Doncaster and Bassetlaw Hospitals NHS
NHS Foundation Trust

Annual Report & accounts 2010/11

WE CARE FOR YOU

Doncaster and Bassetlaw Hospitals NHS Foundation Trust

& Annual Report accounts 2010/11

**Presented to Parliament pursuant to Schedule 7 paragraph 25(4)
of the National Health Service Act 2006**


Main Entrance

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Appendices

The text of this Annual Report & Accounts is available in large print, as a hard copy or electronically, on request. Please contact the Trust's Communications Department on 01302 366666 ext 6085.

For further information on any aspect of this document, please also contact the Trust's Communications Department (as above).

1 CHAIRMAN'S INTRODUCTION

It is my pleasure to present this account of our achievements and use of public funds in 2010/11.

The year was overshadowed by the absence from work and then death in August 2010 of our long-standing Chief Executive, Nigel Clifton. Below, there is a tribute to Nigel. I cannot let this opportunity pass without noting his outstanding leadership of this Trust, and many NHS organisations beforehand, and his commitment to patient care, over many years.

During the year, we invested in clinical and service developments, and improvements to the estate, like eliminating mixed-sex accommodation.

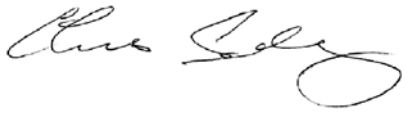
We continued the work which began in 2009/10 to face the impact on the NHS of the economic climate. Readers will see that we made significant savings through our Quality & Transformation programme. But it wasn't all about money - we also made improvements to clinical care that streamlined care for patients and cut out waste and inefficiency.

We worked with Bassetlaw and Doncaster PCTs on their Clinical Services Review – on what services they wish to commission (buy) for their local populations in the years ahead – in order to 'future proof' our services.

We are justly proud of the achievements of the past year, including setting up Clinical Service Units to take much of the managerial responsibility for patient care down to the frontline. I would like to thank our Interim Chief Executive, Peter Reading, for leading this work.

Again, this Annual Report includes an account of all the quality measures that underpinned patient care in 2010/11.

If readers have any questions about any aspect of this Annual Report or our finances, contact details are on the previous page.



Chris Scholey

NIGEL CLIFTON OBE

It was with great sadness that we learned of the death of Nigel Clifton OBE, Chief Executive, who died on Sunday 8 August 2010. Nigel had been absent from work since early 2010 - he died peacefully in Bassetlaw Hospice with his family around him.

Chairman, Chris Scholey, paid tribute to Nigel's achievements: "Nigel joined us in July 1997 after a distinguished career in NHS management.

"He continued to achieve much while in post as our Chief Executive and was highly respected both within the Trust and nationally. In 2000, he led the merger of hospitals in Doncaster and Mexborough with Bassetlaw Hospital & Community Services NHS Trust and was appointed the first Chief Executive of the new joint organisation.

"Nigel led the application to become an NHS foundation trust after consistent ratings as a top-performing 'three star' trust. We were one of the first 10 NHS foundation trusts to be authorised."

Under Nigel's leadership, the hospitals became associate teaching hospitals of Sheffield University, and an Associate College of Sheffield Hallam University.

Interim Chief Executive, Peter Reading, in sending his deepest condolences to staff for the loss of their friend and leader, commented that Nigel made Doncaster & Bassetlaw Hospitals one of the best trusts in the country. He was respected everywhere for his leadership, integrity, humanity, and humour.

The funeral service for family and close friends was held on 16 August. A Memorial Service for colleagues and staff was on 12 November 2010. Many colleagues from across the NHS came to celebrate Nigel's life and contribution to healthcare, both locally and nationally. Tributes were paid by Sir David Nicholson CBE, Chief Executive of the NHS, the Trust's former Medical Director, Dr Emyr Wyn Jones, former Chairman, Margaret Cox, Lynne Rothwell, the Trust's Director of Performance, and Andrew Cash OBE, Chief Executive of Sheffield Teaching Hospitals NHS Foundation Trust.

2 DIRECTORS' REPORT

This section of the Annual Report details the Board of Director's accounts of performance and principal activities during the past year.

The year in numbers

- services at five hospital sites
- 494,062 new and follow-up outpatients
- 157,949 A&E patients
- 92% reduction in MRSA bacteraemia
- over 6200 members of staff (headcount)
- 14,282 foundation trust members.

Board of Directors

People making up the Board of Directors in 2010/11 were:

- Chris Scholey, Chairman
- Nicola Atkin, Non-executive Director
- Joe Barnes, Non-executive Director
- Geraldine Broderick, Non-executive Director
- David Crowe, Non-executive Director
- John Parker, Non-executive Director
- Dr Peter Reading, Interim Chief Executive
- Dr Robin Bolton, Medical Director
- Hilary Bond, Director of Nursing & Quality
- Joe Brayford, Director of Human Resources
- David Pratt, Director of Finance, Information & Procurement (from 7 March 2011)
- Kevin Turner, Director of Finance & Information (to 7 January 2011).

The following directors were non-voting members of the Board:

- Ian Greenwood, Director of Strategic & Service Development
- Lynne Rothwell, Director of Performance
- Roy Tyson, Director of Facilities & Commercial Development (to 31 December 2010).

Full biographies and Board information is available in Chapter 8.

Principal activities

Our services are commissioned by our local primary care trusts - NHS Bassetlaw and NHS Doncaster. We also listen to our patients and are as responsive as we can be in providing the services they want and which fit around their needs.

We are proud of the services we provide.

Our Terms of Authorisation as an NHS foundation trust summarises our principal activities in full and can be found on Monitor's website: http://www.monitor-nhsft.gov.uk/home/about-nhs-foundation-trusts/nhs-foundation-trust-directory/doncaster-and-bassetlaw-hospitals-nh

We are constantly striving to improve the services we provide to both our local population and those who travel from further away to use our services. Some of the achievements during 2010/11 include:

- almost entirely eliminating MRSA infections during the year – there was just one patient with MRSA bacteraemia in 2010/11
- ensuring that appropriate patients are assessed for their risk of having a blood clot
- reducing the most serious pressure ulcers
- eliminating mixed-sex accommodation
- moving children's inpatient wards into brand new, award-winning accommodation at DRI
- starting work on a new breastcare unit at Bassetlaw Hospital
- launching a new bariatric (obesity) surgery service
- upgrading ultrasound and dental X-ray facilities at Montagu Hospital.

Business review

This report considers three main areas of risk: financial, clinical, and reputational. The Trust maintains a risk register, which is updated on approval from the Board of Directors. The top risks in 2010/11 were:

- A&E
- finance and delivery of efficiency targets
- healthcare-associated infections.

Financial risk related to the national economic situation and its impact on the NHS. In 2009/10, we agreed the need to reduce our expenditure by £38m over three years – equivalent to 12% of our turnover. We also had to retain a surplus to pay for developments and equipment throughout 2011/12.

In 2009/10, we launched our 'Delivering Better Health – Quality & Transformation' programme, called Transformation for short. Twenty-seven projects were identified that would improve quality and/or reduce costs. The savings achieved in 2010/11 were £10.2m. All staff vacancies were subject to review and a £1m reduction in management costs was agreed for achievement in 2011/12.

Investment was made in an internal restructuring in order to meet the challenges of the next five to 10 years. Sixteen clinical service units (CSUs) were set up, representing clinical specialties and clinical support services, each headed up by a consultant or equivalent as clinical director. The rationale was to put decision making as close to the patient as possible, engaging clinicians in that decision making, and giving CSUs the financial incentives to transform services by driving through changes in quality and productivity.

The CSUs came into being on 1 November 2010. Nine were income-earning, supported by seven clinical support CSUs, eg Medical Imaging. Each has an average budget of £14m. In addition to the clinical director, supported by a general manager, the management team was complemented by a matron. This gave stronger nursing leadership through line management of ward nursing staff.

The bad winter weather meant cancellations of many outpatient clinics; the bad weather also led to a high number of admissions and this, because beds were occupied, resulted in a number of operations cancelled. This negatively impacted on finances.

Despite our best efforts to recruit to vacant posts, there were a number of senior medical vacancies, including consultant posts. The only way of temporarily filling those vacancies was to employ agency staff leading to an agency medical staff cost of around £13.1m in 2010/11. We successfully negotiated, however, a reduction in rates paid to consultants working overtime.

Clinical risk related to a number of key patient standards. Meeting CQUIN (Commissioning for Quality & Innovation) similarly presented challenges. PCTs withheld payments for failure to meet targets and, despite best efforts, which included a push to meet the Venous Thromboembolism (VTE) risk assessment target, we failed to achieve £1.2m in income in the year.

While MRSA was all but eliminated, wiping out *Clostridium difficile* (known as *C diff*) remained a challenge. Performance against infection control targets is in the Quality Report.

Meeting the four hour target to see, treat and discharge, transfer or admit patients coming into A&E was under pressure. Although the target was reduced to 95%, it was still difficult to transfer those patients needing a bed because of the number of admissions due to seasonal illnesses and injuries.

The number of patients presenting at A&E remained high. Patients were generally more poorly – an increasing trend as people live longer, and live longer with serious illnesses. The following patients were admitted to A&E:

- 44,863 in Bassetlaw (44,912 in 2009/10 and 44,632 in 2008/09)
- 113,086 in Doncaster (108,617 in 2009/10 and 108,744 in 2008/09).

Managing reputational risk became an increasing feature of the year. Necessary changes to services – or changes forced upon us – featured in the media and were a cause for concern to staff.

We ceased doing the Nottinghamshire Coroner's post mortems at Bassetlaw Hospital as our consultant pathologists, who worked for the Coroner privately, withdrew their services from February 2011. Although we offered the use of the mortuary for other visiting pathologists, this option was not pursued. The mortuary remains open, however, as a body store and viewing facility for relatives. Last year, Bassetlaw mortuary received 723 bodies, of which 199 had PMs. From August 2010, the Notts Coroner arranged for bodies requiring Coroner's PMs to go to Mansfield, but relatives can still view their loved ones at Bassetlaw. The remaining 500-plus (non-PM) bodies a year continue to receive their full mortuary service (body store and viewing facility) at Bassetlaw Hospital.

Our workplace nurseries were losing money, effectively subsidised by our NHS budget. Based on the first six months of this year, we projected that the full cost of running the nurseries would be £336,000 higher than the income received. This was despite a new operating policy and prices put in place from late 2009, which had some beneficial impact on the previous (even higher) overspend. In effect, we were subsidising each place by more than £4000 a year – a subsidy that is not available to any other member of staff. Moreover, one-third of the children using the nursery were not children of Trust staff - so we were heavily subsidising non-DBH parents from NHS funding for patient care. The nursery at Bassetlaw Hospital closed, therefore, at the end of the financial year with the nursery at DRI, which had a number of children going to school in the autumn, staying open until the beginning of the 2011/12 school year. Understandably, parents and staff were concerned about the closure and mounted a publicity campaign, supported by the local press, MP, and councillors.

Our two host commissioners, NHS Bassetlaw and NHS Doncaster, continued work on their Clinical Services Review (CSR). Although done with our involvement, it was, and remains, essentially the commissioners' review of the services they wish to buy on behalf of their local populations in the future. Two independent reviews of paediatric and maternity services, raised public suspicion; the future of A&E, and the Intensive Care and Coronary Care Units, at Bassetlaw Hospital also all featured in concerns about the future of services there. These concerns were countered through the press but also through increasing information to staff.

Developing our services

As described above, we worked with NHS Bassetlaw and NHS Doncaster on their joint Clinical Services Review. During the year, the independent reports the PCTs had commissioned were published and made widely available. Two internal groups were set up to consider the findings of the report writers; their deliberations ran into 2011/12, when our responses were handed to the PCTs, which will take them into account.

The PCTs twice deferred public consultation on services at Bassetlaw Hospital. Consultation on their proposed changes to services at Montagu and Tickhill Road Hospitals is planned for summer 2011.

Against this background of the commissioners' review, we proceeded with developments that did not require public consultation. In 2010, emergency abdominal surgery was centralised at DRI, followed by treatment of patients with acute strokes in DRI's stroke unit. Both followed national guidance: where small numbers of patients are involved, their care is demonstrably better when treated in a central unit with the necessary specialist back-up and support services on hand. Although this change mainly affected Bassetlaw patients, the expected gains were considerable. In stroke care, it was estimated that for the Bassetlaw population, this would mean:

- 7-8 more patients going home independent instead of dependent every year
- 1-2 patients going home every year dependent instead of institutional care
- 3 fewer patients every year going into institutional care
- 6 fewer patients dying every year.

We tendered for a range of services, including provision of community services that the PCTs' provider arms were required to divest themselves of. Although largely unsuccessful, we did take on podiatric surgery with staff joining us on 1 April 2011.

DRI became the second vascular surgical hub in South Yorkshire and Bassetlaw. The Vascular Specialist Commissioning Group carried out public consultation in November 2010 – January 2011 and, despite a challenge, the decision was upheld. We will work with staff of Sheffield Teaching Hospitals NHS Foundation Trust, the other centre for emergency and specialist vascular services.

A further development of the Emergency Department and Unplanned Care Centre was taking on responsibility for the out-of-hours call service and the staff that had previously provided the service.

The Pathology CSU developed an ambitious case for a managed equipment service. The first preferred provider pulled out at the 23rd hour so the service was re-tendered for a 10-year contract.

Pathology took on two screening services previously provided by the National Blood Service: antenatal infectious disease screening and antibody and blood grouping.

We won the contract to continue providing a post mortem service for the Doncaster Coroner.

Patient safety

Three new deputy medical directors were appointed with specific roles in standards and patient safety:

- Mr Ray Cuschieri, Deputy Medical Director – Clinical Standards
- Dr Richard Harris, Deputy Medical Director – Professional Standards
- Dr Sewa Singh, Deputy Medical Director – Clinical Productivity & Workforce.

In our hospitals, patients should expect to receive high-quality services and exceptional standards of care, delivered in a clean and safe environment.

Clinical governance is the way we ensure accountability to patients, the public, and commissioners by continuously improving the quality of services and safeguarding high standards of care.

The Board of Directors has overall responsibility ensuring patient safety through this system of clinical governance, supported by the Chief Executive, Medical Director, and the Deputy Medical Director for Clinical Standards.

In 2010/11, three groups managed clinical governance and risk management. These groups were:

- Clinical Governance Standards Committee (CGSC)
- Patient Safety Review Group
- Audit & Non-Clinical Risk Sub-Committee.

The Clinical Governance Standards Committee (CGSC) is a sub-committee of the Board of Directors and sets the direction for clinical governance. The Committee is responsible for monitoring improvements in patient safety and managing all aspects of clinical governance and risk.

Monthly confidential meetings, chaired by a non-executive director, focus on sharing experiences in order to learn from incidents and errors and improve patient care and so reduce risk in the future.

Every year, the Committee receives and comments on reports from clinical colleagues to ensure that issues including policy developments, priorities and areas for action are taken forward. This includes areas like:

- Infection Prevention & Control, Safeguarding Children, Human Tissue Compliance, and the Drug & Therapeutic Committee.

The Patient Safety Review Group (PSRG) is a sub-committee of the Clinical Governance Standards Committee and ensures that safety is continually improving for patients, and everything possible is done to keep risks associated with clinical activity to a minimum. The group ensures that new information is shared across the Trust so all areas can benefit and improve their standards. This group meets monthly and is chaired by the Deputy Medical Director - Clinical Standards.

The Audit & Non-clinical Risk Sub-committee ensures effective internal controls and systems are in place, and that the Trust is compliant with law, guidance, and codes of conduct. More about the committee and the Trust's Statement on Internal Control is in Chapter 13.

In summary, business risk was managed by the Board of Directors and its two assurance committees (below):

Risk area	Responsibility	Policy/Strategy area
Clinical	Clinical Governance Standards Committee (and, reporting to it, the Patient Safety Review Group)	Clinical Governance Risk Management Assurance framework
Non-clinical	Audit & Non-clinical Risk Sub-committee (and, reporting to it, the Information Governance Group)	Non-clinical risk management Assurance framework

Performing with excellence

In 2010/11, the Department of Health's Operating Framework challenged NHS trusts in England to sustain and improve performance in national targets, ensure quality is at the heart of all NHS services, and review how organisations work together in order to transform and improve.

We reviewed and improved how colleagues, departments, and partner organisations work together in order to deliver high-quality, effective and efficient care. The Trust performed well, meeting the majority of key patient targets during 2010/11, including meeting the target for patients to be seen within 18 weeks for treatment across specialties and departments.

Changes to the way performance is monitored

In 2010, significant changes to the way performance is monitored were introduced throughout the NHS in England. Existing measures such as waiting times for accessing care in Accident and Emergency (A&E) and waiting times for operations will be changed.

Four-hour A&E waiting times

A new range of quality indicators have been developed to measure patient experience in emergency care, which will be fully embedded in 2011/12. In 2010/11, the percentage of patients who should be seen within four hours of arriving at A&E changed from 98% to 95%. The severe bad weather experienced during winter 2010/11 placed a significant burden on the hospitals to achieve this target.

The Trust has achieved full compliance with the Monitor quarterly compliance of the 95% four-hour wait target, and has achieved the CQC standard of 95% for 11 out of 12 months. In 2011/12, new quality indicators for A&E will include safety, effectiveness, and patient experience in addition to the current waiting time standard of 95%.

Performance in cancer targets

We experienced some difficulty achieving some cancer waiting time standards throughout the year, especially those linked to the 62-day standards, patients referred for treatment for suspected cancers following referral from an NHS Cancer Screening Service. Despite this, overall compliance with all cancer standards has been achieved. The National Cancer Patient Survey 2010, published in January 2010, rated the Trust's cancer services as good or average in 68 of the 73 areas – 93% - where patients were asked for their opinions. The five areas where we were in the bottom 20% all related to information.

Reducing healthcare-associated infections

Tackling healthcare-associated infections, particularly MRSA and *C difficile*, remains a priority. Levels of both infections reduced overall during 2010/11. *C difficile* has been a more challenging infection, especially during the winter months when very high numbers of patients were admitted, but good progress is being made. Doncaster and Bassetlaw Hospitals has maintained performance within contracted targets.

There is more information on how the Trust is working to eradicate hospital-associated infections in the Quality Report.

18 weeks Referral to Treatment performance

A significant change in the measurement of the 18 weeks target in 2010/11 was the change in measurement from 90% of admitted patients, and 95% of non-admitted, to median wait measures for both pathways.

The Trust ensured that the target for patients to be seen within 18 weeks for treatment was sustained in all specialties, despite a higher number of referrals in many specialties. Both national and locally agreed PCT targets were met. Despite changes to the way waiting times for patients to access care are measured, the Trust will continue to ensure patients are not disadvantaged and waiting times do not increase. Doncaster and Bassetlaw Hospitals recognises patients' rights under the *NHS Constitution* and is committed to ensuring these rights are not breached.

Monitoring quality

Doncaster and Bassetlaw Hospitals, along with all NHS providers, was required to register formally with the Care Quality Commission in 2010/11. Each trust must meet essential standards of quality and safety, and, if a given trust had problems, they were registered with conditions. Doncaster and Bassetlaw Hospitals received registration status with no conditions attached, demonstrating a significant achievement for the Trust.

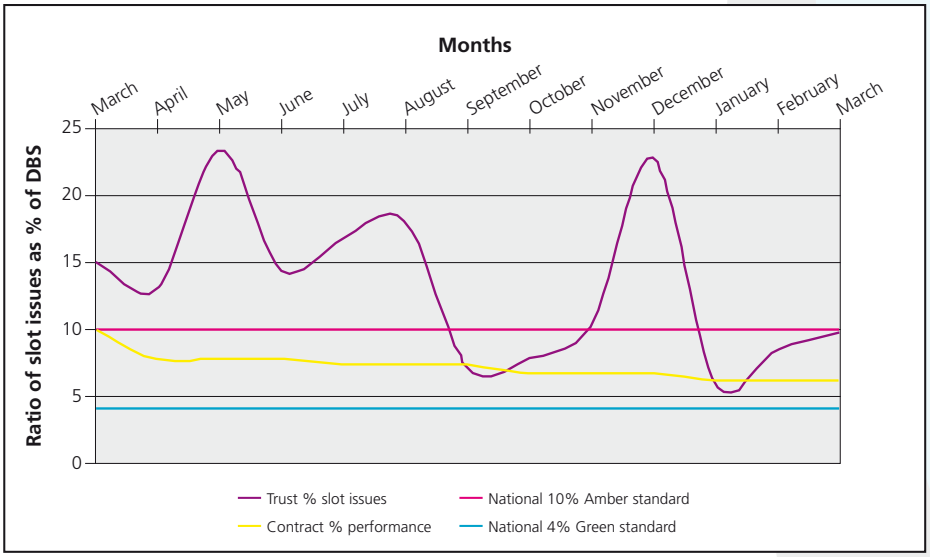
The Trust performed less well than expected in two areas and work has been underway to improve performance in these areas:

- 1.43% of patients' operations were cancelled for non-clinical reasons, against a national target of 0.8%. The Trust is working with a dedicated clinical team to reduce the number of operations cancelled for non-clinical reasons, which will improve patient experience
- the Trust's breast-feeding initiative achieved 64.2% against the local target of 68%. A dedicated midwife has been in post since December 2010 to support this initiative and works to achieve this important target.

The Trust is a consistently high achiever both nationally and locally in offering patients increased choice in their hospital treatment, by using the electronic booking system, Choose & Book. During 2010/11, activity in this system increased, and it proved challenging to ensure capacity matched demand. On occasions, we did not have enough outpatient slots available.

