prior to the doctor’s revalidation date (7 in total). There were a total of 4 deferral requests (3 of the 4 deferral requests related to 1 Doctor who was on long term sick leave) and no notifications of non-engagement. This distribution of recommendations is not of any concern.

See Annual Report Appendix C; Audit of revalidation recommendations

7. Recruitment and engagement background checks

Pre and post-employment checks are routinely carried out for Trust appointees in accordance with the NHS Employers Guidance on recruitment. The Trust Revalidation Support Team carries out routine monitoring of all new starters. Agency locums are checked by their agency and the Trust pre and post-employment information.

Also see “Annual Report Template Appendix E. Audit of recruitment and engagement background” as an example of an audit that can be carried out in this area.

8. Monitoring Performance

As the RO in the Trust is also the Medical Director, he is involved in any formal discussion regarding the performance of doctors. There is a clear clinical leadership model within the Trust through which he monitors medical performance.

9. Responding to Concerns and Remediation

Trust’s Remediation and Responding to Concerns guidance. This will be subject to review by management and staff side colleagues.

10. Risks and Issues

Consideration will need to be given to the provision of some funding for Appraisal and Revalidation purposes and in particular the further refinement of supporting information.

The Responsible Officer still remains concerned about the great difficulties in being able to performance manage all processes within the appraisal cycle. In 2016-2017 the current system took longer to complete appraisals than previous years. There has been a pilot of an electronic system called MyL2P and this will be finalised shortly.
11. Board / Executive Team Reflections

The process of rolling out revalidation for other professional groups should be informed by the process of implementing medical revalidation but the systems and requirements may not be the same. In addition revalidation for doctors is underpinned by specific legislation (The Medical Profession (Responsible Officers) Regulations 2010).

12. Corrective Actions, Improvement Plan and Next Steps

The RO is conducting a review of the resourcing of the Revalidation process, including the electronic system recently piloted and will make recommendations to the Board in due course.

13. Recommendations

The Board is asked to note this Report and to provide any comments regarding it. The Board is asked to approve the ‘statement of compliance’ confirming that the organisation, as a designated body, is in compliance with the regulations.

14. Reporting with small numbers

*When completing appendices A-E, please note:*

It is recommended that the submission of this report to your organisation’s Board takes into account whether the contents should be treated as confidential annexe with an appropriately controlled distribution. Any further publication or dissemination of the report should take into account whether this will identify individuals or make them potentially more identifiable. In such cases, it would be appropriate to provide a summary of the findings that removes or reduces these issues. Organisations with small numbers of relevant staff should take particular note of this issue.

No issues identified in relation to this section.
15. **Annual Report Template Appendix A – Audit of all missed or incomplete appraisals**

<table>
<thead>
<tr>
<th>Doctor factors (total)</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maternity leave during the majority of the ‘appraisal due window’</td>
<td></td>
</tr>
<tr>
<td>Sickness absence during the majority of the ‘appraisal due window’</td>
<td>1</td>
</tr>
<tr>
<td>Prolonged leave during the majority of the ‘appraisal due window’</td>
<td></td>
</tr>
<tr>
<td>Suspension during the majority of the ‘appraisal due window’</td>
<td></td>
</tr>
<tr>
<td>New starter within 3 month of appraisal due date</td>
<td></td>
</tr>
<tr>
<td>New starter more than 3 months from appraisal due date</td>
<td></td>
</tr>
<tr>
<td>Postponed due to incomplete portfolio/insufficient supporting information</td>
<td></td>
</tr>
<tr>
<td>Appraisal outputs not signed off by doctor within 28 days</td>
<td></td>
</tr>
<tr>
<td>Lack of time of doctor</td>
<td></td>
</tr>
<tr>
<td>Lack of engagement of doctor</td>
<td>1</td>
</tr>
<tr>
<td>Other doctor factors</td>
<td></td>
</tr>
<tr>
<td>(describe)</td>
<td></td>
</tr>
</tbody>
</table>

**Appraiser factors**

<table>
<thead>
<tr>
<th>Appraiser factors</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Unplanned absence of appraiser</td>
<td>1</td>
</tr>
<tr>
<td>Appraisal outputs not signed off by appraiser within 28 days</td>
<td>2</td>
</tr>
<tr>
<td>Lack of time of appraiser</td>
<td></td>
</tr>
<tr>
<td>Other appraiser factors (describe)</td>
<td></td>
</tr>
<tr>
<td>(describe)</td>
<td></td>
</tr>
</tbody>
</table>

**Organisational factors**

<table>
<thead>
<tr>
<th>Organisational factors</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Administration or management factors</td>
<td></td>
</tr>
<tr>
<td>Failure of electronic information systems</td>
<td></td>
</tr>
<tr>
<td>Insufficient numbers of trained appraisers</td>
<td></td>
</tr>
<tr>
<td>Other organisational factors (describe)</td>
<td></td>
</tr>
</tbody>
</table>
### 16. Annual Report Template Appendix B – Quality assurance of appraisal inputs and outputs

<table>
<thead>
<tr>
<th>Total number of appraisals completed</th>
<th>Number of appraisal portfolios sampled (to demonstrate adequate sample size)</th>
<th>Number of the sampled appraisal portfolios deemed to be acceptable against standards</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Appraisal inputs</th>
<th>Number audited: 12</th>
<th>See below</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Scope of work: Has a full scope of practice been described?</th>
<th>12</th>
<th>11. additional information submitted to RO by 1 doctor after appraisal (therefore data on all 12 seen)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Continuing Professional Development (CPD): Is CPD compliant with GMC requirements?</td>
<td>12</td>
<td>11. One doctor asked to consider whether CPD relevant to all roles. Data supplied post appraisal. (Therefore RO has seen data on 12 doctors)</td>
</tr>
<tr>
<td>Quality improvement activity: Is quality improvement activity compliant with GMC requirements?</td>
<td>12</td>
<td>12</td>
</tr>
<tr>
<td>Patient feedback exercise: Has a patient feedback exercise been completed?</td>
<td>Where required according to RDaSH policy (every 3 years)</td>
<td></td>
</tr>
<tr>
<td>Colleague feedback exercise: Has a colleague feedback exercise been completed?</td>
<td>12</td>
<td>Where required according to RDaSH policy (every 3 years)</td>
</tr>
<tr>
<td>Review of complaints: Have all complaints been included?</td>
<td>12</td>
<td>12</td>
</tr>
<tr>
<td>Review of significant events/clinical incidents/SUIs: Have all significant events/clinical incidents/SUIs been included?</td>
<td>12</td>
<td>12</td>
</tr>
<tr>
<td>Is there sufficient supporting information from all the doctor’s roles and places of work?</td>
<td>12</td>
<td>9</td>
</tr>
<tr>
<td></td>
<td>See above for 2 doctors for data submitted</td>
<td></td>
</tr>
</tbody>
</table>

12
Is the portfolio sufficiently complete for the stage of the revalidation cycle (year 1 to year 4)?

Explanatory note:

- Has a patient and colleague feedback exercise been completed by year 3?
- Is the portfolio complete after the appraisal which precedes the revalidation recommendation (year 5)?
- Have all types of supporting information been included?