The severe winter weather in 2010/11 also caused operational problems, with some key staff unable to get to work. This unfortunately meant some clinic appointments were cancelled. The Trust increased outpatient slots and worked closely with local commissioners to extend the length of time appointments can be seen on GP booking screens. This has improved the availability of appointments, and in the last part of 2010/11 being within the national appointment slot issues performance of between 4 and 10%.

Appointment Slot Unavailability - March 2010 to March 2011:



During 2011/12, we are focusing on three priorities set out in the NHS Choice Agenda for improving patient choice:

1 *All patients who are referred for an outpatient appointment should be able to choose a named consultant led team where it is clinically appropriate to do so:*

All our clinicians have access to Choose & Book, and GPs can see appointment slots attached to the named clinician.

2 *List their services on Choose & Book in a way that allows users to book appointments with named consultant led teams:*

Our updated Directory of Services ensures that consultants' appointments can be seen by patients and GPs.

3 *Publish information about services so that people can use it to make choices about their healthcare, and support people to use this information:*

We are currently updating all information about Choice and Choose & Book in preparation for this. A full range of Performance indicators is available in Appendix 2.

Creating a green and sustainable Trust

The Trust is committed to reducing our impact on the environment. Delivering world-class health services over several hospital sites has an unavoidable impact on the environment, so we have transformed the way we operate in order to improve health, conserve energy and reduce carbon emissions.

All trusts across the NHS are expected to reduce their estate running costs and carbon emissions, and at Doncaster and Bassetlaw Hospitals we are aiming high – reducing our impact on the environment and demonstrating good corporate citizenship by reducing carbon dioxide emissions to 80% below 2007 levels by 2050.

In 2010/11, further investment in energy efficiency measures included a £500,000 capital allocation for Invest to Save energy and carbon reduction schemes with anticipated cost savings of £147,900 and carbon savings of 506.5 tonnes:

- energy-saving measures included lighting replacement, thermal insulation, and new heating controls

- a carbon reduction campaign through a successful grant application to the Carbon Trust
- improvements in the energy procurement strategy, achieving lower unit costs.

We have significantly reduced the cost of energy over the last year through a number of initiatives. The energy centre is regulated for carbon emissions under the European Union Emission Trading Scheme. Since the Trust joined the scheme in 2005, we have saved 19,000 tonnes of carbon emissions against the allocation received. In 2005, 12,549 tonnes of carbon were emitted, compared with 8784 in 2010.

In 2010, we achieved the Carbon Trust Standard, which recognises good practice in carbon measurement, management and reduction. Our energy conservation efforts were enhanced during 2010/11 with technical improvements including top-range building services controls and Combined Heat & Power (CHP), and an environmental awareness campaign for staff. The Environmental Awareness Campaign is supported by the Carbon Trust and aims to raise awareness and achieve energy savings through everyday actions. A campaign team has been established and volunteer Energy & Environmental Representatives recruited, trained, and supported to reduce our impact on the environment.

We were one of the first health organisations to appoint a dedicated Waste Manager, responsible for minimising waste and complying with legislation. We received aid through the Resource Efficiency for Yorkshire for innovation in a low carbon economy, and joined a number of innovative low carbon economy initiatives.

Water boreholes, developed in previous years at our three main hospital sites, have saved over £100,000 a year since installation. New water conservation measures will be introduced as part of the Carbon Management Strategy, allowing us to build upon previous success to further benefit of the environment.

Performance of the Combined Heat & Power against environmental targets was in line with the Government's Energy and Climate Change Strategy 2000-2010. Doncaster and Bassetlaw Hospitals by far exceeded targets set by the Government to reduce emissions:

	Government target	Trust achievement
Reduction in primary Energy	15%	21.5%
Reduction in CO_2 emissions	20%	39%
Reduction in sulphur dioxides	83%	99%

Our Carbon Management Strategy, approved for 2010-2015, will continue to reduce energy use and CO_2 emissions. The strategy for sustainable management of energy, water, transport, waste and procurement makes a significant commitment to sustainability.

Review and implementation of energy savings and environmental improvements are managed by an Energy & Environmental Working Group, and a Board lead for sustainability and carbon reduction has been appointed. The Trust Board has approved capital investment for energy, Invest to Save measures, and carbon reduction. The in-house Capital Design Team complies with a carbon management strategy for all new healthcare buildings and refurbishments to achieve a minimum of a 'very good standard' for refurbishments and 'excellent' for new buildings.

As a member of the Government's Carbon Reduction Commitment (Energy Efficiency Scheme), the Trust is required to report annually to the Department of Energy and Climate Change on its carbon emissions.

See Appendix 3 for the Sustainability Report.

Our staff and volunteers

The hard work, commitment, and passion of our staff and volunteers is what makes Doncaster and Bassetlaw Hospitals a successful and high-quality Trust. This year, we have continued to improve the way we communicate with, recruit, and develop our staff and reward their dedication.

We held our 17th Staff Annual Awards Ceremony in March 2011. Staff and teams from the hospitals were nominated by patients and their colleagues for the awards, which rewarded long service, most caring staff, infection prevention, quality, the volunteer of the year, and the unsung heroes of the Trust.

The winners of the prestigious award Team of the Year were Medical Ward C1 at Bassetlaw Hospital. Mark Race, Ward C1 Manager, said: "We were delighted to be named Team of the Year at the awards. The team work well together because they are genuinely caring people. They care for the patients and each other. As their ward manager, I am extremely proud of them."

Listening to staff

Following the 2009 Staff Survey, a range of actions were rolled out throughout the Trust during 2010/11, including:

- implement appropriate employee involvement and engagement initiatives at all levels
- all staff to have an annual performance review
- all staff to have regular Health & Safety training, as appropriate to their post. Front-line staff at highest risk of violence, to have conflict resolution training. The Violence & Aggression Group to be reinstated, with a specific action plan to reduce incidents. Bullying & Harassment training is to be provided, initially targeting areas reporting the highest levels of incidence
- provide opportunities for improved health and wellbeing
- managers to implement appropriate communication systems
- managers to ensure that 100% of staff have Equality & Diversity training
- publicise the next Staff Survey to improve the response rate.

The results of the 2010 Staff Survey were published by the Care Quality Commission (CQC) in March 2010. They show across-the-board improvements.

In its summary of 38 key findings, the CQC rated the Trust 'above average' in 13 areas, putting us in the top 20% of acute hospital trusts in the following:

- 77% staff satisfied with the quality of work and patient care they deliver
- 91% agreeing that their role makes a difference to patients
- below average low level of work pressure
- below average number of staff doing extra hours
- 79% staff receiving job-relevant training, learning or development in the past 12 months
- below average number of staff suffering work-related injury in the last 12 months
- below average number of staff suffering work-related stress in the last 12 months

- 75% staff saying hand washing materials are always available
- better than average fairness and effectiveness of incident reporting procedures
- fewer than average number of staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months
- fewer staff saying that their health and wellbeing impacted on their ability to perform work or daily activities
- a drop in the number of staff saying they intend to leave their jobs
- below average in the % staff experiencing discrimination at work in the last 12 months.

The survey was carried out in late 2010. 850 randomly selected staff across the Trust were invited to fill in the questionnaire anonymously; 56.51% of staff responded. This compared well with the average response rate for acute trusts - 50%.

There is more work to be done to improve our position in the bottom ranking scores:

- % of staff having equality and diversity training in the last year
- % of staff feeling pressure in the last 3 months to attend work when feeling unwell
- effective team working
- % of staff able to contribute towards improvements at work.

An action planning day for clinical service units was held in April to agree areas for improvement. The top and bottom survey results were as follows:

	2009/10		2010/11		Trust Improvement/ Deterioration
Response rate	**Trust**	**National Average**	**Trust**	**National Average**	
	51%	51%	56.51%	54%	5.51% improvement
	2009/10		**2010/11**		**Trust Improvement/ Deterioration**
Top 4 Ranking scores	**Trust**	**National Average**	**Trust**	**National Average**	
KF19 % of staff saying hand washing materials are always available	80%	69%	75%	67%	5% deterioration
KF28 Impact of Health and Wellbeing on ability to perform work or daily activities	1.62	1.57	1.49	1.57	0.13 improvement
KF38 % of staff experiencing discrimination at work in last 12 months	8%	7%	9%	13%	1% deterioration
KF17 % of staff suffering work-related injury in the last 12 months	17%	17%	13%	16%	4% improvement
	2009/10		**2010/11**		**Trust Improvement/ Deterioration**
Bottom 4 Ranking scores	**Trust**	**National Average**	**Trust**	**National Average**	
KF36 % of staff having equality and diversity training in the last 12 months	23%	35%	20%	41%	3% deterioration
KF29 % of staff feeling pressure in the last 3 months to attend work when feeling unwell	30%	26%	32%	26%	2% deterioration
KF6 Effective team working	Comparison not possible		3.60	3.69	
KF31 % of staff able to contribute towards improvements at work	55%	61%	57%	62%	2% improvement

Keeping staff safe and well

We are committed to keeping staff safe and well, and to provide a pleasant environment for work.

We ensure that all forms of harassment, discrimination, bullying or other unacceptable behaviour are excluded from working relationships at the Trust.

The Trust's Occupational Health service plays a key role in ensuring staff are safe and well at work. This important area is a priority for us, and we do our best to ensure that we have a happy and healthy workforce.

During 2010/11, the Trust:

- reviewed the way incidents of violence and aggression are dealt with, in order to reduce their impact on staff, and frequency in which they occur
- launched a range of initiatives in order to improve health and wellbeing
- improved the way we assess and support staff following the second national audit of back pain and depression.

The Trust has also worked hard to reduce sickness absence rates, which have presented challenges in the past. Work with the Clinical Service Units to better manage and review the Sickness Absence Policy has been a priority, along with the development of action plans. Sickness absence rates are closely monitored and reduced.

Full sickness absence rates are available in Chapter 10, Additional & Public Interest Disclosures.

Celebrating equality and diversity

We strive to eliminate all forms of discrimination and promote equality.

Staff understand the value of differences among individuals as an asset to our hospitals. We urge people to recognise that every individual's contribution should be valued, that everyone should be treated fairly, with decency, dignity, and respect, and that throughout the organisation everyone's behaviour, as well as management styles and procedures, should be consistent with these principles.

The Trust is committed to shaping its services around the needs and preference of individual patients, their families and carers, and eliminating inequalities in patient experience and health outcome.

Equality and diversity of the workforce is regularly managed using a range of methods, including the annual staff survey, auditing of recruitment and selection, attendance at equality and diversity training and via the Equality & Diversity sub-group.

We have a clear policy and do not tolerate, in any form, discrimination, harassment, stereotyping or prejudicial treatment in employment or in running our services, on the grounds of race, nationality, ethnicity, gender, disability, age, marital status, religion, sexual orientation, or any other reason. We will continue to develop a culture of promoting equality and diversity, which means:

- individuals are treated with respect, dignity and made to feel valued
- differences are recognised, valued and respected
- staff should not be disadvantaged because they belong to a particular group
- members of the community should not be disadvantaged because they belong to a particular group in terms of access to services
- actively seeking the needs and views of 'hard to reach' and minority groups.

During 2010/11, the Trust prepared for the implementation of the Equality Act 2010, updating a range of processes including recruitment and selection, ensuring full compliance with the Act.

The Board received reports on three Equality Schemes – Race, Disability, and Gender – during the year. We, along with all specific organisations, are required to:

- eliminate unlawful racial discrimination
- promote equality of opportunity
- promote good race relations between people of different racial groups.

The ethnicity of staff is predominantly white (88.32%), and predominantly female (82.08%). Further data on the profile of our staff and membership is given below:

Age

Staff

	2008/09		2009/10	
Age	**number**	**%**	**number**	**%**
0-16	0		0	
17-21	279	3.84	242	3.34
22+	6969	96.16	7003	96.66
Not stated	0	0	0	0

Members

	2008/09		2009/10	
Age	**number**	**%**	**number**	**%**
0-16	0		45	0.31
17-21	307	2.60	299	2.10
22+	9380	80	8281	57
Not stated	2024	17.28	5763	40

Gender

Staff

	2008/09		2009/10	
Gender	**number**	**%**	**number**	**%**
Male	1292	17.80	1298	17.92
Female	5956	82.20	5947	82.08
Trans-gender	0		0	

Members

	2008/09		2009/10	
Gender	**number**	**%**	**number**	**%**
Male	2929	25	4580	32
Female	8256	70.50	9574	66
Trans-gender	0		0	
Unspecified	532	4.50	234	1.6

Ethnicity

Staff

	2008/09		2009/10	
Ethnicity	**number**	**%**	**number**	**%**
White	6348	87.59	6400	88.32
Mixed	59	0.81	63	0.87
Mixed Asian or Asian British	239	3.31	238	3.27
Black or Black British	100	1.37	106	1.45
Other	502	6.92	438	6.04

Members

	2008/09		2009/10	
Ethnicity	**number**	**%**	**number**	**%**
White	8507	72.6	6968	48
Mixed				
Mixed Asian or Asian British	316	2.7	266	1.8
Black or Black British	108	0.9	93	0.6
Other	504	4.3	39	0.27
Not stated	2276	19.4	7022	48.8

Recorded disability

Staff

	2008/09		2009/10	
Recorded disability	number	%	number	%
	2		3	

Our Equality Schemes are available at www.dbh.nhs.uk and will continue to be updated with the new Equality Act requirements for 2011/12.

The Trust's priorities to further develop work on diversity are to:

- improve recording of information on diversity
- improve reporting of information internally on diversity
- implement a single equality scheme
- improve staff survey results on equality and diversity.

Volunteers

Volunteering continued to be an important part of life at all our hospitals this year. There has been a steady increase in enquiries, with volunteers joining the hospital for many reasons – from enhancing university applications, looking to obtain permanent employment at the Trust, or simply to give something back to patients and staff at their local hospital.

The Trust has also seen an increase in enquiries from a range of local agencies including Re-think, Doncaster Volunteer Bureau, and the Bassetlaw Community & Voluntary Service (BCVS). In addition, the Epileptic Society has launched a new service for Bassetlaw Hospital, where specially-trained volunteers will attend epilepsy clinics to provide information to patients about all aspects of living with epilepsy.

Volunteers work across a range of areas at our hospitals, including with 'help desk' enquiries, escorting patients and visitors, providing companionship to patients on wards, and helping in busy clinics, the coffee shop, library services and relatives' rooms.

Volunteer Vera Cuckson has been volunteering at Doncaster Royal Infirmary for 10 years. She said:

"I look forward to my time volunteering at the Help Desk on a Friday morning, meeting and helping people, and having a laugh every now and again. It has also given me the chance to make new friends. Volunteering at the hospital also makes you realise how lucky you are to be in good health. Volunteering has had a positive impact on my life especially after the death of my husband and I hope to continue for many years to come."

Volunteers have a huge positive impact on the Trust, not only to patients and their families but also in offering a valuable support network to staff.

Would you like to find out more about volunteering? Go to www.dbh.nhs.uk or contact the Voluntary Services Manager on 01302 366666

Financial performance

Monitor has directed that the financial statements of Foundation Trusts shall meet the accounting requirements of the *NHS Foundation Trust Annual Reporting Manual* (FT ARM), which shall be agreed with HM Treasury. Consequently, the financial statements will be prepared in accordance with the 2010/11 FT ARM issued by Monitor. The accounting policies contained in that manual follow International Financial Reporting Standards (IFRS) and HM Treasury's *Financial Reporting Manual* to the extent that they are meaningful and appropriate to NHS foundation trusts. The accounting policies will be applied consistently in dealing with items considered material in relation to the accounts. The accounting policies for pensions and other retirement benefits are set out in note 9 to the accounts and details of senior employees' remuneration are set out in the Remuneration Report in section 5.

The Trust has complied with the cost allocation and charging requirements set out in HM Treasury and Office of Public Sector Information guidance.

Key performance

The Trust had another very successful year in managing its finances, finishing the year with a financial risk rating from Monitor of 3, indicating that there were no regulatory concerns. This was consistent with our view of performance at the start of the year, published in the Annual Plan 2010/11, which was a financial risk rating of 3. Our governance rating was green, also consistent with the Annual Plan.

Monitor's risk ratings have shown steady improvement in governance ratings and continued high performance in finance:

Quarter	Governance	Finance
Q4 2010/11	Green	3
Q3 2010/11	Green	3
Q2 2010/11	Amber-Green	3
Q1 2010/11	Green	3
2009/10	Green	3
2008/2009	Amber	3
2007/2008	Red	4

When assessing financial risk, Monitor looked at four criteria: achievement of plan, underlying performance, financial efficiency, and liquidity. Achievement against each of these criteria is scored from 5 (lowest risk) to 1 (highest risk). A weighted average of these scores is then used to determine the overall financial risk rating which is intended to reflect the likelihood of a financial breach of the Terms of Authorisation.

The Trust's performance against the criteria set out in its Terms of Authorisation, as reported in the annual accounts, was as follows:

Break-even on income and expenditure

There was a requirement for the Trust to contain its expenditure within the level of income resources received. The income and expenditure account was in surplus by £3,242,000 (2009/10 surplus by £1,299,000).

Private patient income cap

There was a requirement to ensure that the proportion of income from patient activities in respect of private patients did not exceed the proportion received as an NHS Trust in the base year, 2002/03. The Trust received 0.2% (2009/10, 0.3%) of its patient-related income from private patients, which was within the restated cap set at 0.5%.

Working capital facility

External finance used for the purposes of working capital must remain within the facility limit set by Monitor of £15m. The Trust has not required any external finance for this purpose during the year. Cash balances held at 31 March 2011 were £23.3m (31 March 2010, £24.3m), a decrease of £1.0m on the previous year.

Prudential Borrowing Limit

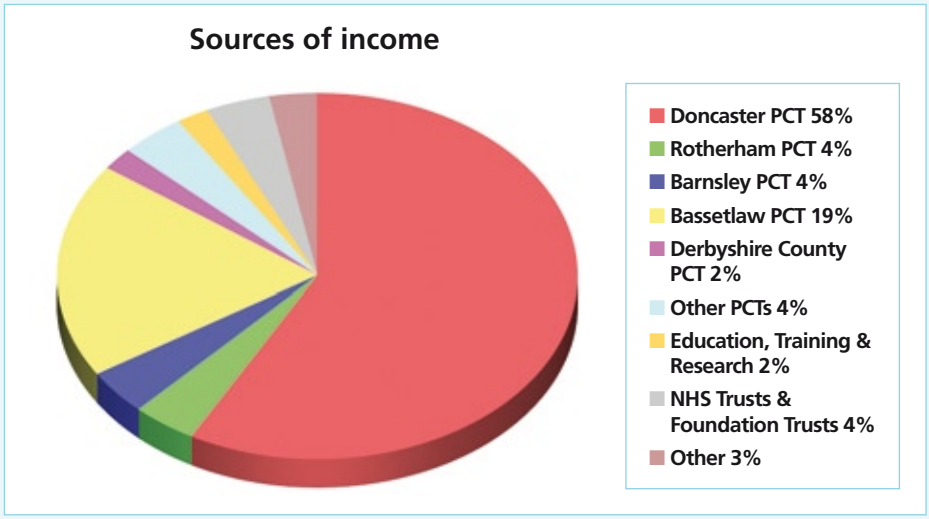
Within the Trust's Terms of Authorisation, a limit on the level of external loans the Trust could take out towards the financing of its capital expenditure was set at £59m as per Monitor's prudential borrowing code. The Trust remained well within the borrowing limits set by Monitor, having loans outstanding at 31 March 2011 of £4.2m (31 March 2010, £4.6m).

Public Dividend Capital (PDC) Dividend

A charge, reflecting the forecast cost of capital utilised by the Trust, was paid over to the Department of Health as PDC dividend; this should be the equivalent of a 3.5% return on average relevant net assets. The Trust was charged a dividend of £4.8m (2009/10, £5.4m), which equates to a 3.5% return.

Income

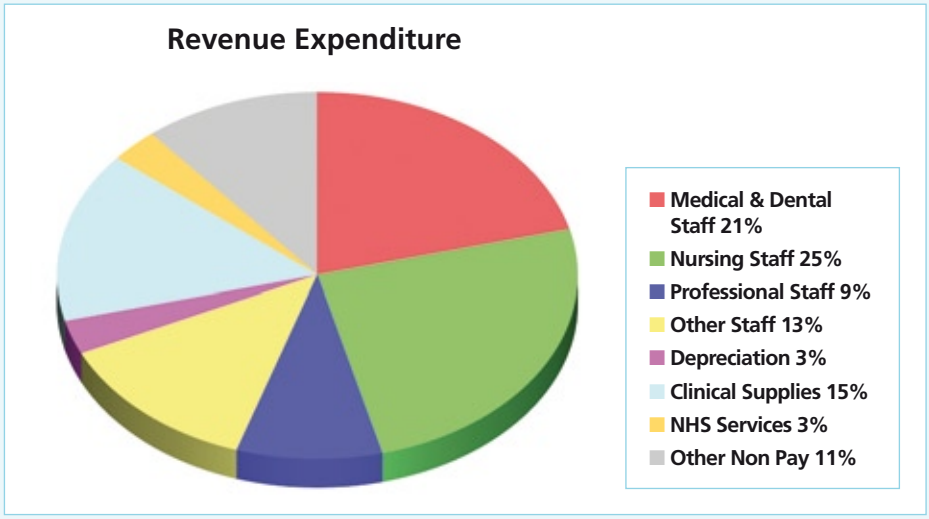
The Trust received £330,178,000 (2009/10, £320,997,000) of income during the year from the following sources:



Included in this is £15,521,000 from providing non-patient care services to other organisations, of which £13,913,000 was received from other NHS bodies. The Trust also generated £8,620,000 of operating income, of which £3,888,000 is income from recharges and £4,332,000 was internally generated. The main sources of this were the catering outlets, car parking charges, day nurseries, and staff accommodation.

Expenditure

The Trust incurred £322,207,000 (2009/10, £310,864,000) of expenditure during the year over the following headings:



Capital expenditure

During the year, the Trust spent £12,994,000 on fixed assets, on the schemes listed below, of which £316,000 were funded by charitable donations and £120,000 by Government grants:

	£000
Maintenance schemes	
Asbestos	172
Computer systems	2181
Disability Discrimination Act	31
Electrical infrastructure	217
Endoscopy	43
Estate investment	701
Fire prevention	111
Health & Safety	122
Improved car parking (DRI/Bassetlaw Hospital)	255
Invest to Save	478
Medical equipment allocation	1559
Medical Imaging (Phased upgrade/replacement)	1450
Capital Team - design time	418
Miscellaneous	676
	8414

	£000
Non-maintenance schemes	
Bariatric services	165
Bassetlaw Breastcare development	86
Discharge lounge	112
Estates strategy	1643
Laparoscopic theatres	874
Medical Assessment Unit redevelopment	81
Medical Imaging (capacity MRI)	1619
	4580
Total capital investment	12,994

The value of fixed assets held at 31 March 2011 can be summarised as follows:

	Protected £000	Unprotected £000	Total £000
Land	18,935	1390	20,325
Buildings and dwellings	128,887	2151	131,038
Equipment		16,749	16,749
Total Tangible Fixed Assets	147,822	20,290	168,112
Software licences		1710	1710
Emissions Trading Scheme Allowances		641	641
Total Fixed Assets	147,822	22,641	170,463

Application of Charitable Funds

Donations to the Trust are managed through its Charitable Fund, a charity registered with the Charity Commission, with the Foundation Trust as the sole corporate trustee. The objects of the charity are for funds to be used 'for any purpose or purposes relating to the National Health Service wholly or mainly for the service provided by Doncaster & Bassetlaw Hospitals NHS Foundation Trust'.

The management of the charitable funds is delegated to the Charitable Funds Sub-committee and Fred & Ann Green Legacy Sub-committee. A number of the Trust's directors are appointed to these committees, which meet at regular intervals throughout the year and are responsible for the management of the investment portfolios and the approval of items of expenditure from funds, in accordance with the Trust's Standing Financial Instructions.

The charity has adopted the policy of purchasing hospital equipment, and funding staff training and education, from donations, legacies, and fund-raising proceeds, through making grants to the Trust. Details of significant activities are contained in the Charitable Funds Annual Report & Accounts, which are available separately from the Trust.

Payment Practice Code

The Trust has adopted the Public Sector Payment Policy, which requires the payment of non-NHS trade creditors in accordance with the CBI prompt payment code and Government accounting rules. The target is to pay these creditors within 30 days of receipt of goods or a valid invoice (whichever is the later) unless other payment terms have been agreed with the supplier.

The Trust's payment performance of paying invoices within 30 days, measured from the invoice date to date of payment without any adjustment for invoices that have been in dispute, is 69% volume (2009/10, 64%) and 72% value (2009/10, 70%).

Independent Auditor

The Trust's independent auditor, PricewaterhouseCoopers (PwC), is appointed by the Board of Governors to undertake regularity audit (adequacy of financial statements, accuracy of annual accounts, etc) and various reviews (including Quality Report assurance) in accordance with a code of practice. In 2010/11, the Trust paid PwC £71,000 (2009/10, £48,000) for these services.

The Trust and PwC have safeguards in place to avoid the possibility that the external auditor's objectivity and independence could be compromised. The Audit & Non-clinical Risk Sub-committee reviews the annual report from the external auditors on the actions they take to comply with professional and regulatory requirements and best practice designed to ensure their independence from the Trust.

The Audit & Non-clinical Risk Sub-committee also reviews the statutory audit, tax, and other services provided by PwC. All engagements with the external auditors over a specified amount require the advance approval of the Board of Governors.

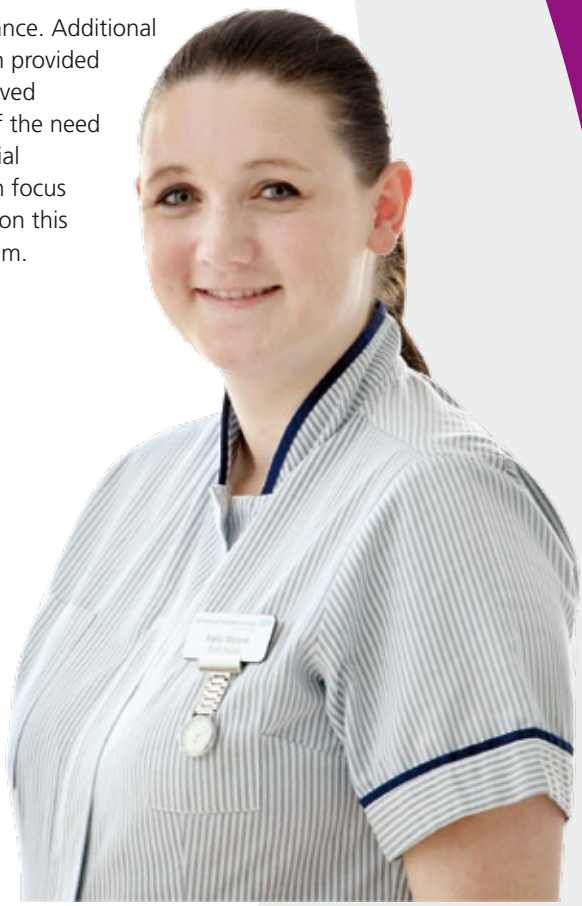
Looking forward to 2011/12

The Trust has set an income and expenditure budget for the new financial year to achieve a surplus of £3.2m with expected income amounting to £323.2m, which will provide sufficient resources to enable it to meet local and national priorities. The Trust must, however, generate savings of £16.1m to achieve its budgeted position.

In addition to this, the Trust also plans to invest £17.6m in its fixed assets, financed through charitable funds, retained surpluses, and internal resources.

The Trust must also successfully manage the following key financial risks:

- delivery of efficiency schemes under the Transformation project. Quarterly 'confirm and challenge' meetings are being introduced to support this. Risk: high
- quality and contract performance/penalties. The NHS standard contract contains inherent risks of key quality targets. Performance management of agreed CSU delivery plans. Risk: medium
- medical staff recruitment and productivity. A significant cost pressure for the Trust remains the use of locum agency and additional sessions at premium rates. Risk: high
- financial governance. Additional training has been provided to support improved understanding of the need for strong financial governance; high focus needs to remain on this area. Risk: medium.



3 PATIENT CARE

Patients are at the heart of everything we do at the Trust, and it's our aim that patients who visit us have the best possible experience. Patients and the public deserve to receive the highest quality healthcare at our hospitals, and our staff provide high-quality care to all patients, where and when they need it, respecting their dignity and individual requirements.

Our foundation trust status means we can provide significant benefits to our patients, as we are a top-performing hospital and so have some extra freedoms. We have greater involvement of local people in developing our hospitals, through foundation trust membership. As we have much more local control, we are able to make decisions much more quickly, and are able to develop services faster by borrowing money where we need to. We can also retain surpluses and use them for future developments.

Performance against key patient targets

The following targets relate to patient care. These targets and Doncaster and Bassetlaw Hospitals' performance against them as at 31 March 2011 are as follows:

Section	Indicator	Description	Target achievement
Health and wellbeing	Access to GUM clinics	Guaranteed access to a GUM clinic within 48 hours of contact is an existing commitment in the 2009/10 NHS Operating Framework	Achieved
	Ethnic coding data quality	Underpins local and national performance on the reduction in health inequalities related to ethnic diversity and the planning of services to reduce barriers to healthcare	Achieved
Clinical Quality	Reperfusion waiting times	The Coronary Heart Disease National Service Framework sets a standard to administer thrombolysis to all eligible patients within one hour of calling for professional help	60-minute call to needle time target achieved
Patient Focus & Access	A&E waiting times	The revised Operating Framework December 2010 reduced this target from 98% to 95% of patients who spend four hours or less in any type of A&E from arrival to admission, transfer or discharge	Monitor target achieved. Achieved CQC target of 11 out of 12 months
	Delayed transfers of care	Measures the impact of community-based services in facilitating timely discharge from hospital, and the mechanism in place to facilitate timely discharge	939 patients had a delayed discharge in 2010/11 (target 959) *Counting methodology changed from last year
	Cancelled operations	Cancelled operations are defined as those that are cancelled on the day of admission or on the day of operation, for non-clinical reasons	713 operations cancelled for non-clinical reasons out of 49,897 planned operations performed (1.43%)
	A two week maximum wait from urgent referral to first outpatient waiting times	All referrals with breast symptoms, regardless of whether cancer is suspected, will be subject to a maximum two week wait, fully implemented by December 2009	Achieved
	Cancer diagnosis to treatment waiting times	No patient should wait longer than one month (31 days) from diagnosis of cancer to the beginning of treatment, except for good clinical reasons. Covers all cancer treatments including second and subsequent treatments, and cancer recurrence	Achieved
	Cancer urgent referral to treatment waiting times	No patient should wait longer than two months (62 days) from GP urgent referral for suspected cancer to beginning of treatment, except for good clinical reasons. Covers both referrals from national screening programmes and from consultants where they request that the patient is managed on a 62-day pathway	Achieved
	Revascularisation times		Not applicable
	Rapid access chest pain waiting times	All patients referred by their GP to a rapid access chest pain clinic should be seen within two weeks. Only applies to those patients whose referral was received within 24 hours of the GP deciding to refer	Achieved

National priority indicators for acute and specialist trusts

Section	Indicator	Description	Target achievement
Health and wellbeing	Smoking during pregnancy, and breastfeeding initiation rates	Smoking during pregnancy is a key determinant of low birth weight	Smoking status of all mothers is recorded. Structured support programme for smokers to reduce smoking through links with Smoking Cessation team
		Significant evidence has shown that breastfeeding is beneficial to both mother and infant	Local target 68%. Trust achieved 64.2%
Clinical Quality	Participation in heart disease audits	To engage all healthcare professionals in systematic evaluation of clinical practice against standards, support and encourage improvement in the quality of treatment and care. There are currently six national cardiac audits for acute and specialist trusts	Achieved
	Engagement in clinical audits	Professional engagement in clinical audit and enabling the local environment to participate in audit activity is necessary to ensure that organisations are embracing the full potential of these methods to inform service delivery	Achieved
	Quality of stroke care	The national Stroke Strategy sets out a quality framework and identifies examples of excellent care to help services make improvements to stroke services	Significant progress implemented on the Stroke Strategy at Doncaster. Plans to roll out to Bassetlaw
	Maternity data Quality	The absence of adequate information on HES restricts the ability to monitor clinical effectiveness and safety of maternity services	HES data is released after the year end. Trust performance against CQC requirements is satisfactory. The implementation of a new system 'Evolution' will provide a quality check of our data
Safety	MRSA Bacteraemias	Trusts are required in 2010/11 to ensure that their agreed 'ceilings' are not exceeded in order to maintain the level of bacteraemias nationally at less than half the number of the baseline year 2003/04	Achieved
	Clostridium difficile infections	Trusts are required to ensure their agreed trajectories are not exceeded	Achieved

Section	Indicator	Description	Target achievement
Patient Focus & Access	18 weeks Referral to treatment waiting times	The Revised Operating Framework 2010 changed the requirement to measure the 18 weeks RTT in terms of maximum acceptable waiting from referral to start of hospital treatment for 90% of admitted and 95% of non-admitted patients. The measurement has changed to the median wait and 95th percentile of waits	All 18 week targets were achieved for 2010/11 including data completeness
	Access to healthcare for people with a learning disability	Trusts are required to collect data to identify people with learning disabilities, and ensure views and interests of this patient group are included in service planning and delivery. The expectation is that 'reasonable adjustments' are made in service delivery to reduce health inequalities	Significant progress is being made. A joint health and social care group is working in collaboration to ensure appropriate processes are in place
	Proportion of patients referred with breast symptoms seen within 2 weeks	The number of patients who are referred with breast symptoms not suspected to be cancer, seen within 2 weeks of referral	Achieved
	Proportion of patients waiting no more than 31 days for second or subsequent cancer treatment (drugs and surgical treatment)	The number of patients who have already been treated for cancer who require a subsequent treatment are treated within 31 days	Not applicable
	Proportion of patients waiting no more than 31 days for second or subsequent cancer treatment (radiotherapy)	The number of patients who have already been treated for cancer who require a subsequent radiotherapy treatment are treated within 31 days	Achieved
	Extended 62 day cancer treatment target - screening	The proportion of patients with suspected cancer detected through screening programmes or by hospital specialist who are upgraded to and wait fewer than 62 days from referral to treatment	Achieved
	Patient experience	The 2010/11 Operating Framework requires each NHS trust to obtain feedback from patients about their experience of care	Achieved
	Staff satisfaction	Improving staff satisfaction is one of the five key areas of the 2010/11 Operating Framework	The results of this year's staff satisfaction survey have shown an improvement

Research & Development

The Trust's Research & Development Department has continued to expand since becoming a stand-alone department in 2009/10, reflecting the importance of research to the wider NHS.

Research has never been more important to the health service: *"Research is vital in providing the new knowledge needed to improve health outcomes and reduce inequalities. It is essential if we are to increase the quality and productivity of the NHS, and to support growth in the economy."* (Department of Health, July 2010).

We are working to use resources more efficiently, and good research finds new ways of preventing and treating illnesses. We take part in many levels of research, from sponsoring trials to participating in multi-centre studies. The team provides support to researchers during the planning, set-up, and delivery phases of research.

During 2010/11, 51 studies were approved, of which 31 have been approved and supported by the Department of Health's National Institute of Health Research. More than 319 participants have been recruited into research studies during this year. There are currently 126 research studies ongoing, including clinical and medical device trials.

Funding is primarily provided through the South Yorkshire Comprehensive Local Research Network (SYCLRN). In 2010/11, the network provided us with an income of £358,728, covering posts in Research Governance, Pharmacy, Pathology, and Medical Imaging. Income provided by the network is based on the Trust's performance, number of studies approved, and number of participants recruited.

In addition, the Trent Stroke Research Network and the Trent Local Children's Research Network provide funding to support staff that carry out research in these areas. Other commercial bodies fund some studies, and have the potential to attract substantial income to the Trust.

In 2010/11, the Research Management & Governance Department merged with the equivalent department at NHS Doncaster to form Doncaster Clinical Research. This joint research office directly aids anyone undertaking research, from making initial applications through to publishing results of completed studies, and solving any issues that may arise during the entire process.

Better communication with our patients

Patient Advice & Liaison Service (PALS)

Patient Advice & Liaison Service staff and volunteers help patients and public who seek advice regarding many aspects of healthcare. PALS is often the first service many people approach when they have comments or concerns about the care they or their family members are receiving.

Whenever possible, PALS staff are able to work with patients and the NHS to resolve concerns quickly and locally. When concerns can't be resolved by PALS, they provide helpful advice on the NHS complaints process and how to access independent advocacy services.

PALS colleagues attend meetings with patients, the public, and clinical staff to assist their understanding of information given and to offer further advice if appropriate. PALS also visit people in their homes if they are unable to attend meetings at the hospital. They may visit to offer advice and guidance or to accompany a member of clinical staff following a complaint or concern that has been investigated. Patients and the public can also contact PALS to feed back their experiences, good and bad, so we can improve the services we offer.

Responding to complaints

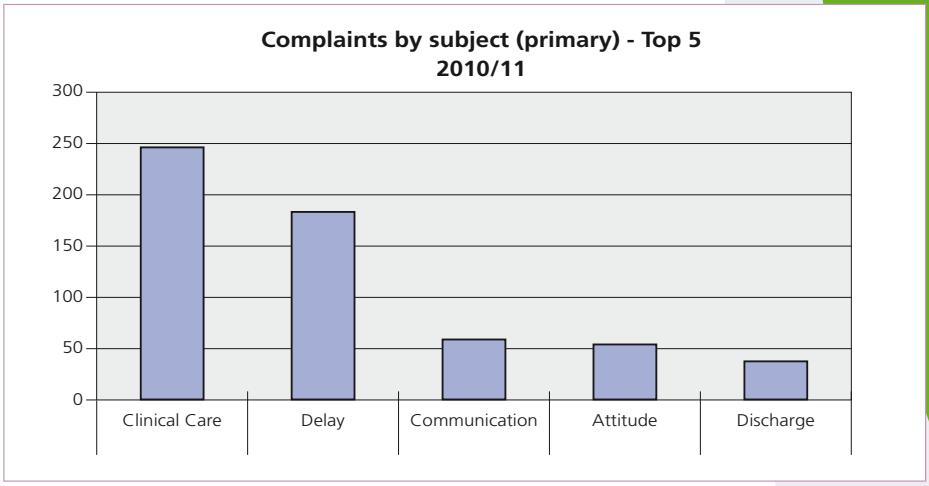
Responding to concerns raised by patients and their families is a critical part of providing an excellent service. When a patient does not receive the high-quality care or efficient service they expect, it's important that we respond quickly and investigate further if required.

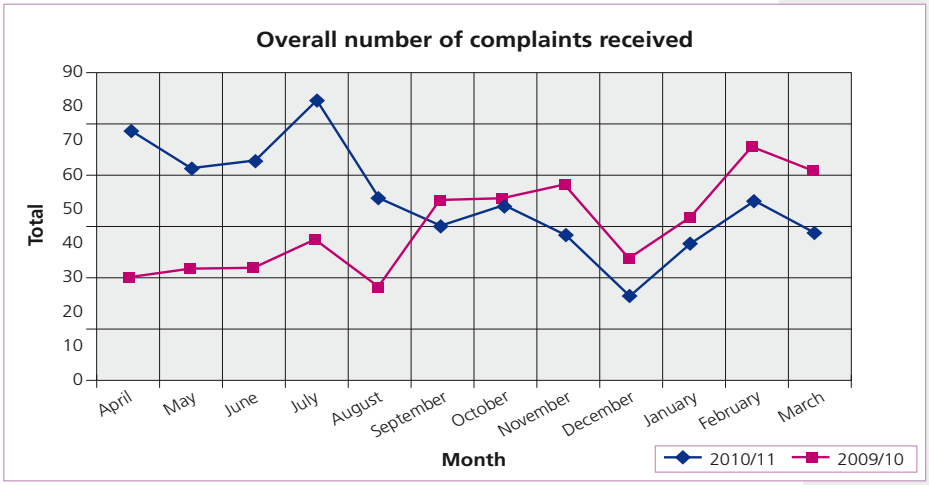
This year, the Trust appointed a Complaints Manager and temporarily increased the number of Complaints Officers to improve the management and response time of complaints. A backlog of existing complaints at the beginning of the year has steadily decreased.

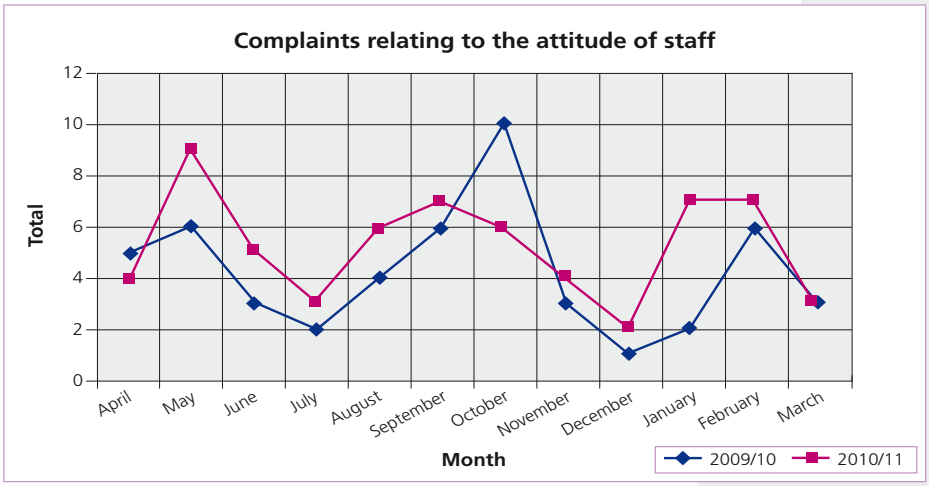
The Trust learns from complaints, comments, and suggestions and is always working to identify ways to make the experience of patients visiting the hospital better. Examples are:

Complaint	Action plan
Patient admitted without own toiletries; the ward could not provide the patient with any	Emergency supply of toiletries purchased
Patient considered that the toilet was too low and required effort, resulting in discomfort, when trying to stand up	Grab rails installed
When the buzzer was pressed for assistance, it was often not answered	Implemented the Productive Ward project to release time to care
Patient left the ward; staff were not aware	Site searched and it was found that the patient had left via a fire exit. Alarms were installed to fire exits located on ground floor level at Bassetlaw Hospital
Lack of signage relating to a viral outbreak on entering a ward	Signage reviewed by Infection Prevention & Control as the existing poster was too large for the entrance

Statistics on complaints received during the year are detailed below:







4 STAKEHOLDER RELATIONS

Improving healthcare through partnerships and alliances

We continued to have strong, positive working relationships with local commissioners and key stakeholders, particularly with NHS Bassetlaw and NHS Doncaster. An effective commissioning and contracting process enabled the Trust to agree contracts for 2010/11 in good time, which gave the Trust a stable position to deliver key financial and non-financial targets. We were involved with the PCTs in discussions on strategic health issues, and were the preferred provider of, or invited to tender for, a range of services. We agreed 'heads of terms' for contracts in 2011/12 in March 2011 and were probably the earliest in the Yorkshire and the Humber region to do so.