<table>
<thead>
<tr>
<th>Appraisal Outputs</th>
<th>12</th>
<th>12</th>
</tr>
</thead>
<tbody>
<tr>
<td>Appraisal Summary</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Appraiser Statements</td>
<td>12</td>
<td>11</td>
</tr>
<tr>
<td>Personal Development Plan (PDP)</td>
<td>12</td>
<td>11</td>
</tr>
</tbody>
</table>

- There is no concern that revalidation recommendations will be affected as appraisals should demonstrate activity of a 5 year period.
17. Annual Report Template Appendix C – Audit of concerns about a doctor’s practice

<table>
<thead>
<tr>
<th>Concerns about a doctor’s practice</th>
<th>High level²</th>
<th>Medium level²</th>
<th>Low level²</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of doctors with concerns about their practice in the last 12 months</td>
<td></td>
<td></td>
<td></td>
<td>2</td>
</tr>
<tr>
<td>Explanatory note: Enter the total number of doctors with concerns in the last 12 months. It is recognised that there may be several types of concern but please record the primary concern</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Capability concerns (as the primary category) in the last 12 months</td>
<td>1</td>
<td></td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Conduct concerns (as the primary category) in the last 12 months</td>
<td>1</td>
<td></td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Health concerns (as the primary category) in the last 12 months</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Remediation/Reskilling/Retraining/Rehabilitation

Numbers of doctors with whom the designated body has a prescribed connection as at 31 March 2015 who have undergone formal remediation between 1 April 2014 and 31 March 2015.

Formal remediation is a planned and managed programme of interventions or a single intervention e.g. coaching, retraining which is implemented as a consequence of a concern about a doctor’s practice

A doctor should be included here if they were undergoing remediation at any point during the year

<table>
<thead>
<tr>
<th>Category</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultants (permanent employed staff including honorary contract holders, NHS and other government /public body staff)</td>
<td>0</td>
</tr>
<tr>
<td>Staff grade, associate specialist, specialty doctor (permanent employed staff including hospital practitioners, clinical assistants who do not have a prescribed connection elsewhere, NHS and other government /public body staff)</td>
<td>0</td>
</tr>
<tr>
<td>General practitioner (for NHS England only; doctors on a medical performers list, Armed Forces)</td>
<td>0</td>
</tr>
<tr>
<td>Trainee: doctor on national postgraduate training scheme (for local education and training boards only; doctors on national training programmes)</td>
<td>0</td>
</tr>
<tr>
<td>Doctors with practising privileges (this is usually for independent healthcare providers, however practising privileges may also rarely be awarded by NHS organisations. All doctors with practising privileges who have a prescribed connection should be included in this section, irrespective of their grade)</td>
<td>0</td>
</tr>
<tr>
<td>Temporary or short-term contract holders (temporary employed staff including locums who are directly employed, trust doctors, locums for service, clinical research fellows, trainees not on national training schemes, doctors with fixed-</td>
<td>0</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Term employment contracts, etc</th>
<th>All Designated Bodies</th>
</tr>
</thead>
<tbody>
<tr>
<td>Other (including all responsible officers, and doctors registered with a locum agency, members of faculties/professional bodies, some management/leadership roles, research, civil service, other employed or contracted doctors, doctors in wholly independent practice, etc)</td>
<td>All Designated Bodies</td>
</tr>
<tr>
<td>TOTALS</td>
<td>0</td>
</tr>
</tbody>
</table>

**Other Actions/Interventions**

| Local Actions: | 0 |

Number of doctors who were suspended/excluded from practice between 1 April and 31 March:

Explanatory note: All suspensions which have been commenced or completed between 1 April and 31 March should be included

Duration of suspension:

Explanatory note: All suspensions which have been commenced or completed between 1 April and 31 March should be included

- Less than 1 week
- 1 week to 1 month
- 1 – 3 months
- 3 - 6 months
- 6 - 12 months

Number of doctors who have had local restrictions placed on their practice in the last 12 months?:

GMC Actions:

Number of doctors who:

- Were referred by the designated body to the GMC between 1 April and 31 March | 0 |
- Underwent or are currently undergoing GMC Fitness to Practice procedures between 1 April and 31 March | 1 |
- Had conditions placed on their practice by the GMC or undertakings agreed with the GMC between 1 April and 31 March | 1 |
- Had their registration/licence suspended by the GMC between 1 April and 31 March | 0 |
- Were erased from the GMC register between 1 April and 31 March | 0 |

National Clinical Assessment Service actions:

Number of doctors about whom the National Clinical Advisory Service (NCAS) has been contacted between 1 April and 31 March for advice or for assessment | 3 |

Number of NCAS assessments performed | 0 |
### 18. Annual Report Template Appendix D – Audit of revalidation recommendations

#### Revalidation recommendations between 1 April 2014 to 31 March 2015

<table>
<thead>
<tr>
<th>Recommendation Type</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recommendations completed on time (within the GMC recommendation window)</td>
<td>11</td>
</tr>
<tr>
<td>Late recommendations (completed, but after the GMC recommendation window closed)</td>
<td>0</td>
</tr>
<tr>
<td>Missed recommendations (not completed)</td>
<td>0</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>11</strong></td>
</tr>
</tbody>
</table>

**Primary reason for all late/missed recommendations**

For any late or missed recommendations only one primary reason must be identified.

<table>
<thead>
<tr>
<th>Reason</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>No responsible officer in post</td>
<td>0</td>
</tr>
<tr>
<td>New starter/new prescribed connection established within 2 weeks of revalidation due date</td>
<td>0</td>
</tr>
<tr>
<td>New starter/new prescribed connection established more than 2 weeks from revalidation due date</td>
<td>0</td>
</tr>
<tr>
<td>Unaware the doctor had a prescribed connection</td>
<td>0</td>
</tr>
<tr>
<td>Unaware of the doctor’s revalidation due date</td>
<td>0</td>
</tr>
<tr>
<td>Administrative error</td>
<td>0</td>
</tr>
<tr>
<td>Responsible officer error</td>
<td>0</td>
</tr>
<tr>
<td>Inadequate resources or support for the responsible officer role</td>
<td>0</td>
</tr>
<tr>
<td>Other</td>
<td>0</td>
</tr>
<tr>
<td><strong>TOTAL</strong> ([sum of (late) + (missed)]</td>
<td><strong>0</strong></td>
</tr>
</tbody>
</table>
### 19. Annual Report Template Appendix E – Audit of recruitment and engagement background checks

<table>
<thead>
<tr>
<th>Number of new doctors (including all new prescribed connections) who have commenced in last 12 months (including where appropriate locum doctors)</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Permanent employed doctors</td>
<td>Number: 3</td>
</tr>
<tr>
<td>Temporary employed doctors</td>
<td>Number: 3</td>
</tr>
<tr>
<td>Locums brought in to the designated body through a locum agency</td>
<td>Number: 31</td>
</tr>
<tr>
<td>Locums brought in to the designated body through ‘Staff Bank’ arrangements</td>
<td>Number: 0</td>
</tr>
<tr>
<td>Doctors on Performers Lists</td>
<td>Number: 0</td>
</tr>
<tr>
<td>Other</td>
<td>Number: 0</td>
</tr>
</tbody>
</table>

**Explanatory note:** This includes independent contractors, doctors with practising privileges, etc. For membership organisations this includes new members, for locum agencies this includes doctors who have registered with the agency, etc

**TOTAL** Number: 37

For how many of these doctors was the following information available within 1 month of the doctor’s starting date (numbers)

<p>| Permanent employed doctors | 3 | 3 | 3 | 3 | 3 | 3 | 3 | 3 | 3 | 3 | 3 | 3 | 3 | 3 | - | 3 |
| Temporary employed doctors | 3 | 3 | 3 | 3 | 3 | 3 | 3 | 3 | 3 | 3 | 3 | 3 | 3 | 3 | - | 3 |
| Locums brought in to the designated body through | 31 | N/A | N/A | N/A | N/A | N/A |</p>
<table>
<thead>
<tr>
<th>Locum use by specialty:</th>
<th>Total establishment in specialty (current approved WTE headcount)</th>
<th>Consultant: Overall number of locum days used</th>
<th>SAS doctors: Overall number of locum days used</th>
<th>Trainees (all grades): Overall number of locum days used</th>
<th>Total Overall number of locum days used</th>
</tr>
</thead>
<tbody>
<tr>
<td>Surgery</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medicine</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Psychiatry</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Obstetrics/Gynaecology</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

---

**For Providers of healthcare i.e. hospital trusts – use of locum doctors:**

Explanatory note: Number of locum sessions used (days) as a proportion of total medical establishment (days)

The total WTE headcount is included to show the proportion of the posts in each specialty that are covered by locum doctors

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Total establishment in specialty (current approved WTE headcount)</th>
<th>Consultant: Overall number of locum days used</th>
<th>SAS doctors: Overall number of locum days used</th>
<th>Trainees (all grades): Overall number of locum days used</th>
<th>Total Overall number of locum days used</th>
</tr>
</thead>
<tbody>
<tr>
<td>Surgery</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medicine</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Psychiatry</td>
<td>57.9 WTE</td>
<td>7.5 WTE across the year</td>
<td>6 WTE across the year</td>
<td>5.5 WTE across the year</td>
<td>19 WTE across the year</td>
</tr>
<tr>
<td>Obstetrics/Gynaecology</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
## OFFICIAL

<table>
<thead>
<tr>
<th>Category</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Accident and Emergency</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Anaesthetics</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Radiology</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pathology</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Total in designated body (This includes all doctors not just those with a prescribed connection)
## Committee Name
Board of Directors

## Agenda Item
K

## Date
27th July 2017

## Title of Paper
Report from the Finance Performance and Informatics Committee (FPIC)

## Prepared by
Steve Hackett – Director of Finance and Performance

## Presented by
Tim Shaw - Non-Executive Director, Chair of FPIC

### Delivery against

<table>
<thead>
<tr>
<th>Strategic Goal(s)</th>
<th>Strategic Risk(s)</th>
<th>CQC Domain</th>
</tr>
</thead>
<tbody>
<tr>
<td>3</td>
<td>3.1-3.2</td>
<td>S</td>
</tr>
<tr>
<td>4</td>
<td>4.1-4.2</td>
<td>E</td>
</tr>
<tr>
<td>5</td>
<td>4.3-5.3</td>
<td>W</td>
</tr>
</tbody>
</table>

### Financial/Budget
Overall budgets

### Equality & Diversity
All activities are considered in accordance with the Trust’s Equality and Diversity policies and processes.

### Previously Presented to
Not applicable

### Action Required

<table>
<thead>
<tr>
<th>Decision</th>
<th>Assurance</th>
<th>Information</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>X</td>
<td>X</td>
</tr>
</tbody>
</table>

### Background / Key Points / Outcome

**The assurances provided via the Committee in Section 1 of this report in relation to:**

The achievement of financial targets as at Month 3 of the Financial Year 2017/18.

The achievement of the Single Oversight Framework performance requirements.

**The key risks discussed at the Committee as highlighted in Section 2 of this report as follows:**

The actions in relation to the performance hotspots for CAMHS and ADHD.

The update on the PMO.

Achievement of the Month 3 - 2017/18 Agency Cap.

**The updates on other issues:**

Flourish Enterprise Annual Accounts.
1. **Assurances**

1.1 The Financial position as at Month 3 for the Financial Year 2017/18

The summary below describes the Month 3 financial position as discussed at the Committee. The key messages are as follows:

<table>
<thead>
<tr>
<th>June 2017</th>
<th>Executive Summary / Key Performance Indicators</th>
</tr>
</thead>
<tbody>
<tr>
<td>No.</td>
<td>Performance Indicator</td>
</tr>
<tr>
<td>1</td>
<td>NHS Improvement Risk Rating</td>
</tr>
<tr>
<td>2</td>
<td>Control Total Surplus</td>
</tr>
<tr>
<td>3a</td>
<td>Agency Cap</td>
</tr>
<tr>
<td>3b</td>
<td>Medical Agency cap</td>
</tr>
<tr>
<td>4</td>
<td>Cash</td>
</tr>
<tr>
<td>5</td>
<td>Capital</td>
</tr>
<tr>
<td>6</td>
<td>Delivery of CIP</td>
</tr>
<tr>
<td>7</td>
<td>Better Payments</td>
</tr>
</tbody>
</table>

**Legend:***
- **Red**: Variance from Plan greater than 15%
- **Amber**: Variance from Plan ranging from 5% to 15%
- **Green**: In line, or Greater than Plan
1.2 NHS Improvement Single Oversight Framework (SOF) performance targets

The Committee received a report detailing the current position in relation to the Single Oversight Framework performance targets. The report gave assurance that the Trust was achieving all the current requirements.

2. Risks

The Committee discussed the following risks:

2.1 Performance Hotspots

The key performance issues are:

a) CAMHS Waiting times in Rotherham
   - The Trust is achieving the 18 week referral to treatment target, with the focus now on delivering the improvement trajectory for 6 week referral to assessment.

b) ADHD
   - 111 waits over 20 weeks for Adult ADHD Clinic but with an action plan to reduce. However, the plan is likely to have limited impact due to resourcing and capacity issues. A business case is to be presented to Doncaster CCG recommending further investment to address these issues.

2.3 Performance against the Agency Cap

- The Figure for June 2017 is 22% below the target;
- There is an additional Medical Target of £391k, which will provide an additional challenge.
- The Trust has spent £1.08m on agency expenditure to June 2017, which is 3.6% of the pay bill.

Below is a breakdown of the £1.08m:-

<table>
<thead>
<tr>
<th>Run rate</th>
<th>Actual spend per month (inc. accruals)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staff type</td>
<td>Mth 11</td>
</tr>
<tr>
<td>Administration &amp; Clerical</td>
<td>31,812</td>
</tr>
<tr>
<td>Ancillary Staff Pay</td>
<td>0</td>
</tr>
<tr>
<td>General / Senior Managers</td>
<td>0</td>
</tr>
<tr>
<td>Medical Staff Pay</td>
<td>205,079</td>
</tr>
<tr>
<td>Nurses Pay</td>
<td>55,004</td>
</tr>
<tr>
<td>Nurses Pay (Non Qualified)</td>
<td>54,580</td>
</tr>
<tr>
<td>Other Agency Staff</td>
<td>0</td>
</tr>
<tr>
<td>Professional &amp; Scientific Pay</td>
<td>22,893</td>
</tr>
<tr>
<td>Professional &amp; Technical - PtB</td>
<td>0</td>
</tr>
<tr>
<td>Profs Allied To Medicine Pay</td>
<td>15,930</td>
</tr>
<tr>
<td>Seconded Staff</td>
<td>0</td>
</tr>
<tr>
<td>Social Workers Pay</td>
<td>-11,031</td>
</tr>
<tr>
<td>CAMHS practitioners</td>
<td>31,076</td>
</tr>
<tr>
<td>Chairman &amp; Non Exec Members</td>
<td>0</td>
</tr>
<tr>
<td>Total</td>
<td>405,342</td>
</tr>
</tbody>
</table>

Key
- **Continued reduction over last 3 months**
- **Continued increase over the last 3 months**
- **Increases and reductions over 3 months**
The Committee noted upcoming potential challenges to the Agency Cap position with forthcoming Medical Staff departures.

2.4 Project Management Office Report (PMO)

The Committee received an update report on the PMO process following recent considerations at the Executive Programme Board and Executive Management Team.

The Committee were reminded that the PMO provides a strategic overview of the change management and delivery processes for the 7 workstreams within the Strategic Portfolio. The team support the 7 projects and report on the progress to date. The main update was in relation to:

- The PMO approach;
- Transformation Programme Assurance;
- Financial assurance; and
- Quality Assurance.

The Committee received a report on the 2017/18 QiPP of £3.73m, which presented a recurrent gap of £0.9m. The Committee were advised that as at July 2017 full assurance on the ability to deliver the entire 2017/18 QiPP programme (£3.067m) could not be provided. To date £0.74m had been delivered and a further £2.06m had plans in place.

The Committee were assured that the on-going delivery will be the subject of close scrutiny by the Executive Programme Board. Regular updates provided to the Committee would be provided as a routine.