A shadow Joint Implementation Executive Board (JIEB) was set up in January 2011 to oversee the development and transformation of the 'one team' approach to deliver a single social care, mental health, and community health approach accessed through a single point of access. The shadow Board became a fully-functioning JIEB in April 2011. Membership was drawn from Doncaster Council's adult and children's services, Rotherham Doncaster & South Humber Healthcare NHS Foundation Trust (RDaSH), Doncaster GP Pathfinder project, and this Trust.

JIEB began work on developing a strategic plan for the future service model from April 2011, overseeing the integration of Doncaster's community services into RDaSH, the successful bidder to provide local community services from April 2011, develop an integrated transformation plan, and ensure full integration of community, social care and mental health services by April 2012.

Details of services for which we tendered, or services where changes were made to improve outcomes for patients, are outlined in section 2.

We are a key partner in Bassetlaw's Local Strategic Partnership, and of Doncaster's Strategic Partnership. We are also a formal member of the Healthy Doncaster Board. The Trust was represented at local Overview & Scrutiny Committees on specific issues. Local authorities are represented as partner governors on the Board of Governors.

Formal mechanisms for stakeholder relations with both NHS Bassetlaw and NHS Doncaster included monthly commissioning forums, regular meetings with general practitioners, joint work, and QIPP (Quality Improvement Productivity Prevention) programme structures.

During the year, the Safeguarding Children and Safeguarding Adults teams were working to full strength. The lead safeguarding staff amalgamated into one team. The aim was to streamline safeguarding activities, including the introduction of joint Safeguarding Forums, delivery of training, audit, and supervision in order to make the best use of resources within the Trust.

From a Safeguarding Children perspective, we contributed to one Serious Case Review in Nottinghamshire and two Lessons Learned Reviews in Doncaster. The progress with the resulting action plans continues. Additionally, the Care Quality Commission and Ofsted carried out a joint inspection of Safeguarding Children social care and partner agency services during March 2011 in Doncaster. While the inspection received an overall adequate rating for Safeguarding Children Services and some very positive practice was observed, there have been identified actions for most agencies involved, including the Trust. We are working as part of the health community to complete the action plans and improve outcomes for children.

With NHS Doncaster and Rotherham Doncaster & South Humber Healthcare NHS Foundation Trust, we began developing a new service for older people with mental health problems, and for younger people with early-onset dementia. Work is led by the Care of Older People, Rehabilitation & End-of-Life Care CSU. It is estimated that, at any one time, the three Doncaster hospitals have 278 older people with a mental health problem (of whom 222 will have diagnosed or undiagnosed dementia) as inpatients. The recommendation is for six RMNs (Registered Mental Health Nurses), 1 wte mental health physiotherapist (in addition to the current service), and a part-time consultant psychiatrist. The CSU will convert funding for one general staff nurse post to an RMN on Ward 25 at DRI as this is the ward with the majority of patients with dementia. The proposal is for one year only to assess the impact on incidents, length of stay, complaints and patient experience.

With the planned demise of primary care trusts, and local consortia of GPs taking on commissioning functions, we set up regular meetings with the emerging commissioning organisations, Bassetlaw Commissioning Organisation (BCO) and Doncaster Health Consortium (DHC). Both are 'pathfinders' so can expect to be in the vanguard of new ways of commissioning from 2012/13. Two part-time associate medical directors were appointed from within our consultant body, Drs Jenny Jessop and Mahmoud Al-Khoffash, with a remit to develop relationships with DHC and BCO, respectively.

Membership

As a Foundation Trust, our members are crucial to the future of the hospital. Members can have a say in the future of the hospital, influence proposed changes and plans, and really be a part of the hospital.

There are three categories of members:

- patient members are individuals who live outside the Trust area and have been patients at any of the Trust's hospitals within the last 10 years
- public members are people who live within the areas covered by Bassetlaw District Council and Doncaster Metropolitan Borough Council
- Trust staff automatically become members unless they decide to 'opt-out'. There are four staff classes:
  - Medical & Dental
  - Nurses & Midwives
  - Other healthcare professionals
  - Non-clinical.

At 31 March 2011, there were 14,282 members. An analysis of our current membership body is provided below:

	Number of members at 31 March 2011
Public Constituency	**6934**
Doncaster	4858
Bassetlaw	2076
Staff Constituency	**6238**
Medical and Dental	728
Nurses and Midwives	1619
Other healthcare professionals	1034
Non-clinical	2857
Patient Constituency	**1110**
TOTAL	**14,282**

Demographic breakdown

Age (years):	Public Constituency	Patient Constituency	Local Population
0-16	0	0	82,218
17-21	140	18	26,154
22+	5055	855	297,539
Unknown	1739	237	
Ethnicity	**Public Constituency**	**Patient Constituency**	**Local Population**
White	4613	756	386,308
Mixed	15	2	2248
Asian or Asian British	48	8	3581
Black or Black British	36	1	1432
Other	16	2	939
Unknown	2206	341	
Socio Economic Groupings	**Public Constituency**	**Patient Constituency**	**Local Population**
ABC1	3863	608	108,528
C2	1272	205	54,116
D	1349	222	64,404
E	449	74	17,467
Unknown	1	1	
Gender	**Public Constituency**	**Patient Constituency**	**Local Population**
Male	2915	476	200,569
Female	3996	633	205,342
Unknown	23	1	

We want to better engage and inform our members, keeping them informed and involved in decision making processes through effective communications.

We would like to grow a representative membership body to over 18,000 members, of which two thirds will be patient or public members, by 2012. We want to better engage and inform our members, keeping them up-to-date and involved in decision making processes through effective communications.

Progress towards recruitment targets

Public Constituency	2010/11	Next year - 2011/12 (estimated)
At year start	7317	6934
New members	456	3566
Members leaving	-839	-500
At year end	6934	10,000

Staff Constituency	2010/11	Next year - 2011/12 (estimated)
At year start	6072	6238
New members	431	0
Members leaving	-265	-238
At year end	6238	6000

Patient Constituency	2010/11	Next year - 2011/12 (estimated)
At year start	946	1110
New members	275	1000
Members leaving	-111	-110
At year end	1110	2000

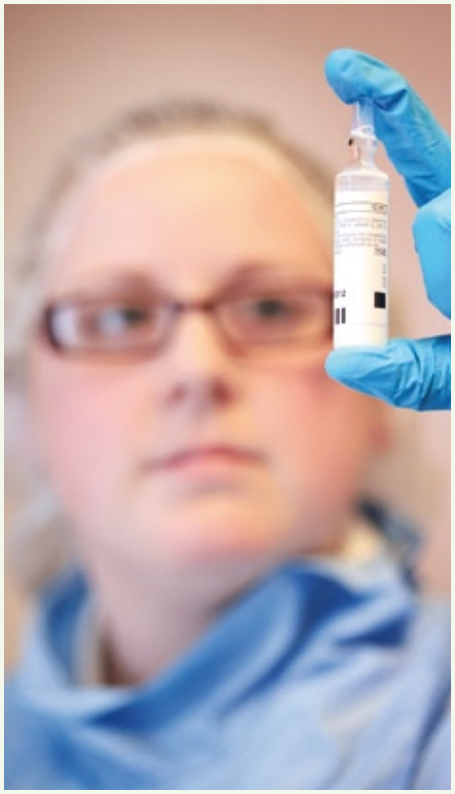
In 2010/11, we consulted members on their priorities for patient experience. It's our aim that patients have the best possible experience when at the Trust, whether they are inpatients, visiting for an appointment, or having an operation.

We surveyed members on how they wished to be involved with the Trust, so we could ensure we are engaging with them in the most targeted and successful way. Our 2010/11 member event was aimed at older people in the local community, and we also attended community events and meetings, including Doncaster and Nottinghamshire County LINk events and a Citizenship Event at Worksop National Fluid Power Centre.

In addition to these events, a large number of members attended our Annual General Meeting, where colleagues from the Trust displayed the benefits of becoming a member.

This year, we continued to improve the quality and amount of our engagement with our members by:

- continuing to communicate and regularly consult the membership on the forward plans of the Trust through the member newsletter, *Foundations for Health*
- improving the way we communicate with our members based on their views received in the last member survey
- sharing the activities of the Trust's governors and increasing their attendance at local community events
- supporting governors to hold further member events on the topics that our members are interested in
- recruiting and engaging with more young members, who are currently under-represented, through governor attendance at community SureStart centres
- promoting governorship through publications and mailings to members and the public, working to ensure contested Governor elections and improve member participation in elections.



5 REMUNERATION REPORT

The membership of the Appointments & Remuneration Sub-committee in 2010/11 consisted of:

Name	Role	Attendance
Chris Scholey	Chairman	2 of 3
Dr Syed Jamal Ahmad	Staff Governor	1 of 3
Joan Beck	Partner Governor	1 of 3
Peter Husselbee	Public Governor, Bassetlaw	3 of 3
John Plant	Public Governor, Doncaster	3 of 3
Alan Sutton	Public Governor, Bassetlaw	2 of 3
George Webb	Public Governor, Doncaster	2 of 3
David Whitham	Partner Governor	0 of 3

The Committee met on three occasions to discuss two non-executive directors' terms of office, and to agree the re-appointment of Joe Barnes and Geraldine Broderick. The Committee did not use open advertising to recruit candidates on this occasion.

The Committee's recommendation to re-appoint Joe Barnes for a further term of office of one year commencing 1 October 2010 was approved by the Board of Governors at its meeting in September 2010. The Committee's recommendation to re-appoint Geraldine Broderick for a further term of office of three years commencing 1 April 2011 was approved by the Board of Governors at its meeting in January 2011.

The Appointments Sub-committee of the Board of Directors, which appoints executive directors, was convened to consider the appointment of David Pratt as Director of Finance, Information & Procurement commencing 7 March 2011. Open advertising was used to recruit.

Membership of the committee consisted of the Chairman, Interim Chief Executive, Deputy Chairman, and Chair of the Audit & Non Clinical Risk Sub-committee. Interviews were held on 16 December 2010, with Paul Briddock, Director of Finance & Contracting, Chesterfield Royal Hospital NHS Foundation Trust, acting as external assessor.

The Appointments Sub-committee of the Board of Directors had also been convened to commence the process of recruiting and appointing a substantive Chief Executive during 2011.

The Trust follows the Department of Health recommendations on pay for very senior managers. As at 31 March 2011, with the exception of executive directors, all senior managers are paid in accordance with Agenda for Change (the national pay evaluation scheme) terms and conditions. There are no plans to change. (The pay scales and clinical excellence awards for medical staff are determined by the Pay Review Body on Doctors' & Dentists' Remuneration). The Interim Chief Executive was recruited on a short-term contract; executive directors have contracts without term, using standard contracts of employment. There are no benefits for directors over and above those available to all staff under Agenda for Change terms and conditions.

There were no terminations of contract during the year. Appraisal processes, employment policies, and terms and conditions of employment are in place to address any performance issues that arise. There is no performance-related pay.

The salaries and pension entitlements of senior managers (interpreted as directors) are as follows:

Remuneration

Name and Title	2010-11			2009-10		
	Salary	Other Remuneration	Benefits in Kind	Salary	Other Remuneration	Benefits in Kind
	(bands of £5000) £000	(bands of £5000) £000	Rounded to the nearest £100	(bands of £5000) £000	(bands of £5000) £000	Rounded to the nearest £100
Chris Scholey - Chairman	40-45			40-45		
Nicola Atkin - Non-executive Director	10-15			5-10		
Joseph Barnes - Non-executive Director	10-15			5-10		
Geraldine Broderick - Non-executive Director (from April 2009)	10-15			5-10		
David Crowe - Non-executive Director (from April 2009)	10-15			5-10		
John Parker – Non-executive Director	10-15					
Dr Peter Reading - Interim Chief Executive (from April 2010)	230-235 (See Note 1)					
Dr Robin Bolton - Medical Director (from April 2010)	165-170	35-40				
Hilary Bond - Director of Nursing & Quality	100-105			100-105		
Joe Brayford - Director of Human Resources	105-110			105-110		

Name and Title	2010-11			2009-10		
	Salary	Other Remuneration	Benefits in Kind	Salary	Other Remuneration	Benefits in Kind
	(bands of £5000) £000	(bands of £5000) £000	Rounded to the nearest £100	(bands of £5000) £000	(bands of £5000) £000	Rounded to the nearest £100
Ian Greenwood - Director of Strategic & Service Development	100-105			100-105		
Dr Emyr Jones - Medical Director (to March 2010)				150-155	35-40	
David Pratt - Director of Finance, Information & Procurement (from March 2011)	5-10					
Lynne Rothwell - Director of Performance	100-105			100-105		
Sandra Taylor - Acting Director of Finance (January - March 2011)	15-20	60-65				
Kevin Turner - Director of Finance & Information (to January 2011)	90-95		200 (See Note 2)	120-125		300 (See Note 2)
Roy Tyson - Director of Facilities & Commercial Development	100-105			100-105		

Note 1 - The Interim Chief Executive's salary was as shown above. He was employed through a third party company with which costs have been incurred of £59,000, plus VAT.

Note 2 - Monetary value of P11D taxable benefit, as assessed by the Inland Revenue, re provision of a car.

Pension benefits

Name and title	Real increase in pension and related lump sum at age 60 - See note 2	Total accrued pension and related lump sum at age 60 at 31 March 2011	Cash Equivalent Transfer Value at 31 March 2011	Cash Equivalent Transfer Value at 31 March 2010	Real Increase/ Decrease (-) in Cash Equivalent Transfer Value - See Note 2	Employers Contribution to Stakeholder Pension
	(bands of £2500)	(bands of £5000) £000	£000	£000	£000	To nearest £100
Nigel Clifton - Chief Executive (to August 2010)	2.5-5.0	305-310	0	1886	N/A	0
Dr Peter Reading - Interim Chief Executive (from April 2010)	See Note 1					
Dr Robin Bolton - Medical Director (from April 2010)	72.5-75.0	315-320	0	N/A	N/A	0
Hilary Bond - Director of Nursing & Quality	5.0-7.5	185-190	920	959	(39)	0
Joe Brayford - Director of Human Resources	5.0-7.5	210-215	1,158	1206	(48)	0
Ian Greenwood - Director of Strategic & Service Development	5.0-7.5	140-145	510	572	(62)	0
David Pratt - Director of Finance, Information & Procurement (from March 2011)	0-2.5	55-60	186	201	(1)	0
Lynne Rothwell - Director of Performance	10.0-12.5	170-175	748	773	(25)	0
Sandra Taylor - Acting Director of Finance (January - March 2011)	0-2.5	70-75	277	257	3	0
Kevin Turner - Director of Finance & Information (to January 2011)	7.5-10.0	195-200	864	892	(22)	0
Roy Tyson - Director of Facilities & Commercial Development	5.0-7.5	210-215	0	N/A	N/A	0

Note 1 - The Trust has made no pension contributions

Note 2 - No inflation factor has been applied in 2010-2011

There are no entries in respect of pensions for non-executive directors as they do not receive pensionable remuneration.

Cash Equivalent Transfer Value (CETV)
The CETV is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's pension payable from the scheme. A CETV is a payment made by a pension scheme, or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme. The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which the disclosure applies. The CETV figures, and from 2004/05 the other pension details, include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS pension scheme. They also include any additional benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost. CETVs are calculated within the guidelines and framework prescribed by the Institute & Faculty of Actuaries.

Real increase in CETV This reflects the increase in CETV effectively funded by the employer. It takes account of the increase in accrued pension due to inflation, contributions paid by the employee (including the value of any benefits transferred from another pension scheme or arrangement) and uses common market valuation factors for the start and end of the period. On 1 October 2008, there was a change in the factors used to calculate CETVs as a result of the Occupational Pension Scheme (Transfer Value Amendment) regulations. These placed responsibility for the calculation method for CETVs (following actuarial advice) on scheme managers or trustees. Further regulations from the Department for Work & Pensions to determine CETV from Public Sector Pension Schemes came into force on 13 October 2008.

In his budget of 22 June 2010, the Chancellor announced that the uprating (annual increase) of public sector pensions would change from the Retail Prices Index (RPI) to the Consumer Prices Index (CPI) with the change expected from April 2011. As a result the Government Actuaries Department undertook a review of all transfer factors. The new CETV factors have been used in the above calculations and are lower than the previous factors we used. As a result, the value of the CETVs for some members has fallen since 31 March 2010.

Dr Peter Reading
Interim Chief Executive
6 June 2011

6 NHS FOUNDATION TRUST CODE OF GOVERNANCE

The Board of Directors is committed to high standards of corporate governance, understanding the importance of transparency, accountability and how the Board's effectiveness impacts on organisational performance.

The Trust has undertaken important work to ensure that its governance procedures are in line with the principles of the Code in 2010/11, including:

- conducting a Board self-evaluation process in July 2010
- continuing to carry out a rolling programme of audits over a three year period to ensure compliance with the provisions of the Code of Governance
- ensuring that the Board membership has an appropriate balance of skills and experience by supporting governors to target specific skills when appointing non-executive directors
- improving the ways in which governors engage with and hold the Board to account by enabling governors to attend the governance sub-committees of the Board and working with governors in 'time out' sessions
- ensuring that all directors and governors receive a comprehensive and tailored induction.

For the year ending 31 March 2011, the Board considers that it was fully compliant with the provisions of the NHS Foundation Trust Code of Governance.

7 BOARD OF GOVERNORS

As a foundation trust, the Board of Governors has responsibility to represent the views and interests of the membership.

The statutory responsibilities of the Board of Governors are as follows:

- appoint or remove the Chairman and the other Non-executive Directors
- approve the appointment of the Chief Executive
- appoint or remove the Trust's auditors
- decide the remuneration and other terms and conditions of the Chairman and the other Non-executive Directors
- receive the NHS foundation trust's annual accounts, any report of the auditor on them and the annual report.

The Board of Governors has undertaken the following responsibilities towards members and other stakeholders:

- promoting membership and governorship of the Trust
- establishing links with the members and stakeholders who elected or appointed them and maintaining these links through effective communication and engagement
- seeking the views of members in order to inform the work of the Board of Governors and the Trust
- representing the interests of the local community, staff, patients and the partner organisations which work with the Trust
- communicating information about the activities and plans of the Trust with the members and stakeholders who elected or appointed them
- raising awareness of developments and service improvements at the Trust among the members and stakeholders who elected or appointed them.

In addition to the responsibilities listed above, the powers of each body, and those delegated to specific officers, are detailed in the Trust's *Reservation of Powers to the Board and Delegation of Powers.*

Would you like more information?

There is more information on the role and responsibilities of the Board of Governors available from the Trust.

Get it here:

- e: foundation.office@dbh.nhs.uk
- t: 0800 169 4857/01302 381355
- a: Trust Board Secretary, Doncaster Royal Infirmary, Armthorpe Road, Doncaster, DN2 5LT.

Understanding the views of governors and members

Executive and non-executive directors attend Board of Governors meetings to offer their knowledge and particular expertise and to listen to the views of governors. The Chairman also chairs the Board of Governors; executive and non-executive directors are not members.

Directors are committed to listening and understanding the views of governors and members and have undertaken the following steps:

- agreed governor observers are invited to attend the Board of Directors
- attendance at governors' quarterly 'time out' sessions
- involvement in the Board of Governors activities
- attendance at some Board of Governors' sub-committee meetings
- accessibility of the Chairman, Deputy Trust Board Secretary, Senior Independent Director, and Membership Office
- governors are invited to sit on groups and committees with directors, including the Organ Donation Committee, and the Fred & Ann Green Legacy Advisory Group
- nominated governor observers are invited to attend the two governance sub-committees of the Board of Directors
- governor participation in unannounced Patient Safety ward visits
- governor sponsorship of wards involved in the Productive Ward programme
- consultation sessions with governors regarding the development of the Trust's strategic direction and quality priorities
- member survey on members' patient experience priorities
- inviting the governors to comment on the performance of the Chairman and Non-executive directors as part of the annual appraisal process
- sharing information, such as Board minutes, Governors' Brief, reports and briefing papers and *Foundations for Health*, the members' newsletter

Members

There are 35 members of the Board of Governors. The patient, public and staff governors are elected by their members for a term of office of three years and are eligible to stand for re-election at the end of that period.

Through community and staff networks, patient, public and staff governors are responsible for representing the views and ideas of their members into the Board of Governors.

Partner governors are appointed by the Trust's partner organisations for a term of office of three years. They speak with authority for the organisation they represent and communicate on topics emerging from the Board of Governors, Board of Directors, and the Foundation Trust.

Elected Governors

- 2 Patient Governors
- 5 Public Governors for the Bassetlaw public constituency
- 13 Public Governors for the Doncaster public constituency
- 6 Staff Governors
  - 1 Staff Governor (Medical & Dental)
  - 1 Staff Governor (Other professionals)
  - 2 Staff Governors (Nurses & Midwives)
  - 2 Staff Governors (Non-clinical).

Appointed Governors

- 1 Governor from NHS Doncaster (formerly Doncaster PCT)
- 1 Governor from NHS Bassetlaw (formerly Bassetlaw PCT)
- 4 Local Authority Governors
  - 2 Doncaster Metropolitan Borough Council
  - 1 Bassetlaw District Council
  - 1 Nottinghamshire County Council

- 1 Governor from Sheffield University
- 1 Governor from Sheffield Hallam University
- 1 Governor from Doncaster and Bassetlaw CVS.

Elections to the Board of Governors

During the year ending 31 March 2011, elections were held for governor seats in both the Patient constituency and Staff constituency.

Governor seats up for election (to commence in post 17.10.10)	Number of Candidates standing	Voting turnout
2 Patient	0	n/a
2 Staff (Nurses & Midwives)	2	uncontested

Meetings

Board of Governors meetings are held in public and advertised to the community in the local press. They are held quarterly, at locations rotating across Bassetlaw, Doncaster and Mexborough.

During the year ending 31 March 2011, there were four Board of Governors meetings:

- 13 April 2010 in Doncaster
- 29 June 2010 in Worksop
- 28 September 2010 in Mexborough (AGM and Board of Governors)
- 26 January 2011 in Worksop.

All meetings were quorate with executive and non-executive directors in attendance.

Members of the Board of Governors, and attendance at Board of Governors meetings

Governor	Constituency	Attendance
John Bradshaw	Public - Doncaster (to 17.12.10)	3 out of 3
Nic Davison	Public - Doncaster	3 out of 4
Eddie Dobbs	Public - Doncaster	4 out of 4
Eddie Durdy	Public - Doncaster	1 out of 4
Ronald Hughes	Public - Doncaster	4 out of 4
Peter Husselbee	Public - Bassetlaw	3 out of 4
Rosalind Marsh	Public - Bassetlaw	4 out of 4
Lynne McWhinnie	Public - Doncaster	4 out of 4
Susan Overend	Public - Bassetlaw	4 out of 4
John Plant	Public - Doncaster	4 out of 4
Dennis Shaw	Public - Doncaster	4 out of 4
Mike Smith	Public - Bassetlaw	3 out of 4
Alan Sutton	Public - Bassetlaw	4 out of 4
Howard Taylor	Public - Doncaster	1 out of 4
Dave Trickett	Public - Doncaster	3 out of 4
George Webb	Public - Doncaster (Vice Chair and Lead Governor)	4 out of 4
John Weston	Public - Doncaster	3 out of 4
Maureen Young	Public - Doncaster	4 out of 4
vacancy	Public - Doncaster (from 18.12.10)	n/a
vacancy	Patient	n/a
vacancy	Patient	n/a

Governor	Constituency	Staff class	Attendance
Dr Jamal Ahmad	Staff	Medical and Dental	2 out of 4
Jane Barber	Staff	Other Professionals	4 out of 4
Lynn Hunt	Staff	Nurses and Midwives (from 17.10.10)	1 out of 1
Debbie McKnight	Staff	Nurses and Midwives (to 16.10.10)	3 out of 3
Adam Sanders	Staff	Non-Clinical	3 out of 4
Sharon Smithson	Staff	Nurses and Midwives (from 17.10.10)	1 out of 1
Roy Underwood	Staff	Non-Clinical	3 out of 4
vacancy	Staff	Nurses and Midwives (to 16.10.10)	n/a

Governor	Partner Organisation	Attendance
Dr Oliver Bandmann	Sheffield University	2 out of 4
Joan Beck	Doncaster MBC	2 out of 4
Elaine Brookes	Sheffield Hallam University	4 out of 4
Jon Cooke	NHS Doncaster (PCT)	3 out of 4
Debra Fores	NHS Bassetlaw (PCT)	2 out of 4
Dick Hassett	Bassetlaw & Doncaster CVS	3 out of 4
Cllr Barbara Hoyle	Doncaster MBC (to 01.10.10)	3 out of 3
Cllr Christine Mills	Doncaster MBC (from 02.10.10)	1 out of 1
Cllr Chris Wanless	Bassetlaw District Council	3 out of 4
David Whitham	Nottinghamshire County Council (to 31.12.10)	2 out of 3
vacancy	Nottinghamshire County Council (from 01.01.11)	n/a

Directors are in attendance at Board of Governors meetings to listen to Governors' views and to brief and advise governors on issues relating to the business of the Trust.

Director	Role	Attendance
Chris Scholey	Chairman	4 out of 4
Peter Reading	Interim Chief Executive	4 out of 4
Nicola Atkin	Non-executive Director	3 out of 4
Joe Barnes	Non-executive Director	3 out of 4
Dr Robin Bolton	Medical Director	3 out of 4
Hilary Bond	Director of Nursing & Quality	1 out of 4
Joe Brayford	Director of Human Resources	2 out of 4
Geraldine Broderick	Non-executive Director	4 out of 4
David Crowe	Non-executive Director	3 out of 4
John Parker	Non-executive Director	3 out of 4
Kevin Turner	Director of Finance & Information	3 out of 3

The Trust can specifically confirm that there are no material conflicts of interest in the Board of Governors.

Company directorships and Register of Interests of the Board of Governors

All Governors are required to declare their interests on taking up appointment and as appropriate at quarterly Board of Governors meetings in order to keep the register up-to-date.

The Trust can specifically confirm that there are no material conflicts of interest in the Board of Governors.

The register of Governors' interests is available via the contact details below:

- e: foundation.office@dbh.nhs.uk
- t: 0800 169 4857/01302 381355
- a: Trust Board Secretary, Doncaster Royal Infirmary, Armthorpe Road, Doncaster, DN2 5LT

Members wishing to contact governors or directors should contact the Trust Board secretary, details above.

John Bradshaw

We were saddened to learn of the sudden death of John Bradshaw, Doncaster Public Governor, in December 2010.

John was an active and constructive governor, who was always willing to give his time and effort to benefit the Trust and his constituency members. He chaired the Communication, Engagement & Membership Sub-committee of the Board of Governors and was a member of the Trust's Equality & Diversity Group.

He was highly respected by Trust staff and fellow governors, and will be remembered with great affection.

8 BOARD OF DIRECTORS

This section sets out the composition of the Board of Directors:

Name	Position	Term of office	Term of office from	Attendance
Chris Scholey	Chairman	4 years	1 January 2009	12 out of 12
Nicola Atkin	Non-executive Director	2 years	1 November 2009*	10 out of 12
Joe Barnes	Non-executive Director (Deputy Chairman, Senior Independent Director)	1 year	1 October 2010*	9 out of 12
Geraldine Broderick	Non-executive Director	2 years	1 April 2009	12 out of 12
David Crowe	Non-executive Director	3 years	1 April 2009	12 out of 12
John Parker	Non-executive Director	3 years	1 April 2010	11 out of 12
Peter Reading	Interim Chief Executive			12 out of 12
Dr Robin Bolton	Medical Director			11 out of 12
Hilary Bond	Director of Nursing & Quality			10 out of 12
Joe Brayford	Director of Human Resources			12 out of 12
Kevin Turner	Director of Finance & Information (to 5 January 2011)			10 out of 10
Sandra Taylor	Acting Director of Finance & Information (6 January to 6 March 2011)			2 out of 2

* Extension of previous term of office

The following also attended meetings of the Board of Directors:

Ian Greenwood	Director of Strategic & Service Development
Lynne Rothwell	Director of Performance
Roy Tyson	Director of Estates & Commercial Development (to 31 December 2010)

David Pratt, Director of Finance, Information & Procurement, joined the Board on 7 March 2011.

The Board is responsible for operational management, including strategic and capital development, service performance, Trust-wide policies, and risk assurance and governance. The Board of Directors also sets the strategic direction of the Trust, taking account of the views of the Board of Governors.

Although the Board remains accountable for all its functions, the implementation of Trust policies, plans and procedures is delegated to Trust managers. The Board receives information to monitor overall performance.

All non-executive directors (NEDs) are considered to be independent, meeting the criteria for independence as laid out in *The NHS Foundation Trust Code of Governance.*

Non-executive directors, including the Chairman, are appointed and may be removed by the Board of Governors. The Board of Governors delegates the recruitment and selection of candidates to its Appointments & Remuneration Sub-committee.

During 2010/11, the committee conducted an appointments process and re-appointed two non-executive directors:

- Geraldine Broderick for a term of three years commencing 1 April 2011
- Joe Barnes for a term of one year commencing 1 October 2010

The Chairman conducts performance appraisals of non-executive directors, and, in turn, NEDs, led by the Senior Independent Director, conduct the performance appraisal of the Chairman. The Board of Governors determines the objectives of the Chairman and NEDs, and governors feed into the appraisal process by providing commentary regarding the performance of the Chairman and NEDs. The performance review of executive directors is carried out by the Chief Executive.

Non-executive directors are appointed to bring particular skills to the Board, ensuring the balance, completeness and appropriateness of the Board membership. The skill mix of the Board was considered by the Appointments & Remuneration Sub-committee of the Board of Governors during 2010/11, as part of the non-executive director appointments process.

The Board conducted a follow-up self-evaluation of its performance in July 2010, which included an appraisal of governance processes, procedures, behaviours, culture and effectiveness. An action plan which resulted from this review was implemented, monitored by the Board. The performance, membership and Terms of Reference of the sub-committees of the Board of Directors are also subject to annual review.

Members of the Board of Directors can be contacted via the Trust Board Secretary:

- e: foundation.office@dbh.nhs.uk
- t: 0800 169 4857/01302 381355
- a:Trust Board Secretary, Doncaster Royal Infirmary, Armthorpe Road, Doncaster, DN2 5LT.

Biographies of directors who served during 2010/11

Chris Scholey became Chairman in January 2009. Previously Managing Director of Renaissance South Yorkshire, he was UK Sales & Marketing Director then UK Managing Director of Rexam Glass from 1988 to 2005. Chris lives in Dinnington and has a physics degree from Liverpool.

Nicola Atkin is Senior Manager at Charter Mark Assessment Services and part-time tutor for the Open University. She was educated at Doncaster High School for Girls, then graduated from London University. She has an MA in Education from the Open University and has taught in schools in London, United Arab Emirates and Nottinghamshire. Nicola was appointed for her experience in corporate governance and business strategy and lives in Doncaster.

Joe Barnes was recently Head of Pensions, Network Rail Ltd, a post he held since 2001. Other key posts included Deputy Chief Executive, Coal Pension Trustees Services Ltd (CPT); Head of Investment Monitoring, Audit and Contracts, CPT; Manager, Corporate Finance, British Coal Corporation (BCC); Senior Auditor rising to Principal Auditor, BCC; and Pensions Administrator rising to Head of Systems, BCC Pensions. He was appointed for his expertise in corporate finance and lives in Doncaster.

Geraldine Broderick was Managing Director for three companies of the Barlow Group from 1997 to 2001 and was responsible for combining the eight companies into one from 2001 to 2005. Geraldine now runs Leah & Broderick Associates, a management consultancy specialising in interim management and business turnaround. Geraldine lives in Everton, near Bawtry, and has resided in the area for nearly 20 years.

David Crowe has a background in human resources management and has worked in a variety of industries, most recently as HR Director for Benhamgoodheadprint. From 2000 to 2006, he was HR Director of the UK's largest independent print group, Polestar, working across 10 main sites and five satellite units. David lives in Carlton-in-Lindrick, near Worksop.

John Parker is a Senior Lecturer in Finance and Accounting at Sheffield Hallam University Business School - a position he has held since September 2005. John worked as Finance Director for the British Geological Survey between January and September 2005, taking overall responsibility for the financial and management accounts of an £80m business. John has also worked for HM Inland Revenue, progressing from position of Inspector of Taxes in 1988 to Deputy Director of Learning, holding overall responsibility for financial training within the Inland Revenue until 2004. He has been appointed for a three-year term of office and brings with him finance and accountancy expertise. John lives in Saxilby, Lincoln.

Dr Peter Reading joined the Trust on 6 April 2010 as Interim Chief Executive for up to a year (extended to oversee the recruitment and appointment of a new chief executive). Since 2007, Peter has been running his own strategic consulting company. Before that, he was Chief Executive of University Hospitals of Leicester NHS Trust from 2000-2007, of University College London from 1998-2000, and of Lewisham & Guy's Mental Health NHS Trust from 1988-98. Peter joined the NHS in 1984 as a national management trainee at Guy's Hospital and the King's Fund College. He has a first degree in economics and history and a PhD in Russian economic history.

Dr Robin Bolton was educated in Blackburn and at Cambridge University, and attended Oxford University Medical School. He has worked at the Trust as Consultant Physician with a special interest in Gastroenterology since March 1988, and was Clinical Director for Medicine for nine years until 2007. He was appointed as Deputy Medical Director-Professional Standards in September 2008. Previously, Dr Bolton worked as a lecturer at St James' University Hospital, Leeds, and during his career he has had the opportunity to teach advanced endoscopy skills and lecture at hospitals in China and Thailand.

Hilary Bond started her nursing career at University College, London, where she was awarded Registered General Nurse. She qualified in midwifery at the Jessop Hospital for Women, Sheffield, and worked there until 1990. She was appointed Assistant Director of Midwifery at Bassetlaw Hospital and went on to further posts in midwifery management at Bassetlaw Hospital before being appointed Deputy Director of Nursing, then Director of Nursing & Quality.

Joe Brayford worked for Barnsley Health Authority from 1972, moving to Barnsley General Hospital as Hospital Personnel Officer in 1978, and to Doncaster Health Authority as Deputy Director of Personnel Services in 1983. Joe was promoted to Director of Personnel in 1987, and then joined the Trust as Director of Human Resources when it first came into being in 1991. He is a Fellow of the Chartered Institute of Personnel and Development.

David Pratt took up his appointment as the Trust's new Director of Finance, Information & Procurement in March 2011. David began his NHS career in 1989 as a Graduate Trainee in Financial Management working in Harrogate and at Dewsbury District Hospital. After qualification, he worked in North East Lincolnshire NHS Trust then University College London Hospitals NHS Trust, where he led financial management and reporting, contracting with PCTs and budget setting in one of the largest and most complex NHS organisations. He joined us from Ealing Hospital NHS Trust where he had been Director of Finance.

Kevin Turner began his career in the NHS as a Finance Trainee in 1979 at Doncaster Health Authority and worked in a number of finance posts, including Director of Finance at Lincolnshire Health Authority and North East Lincolnshire NHS Trust. Kevin joined the Trust in May 2008 after working as Director of Finance, Information and Performance at the North Lincolnshire & Goole Hospitals NHS Foundation Trust. Kevin is a member of the Chartered Institute of Public Finance & Accountancy and completed the NHS Strategic Financial Leadership Programme in 2007. Kevin left the Trust in January 2011.

Register of Directors' Interests

All Board members are required to declare their interests on taking up appointment and as appropriate at monthly Board meetings in order to keep the register up-to-date. The Trust can specifically confirm that there are no material conflicts of interest in the Board.

The Trust can confirm that the Chairman does not have any other significant commitments, and that there has been no change to this position during the year.

The register of Directors' interests is available from the Trust Board Secretary:

- e: foundation.office@dbh.nhs.uk
- t: 0800 169 4857/01302 381355
- a:Trust Board Secretary, Doncaster Royal Infirmary, Armthorpe Road, Doncaster, DN2 5LT

9 AUDIT & NON-CLINICAL RISK COMMITTEE

The Committee's remit is to make sure that effective internal controls and systems are in place, and ensure compliance with law, guidance and codes of conduct. The Committee has three members – all non-executive directors, excluding the Chairman. One member has recent and relevant financial experience. Membership and attendance at meetings are listed in the Appendix.

The Committee:

- ensured that the Trust's activities and expenditure are within the law and regulations governing NHS Foundation Trusts
- ensured that effective internal control and systems are established and maintained, including Financial Controls Assurance Statements
- ensured value for money
- reviewed the standard of financial reporting
- approved both internal and external audit plans each year and associated costs
- evaluated the extent to which the Internal Audit Service complies with the mandatory audit standard and agreed performance measures
- received an executive summary of internal audits and annual report
- received the External Auditor's opinion on the financial statements of the Trust
- received the External Auditor's Annual Audit Plan and Report to those charged with governance
- reviewed proposed changes to Standing Orders and Standing Financial Instructions and examined the circumstances when Standing Orders are waived
- reviewed schedules of losses and compensations and made recommendations to the Board of Directors
- ensured that the standards of business conducted by and for the Board, and the Trust in general, protect the public purse and ensure probity.

The Board of Governors approved the Audit Committee's recommendation to appoint PricewaterhouseCoopers (PwC) as external auditor for a three-year period from 2009/10. External auditors review the accuracy of the Annual Accounts and may carry out various reviews (including value for money) in accordance with the Audit Code for NHS Foundation Trusts, published by Monitor.

Directors made the auditors aware of all the information that they require to carry out their audit responsibilities in accordance with the Audit Code. The Committee seeks to ensure that the Trust's activities and expenditure are within the law and regulations governing NHS foundation trusts.

Membership of the Audit & Non-clinical Risk Committee as at 31 March 2011 is in the Appendix.

10 ADDITIONAL & PUBLIC INTEREST DISCLOSURES

Preparation of accounts

Monitor has directed that the financial statements of NHS foundation trusts shall meet the accounting requirements of the *NHS Foundation Trust Annual Reporting Manual*, which shall be agreed with HM Treasury. Consequently, the financial statements will be prepared in accordance with the *2010/11 NHS Foundation Trust Annual Reporting Manual* issued by Monitor. The accounting policies contained in that manual follow International Financial Reporting Standards (IFRS) and HM Treasury's *Financial Reporting Manual* to the extent that they are meaningful and appropriate to NHS foundation trusts. The accounting policies have been applied consistently in dealing with items considered material in relation to the accounts.

Going concern

After making enquiries, the directors are satisfied that the Trust has adequate resources to continue in operational existence for the foreseeable future. For this reason, they continue to adopt the going concern basis in preparing the accounts.

Company directorships and other significant interests held by directors or governors

Directors and governors declared no company directorships that may conflict with their management responsibilities. The Register of Directors' Interests and the Register of Governors' Interests are available on request from the Deputy Trust Board Secretary, at Doncaster Royal Infirmary. Other interests are listed in sections 7 and 8.

Political/charitable donations

The Trust made no political or charitable donations during the year.

Audit statement by directors

As far as directors were aware, there was no relevant audit information of which the auditors are unaware. Directors took all necessary steps to make themselves aware of any relevant audit information and to establish that the auditors were aware of this information.

Public interest disclosures

Doncaster & Bassetlaw Hospitals NHS Foundation Trust became one of the first 10 NHS foundation trusts on 1 April 2004. Our foundation trust status means we can shape our health services around local needs and priorities.

NHS foundation trusts were set up as independent bodies, free from central Government control with directors and clinicians deciding which services to develop or retract, and improve. We can retain the financial surpluses we generate or borrow money for investments and are committed to establishing strong connections with our local communities by offering membership to local people and through governors and the Board of Governors. NHS foundation trusts remain providers of healthcare according to core NHS principles: free care at the point of delivery, based on need and not the ability to pay. An independent regulator, Monitor, assessed our application for NHS foundation trust status and makes sure we live up to our obligations.

Our services are provided on five hospital sites, and throughout the community, including in local prisons. The population served is sufficiently large to offer a broad range of clinical services in three hospitals owned by the Trust: Bassetlaw Hospital, Doncaster Royal Infirmary, and Montagu Hospital. Outpatient services are provided at Retford Hospital and the Vermuyden Centre, Thorne, and rehabilitation services for elderly people at Tickhill Road Hospital, owned by NHS Bassetlaw, Doncaster PCT and Rotherham Doncaster & South Humber Healthcare NHS Foundation Trust respectively.

The history of each hospital shows a commitment to local healthcare:

- Bassetlaw Hospital, Worksop, celebrated 100 years of service on the Kilton Hill site in 2002
- Doncaster Royal Infirmary's life began in 1792 in the town centre, moving to the Armthorpe Road site in 1930. New buildings were added in 1969 (East Ward block), 1989 (Children's Hospital), and, in 1994, new theatres and hospital unit, leased to the independent sector
- Montagu Hospital, Mexborough, also began in a town centre location in 1890. It moved to the current site, with a major expansion, in 1904, and celebrated the centenary in our first year as a foundation trust. A further major redevelopment was completed in the 1990s.

The Trust also provides services in community locations, particularly physiotherapy, midwifery, and nutrition and dietetics.

The Trust had 234 active Approved Policy Documents (APDs) (at 31 March 2011), which underpin clinical and non-clinical practice and support good practice in all spheres across the Trust. A rolling review of all policies is done by a policy review group that meets monthly.

During the year, 19 new and 65 revised policies were issued, and three policies were withdrawn. Efforts were made to tackle the number of policies that were overdue for review.

The Joint Staffs Consultative Committee (JSCC) is an active staff side forum for informing staff representatives and employees, and for consultation with staff. These arrangements with the JSCC help to discharge the Trust's duty on information to and consultation with staff. Notes of the meetings are circulated to ward and CSU/corporate directorate managers, for onward cascade.

During 2010/11, the JSCC was consulted on the Trust's financial prospects and the Transformation programme (section 2). A commitment was made that the Staff Side would be briefed regularly by executives on its work and on progress. Key decisions during the year, on which the unions were consulted, were the closure of the Trust's two nurseries and the closure of the laundry/boiler house at Bassetlaw Hospital. Closure of the Doncaster laundry was also on the agenda but action deferred pending the outcome of the national agreement on outsourcing.