The Committee received and noted the current PMO arrangements and status of the projects and requested receipt of regular updates around delivery of 2017/18 but also requested that focus and attention needs to be applied to preparation for the delivery of 2018/19 QiPP.

The Executive Programme Board was also asked to consider resetting the project milestones, where appropriate, to enable all Executive Sponsors to set stretching but realistic project milestones.

3. Other information

3.1 Flourish Enterprise Annual Accounts:
Flourish is the Trust’s Community Interest Company that provides a range of service including Woodfield24, which provides end of life domiciliary care.
The Committee received a presentation of the 2016/17 Annual Accounts for Flourish. The overall position was positive and showed a surplus of £12k in year, which was ahead of the original planned forecast.
The Committee also received a report from Flourish’s Business Manager on its trading activities and the above average success rates in its rehabilitation work. Its main objectives are:

- Provide work, vocational training and therapeutic opportunities to the people who need the company’s support;
- Work with partners and stakeholders to provide a valuable contribution to the local economy;
- Provide opportunities for community involvement; and
- Be financially stable and sustainable.
4 Recommendation

The Board of Directors are asked:

4.1 To note the updates and assurances provided in section 1 of the report, including the Month 3 Single Oversight Framework declaration.

4.2 To note the risks and mitigations detailed in section 2 of the report.

4.3 To note the report on Flourish
## Corporate Overview

### Financial Performance - 1st April 2017 to 30 June 2017

<table>
<thead>
<tr>
<th></th>
<th>Plan 30 June 2017</th>
<th>Actual 30 June 2017</th>
<th>Variance £m</th>
<th>Plan 31 March 2018</th>
<th>Actual 31 March 2018</th>
<th>Variance £m</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Trading Position</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Income</td>
<td>37.8</td>
<td>38.5</td>
<td>0.7</td>
<td>151.6</td>
<td>151.6</td>
<td>0.0</td>
</tr>
<tr>
<td>Expenditure</td>
<td>-35.2</td>
<td>-35.9</td>
<td>-0.7</td>
<td>-142.0</td>
<td>-142.0</td>
<td>0.0</td>
</tr>
<tr>
<td>Interest, Depreciation and Dividends Paid</td>
<td>-1.9</td>
<td>-1.8</td>
<td>0.1</td>
<td>-7.5</td>
<td>-7.5</td>
<td>0.0</td>
</tr>
<tr>
<td>Retained Surplus / (Deficit) before impairment</td>
<td>0.7</td>
<td>0.8</td>
<td>0.0</td>
<td>2.1</td>
<td>2.1</td>
<td>0.0</td>
</tr>
<tr>
<td>Impairment / Loss on Disposal</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
</tr>
<tr>
<td>Retained Surplus / (Deficit) after impairment</td>
<td>0.7</td>
<td>0.8</td>
<td>0.0</td>
<td>2.1</td>
<td>2.1</td>
<td>0.0</td>
</tr>
</tbody>
</table>

### Key Exceptions:

#### Balance Sheet

<table>
<thead>
<tr>
<th></th>
<th>Plan 30 June 2017</th>
<th>Actual 30 June 2017</th>
<th>Variance £m</th>
<th>Plan 31 March 2018</th>
<th>Actual 31 March 2018</th>
<th>Variance £m</th>
</tr>
</thead>
<tbody>
<tr>
<td>Long Term Assets (non-current)</td>
<td>94.3</td>
<td>93.9</td>
<td>-0.5</td>
<td>96.1</td>
<td>96.1</td>
<td>0.0</td>
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<tr>
<td>Net Current Assets / Liabilities</td>
<td>7.6</td>
<td>8.8</td>
<td>1.1</td>
<td>6.9</td>
<td>6.9</td>
<td>0.0</td>
</tr>
<tr>
<td>Long Term Liabilities (non-current)</td>
<td>-17.0</td>
<td>-18.3</td>
<td>-1.3</td>
<td>-16.7</td>
<td>-16.7</td>
<td>0.0</td>
</tr>
<tr>
<td>Total Assets Employed</td>
<td>84.9</td>
<td>84.3</td>
<td>-0.6</td>
<td>86.3</td>
<td>86.3</td>
<td>0.0</td>
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</tbody>
</table>

#### Key Exceptions:

#### Liquidity

<table>
<thead>
<tr>
<th></th>
<th>Plan 30 June 2017</th>
<th>Actual 30 June 2017</th>
<th>Variance £m</th>
<th>Plan 31 March 2018</th>
<th>Actual 31 March 2018</th>
<th>Variance £m</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cash at Bank and in Hand</td>
<td>24.8</td>
<td>26.9</td>
<td>2.1</td>
<td>24.9</td>
<td>24.9</td>
<td>0.0</td>
</tr>
</tbody>
</table>

#### Key Exceptions:

#### Capital Investment

<table>
<thead>
<tr>
<th></th>
<th>Plan 30 June 2017</th>
<th>Actual 30 June 2017</th>
<th>Variance £m</th>
<th>Plan 31 March 2018</th>
<th>Actual 31 March 2018</th>
<th>Variance £m</th>
</tr>
</thead>
<tbody>
<tr>
<td>Depreciation and PDC funded Schemes</td>
<td>-0.6</td>
<td>-1.0</td>
<td>-0.4</td>
<td>-5.3</td>
<td>-5.3</td>
<td>0.0</td>
</tr>
<tr>
<td>Total Capital Investment</td>
<td>-0.6</td>
<td>-1.0</td>
<td>-0.4</td>
<td>-5.3</td>
<td>-5.3</td>
<td>0.0</td>
</tr>
</tbody>
</table>

#### Key Exceptions:

#### Key Performance Against Terms of Authorisation

<table>
<thead>
<tr>
<th></th>
<th>Plan 30 June 2017</th>
<th>Actual 30 June 2017</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>EBITDA Margin</strong></td>
<td>6.91%</td>
<td>6.68%</td>
</tr>
<tr>
<td>Capital service rating</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td>Liquidity rating</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>I&amp;E Margin rating</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>I&amp;E Variance from plan rating</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Agency rating</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Use Of Resources Rating after overrides</td>
<td>1</td>
<td>1</td>
</tr>
</tbody>
</table>

#### Key Performance: Autonomy

- 1: Maximum Autonomy
- 2: Targeted Support
- 3: Mandated Support
- 4: Special Measures

Best Score: 1
Worst Score: 4
<table>
<thead>
<tr>
<th>Committee Name</th>
<th>Board of Directors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Agenda Item</td>
<td>L</td>
</tr>
<tr>
<td>Date</td>
<td>27 July 2017</td>
</tr>
<tr>
<td>Title of Paper</td>
<td>Board Assurance Framework 2017/18 - Overview</td>
</tr>
<tr>
<td>Action Required</td>
<td>Decision</td>
</tr>
<tr>
<td>Prepared by</td>
<td>Jane Charlesworth, Risk and Assurance Officer</td>
</tr>
<tr>
<td></td>
<td>Phil Gowland, Board Secretary/Director of Corporate Assurance</td>
</tr>
<tr>
<td>Presented by</td>
<td>Phil Gowland, Board Secretary/Director of Corporate Assurance</td>
</tr>
<tr>
<td>Delivery against</td>
<td>Strategic Goal(s)</td>
</tr>
<tr>
<td>Financial/Budget</td>
<td>Any financial implications are noted within the risks</td>
</tr>
<tr>
<td>Equality &amp; Diversity</td>
<td>None identified</td>
</tr>
<tr>
<td>Previously Presented to</td>
<td>Executive Management Team</td>
</tr>
</tbody>
</table>

The attached report outlines the development of the Board Assurance Framework 2017/18 to date and provides the Overview position which has been populated with the following:

- Risk description,
- Initial Risk Score
- Risk Appetite,
- Key Controls,
- Sources of Assurance,
- Gaps,
- Target Risk Score,
- Lead Director,
- Monitoring Committee.

The Board of Director is asked to review and approve the content of the Board Assurance Framework Overview and to support the proposed next steps, as set out in the paper – which will require the lead director and the monitoring committee to review further the risks and controls and to ensure appropriate arrangements are in place to receive the identified assurances.
1. Development to date

In May 2017 the Board of Directors confirmed the strategic goals for 2017/18 and these were presented in the public session of their meeting in June 2017.

The Executive Management Team has reviewed the goals and identified the potential risks to the achievement of those goals.

A number of further meetings have been held with lead Directors during July 2017 to refine those risks and to identify an initial risk score (and target score); to identify controls to mitigate the risks; and to identify potential sources of assurance (that will be used to confirm that the controls are operating as planned.)

In undertaking this work, consideration has been given to the recently issued NHS Improvement guidance, “Developmental reviews of leadership and governance using the well-led framework.” – not only in respect of Strategic Goal 5 (which specifically refers to a 'well-led' organisation) but to ensure that the eight key lines of enquiry (KLOE) for a well-led review are included. This is to demonstrate that the trust’s achievement of all its goals – whether it is finance, quality or workforce) are impacted upon by how ‘well-led’ the Trust is.

In addition to this the risk appetite included for each risk in the overview has been assessed using a matrix developed by the Good Governance Institute. This risk appetite matrix provides greater detail and explanation in defining each level, which makes the understanding of the chosen level clearer.

2. Next Steps

The development of the Board Assurance Framework is an ongoing process and it will need to be further refined in the year from the position in the stated overview.

Subject to the approval by the Board of Directors of this BAF Overview, the component parts will be presented for further discussion at the respective ‘lead Committee’ where the risks, controls and assurances will be further expanded, with the identified sources of assurance being scheduled into the work plan for the Committees through the remainder of the year. Where any gaps in control or assurance are recorded, the Committee will consider how and when these gaps will be addressed. The Committees will consider within this, the key actions and assurances that will need to be delivered in order that there can be the desired change in the risk scoring.

3. Reporting

Reporting of the Board Assurance Framework will be on a quarterly basis to the Quality Committee and Finance, Performance and Informatics Committee for monitoring and review. The Board of Directors and Audit Committee will receive an overview report on a quarterly basis.

To support the process and to ensure that there is greater clarity about the assurances being presented through the papers to the respective Committees and the Board of
Directors, the cover sheet and format of such papers is being refined. Draft proposals are being considered with a view to implementing them during August 2017.