So staffing costs were subject to difficult decisions to be made about the size and shape of the workforce. Union representatives attended many Transformation staff forums and were invited to attend manager's briefings.

Improvements were made to informing and consulting with staff: the monthly Staff Brief process began with a manager's briefing that was accessible to more staff by videoconference at the three main hospital sites. Plans were in place to record the Interim Chief Executive's presentation to be put on the intranet and so available to more staff.

Staff were informed of developments to services – and misinformation countered – through a series of Fact Sheets and face-to-face meetings with the Interim Chief Executive.

The monthly Trust's Medical Committee (TMC) is open to all consultants for information exchange. In addition to the TMC, there is a formal negotiating committee for consultants (the Local Negotiating Committee), which meets bi-monthly.

The Trust has a duty of care to staff and the Health & Wellbeing steering group was re-launched with a series of Health & Wellbeing days held at the three main hospital sites.

The Trust employed a Local Counter Fraud Specialist (LCFS), who ensured compliance with best practice in countering fraud. The topic was publicised through the local media, staff publications, the LCFS website, and roadshows.

The Trust has adopted the Public Sector Payment Policy, which requires the payment of non-NHS trade creditors in accordance with the CBI prompt payment code and Government accounting rules. The target is to pay these creditors within 30 days of receipt of goods or a valid invoice (whichever is the latter) unless other payment terms have been agreed with the supplier (see section 2).

Patient & Public Involvement Forums were dissolved on 31 March 2008 following the establishment of Local Involvement Networks (LINks). A number of governors have links with LINks, and the Board of Governors considered ways of a more formal relationship between LINks and NHS foundation trusts (April 2011).

We attend the local Overview & Scrutiny Committees run by local authorities on request to discuss any health-related matters on which members wish to be briefed.

Sickness absence is reported quarterly to the Board. The latest report shows that sickness absence figures for 2010/11 are listed below. Every effort is made to reduce these figures. The NHS average is 5%. Each clinical and corporate area where the sickness rate was above 5% was asked to review sickness procedures and ensure that the Trust's policy for managing sickness absence is applied correctly. The target for 2009/10 was 4.5%, reduced to 4% in 2010/11.

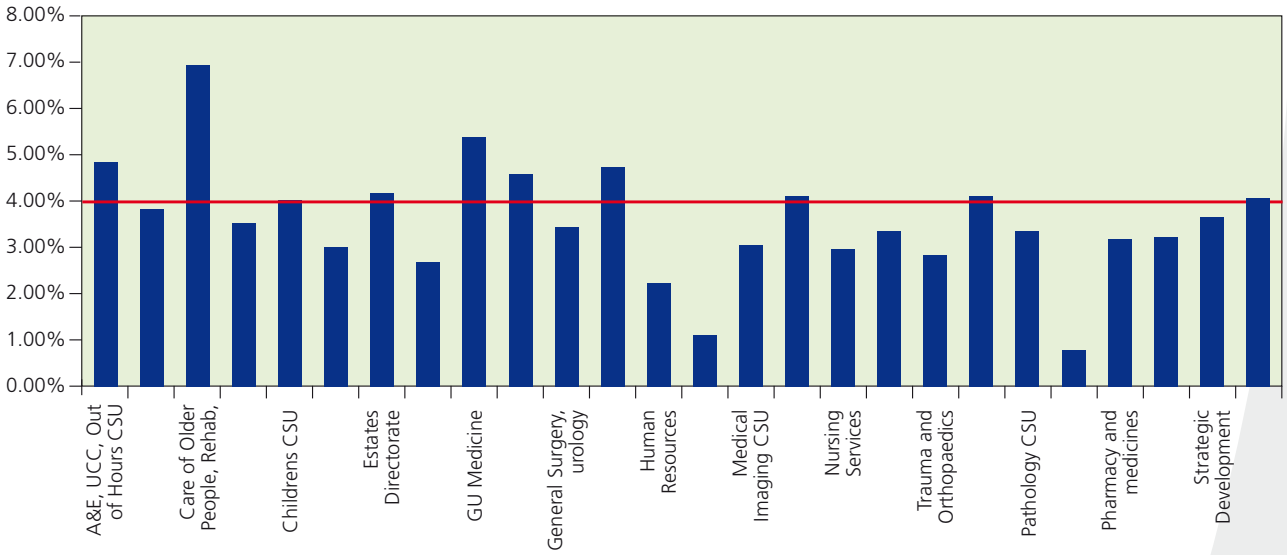
Sickness absence

Quarter 1 2010/11 to Quarter 4 2010/11

CSU/Directorate	Q1 2010/11	Q2 2010/11	Q3 2010/11	Q4 2010/11	Cumulative % Abs Rate	Headcount
	% Abs Rate	% Abs Rate	% Abs Rate	% Abs Rate		
A&E, UCC, Out of Hours CSU	4.05%	5.03%	5.82%	4.70%	4.90%	199
Anaesthetics, Critical Care and Pain Management CSU	3.94%	3.30%	3.87%	4.29%	3.85%	283
Care of Older people, Rehab, End of Life Care CSU	5.89%	6.73%	8.35%	6.85%	6.97%	180
Chief Executive's office	7.61%	4.33%	1.26%	0.37%	3.53%	12
Children's CSU	3.64%	3.24%	4.26%	5.35%	4.07%	244
Clinical Therapies CSU	2.67%	2.81%	3.77%	2.86%	3.03%	416
Estates Directorate	5.74%	5.24%	3.49%	2.19%	4.20%	162
Finance & Information Directorate	2.21%	3.31%	2.32%	3.02%	2.71%	188
GU Medicine	6.21%	7.96%	5.07%	2.26%	5.42%	59
General & Acute Medicine CSU	4.37%	3.96%	4.98%	5.16%	4.60%	645
General Surgery, Urology CSU	2.84%	2.81%	4.04%	4.12%	3.44%	324
Hotel Services Directorate	4.82%	4.84%	4.84%	4.57%	4.77%	839
Human Resources Directorate	2.50%	1.98%	3.02%	1.55%	2.28%	115
Medical Director Directorate	0.14%	1.18%	1.41%	1.74%	1.13%	20
Medical Imaging CSU	3.85%	2.82%	2.37%	3.16%	3.05%	211
Medical Specialty Federation CSU	4.75%	3.51%	3.56%	4.61%	4.11%	272
Nursing Services Directorate	2.39%	2.32%	2.47%	4.70%	3.01%	82
Women's & Maternity CSU	2.81%	3.32%	3.43%	3.96%	3.37%	366
Trauma & Orthopaedics CSU	2.78%	2.48%	3.21%	2.93%	2.84%	245
Outpatients and Admin CSU	2.28%	2.58%	5.06%	4.42%	4.11%	454
Pathology CSU	3.18%	2.70%	4.12%	3.51%	3.37%	213
Performance Management Directorate	0.00%	3.05%	0.00%	0.00%	0.81%	14
Pharmacy & Medicines Management CSU	2.78%	3.07%	4.48%	2.37%	3.18%	129
Head and Neck, ENT & Ophthalmology CSU	2.67%	2.81%	3.53%	3.45%	3.11%	201
Strategic & Service Development Directorate	0.09%	2.06%	5.66%	5.75%	3.68%	19
Theatres, Day Surgery and Endoscopy CSU	3.55%	3.48%	4.03%	5.36%	4.10%	331
Totals	3.67%	3.61%	4.16%	4.13%	3.89%	**6223**

Key ■ Over 4% ■ 3.75% - 4% ■ Below 3.75%

Sickness absence by CSU Q1 2010-11 to Q4 2010-11 (Cumulative)



Dr Peter Reading
Interim Chief Executive
6 June 2011

11 QUALITY REPORT

Index

Key

Indicates the direction of travel/performance for 2010/2011

= Performance achieved or exceeded trajectory for 2010/11

= Performance improved but not achieved trajectory/performance for 2010/11

= Performance not achieved trajectory

Chief Executive's Statement

Throughout this year, I have been proud to witness the ongoing commitment and enthusiasm within this Trust for improving the quality of our services and ensuring that our patients have a good experience when they attend our hospitals. The Board has focused a large proportion of its time on quality, looking at the things that really matter to our patients – safe services, high levels of patient satisfaction, and improved clinical outcomes.

We have achieved considerable improvement in many of the areas that we identified as our priorities for 2010/11, and it is this progress on which we are reporting this year. In order to build on this work and further improve the quality of our services, we have also identified several priorities and objectives for 2011/12.

We have involved our governors and members in determining our ambitions for the year ahead, and have worked hard to ensure that we take on board our patients' views because we believe it is important that patients and the public, who are at the heart of our hospitals, have a say in what we do.

We have developed systems which enable us to survey patients about their experiences in all clinical areas and departments every month. As well as providing the basis for action by individual departments, this information is reported to the Board of Directors, to help determine our priorities and ensure we focus on the things that really matter to our patients.

One of our objectives was to reduce the number of patients who develop a blood clot (Venous Thromboembolism or VTE) within 28 days of inpatient hospital treatment. In order to do this, we need to ensure that all inpatients are assessed to see whether they are at risk of VTE. Following concerted effort by our clinical staff, we achieved this for over 90% of our patients.

We made significant progress in the prevention and control of healthcare-associated infections. The Trust had a single case of MRSA bloodstream infection in April 2010 so for 11 months there were no infections. (As I write, there has been one case in April 2011). This is an achievement of which our staff can be extremely proud. Despite experiencing challenging times over the winter period, we achieved a year end position of 1 case of MRSA and 67 cases of *C difficile*.

We have also signed up to NHS Quest, an exclusive group of 12 NHS trusts that has pledged to achieve a level of excellence in quality and safety beyond current expectations. Our hospitals have always had quality at the top of the agenda, but being part of NHS Quest means that we will be pushing the boundaries even further.

We recognise there are areas where we have further work to do. Whilst we have significantly reduced the number of patients who suffer from grade four pressure ulcers, reducing the number of grade three pressure ulcers remain a high priority for the year ahead.

We have made experience of patients with dementia and their carers a high priority for the coming year and expect to show improved care planning, communication and involvement of carers through our focus on staff training.

Finally, I'd like to thank and congratulate all our staff for their achievements over the past year and their ongoing work to improve the quality of our services for patients. There will always be areas for improvement, and we will continue to strive for the highest quality in all care we provide and put our patients at the heart of everything we do.

To the best of my knowledge the information contained within this report is accurate.

Dr Peter Reading
Interim Chief Executive
6 June 2011

Priorities for improvement 2011/12

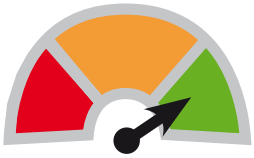
When identifying priorities for quality improvement in 2009/10, our doctors, nurses, managers and directors all agreed that the areas where most benefit for patients could be gained were not one-year-long initiatives. Therefore, many of our priorities since 2008/09, including the current reporting period (2010/11) and for the forthcoming year, continue. In the year 2011/12, we plan to focus on creating harm-free wards, particularly reducing falls, pressure ulcers, infections associated with urinary catheters, and hospital-acquired Venous Thromboembolism. We will focus on ensuring appropriate discharge from hospital for our patients thus reducing the need for readmission. We will continue to focus on reducing deaths that may have been preventable.

The Board of Directors will receive monthly reports relating to our quality objectives covering all three aspects of quality: safety, effectiveness and experience.

For 2011/12, these are:

		Trajectory
Patient Safety	Take a zero tolerance approach to 'never events'	0
	Reduce the number of healthcare-associated infections ■ MRSA	5
	■ *Clostridium difficile*	57
	■ MSSA (Methicillin Sensitive *Staphylococcus Aureus*)	Surveillance only
	■ *E Coli* (from June)	Surveillance only
	Reduce the number of patient falls causing harm	40% reduction
	Reduce the number of hospital-acquired pressure ulcers	30% reduction in Category 3 and Ungradeable pressure ulcers Zero tolerance of Category 4 pressure ulcers
Clinical Effectiveness	Reduce the number of deaths which may have been preventable ■ focus on the acutely-ill deteriorating patient	To continue to work towards the HSMR ratio of 80 within five years as agreed and started in 2009/10
	Embed implementation of Venous Thromboembolism guidelines and further extend Board monitoring of the prescribing of prophylaxis (preventive measures) for high-risk patients	90% of patients to have VTE risk assessments completed 100% of high-risk patients to receive prophylaxis
	Monitor the appropriateness of urinary catheter usage	90% of patients have appropriate use of catheter
Patient Experience	Improving patient experience which will be monitored using real-time electronic technology	Maintain improvements in relation to patient experience
	Reduce the number of patients and carers who have the quality of their hospital experience effected by the attitude of staff	25% reduction
	Increase awareness of dementia throughout the organisation	90% of clinical staff have undertaken dementia awareness training
	Assess carers'/family needs for all patients on End of Life care pathway	80% of care needs have been assessed

Achievements against Quality Improvement Priorities 2010/2011

Priority 1:	**Patient Safety**	
Take a zero tolerance approach to 'Never events'		
Aim: Stop all harmful clinical events that must never happen (never events)		
Rationale: These are largely preventable patient safety incidents that should not occur if preventative measures have been implemented within the Trust		
2009/2010	4 reported incidents	
2010/2011	0 reported incidents	
Progress, Monitoring & Reporting	To implement processes to prevent such never events from occurring. The number of never events occurring will quantify the effectiveness of these measures	

Never events as defined by National Patient Safety Agency (NPSA)

- Wrong site surgery
- Retained instruments post procedure
- Wrong route administration of chemotherapy
- Misplaced nasogastric or orogastric tube not detected prior to use
- Maternal death from post partum haemorrhage after elective caesarean section
- IV administration of concentrated potassium chloride
- Inpatient suicides using non-collapsible rails.

Never events are defined as "serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented by healthcare providers".

In 2009/10, there were four never events within the organisation. These events prompted actions across our hospitals in order to further minimise the risk or reoccurrence. These actions included raising awareness of the occurrence of never events, training where necessary, and use of additional checklists for theatres. We are proud to report that this organisation did not have any 'never events' during 2010/11.

Priority 1:	Patient Safety

Take a zero tolerance approach to 'Never events'

The National Patient Safety Agency has increased the list of Never events for 2011/12:

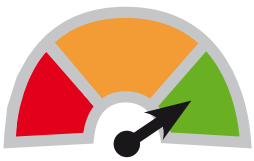
- Wrong site surgery
- Wrong implant/prosthesis
- Retained foreign object post-operation
- Wrongly prepared high-risk injectable medication
- Maladministration of potassium-containing solutions
- Wrong route administration of chemotherapy
- Wrong route administration of oral/enteral treatment
- Intravenous administration of epidural medication
- Maladministration of Insulin
- Overdose of midazolam during conscious sedation
- Opioid overdose of an opioid-naïve patient
- Inappropriate administration of daily oral methotrexate
- Suicide using non-collapsible rails
- Escape of a transferred prisoner
- Falls from unrestricted windows
- Entrapment in bedrails
- Transfusion of ABO-incompatible blood components
- Transplantation of ABO or HLA-incompatible organs
- Misplaced naso- or oro-gastric tubes
- Wrong gas administered
- Failure to monitor and respond to oxygen saturation
- Air embolism
- Misidentification of patients
- Severe scalding of patients
- Maternal death due to post partum haemorrhage after elective Caesarean section.

Priority 2:	Patient Safety

Reduce the number of Healthcare-associated Infections

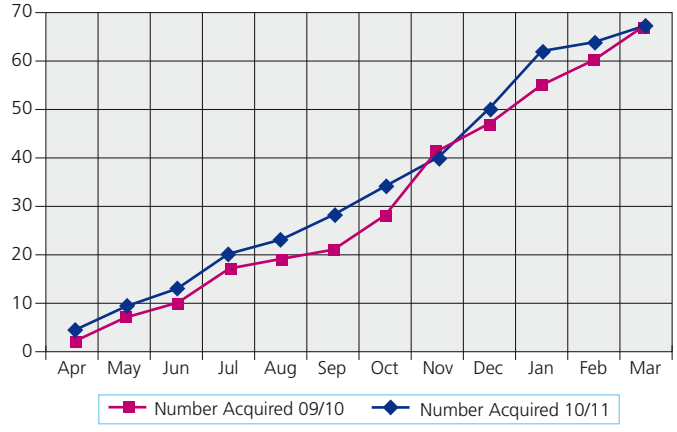
Aim: To reduce levels of hospital-acquired MRSA* bacteraemia and *C diff***

Rationale: The Trust wishes to ensure the safest possible care for patients. National priority within the Operating Framework 2010/2011

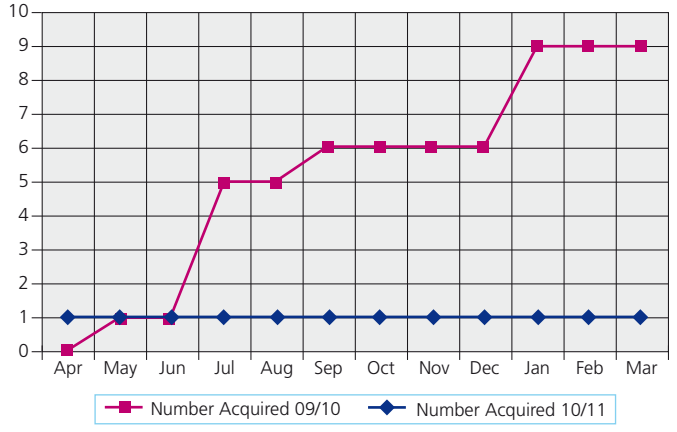
	MRSA*	*C Diff***
		
2009/2010	12	67
2010/2011	1	67
2011/2012 Ceiling	5	57
Progress, Monitoring & Reporting	A series of dashboards have been developed to ensure standards and trajectories are monitored and maintained	

* *MRSA* - Methicillin-resistant *Staphylococcus aureus* ** *C diff* - *Clostridium difficile*

Reduce the number of patients acquiring *Clostridium Difficile* Infections



MRSA - Post 48hrs attributable to Doncaster and Bassetlaw Hospitals NHS Foundation Trust

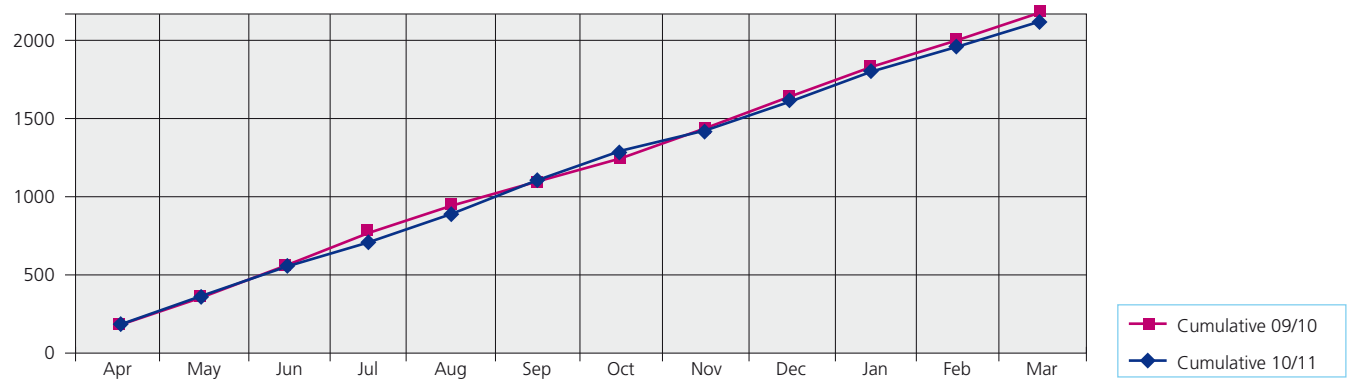


Healthcare-associated infections, such as MRSA and *Clostridium difficile*, continue to be national patient safety issues and remain within the Operating Framework for the NHS 2011/12 as one of the main priorities. This organisation is delighted that we have had only one case of MRSA bacteraemia in 2010/11, which was in April 2010.

The Trust's success with a further reduction in *C diff* has been more challenging. A thorough review of all cases of *C diff* is carried out to determine whether all appropriate treatment/care had been provided to those patients with the aim of prevention of future cases. We have a number of strategic actions and will be working with community healthcare partners to reduce antibiotic prescribing.

Priority 3:	Patient Safety	
Reduce the number of patient falls		
Aim: To reduce the number of patient falls in hospital by 5%		
Rationale: To prevent injury to our patients		
2009/2010	**2162**	
2010/2011	**2114** This is a 2.3% reduction, based on the number reported in 2009/2010	
2011/2012	**Baseline for 2010/11** There were 101 moderate and severe fractures recorded for this period. Aim to reduce the number of patients who sustain injury from falls (fractures) by 40%	
Progress, Monitoring & Reporting	■ review trends relating to incidents reported ■ audit of falls assessments for all admitted patients over 60 years of age ■ monthly report to the Board of Directors	

Reduce the number of patient falls in hospitals by 5%



Patient safety incidents relating to falls account for almost one third of all patient safety incidents reported by acute trusts (NPSA 2007). This Trust recognises the importance of fall prevention strategies and will continue to have a reduction in patient falls as a priority for ongoing improvement. We set ourselves a target of a 5% reduction for this year. Although 39 fewer patients had falls in 2010/11, we did not achieve the 5% reduction. Our priorities for 2011/12 will focus on monitoring the falls assessment of patients when they are admitted to hospital and reduction in falls causing harm (fractures).