4. Action Required

The Board of Directors is asked to review and approve the 2017/18 Board Assurance Framework Overview and note and support the proposed next steps (through the Committees) and the reporting process as outlined.
<table>
<thead>
<tr>
<th>Strategic Goal</th>
<th>Initial Risk Score</th>
<th>Risk Appetite</th>
<th>Key Controls</th>
<th>Source of Assurances</th>
<th>Gaps in Control and/or Assurance</th>
<th>Target Risk Score</th>
<th>Lead Director</th>
<th>Monitoring Meeting</th>
</tr>
</thead>
</table>
| 1.1 - If we do not deliver care to our patients and service users in line with quality and safety standards then this may lead to avoidable harm | I x 5  
L x 2  
RS = 10 | Cautious | 1. CQC Fundamental Standards (Safe, Caring)  
2. Quality Priorities (Safe & effective)  
3. Statutory Duties e.g. H & S, IPC, Safeguarding  
4. Patient Safety monitoring, oversight and escalation processes  
5. Clinical Policies and Procedures  
6. H & S Policies and Procedures  
7. Quality & Safety Impact Assessment Process | - Quality Dashboard Reporting (Patient Safety)  
- Quality Priorities Reporting  
- Audit Outcomes (Clinical, Place etc)  
- Outcomes from Mortality Surveillance Group  
- Outcomes from Quality Assurance Sub Committee  
- CQC Action Plan monitoring  
- QSA Reporting  
- Internal Audit Plan Outcomes (Quality Governance) | - Data analysis  
I x 5  
L x 2  
RS = 10 | Director of Nursing & Quality Committee |
| 1.2 - If we do not provide safe, sustainable & productive staffing in line with the National Quality Board standards then this could lead to avoidable harm | I x 4  
L x 2  
RS = 8 | Cautious | 1. National Quality Board Standards  
2. CQC Fundamental Standards (Safe)  
3. CSGR annual review of staffing levels  
4. Quality & Safety Impact Assessment Process | - Staffing Reporting  
- Safer Staffing Declaration  
- Workforce Reporting (MAST & PDR compliance)  
- QSA Reporting | - National Guidance for community  
- Community models  
- Community reporting  
I x 4  
L x 2  
RS = 8 | Director of Nursing & Quality Committee |
| 1.3 - If we do not deliver effective and innovative care then this may lead to an inability to provide high quality care experiences. | I x 4  
L x 3  
RS = 12 | Cautious / Open | 1. CQC Fundamental Standards (effective)  
2. Quality Priorities (Holistic)  
3. Investigation processes - Consequence UK (SI, IR1, Complaints etc) including learning outcomes  
4. NICE Guidance implementation  
5. Research Strategy  
6. Quality & Safety Impact Assessment Process | - Quality Dashboard Reporting (Clinical Effectiveness)  
- Quality Priorities Reporting  
- Outcomes from Investigations  
- Research Activity Reporting  
- Outcomes from Learning & Development Forum  
- QSA Reporting  
- Internal Audit Plan Outcomes (Mortality, Patient Safety Investigation approach methodology, Lampard Action Plan Review) | - Implementation of Consequence UK  
- National Guidance - Mortality (MH)  
I x 4  
L x 2  
RS = 8 | Director of Nursing & Quality Committee |
<table>
<thead>
<tr>
<th>Strategic Goal</th>
<th>Initial Risk Score</th>
<th>Risk Appetite</th>
<th>Key Controls</th>
<th>Source of Assurances</th>
<th>Gaps in Control and/or Assurance</th>
<th>Target Risk Score</th>
<th>Lead Director</th>
<th>Monitoring Meeting</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.4 - If we do not engage with and actively listen to patients, service users,</td>
<td><strong>1 x 4</strong>&lt;br&gt;<strong>L x 3</strong>&lt;br&gt;<strong>RS = 12</strong></td>
<td>Seek</td>
<td>1. CQC Fundamental Standards (responsive)&lt;br&gt;2. Quality Priorities (Listen &amp; Respond)&lt;br&gt;3. Patient, Caregiver and Public Engagement&lt;br&gt;4. Experience Strategy&lt;br&gt; - Triangle of Care Standards&lt;br&gt; - Learn to Listen&lt;br&gt; - Caregiver Champions&lt;br&gt;4. Investigation processes (SI, IR1, Complaints etc) including learning outcomes&lt;br&gt;5. Quality &amp; Safety Impact Assessment Process&lt;br&gt;6. Mortality Process</td>
<td>- Quality Dashboard Reporting (PPEE)&lt;br&gt;- Quality Priorities Reporting&lt;br&gt;- PPEE Reporting, National &amp; Listen to Learn&lt;br&gt;- Outcomes from Consequence UK&lt;br&gt;- Outcome from Mortality Surveillance Group&lt;br&gt;- Wider community engagement with independent groups</td>
<td>I x 4&lt;br&gt;<strong>L x 2</strong>&lt;br&gt;<strong>RS = 8</strong></td>
<td>Director of Nursing &amp; Quality</td>
<td>Quality Committee</td>
<td></td>
</tr>
<tr>
<td>their families and carers then this may lead to services not being responsive and</td>
<td></td>
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<tr>
<td>not meet the needs of patients</td>
<td></td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>1.5 - If we do not clearly define our clinical pathways, process and reporting requirements, we will not maximize the benefits of the new</td>
<td><strong>1 x 4</strong>&lt;br&gt;<strong>L x 3</strong>&lt;br&gt;<strong>RS = 12</strong></td>
<td>Cautious / Open</td>
<td>1. Unity Implementation Plan&lt;br&gt;2. Unity Steering Group oversees and monitors implementation&lt;br&gt;3. Design Authority&lt;br&gt;4. Quality Priorities (EPR)&lt;br&gt;5. Quality &amp; Safety Impact Assessment Process</td>
<td>- Unity Programme Reporting (PMO)&lt;br&gt;- Outcomes from OMM (Transformation)&lt;br&gt;- Quality Priorities Reporting&lt;br&gt;- QSI Reporting&lt;br&gt;- End to end Unity Implementation Plan is subject to agreement - Due July 2017</td>
<td>I x 4&lt;br&gt;<strong>L x 2</strong>&lt;br&gt;<strong>RS = 8</strong></td>
<td>Director of Health Informatics</td>
<td>Board of Directors</td>
<td></td>
</tr>
<tr>
<td>EPR. This may affect the ability to provide safe, effective care.</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>2.1 - If we do not attract, recruit and retain a high quality workforce then this may negatively affect the quality of care and the performance</td>
<td><strong>1 x 4</strong>&lt;br&gt;<strong>L x 3</strong>&lt;br&gt;<strong>RS = 12</strong></td>
<td>Open</td>
<td>1. Workforce Strategy &amp; Plan&lt;br&gt;2. Employment Policies and Procedures&lt;br&gt;3. Appraisal/Performance processes&lt;br&gt;4. Health &amp; Wellbeing Initiative</td>
<td>- Workforce Reporting (Turnover of staff/vacancies &amp; PDR compliance )&lt;br&gt;- Internal Audit Plan Outcomes (Pre-employment checks, Equality &amp; Diversity)</td>
<td>I x 4&lt;br&gt;<strong>L x 2</strong>&lt;br&gt;<strong>RS = 8</strong></td>
<td>Director of Workforce &amp; OD</td>
<td>Quality Committee</td>
<td></td>
</tr>
<tr>
<td>of the Trust</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>2.2 - If we do not grow our workforce through effective education, training and leadership opportunities then this may lead to a culture</td>
<td><strong>1 x 4</strong>&lt;br&gt;<strong>L x 3</strong>&lt;br&gt;<strong>RS = 12</strong></td>
<td>Open</td>
<td>1. Workforce Strategy &amp; Plan&lt;br&gt;2. Training Policies and Procedures&lt;br&gt;3. Education programme&lt;br&gt;4. Appraisal/Performance processes</td>
<td>- Workforce Reporting (MAST &amp; PDR compliance)&lt;br&gt;- Quality Dashboard Reporting (Professional Leadership)&lt;br&gt;- Medical Revalidation Monitoring&lt;br&gt;- Nurse revalidation Monitoring</td>
<td>I x 4&lt;br&gt;<strong>L x 2</strong>&lt;br&gt;<strong>RS = 8</strong></td>
<td>Director of Workforce &amp; OD</td>
<td>Quality Committee</td>
<td></td>
</tr>
<tr>
<td>that does not support high performance.</td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.3 - If we do not engage with our workforce and act on feedback then this may lead to a culture that does not support high performance.</td>
<td><strong>1 x 4</strong>&lt;br&gt;<strong>L x 3</strong>&lt;br&gt;<strong>RS = 12</strong></td>
<td>Seek</td>
<td>1. Workforce Strategy &amp; Plan&lt;br&gt;2. HR Policies and Procedures&lt;br&gt;3. Listening into Action&lt;br&gt;4. Internal Comms Programme</td>
<td>- Workforce Reporting (Sickness)&lt;br&gt;- Feedback from 'Freedom to Speak Up Guardian'&lt;br&gt;- Staff Survey Outcomes&lt;br&gt;- Pulse Check Reporting&lt;br&gt;- Internal Audit Plan Outcomes (Sickness Absence, Equality &amp; Diversity)</td>
<td>I x 4&lt;br&gt;<strong>L x 2</strong>&lt;br&gt;<strong>RS = 8</strong></td>
<td>Director of Workforce &amp; OD</td>
<td>Quality Committee</td>
<td></td>
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</tr>
<tr>
<td>Strategic Goal</td>
<td>Initial Risk Score</td>
<td>Risk Appetite</td>
<td>Key Controls</td>
<td>Source of Assurances</td>
<td>Gaps in Control and/or Assurance</td>
<td>Target Risk Score</td>
<td>Lead Director</td>
<td>Monitoring Meeting</td>
</tr>
<tr>
<td>---------------</td>
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<td>-------------------</td>
</tr>
<tr>
<td>3.1 - If we do not deliver the financial plan and meet its objectives then this may impact on the ability to provide sustainable services.</td>
<td>I x 4 L x 3 RS = 12</td>
<td>Cautious / Open</td>
<td>1. 2017/19 Operational Plan 2. SFIs and Finance Policies and Procedures 3. Financial Budgetary System for monitoring 4. Programme Management Office to oversee Non Pay project</td>
<td>- Finance Reporting (monthly position, exceptions, performance against targets) - Internal Audit Plan Outcomes (Financial Systems, Integrity of GL and Financial Reporting)</td>
<td></td>
<td>I x 2 L x 2 RS = 12</td>
<td>Director of Finance</td>