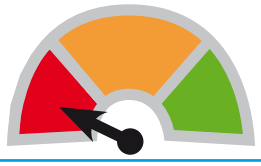
Priority 4:	Patient Safety

Reduce the number of Hospital-acquired Pressure Ulcers

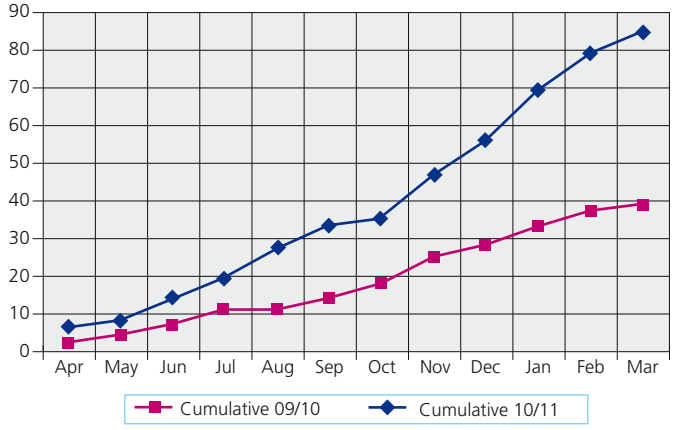
Category 3 & Category 4

Aim: To reduce the number of hospital acquired category 3 & category 4 pressure ulcers

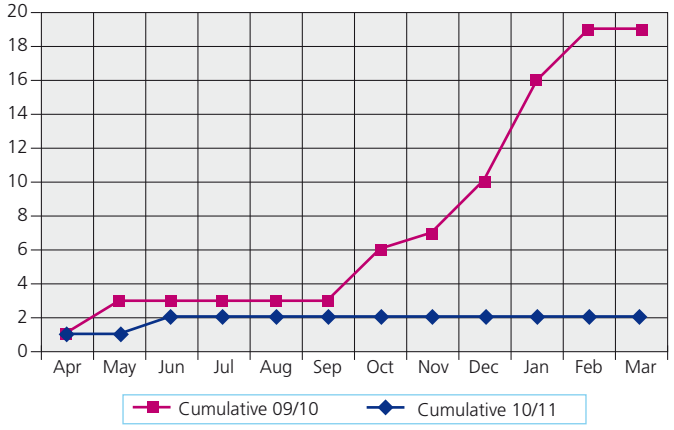
Rationale: To prevent injury to our patients relating to hospital acquired pressure ulcers, our Trust has adopted a zero tolerance approach

	Grade 3/Ungradeables	Grade 4
		
2009/2010	**39**	**19**
2010/2011	**85**	**2**
2011/2012	■ 30% reduction in Category 3/Ungradeable pressure ulcers ■ zero tolerance of Category 4 pressure ulcers	
Progress, Monitoring & Reporting	■ review trends relating to incidents reported ■ regular monitoring of improvement plans ■ monthly report to the Board of Directors	

Reduce number of patients acquiring Ungradeable & Category 3 Pressure Ulcers whilst an inpatient



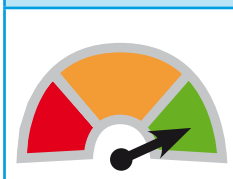
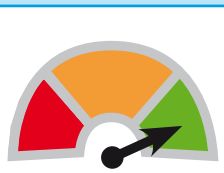
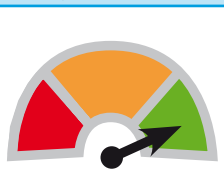
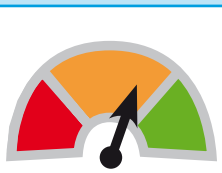
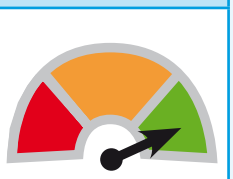
Reduce number of patients acquiring Category 4 Pressure Ulcers whilst an inpatient



A Tissue Viability Task Force was established in January 2010, from which a ward-based educational programme was developed. The programme has a competency-based focus. The nursing notes of patients who develop a hospital-acquired pressure ulcer of ungradeable, category 3, or category 4 are audited using the Essence of Care Audit tool and the results are fed back via an accountability process.

The launch of the term 'ungradeable' pressure ulcer in 2009 by the European Pressure Ulcer Advisory Panel has caused inconsistencies in the way in which ungradeable pressure ulcers are recorded. To date, there is no national consensus on how to report ungradeable pressure ulcers. The Trust took the decision to include ungradeable along with the category 3 pressure ulcers. The total number of confirmed category 3 pressure ulcers for 2010/11 is four.

The Trust has made significant progress in the reduction in the severity of pressure ulcers: the actual number of category 4 pressure ulcers was two in 2010/11.

Priority 5:	Patient Safety				
Trigger Incidents					
Aim: To increase staff awareness of the need to report serious incidents to support the objective of no avoidable deaths and no avoidable harm to patients					
Rationale: Comparison of data in 2009/10 with national benchmarks identified low level of reporting 'known complications'. This led to a focus on staff reporting 'Trigger Incidents' to raise awareness and enable a review of each case to identify areas for learning, improvement, and recognition of good practice					
	Non-planned returns to theatre	Unexpected death	Unexpected damage to tissue, organ or nerve during procedure	Unexpected admission to Critical Care	Significant blood loss resulting in unexpected blood transfusions
					
2009/2010	**13**	**6**	**19**	**3**	**4**
2010/2011	**54**	**13**	**21**	**3**	**5**
2011/2012	Awareness has been raised regarding the need to use standard adverse incident report forms for these incidents. This indicator will not be carried forward to 2011/12 but monitoring will be maintained				
Progress, Monitoring & Reporting	■ review trends relating to monthly reported incidents ■ regular monitoring of improvement plans ■ monthly report to the Board of Directors				

In 2010/11, an analysis of complaints and litigation claims for the previous three years revealed recurring themes relating to the five areas above.

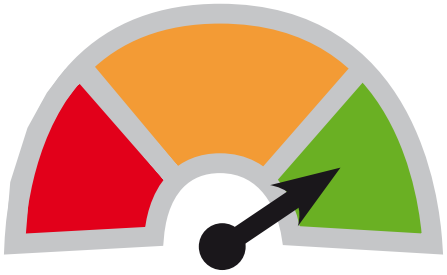
When this analysis was compared to incidents reported in relation to the same five areas, it became evident that the reporting process was not robust.

Therefore, additional awareness-raising throughout the Trust was implemented. Special incident reporting forms (internally these were named 'trigger forms') were put in use with the specific aim of improving incident reporting.

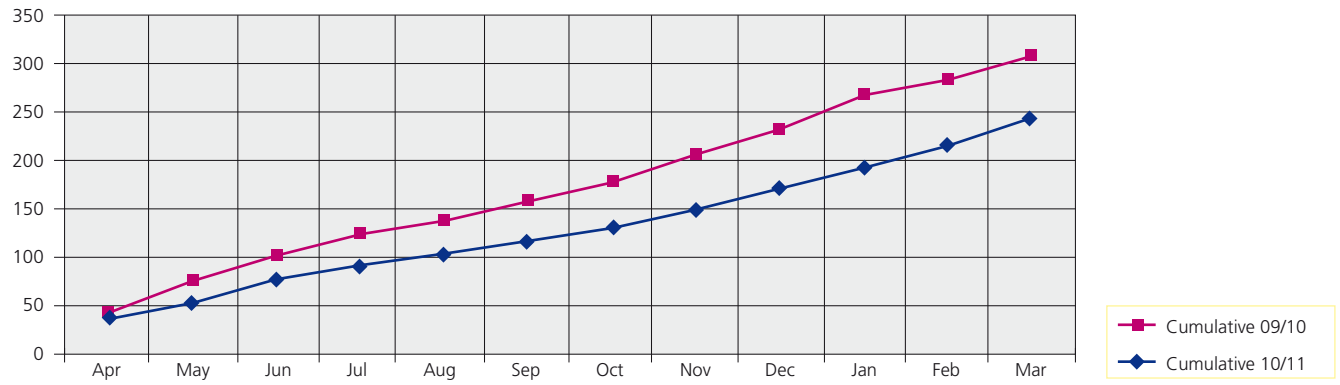
This did have the desired effect, as identified within the table above.

Following the improved awareness of the requirement to report these incidents, the use of specific trigger forms has ceased. These incidents are now being reported via the usual incident reporting mechanism.

Priority 6:	Clinical Effectiveness
To reduce the number of deaths which may have been preventable	
Aim: Focus on identification and management of deteriorating acutely ill patients	
Rationale: The Trust wishes to ensure the safest possible care for patients and we aim to have a year-on-year reduction in cardiac arrests	
2009/2010	**307**
2010/2011	**221***
2011/2012	For 2011/12, although total cardiac arrest numbers will still be reported, the focus will be on identifying possibly preventable cardiac arrest and reducing those with the adoption of a zero tolerance approach A Trust-wide drive on ensuring compliance with the 'Do not attempt resuscitation' policy is also underway
Progress, Monitoring & Reporting	■ continue to focus on identification and early intervention for the deteriorating acutely ill patients, ie early warning scores and observation chart audits ■ during 2011, the SBAR** communication tool will be rolled out across the Trust to support this ■ monitor cardiac arrests ■ monthly reporting to Board of Directors



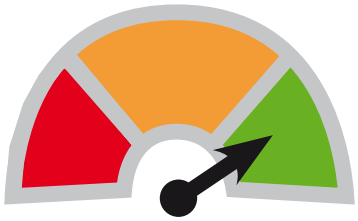
Cardiac Arrests



By addressing the failure to recognise the acutely ill deteriorating patient, preventable cardiac arrests continue to reduce. It is acknowledged that many cardiac arrests are unpreventable (eg some patients who attend Accident & Emergency Departments in a critically-ill condition) and therefore cardiac arrests will always continue to occur.

*From this year, the Trust has not reported patients who attend A&E
** SBAR – Situation, Background, Assessment, Recommendation

Priority 7:	Clinical Effectiveness
Accessible information to support mortality review	
Aim: Implement system for continuous review of HSMR* *(Hospital Standardised Mortality Ratio)*	
Rationale: This system will support achievement of priority 5 – To have no avoidable deaths and no avoidable harm to patients	
2009/2010	**107**
2010/2011	**93**
2011/2012	To continue to work towards the ratio of 80 within five years as agreed and started in 2009/10
Progress, Monitoring & Reporting	■ continue to review HSMR utilising Trust policy ■ overseen by Review of Mortality Group ■ monthly reporting to the Board of Directors



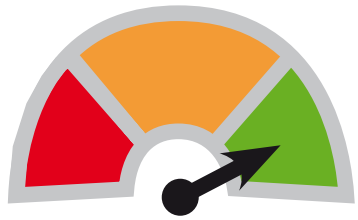
Monitoring HSMR* on a monthly basis enables the Trust to identify areas where the death rate may be higher than expected for specific conditions, thus facilitating the review of cases where there is a possibility that the death may have been avoided. The Trust's mortality review group assesses all these cases where the Dr Foster** system identified possible anomalies.

* HSMR is an overall quality indicator and measurement tool that compares our hospitals' mortality rates with the overall average rate. It has been used by many hospitals worldwide to assess and analyse mortality rates and to identify areas for improvement. The HSMR is calculated as the ratio of the actual number of deaths to the expected number of deaths among hospital patients. It is adjusted for other factors affecting mortality, such as age, sex, and length of hospital stay.

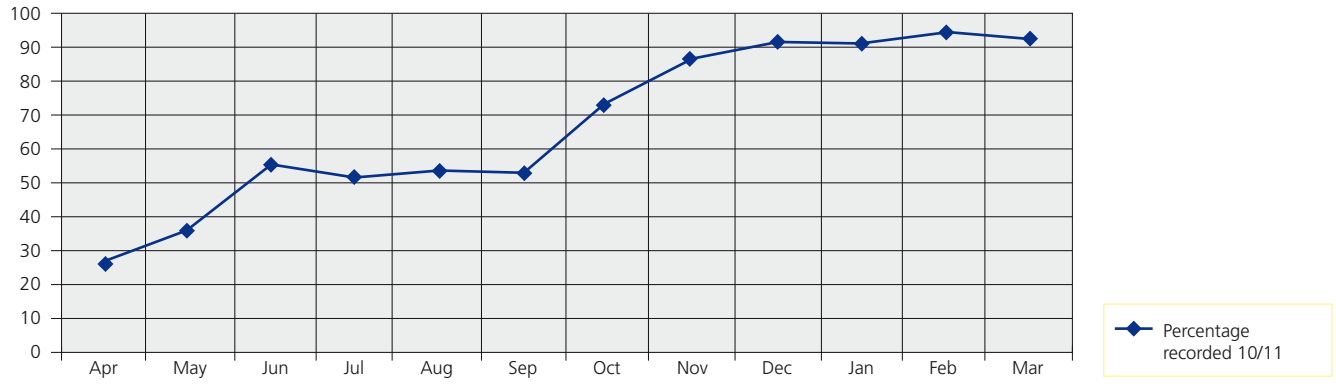
** Dr Foster Intelligence Real Time Monitoring (RTM) alerts trusts of areas where there has been a statistically significant high mortality rate. It does so using a relative risk rating that is drawn from analysing actual mortality rates against expected and national benchmarking.

HSMR is due to be replaced by the Standardised Hospital Mortality Index (SHMI) from April 2011.

Priority 8:	Clinical Effectiveness
Embed implementation of Venous Thromboembolism (VTE) guidelines	
Aim: To reduce the number of patients who develop a VTE (blood clot) within 28 days of inpatient hospital treatment	
Rationale: The Trust is aware that it has significant room for improvement relating to VTE risk assessment to comply with recommendations in NICE guidance 2010 and this is also one of the national priorities within the CQUIN Framework	
2009/2010	■ 15% of all eligible patients had a documented risk assessment ■ 71% of all eligible patients received Thromboprophylaxis* (types of prevention)
2010/2011	See graph below
Progress, Monitoring & Reporting	■ use a taskforce approach to VTE risk assessment ■ collect monthly data to monitor and ensure compliance ■ link with National CQUIN Framework ■ monthly speciality reports ■ monthly reporting to the Board of Directors ■ monthly audits for patients who were assessed as high risk



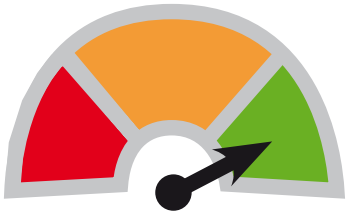
VTE Risk Assessments



Ensuring patients have a risk assessment relating to the possibility of developing a healthcare-related thrombosis/embolism has been a priority of the Trust for the past three years. In 2010/11, this also became a national priority, with the introduction of a CQUIN indicator (Commissioning for Quality & Innovation). The Trust is delighted with the improvement in being able to evidence that patients have had a VTE risk assessment.

* Preventative treatment for blood clotting.

Priority 9:	Clinical Effectiveness
Achieve optimal nutritional and hydration for patients	
Aim: Optimising the nutritional care of patients	
Rationale: To ensure that our patients' dietary needs are met so they recover as quickly as possible. The Board of Governors identified this as a priority for quality improvement. This is also part of the CQUIN Framework	
2010/2011	Percentage of patients underwent nutritional screening on admission – 95% Percentage of patients underwent nutritional screening on discharge – 96% Percentage of patients assessed as 'high' nutritional risk with appropriate referrals/ continuing care plans in place – 100%
Progress, Monitoring & Reporting	■ develop electronic systems for MUST data capture ■ robust nutritional screening and care processes on all adult wards ■ regular review of improvement plans ■ monthly report to Board of Directors



Since September 2010, 1162 patients have been surveyed across the Trust. Four questions were put to each patient, which mirror those posed in the National Inpatient Survey. However, as one of the questions deals not with quality but subjective opinion ("Could you suggest changes to the menu") this has been eliminated from the results, which were as follows:

Q1 Did the patient enjoy their meal: Yes 94% No 6%
Q2 Did the patient get the meal they wanted: Yes 94% No 6%
Q3 Were there enough Healthy Eating Choices: Yes 97% No 3%

It is worthy of note that, when interviewed on their views, many patients who did not enjoy their meal (Q1) were the same patients who did not get the meal they wanted (Q2). Reasons for this ranged from human error on the part of hospital staff but, more commonly, because patients were in no position to order their own food as they were undergoing or recovering from surgical procedures or because they were admitted shortly before the meal service so had no opportunity to choose.

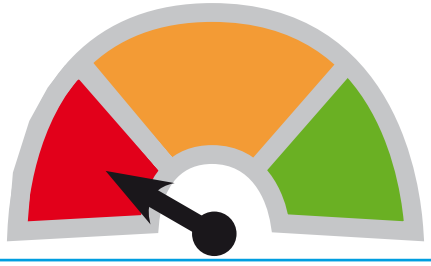
PATIENT ENVIRONMENT ACTION TEAM ASSESSMENTS (PEAT) 2011

The PEAT results 2011 for environment, food, and privacy and dignity for each hospital within our Trust are in the table below:

Site Name	Environment Score		Food Score		Privacy & Dignity Score	
	2010	2011	2010	2011	2010	2011
Bassetlaw Hospital	Good	Good	Good	Excellent	Good	Good
Doncaster Royal Infirmary	Good	Good	Good	Excellent	Good	Good
Montagu Hospital	Good	Good	Good	Excellent	Good	Good
Tickhill Road Hospital	Good	Good	Good	Good	Good	Good

There has been an improvement in the scores relating to food, with all other scores remaining at 'Good'.

Priority 10:	Patient Experience
Reduce the number of patients and carers who have the quality of their hospital experience affected by the attitude of staff	
Aim: To improve the patient experience by reducing the number of complaints relating to the attitude of staff	
Rationale: Ensuring our patients are at the heart of everything we do	
2009/2010	Of the 536 complaints which were received in 2009/10, 51 were about the attitude of staff (9.51%)
2010/2011	Of the 631 complaints which were received in 2010/11, 64 were about the attitude of staff (10.14%)
2011/2012	Reduce the number of complaints received relating to staff attitude by 25%
Progress, Monitoring & Reporting	■ implement near time patient experience surveys in wards and departments ■ monthly reporting to Board of Directors



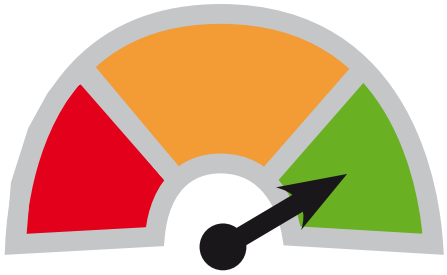
This year, the percentage of complaints that relate to the perceived poor attitude of our staff has not reduced. We will continue to work with staff from all areas in order to improve the experience for our patients by involving staff in developing a set of values which will reflect the NHS Constitution, and develop a vision for our service. We will expect all staff, including doctors, to recognise and describe appropriate and inappropriate attitude and behaviour (code of behaviour). Clinical and non-clinical teams will use the code of behaviour and be supported to raise and address concerns if they arise

Priority 11:	Patient Experience

Near-time patient experience monitoring

Aim: Development of near-time electronic patient experience reporting

Rationale: The Trust believes that every patient should feel that they matter and are at the heart of everything we do. Improving the patient experience is a national priority within the Operating Framework 2009/2010 and 2010/2011 and is also part of the CQUIN Framework



Progress, Monitoring & Reporting

- develop systems for capture of patient experience
- reporting near time experience to all clinical areas and departments
- robust regular reviews of improvement plans
- monthly reporting to Board of Directors

During the year, between 800 and 1000 patients every month have kindly provided us with their comments on over 60 patient experience measures. Reports are provided from 'Ward to Board', with appropriate improvement plans where required. Due to the success of patients reporting improvements relating to their experience, we are expanding this further for 2011/12

*** Please note that these results have been collated using the methodology of 'problem scores' that means lower scores are better*

Inpatient Questions	July 2010	March 2011	
At anytime during your stay at hospital did you share a sleeping area? For example room or bay with patients of the opposite sex	9%	8%	↑
Did you get enough information about ward routines?	21%	5%	↑
Were you ever bothered by noise at night from other patients or hospital staff?	35%	33%	↑
Were you asked how you would like to be addressed?	27%	20%	↑
Did staff address you by your preferred option?	11%	4%	↑
In your opinion how clean was the hospital room or ward that you were in?	10%	0%	↑
Did you get enough help to eat your meals?	7%	1%	↑
When you had questions to ask staff, did you get answers that you could understand?	22%	2%	↑
Did you have confidence & trust in the nurses treating you?	11%	2%	↑
Did nurses talk in front of you as if you were not there?	22%	14%	↑
Were you involved as much as you wanted to be in decisions about your care and treatment?	31%	7%	↑
Were your carers involved in your care as much as you would have liked?	29%	4%	↑
If your family or someone else close to you wanted to talk to a doctor, did they have enough opportunity to do so?	32%	8%	↑
Did you find someone on the hospital staff to talk to you about your worries and fears?	29%	10%	↑
When you needed help from staff getting to the bathroom or toilet, did you get it in time?	16%	4%	↑
Did a doctor or nurse explain the results of the test in a way that you could understand?	27%	9%	↑
Did you feel you were involved in decisions about your discharge from hospital?	14%	14%	→
Overall, did you feel you were treated with respect and dignity while you were in hospital?	7%	0%	↑
Would you recommend this hospital to your family and friends?	3%	3%	→
While in hospital did you ever see any posters or leaflets explaining how to complain about your care?	65%	52%	↑

Priority 11:	Patient Experience

Near-time patient experience monitoring

Outpatients Questions	July 2010	March 2010	
If there was a delay were you told about the delay?	64%	44%	↑
Were you given regular updates about the delay?	80%	61%	↑
Did you have enough time to discuss health or medical problems with a healthcare professional?	3%	1%	↑
Did the healthcare professional listen to what you had to say?	1%	0%	↑
Did you feel able to ask questions you may have had?	2%	0%	↑
Did a member of staff explain why you needed any tests?	12%	9%	↑
Were you told how you would find out the test results?	11%	10%	↑
Were the test results explained in a way you understood?	2%	2%	→
Did you receive copies of letters sent between the hospital team and GP?	66%	71%	↓
Were you told who to contact if you were worried about your condition or treatment?	30%	16%	↑
In your opinion, how clean was the department you attended?	17%	2%	↑
How clean were the toilets that you used in the hospital?	27%	5%	↑
Did you find car parking/Park & Ride facilities easy to access?	31%	14%	↑
Did staff talk in front of you as if you were not there?	6%	6%	→
Did you feel that you were given enough privacy and treated with dignity during your consultation?	3%	0%	↑
Did staff introduce themselves before treating or examining you?	14%	5%	↑
Was the main reason why you went to the outpatient department dealt with to your satisfaction?	3%	1%	↑
Was the department well organised on your visit?	3%	2%	↑

Smoking Survey Questions	July 2010	March 2011	
Were you informed that the Trust operates a no smoking policy?	16%	5%	↑
Were you offered Nicotine Replacement Therapy patches during your admission?	63%	38%	↑
Were you given health advice about the risks associated with smoking?	57%	26%	↑
Were you given specific health advice related to your condition and smoking?	61%	28%	↑
Were you given any information/advice about accessing smoking cessation service following discharge from hospital?	69%	52%	↑
Were you made to feel uncomfortable/guilty or embarrassed about smoking during your stay in the hospital?	13%	6%	↑
Were you asked whether you wanted to be referred to stop smoking services?	77%	38%	↑
If you wished to be referred to stop smoking services were you referred?	80%	55%	↑

A&E Survey Questions	July 2010	March 2011	
In your opinion, how clean was the department you attended?	25%	2%	↑
How clean were the toilets that you used in the hospital?	31%	1%	↑
Did you find car parking/Park & Ride facilities easy to access?	20%	20%	→
Did staff talk in front of you as if you were not there?	5%	8%	↓
Did you feel that you were given enough privacy and treated with dignity during your consultation?	1%	2%	↓
Did you feel that if you needed attention whilst you were waiting that a member of staff would have noticed you need help?	20%	24%	↓
Did staff introduce themselves before treating or examining you?	26%	12%	↑
Was the main reason why you went to A&E dealt with to your satisfaction?	1%	0%	↑
Was the department well organised on your visit?	3%	4%	↓

Review of Services

During 2010/11, Doncaster & Bassetlaw Hospitals NHS Foundation Trust provided and/or sub-contracted 39 NHS services.