<td>Finance, Performance and Informatics Committee</td>
</tr>
<tr>
<td>3.2 - If there are services which are not financially viable then this may result in the organisation not being sustainable in the longer term.</td>
<td>I x 3 L x 3 RS = 9</td>
<td>Open</td>
<td>1. 5 Year Plan 2. 2017/19 Operational Plan 3. Contract Negotiation &amp; Monitoring</td>
<td>- Finance Reporting (monthly position, exceptions, performance against targets) - Service line Reporting</td>
<td></td>
<td>I x 3 L x 2 RS = 6</td>
<td>Director of Finance</td>
<td>Finance, Performance and Informatics Committee</td>
</tr>
<tr>
<td>3.3 - If we do not work with partners to deliver the system wide efficiencies then this may undermined the Trust financial position and that of the ACO's/Place Based Plans.</td>
<td>I x 4 L x 2 RS = 12</td>
<td>Cautious</td>
<td>1. 5 Year Plan 2. Regional Sustainability &amp; Transformation Plans (STP)</td>
<td>- Monthly Reporting of Financial Position - STP Reporting - Programme Management Office</td>
<td></td>
<td>I x 4 L x 2 RS = 8</td>
<td>Director of Finance</td>
<td>Finance, Performance and Informatics Committee</td>
</tr>
<tr>
<td>4.1 - If we do not deliver the objectives of the clinically led services review then this may adversely affect the credibility of the Trust as a provider.</td>
<td>I x 5 L x 3 RS = 15</td>
<td>Open</td>
<td>1. Project Plan 2. Programme Management Office to oversee projects</td>
<td>- Clinically-Led Service Review Project Reporting (PMO)</td>
<td></td>
<td>I x 5 L x 2 RS = 10</td>
<td>Chief Operating Officer</td>
<td>Board of Directors</td>
</tr>
<tr>
<td>4.2 - If we do not engage with local partners and act on feedback then this may impact on the Trusts ability to influence the progress of ACO's/Place Based Plans.</td>
<td>I x 4 L x 2 RS = 8</td>
<td>Open</td>
<td>1. Commissioner Contract Meetings 2. Board to Board Meetings 3. Place Based Plans</td>
<td>- STP Reporting - Place Plan implementation assessments</td>
<td></td>
<td>I x 4 L x 2 RS = 8</td>
<td>Chief Executive</td>
<td>Board of Directors</td>
</tr>
<tr>
<td>Strategic Goal</td>
<td>Initial Risk Score</td>
<td>Risk Appetite</td>
<td>Key Controls</td>
<td>Source of Assurances</td>
<td>Gaps in Control and/or Assurance</td>
<td>Target Risk Score</td>
<td>Lead Director</td>
<td>Monitoring Meeting</td>
</tr>
<tr>
<td>----------------</td>
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<td>---------------------------------</td>
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<td>-------------------</td>
</tr>
</tbody>
</table>
| 5.1 - If we do not have an effective leadership (capacity & capability) then this may lead to a culture of poor quality service delivery. | I x 4  
L x 3  
RS = 12 | Open | 1. NHSI Development Reviews of Leadership & Governance using Well-led Framework  
2. Workforce and OD Strategy  
3. CQC Fundamental Standards (Well Led)  
4. Education programme | - Quality Dashboard Reporting (Professional Leadership)  
- Outcomes from Staff Survey  
- Internal Audit Plan Outcomes (Conflict of Interests, Equality & Diversity) | | | Chief Executive | Board of Directors |
| 5.2 - If we do not have a robust governance process in place with clear lines of accountable reporting (risks, issues & performance) then this may lead to the Trust being ineffective and a poor performer. | I x 5  
L x 3  
RS = 15 | Cautious | 1. Governance & Reporting Structure  
2. Board Assurance Framework  
3. Code of Governance  
4. ACO/Place Based Plans  
5. Internal Audit Plan | - Governance effectiveness Assessments  
- BAF Reporting  
- Risk Management Annual Report  
- Committee Review of Terms of Reference  
- Internal Audit Plan Outcomes (Risk Management, Policy Management, Head of Internal Audit Opinion) | Care group Accountability Framework | I x 5  
L x 2  
RS = 10 | Director of Corporate Assurance | Board of Directors |
| 5.3 - If we do not comply with statutory legislative requirements then this may lead to compliance notices, breach of FT license, sanctions and/or financial penalties and reputational damage | I x 5  
L x 2  
RS = 10 | Avoid | 1. NHS Improvement License  
2. CQC Fundamental Standards  
3. Legislation | - NHS Improvement ratings  
- Internal Audit Plan (IG toolkit, Compliance with MH and Capacity legislation) | | | Director of Corporate Assurance | Finance, Performance and Informatics Committee / Quality Committee |
| 5.4 - If there is not a clear vision and credible strategy in place, there is a risk to the delivery of high quality, sustainable care. | I x 4  
L x 2  
RS = 8 | Cautious | 1. 5 Year Plan and associated strategies  
2. Mission, Vision & Values | - NHS Improvement assessment | | | Chief Executive | Board of Directors |
<table>
<thead>
<tr>
<th>Risk levels</th>
<th>Avoid</th>
<th>Minimal</th>
<th>Cautious</th>
<th>Open</th>
<th>Seek</th>
<th>Mature</th>
</tr>
</thead>
<tbody>
<tr>
<td>Key elements</td>
<td>Avoidance of risk and uncertainty is a Key Organisational objective</td>
<td>Preference for ultra-safe delivery options that have a low degree of inherent risk and only for limited reward potential</td>
<td>Prepared to accept possibility of some limited financial loss. VfM still the primary concern but willing to consider other benefits or constraints. Resources generally restricted to existing commitments.</td>
<td>Prepared to invest for return and minimise the possibility of financial loss by managing the risks to a tolerable level. Value and benefits considered (not just cheapest price). Resources allocated in order to capitalise on opportunities.</td>
<td>Investing for the best possible return and accept the possibility of financial loss (with controls may in place). Resources allocated without firm guarantee of return – ‘investment capital’ type approach.</td>
<td>Consistently focussed on the best possible return for stakeholders. Resources allocated in ‘social capital’ with confidence that process is a return in itself.</td>
</tr>
<tr>
<td>Financial / VFM</td>
<td>Avoidance of financial loss is a key objective. We are only willing to accept the low cost option as VfM is the primary concern.</td>
<td>Only prepared to accept the possibility of very limited financial loss if essential. VfM is the primary concern.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Compliance / Regulatory</td>
<td>Play safe, avoid anything which could be challenged, even unsuccessfully.</td>
<td>Limited tolerance for sticking out neck out. Want to be reasonably sure we would win any challenge.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Innovation / Quality / Outcomes</td>
<td>Defensive approach to objectives – aim to maintain or protect, rather than to create or innovate. Priority for tight management controls and oversight with limited devolved decision taking authority. General avoidance of systems / technology developments.</td>
<td>Innovations always avoided unless essential or commonplace elsewhere. Decision making authority held by senior management. Only essential systems/technology developments to protect current operations.</td>
<td>Tendency to stick to the status quo, innovations in practice avoided unless really necessary. Decision making authority generally held by senior management. Systems / technology developments limited to improvements to protection of current operations.</td>
<td>Innovation supported, with demonstration of commensurate improvements in management control. Systems / technology developments used routinely to enable operational delivery. Responsibility for non-critical decisions may be devolved.</td>
<td>Innovation pursued – desire to ‘break the mould’ and challenge current working practices. New technologies viewed as a key enabler of operational delivery. High levels of devolved authority – management by trust rather than tight control.</td>
<td>Innovation the priority – consistently ‘breaking the mould’ and challenging current working practices. Investment in new technologies as catalyst for operational delivery. Devolved authority – management by trust rather than tight control is standard practice.</td>
</tr>
<tr>
<td>Reputations</td>
<td>No tolerance for any decisions that could lead to scrutiny of, or indeed attention to, the organisation. External interest in the organisation viewed with concern.</td>
<td>Tolerance to risk taking limited to those events where there is no chance of any significant repercussion for the organisation. Senior management distance themselves from the chance of exposure to attention.</td>
<td>Tolerance for risk taking limited to those events where there is little chance of any significant repercussion for the organisation should there be a failure. Mitigation in place for any undue interest.</td>
<td>Appetite to take decisions with potential to expose the organisation to additional scrutiny/interest. Prospective management of organisation's reputation.</td>
<td>Willingness to take decisions that are likely to bring scrutiny of the organisation but where potential benefits outweigh the risk. New ideas seen as potentially enhancing reputation of organisation.</td>
<td>Track record and investment in communications has built confidence in the public, press and politicians that organisation will take the difficult decisions for the right reasons with benefits outweighing the risks.</td>
</tr>
</tbody>
</table>
Impact Score 1 - Rare 2 - Unlikely 3 - Possible 4 - Likely 5 - Almost certain

<table>
<thead>
<tr>
<th>Impact Score</th>
<th>1 - Rare</th>
<th>2 - Unlikely</th>
<th>3 - Possible</th>
<th>4 - Likely</th>
<th>5 - Almost certain</th>
</tr>
</thead>
<tbody>
<tr>
<td>5 - Catastrophic</td>
<td>5</td>
<td>10</td>
<td>15</td>
<td>20</td>
<td>25</td>
</tr>
<tr>
<td>4 - Major</td>
<td>4</td>
<td>8</td>
<td>12</td>
<td>16</td>
<td>20</td>
</tr>
<tr>
<td>3 - Moderate</td>
<td>3</td>
<td>6</td>
<td>9</td>
<td>12</td>
<td>15</td>
</tr>
<tr>
<td>2 - Minor</td>
<td>2</td>
<td>4</td>
<td>6</td>
<td>8</td>
<td>10</td>
</tr>
<tr>
<td>1 - Negligible</td>
<td>1</td>
<td>0</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

1 - 3 Low
4 - 6 Moderate
8 - 12 High
15 - 25 Extreme
<table>
<thead>
<tr>
<th>Committee Name</th>
<th>Board of Directors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Agenda Item</td>
<td>M</td>
</tr>
<tr>
<td>Date</td>
<td>27 July 2017</td>
</tr>
<tr>
<td>Title of Paper</td>
<td>Extreme Risks</td>
</tr>
<tr>
<td>Action Required</td>
<td>Decision ✓</td>
</tr>
<tr>
<td></td>
<td>Assurance ✓</td>
</tr>
<tr>
<td></td>
<td>Information ✓</td>
</tr>
<tr>
<td>Prepared by</td>
<td>Phil Gowland, Board Secretary/Director of Corporate Assurance</td>
</tr>
<tr>
<td>Presented by</td>
<td>Phil Gowland, Board Secretary/Director of Corporate Assurance</td>
</tr>
<tr>
<td>Delivery against</td>
<td>Strategic Goal(s)</td>
</tr>
<tr>
<td></td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>Strategic Risk(s)</td>
</tr>
<tr>
<td></td>
<td>5.3</td>
</tr>
<tr>
<td></td>
<td>CQC Domain</td>
</tr>
<tr>
<td>Financial/Budget</td>
<td>The financial implications are noted within the risks – specifically within the risk that relates to the delivery of the financial plan</td>
</tr>
<tr>
<td>Equality &amp; Diversity</td>
<td>None identified</td>
</tr>
<tr>
<td>Previously Presented to</td>
<td>Executive Management Team – 19 July 2017</td>
</tr>
<tr>
<td></td>
<td>Finance, Performance and Informatics Committee – 20 July 2017</td>
</tr>
</tbody>
</table>

### Background / Key Points / Outcome

The Board of Directors is responsible for the overseeing the effectiveness of the Risk Management Framework to manage the strategic and operational risks that may prevent the achievement of the strategic goals.

This report provides an overview of the operational risks including the outline of the reporting and monitoring in place.

The three extreme risks included in this paper were presented to and discussed by the Finance, Performance and Informatics Committee; two are longer standing risks and the third is an escalated new extreme risk.

**The Board of Directors is asked to note Risk Register Update Report**
Extreme Risks Report

July 2017
1. **INTRODUCTION**

The Board of Directors is responsible for the implementation of the Risk Management Framework and for overseeing the effectiveness of processes for the identification, assessment, management and mitigation of risk.

To assist the Board of Directors in its duties the Committees are responsible for providing assurance in relation operational risks under the remit of their Terms of Reference. The Committees are scheduled to:

- Review all extreme operational risks on a monthly basis
- Review all operational risks on a quarterly basis

2. **OPERATIONAL RISKS**

**Extreme Operational Risks**

There are currently three extreme operational risks as at 21 July 2017 which are summarised below. These were discussed in the month by both the Executive management Team and by the Finance, performance and Informatics Committee.

<table>
<thead>
<tr>
<th>Risk</th>
<th>Score</th>
<th>Days as extreme</th>
<th>Responsible Committee</th>
</tr>
</thead>
<tbody>
<tr>
<td>FIN 8/16</td>
<td>I x 5 L x 4 RS= 20</td>
<td>178</td>
<td>FPIC</td>
</tr>
<tr>
<td>HI 2/16</td>
<td>I x 5 L x 3 RS = 15</td>
<td>133</td>
<td>FPIC/QC</td>
</tr>
<tr>
<td>HI 10/14</td>
<td>I x 4 L x 5 RS = 20</td>
<td>7</td>
<td>FPIC</td>
</tr>
</tbody>
</table>

**FIN 8/16** - Q1 financial position now known. The risks as stated is an ‘all-encompassing’ risk, the mitigation to which will require a number of strands of actions relating to the delivery of the QIPP savings, the delivery of the CQUIN targets, maintenance of income streams and strong control over ongoing expenditure. Collectively these strands result in the current ‘extreme’ risk and the Director of Finance will continue to consider the ongoing action needed to mitigate.

**HI10/14** – The escalation of the risk was necessary as a further response to a number of significant staff changes within the team. A review of the workload, the additional requests (sources of and number of) and the staffing in place within the team is underway in response to this change.

**Other Operational Risks**

There are currently 58 Operational (including the extreme rated risks). Each has a designated lead responsible for managing the risk and oversight – in terms of ensuring updates are undertaken - is provided by the relevant Committee and sub-committee.
Moderation by EMT

EMT is responsible for the implementation of risk management and is scheduled to:

- Review all risks on a quarterly basis to provide a confirm and challenge function and moderate all risk
- Moderation all risks score 15 or above onto and off the Extreme Operational Risk Register
- Moderate the tolerated risk scored 8 or above where the likelihood is 3 or above.

The first set of meetings for the moderation of all risks took place in May 2017 and changes actioned. The next round of moderation will take place in August 2017.

The moderation process in July resulted in the escalation of the third extreme risk above relating to the resources available in the data warehouse.
<table>
<thead>
<tr>
<th>Committee Name</th>
<th>Board of Directors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Agenda Item</td>
<td>N</td>
</tr>
<tr>
<td>Date</td>
<td>27 July 2017</td>
</tr>
<tr>
<td>Title of Paper</td>
<td>Annual Report and Accounts 2016/17</td>
</tr>
<tr>
<td>Action Required</td>
<td>Decision, Assurance, Information</td>
</tr>
<tr>
<td>Prepared by</td>
<td>Phil Gowland, Board Secretary/Director of Corporate Assurance</td>
</tr>
<tr>
<td>Presented by</td>
<td>Phil Gowland, Board Secretary/Director of Corporate Assurance</td>
</tr>
<tr>
<td>Delivery against</td>
<td>Strategic Goal(s) All, Strategic Risk(s) I, CQC Domain W</td>
</tr>
<tr>
<td>Financial/Budget</td>
<td>The Annual Report and Accounts includes the financial performance of the Trust for 2016/17 and confirms the delivery of the financial plans and includes an unqualified opinion on the accounts from the external auditors.</td>
</tr>
<tr>
<td>Equality &amp; Diversity</td>
<td>Reference is made within the Annual Report to the work underway across the organisation in respect of equality and diversity.</td>
</tr>
<tr>
<td>Previously Presented to</td>
<td>Throughout April, May and June 2017 the report, or component parts of the report and accounts, were presented to the Quality Committee, Finance, Performance and Informatics Committee, Audit Committee (who recommended the formal adoption) and the Board of Directors.</td>
</tr>
</tbody>
</table>
| Background / Key Points / Outcome| The production of the Annual Report and Accounts is a requirement of all foundation trusts and the format of the documents and the timetable for production are heavily prescribed. The Annual Report and Accounts, including the Quality Report are subject to external audit. 
At its (private) meeting in May 2017, on receipt of a recommendation from the Audit Committee, the Board of Directors formally adopted the Annual Report and Accounts 2016/17. Through the external audit review it was confirmed that all requirements had been achieved and as a result an unqualified opinion was received. The Annual Report and Accounts have subsequently been submitted to NHS Improvement and were laid before Parliament on 6 July 2017. The Annual Report and Accounts are now available on the Trust’s website at http://www.rdash.nhs.uk/45637/rdash-annual-report-201617/ (Printed copies are available from the Board Secretary) 
The Trust will host its Annual Members Meeting on 10 August 2017 at the Carlton Park Hotel in Rotherham – the event will include a Trust Showcase from 1pm, where there will be an opportunity to see and hear more about the Trust’s services, working or volunteering at the Trust, and to learn about how the Trust listens, learns and engages with the public, its patients, carers and staff. |
At 3pm the formal meeting will commence and there will be a number of presentation relating to the Annual Report and Accounts focusing on the ‘story of the year and the future plans; the financial performance; quality’ and the work of the Council of Governors in the year.

The day will also then feature the next Council of Governors meeting from 4pm. During this meeting the external auditors will be present and will deliver the outcome of their work, including the opinions they have previously provided to the Trust on the Annual Report and Accounts. This is in recognition that it is the responsibility of the Council of Governors to appoint the external auditors of the Trust.

The Board of Directors is asked to note the completion of the work to produce the Annual Report and Accounts 2016/17, and following the final submission (to Parliament) that the document is now publicly available and will be the focus of the Annual Members Meeting on 10 August 2017.