The Trust has reviewed all the data available to them on the quality of care in these 39 NHS services.

The income generated by the NHS services reviewed in 2010/11 represents 79.12% of the total income generated from the provision of NHS services by Doncaster and Bassetlaw Hospitals NHS Foundation Trust for 2010/11.

Participation in Clinical Audits

During 2010/11, 37 national clinical audits and three national confidential enquiries covered NHS services that Doncaster & Bassetlaw Hospitals NHS Foundation Trust provides.

During that period, the Trust participated in 92% of national clinical audits and 100% of national confidential enquiries of the national clinical audits and national confidential enquiries in which it was eligible to participate.

The national clinical audits and national confidential enquiries that Doncaster & Bassetlaw NHS Foundation Trust was eligible to participate in during 2010/11 are as follows:

National audits	Participation	% of cases submitted
Peri- and Neonatal		
Neonatal intensive and special care (NNAP)	Continuous	100%
Perinatal mortality (CEMACH)	Continuous	100%
Children		
Childhood epilepsy (RCPH National Childhood Epilepsy Audit)	Continuous	100%
Diabetes (RCPH National Paediatric Diabetes Audit)	Continuous	100%
Paediatric asthma (British Thoracic Society)	Sample	100%
Paediatric cardiac surgery (NICOR Congenital Heart Disease Audit)	Continuous	100%
Paediatric fever (College of Emergency Medicine)	Sample	100%
Paediatric intensive care (PICANet)	Continuous	100%
Paediatric pneumonia (British Thoracic Society)	Sample	100%
Acute care		
Adult community acquired pneumonia (British Thoracic Society)	Continuous	100%
Adult critical care (Case Mix Programme)	Continuous	100%
Cardiac Arrest (National Cardiac Arrest Audit)	No	
Emergency use of oxygen (British Thoracic Society)	No	
Non invasive ventilation (NIV) – adults (British Thoracic Society)	Continuous	100%
Pleural procedures (British Thoracic Society)	Sample	100%
Potential Donor Audit (NHS Blood & Transplant)	Yes	100%
Vital signs in majors (College of Emergency Medicine)	Sample	100%
Long term conditions		
Adult asthma (British Thoracic Society)	Sample	100%
Bronchiectasis (British Thoracic Society)	No	
Chronic pain (National Pain Audit)	Started May 2011	
COPD (British Thoracic Society/European Audit)	Sample	100%
Diabetes (National Adult Diabetes Audit)	No	
Heavy menstrual bleeding (RCOG National Audit of HMB)	Started May 2011	
Parkinson's Disease (National Parkinson's Audit)	No	
Ulcerative colitis & Crohn's disease (National IBD Audit)	Sample	100%
Elective procedures		
CABG and valvular surgery (Adult Cardiac Surgery Audit)	No	
Cardiothoracic transplantation (NHSBT UK Transplant Registry)	No	
Carotid interventions (Carotid Intervention Audit)	Continuous	100%
Coronary angioplasty (NICOR Adult cardiac interventions audit)	Continuous	100%
Elective surgery (National PROMs Programme)	Continuous	100%
Hip, knee and ankle replacements (National Joint Registry)	Continuous	100%
Liver transplantation (NHSBT UK Transplant Registry)	No	
Peripheral vascular surgery (VSGBI Vascular Surgery Database)	Continuous	100%

National audits	Participation	% of cases submitted
Cardiovascular disease		
Acute Myocardial Infarction & other ACS (MINAP)	Continuous	100%
Familial hypercholesterolaemia (National Clinical Audit of Mgt of FH)	No	
Heart failure (Heart Failure Audit)	Continuous	100%
Pulmonary hypertension (Pulmonary Hypertension Audit)	No	
Acute Stroke (SINAP)	No	
Stroke care (National Sentinel Stroke Audit)	Sample	100%
Renal disease		
Patient transport (National Kidney Care Audit)	Continuous	100%
Renal colic (College of Emergency Medicine)	No	
Renal replacement therapy (Renal Registry)	Continuous	100%
Renal transplantation (NHSBT UK Transplant Registry)	Continuous	100%
Cancer		
Bowel cancer (National Bowel Cancer Audit Programme)	Continuous	75%
Head & neck cancer (DAHNO)	Continuous	100%
Lung cancer (National Lung Cancer Audit)	Continuous	100%
Trauma		
Falls and non-hip fractures (National Falls & Bone Health Audit)	Sample	100%
Hip fracture (National Hip Fracture Database)	Continuous	100%
Severe trauma (Trauma Audit & Research Network)	Continuous	70%
Blood transfusion		
O neg blood use (National Comparative Audit of Blood Transfusion)	Sample	100%
Platelet use (National Comparative Audit of Blood Transfusion)	Sample	100%
Psychological Conditions		
Depression & Anxiety (National Audit of Psychological Therapies)	No	
Prescribing in Mental Health Services (POMH)	No	
National Audit of Schizophrenia	No	

National Confidential Enquiries	Participation	% cases submitted
NCEPOD (National Confidential Enquiry into Patient Outcome and Death)		
Surgery in children	Yes	100
Peri-operative care	Yes	100
Cardiac arrest procedures	Yes	100
National Confidential Enquiry into Maternal & Child Health	Yes	100
National Confidential Inquiry (NCI) into Suicide & Homicide by People with Mental Illness (NCI/NCISH)		

All Annual Reports from national clinical audits are reviewed by the relevant Clinical Service Unit and actions are taken, where necessary, to improve the quality of healthcare provided.

National Adult Diabetes Audit The Trust did not take part in this audit. This is an outpatient audit and a very small number of trusts nationwide contributed; there are many other official bodies doing the same work. The NHS Atlas of Variation audited completion of nine key care processes across all English PCTs. In this comprehensive audit, 100% of PCT performance was reviewed and Doncaster was ranked fourth best of all English PCTs. The ability to complete these nine processes is a joint PCT/Trust responsibility. We consider we are well placed to respond to any questions regarding management of adult diabetes.

Cardiac Arrests (National Cardiac Arrest Audit) The Trust did not take part in this audit as the department involved has an in-house robust database. However, the Trust is considering taking part next year for benchmarking purposes.

There are other national clinical audits our Trust did not take part in because they were not relevant to this Trust.

The reports of two national clinical audits were reviewed by the provider in 2010/11 and Doncaster & Bassetlaw Hospitals NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided:

- introduction of Nutrition IPOC (Integrated Pathway of Care)
- guidelines for assessment of renal function on the Medical Assessment Unit.

There were 260 local clinical audits registered during 2010/11, 175 of which were completed within this timeframe. The reports of 175 local clinical audits were reviewed by the provider in 2010/11 and Doncaster & Bassetlaw Hospitals NHS Foundation Trust intends to take the following actions from three of those audits to improve the quality of

healthcare provided:

Patient Normothermia:

- temperature strips purchased; later upgraded to Tympanic probes
- Bair Paws warming devices purchased
- patient temperature now part of WHO checklist

DVT assessment:

- 100% improvement in monitoring assessments in Day Surgery
- theatre admission staff received training on assessment and pedal pulses and can now prescribe TEDS

Minimal enteral feeding for pre-term babies:

- donor breast milk purchased as required.

Participation in Clinical Research

The number of patients receiving NHS services provided or sub contracted by Doncaster & Bassetlaw Hospitals NHS Foundation Trust in 2010/11, who were recruited during that period in order to participate in research approved by a research ethics committee, was 474.

During 2010/11, 51 additional studies were approved within the Trust, which include clinical trials of investigational medicinal products (CTIMPs) and medical device trials.

The Trust supports research in differing roles, either as a sponsoring organisation, a participating organisation, or as a participant identification centre. The Directorate of Research is expanding to reflect both the increasing level of research activity and also to support the continuing advancement of research within the Trust, with the research team providing comprehensive support to researchers during the planning, set-up, and delivery phases of research.

Participation in clinical research demonstrates the Trust's commitment to improving the quality of care we offer and to making our contribution to wider health improvement. Our clinical staff stay abreast of the latest possible treatment possibilities; active participation in research leads to successful patient outcomes. Our engagement with clinical research demonstrates our commitment to testing and offering the latest medical treatments and techniques.

CQUIN payment framework

A proportion of Doncaster & Bassetlaw Hospitals NHS Foundation Trust income in 2010/11 was conditional on achieving quality improvement and innovation goals agreed between the Trust and any person or body they entered into a contract, agreement, or arrangement with for the provision of NHS services, through the Commissioning for Quality & Innovation (CQUIN) payment framework.

The monetary total in 2010/11, conditional upon achieving quality improvement and innovation goals, was £4.2m. An assessment of the monetary total for the associated payment in 2010/11 was £3.0m.

Further details of the agreed goals for 2010/11 and for the following 12-month period are available on request from:

Hazel Brand
Communications Manager
Doncaster & Bassetlaw Hospitals NHS Foundation Trust
Doncaster Royal Infirmary
Armthorpe Road
Doncaster DN2 5LT.

Statement from the CQC

Registration

Doncaster & Bassetlaw Hospitals NHS Foundation Trust is required to register with the Care Quality Commission and its current registration status is full registration compliance. The Trust has no conditions on registration.

The Care Quality Commission has not taken enforcement action against Doncaster & Bassetlaw Hospitals NHS Foundation Trust during 2010/11.

Doncaster & Bassetlaw Hospitals NHS Foundation Trust is subject to periodic review by the Care Quality Commission. The Trust has not had a full planned inspection by the Care Quality Commission.

Doncaster & Bassetlaw Hospitals NHS Foundation Trust has been participating in an Ofsted/CQC Integrated Inspection for safeguarding and care of looked-after children, which took place from 21 March to 1 April 2011. The Trust has been visited and inspected as part of this process. A full written report of the findings of the inspection is now awaited.

Data Quality

Doncaster & Bassetlaw Hospitals NHS Foundation Trust submitted records during 2010/11 to the Secondary Uses for inclusion in the Hospital Episode Statistics, which are included in the latest published data.

The percentage of records in the published data (cumulative position to Month 10 2010/11)

- which included the patient's valid NHS number was:

  99.4% for admitted patient care – national position 98.4%

  99.5% for outpatient care – national position 98.8%

  93.7% for Accident & Emergency care – national position 91.6%

- which included the patient's valid General Medical Practice Code was:

  100% for admitted patient care – national position 99.8%

  100% for outpatient care – national position 99.8%

  99.8% for Accident & Emergency care – national position 99.7%.

Doncaster & Bassetlaw Hospitals NHS Foundation Trust will be taking the following actions to improve data quality:

- implement a Trust Data Quality Team
- joint working with main commissioners to improve NHS number coverage at the point of referral from primary care
- continue to provide focus on key performance areas through the Data Quality Sub-group meetings
- continue the annual programme of Data Quality Workshops
- develop enhanced missing data/error reports that target known issues and, via the data quality team, monitor their timely completion
- carry out work on understanding patient pathways linked to data recording and quality
- through the Data Quality Workshops, PAS training sessions, and other relevant opportunities, promote the principle of 'Right First Time' in recording patient information; all new staff attend for PAS training before they are given access to the system
- PAS trainers produce module-based user guides that provide an ongoing reference for staff in their workplace; PAS trainers also produce quarterly PAS newsletters that are circulated in hard copy to relevant departments and posted on the Trust intranet; content may include information on system updates, news of training sessions and reminders of key data quality items.

The Trust recognises the importance of high-quality information as a fundamental requirement for the prompt and effective treatment of patients.

The Trust recognises the importance of high-quality information as a fundamental requirement for the prompt and effective treatment of patients. High-quality information is crucial to the delivery of high-quality care to patients and in meeting the needs of clinical governance, management information, accountability, financial control, health planning, and service agreements.

The delivery of high-quality care to patients in relation to safety, effectiveness, and patient experience is fundamentally dependent on high-quality data and, as such, is a key business driver.

High-quality business information supports decision making as well as ensuring that the Trust reports its performance accurately both internally and externally to commissioners, Monitor, the Department of Health, strategic health authorities, and the Care Quality Commission. Achievement of CQUIN income through robust data collection and reporting is also reliant on high-quality data.

Reporting patient activity accurately ensures commissioner confidence in the information base, on which they rely for making payments for activity. Currently, there is an Information Assurance project underway with local commissioners to enhance this confidence level. It is acknowledged that poor quality data could result in the Trust losing income or payments not reconciling to the services being delivered.

Through the remit of the Data Quality Sub-group, regular monitoring of key data quality metrics is fed back within the organisation. For example, during 2010/11 the following metrics have been standing agenda items:

- % coverage of patient ethnicity data for admitted and non-admitted care (Table 1)
- timely reconciliation of outpatient clinic sessions and completeness of outcomes
- improving accuracy around outpatient referral sources, specifically where patients are referred from one consultant to another within the Trust (Table 2)
- outpatient appointment cancellations – reviewing the reasons for cancellation offered to PAS system users to add value and intelligence when reporting on clinic cancellations; the new codes have been rolled out on PAS from 1 April 2011.
- validation of telephone consultation recording – by providing CSUs with the facility to access their own specialty-level reports over the intranet, to ensure that telephone consultations are being accurately recorded and that all relevant activity is captured.

Improvements have been demonstrated in the above areas. These successes have also been highlighted in the Data Quality Workshop sessions, evidencing to staff that improvements are achievable.

Example summaries of improvement are shown below:

Table 1

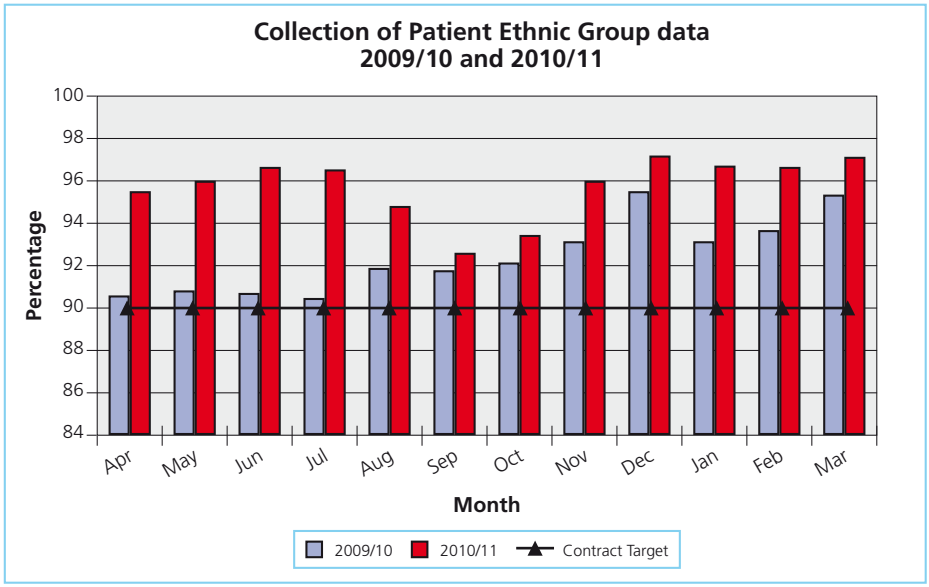


Table 2

Consultant-to-Consultant referrals within the Trust (Outpatient appointments February and March 2011)

	General Surgery	Urology	Breast	Vascular	Orthopaedic	ENT	Ophthalmology	Oral Surgery	Orthodontic	Pain Management	General Medicine
% where Referrer is Blank	11.5%	10.9%	40.0%	22.5%	22.4%	47.2%	12.8%	12.2%	83.3%	3.5%	6.9%
Direction of Change from December and January	↓	↑	↓	↓	↓	↑	↓	↓	↑	↑	↑

	Haematology	Gastroenterology	Cardiology	Paediatric Cardiodiology	Dermatology	Respiratory	Renal	Rheumatology	Paediatric	Medical Ophthalmology	Gynaecology
% where Referrer is Blank	10.3%	0.0%	8.6%	0.0%	11.4%	5.6%	16.0%	5.8%	28.9%	40.9%	14.0%
Direction of Change from December and January	↑	↓	↓	↓	↑	↓	↓	↓	↓	↑	↑

Table 3

2010/11 Data Quality Workshop evaluation summary (where forms were completed)

Workshop Element	**% of responses Excellent/Very Good/Good**	**Percentage of responses Fair/Poor**	**Attenders who found workshop useful**	**Attenders who did not find workshop useful**	**% of staff who found course useful**
Workshop pack - Quiz Questions	94.20%	5.80%			
Introduction and Aims	95.48%	4.52%			
Data Quality and Activity	95.48%	4.52%			
PCT Perspective	93.64%	6.36%			
18 Weeks	93.17%	6.83%			
Understanding Patient Pathways	94.17%	5.83%			
Demographics/ Duplicate Registrations	95.12%	4.88%			
PAS Demonstrations	97.06%	2.94%			
Summary and Key messages	96.41%	3.59%			
Overall			188	10	
Grand Total	**94.60%**	**5.40%**	**188**	**10**	**94.95%**

The following local procedure has been developed. It provides a reminder to outpatient receptionists of the demographic data items that they should be checking with each patient on arrival for their appointment:

Procedure for interviewing a patient who attends an outpatient clinic

Introduction

It is essential that all information held within medical records is accurate, legible, and filed in a structured manner. This procedure has been developed to ensure that the receptionist checks patient and GP details held on the Patient Administration System (PAS) every time the patient attends clinic and, if there are any changes to those details, to ensure that PAS is updated. The Trust also has a legal obligation under the Data Protection Act to ensure that patients' personal data is maintained accurately.

Procedure

When the patient (new or follow-up) arrives for their appointment, the receptionist must advise the patient that they will check their personal details with them to ensure that they are correct.

They will then ask the patient to confirm the following details on PAS:

- ask the patient their full name
- is that Mr, Mrs, Miss, Ms or other title?
- what are your first names? Check spelling if necessary
- can you tell me your date of birth?
- do you have a religion?
- what is your address?
- what is the postcode?
- do you have a telephone or mobile 'phone number?
  This must be entered in number format only with no gaps between. No words, eg, Mum's number)
- is there a work number we can use to contact you in the day?
  Inform the patient that their phone number will be used to remind the patient of any future appointment a week before the appointment
- for children, ask which school they attend (Child Protection)
- for all patients, who is your next of kin? Is that your husband/wife? Is that the same address as you?
- who is your own doctor/GP? What is the surgery where you see your doctor (ie address)?
- how long have you been a resident in the UK?
  If the patient has not lived in UK for the last 12 months, the Overseas Visitor procedure must be followed
- if missing on PAS or a code Z is recorded, ask the patient to select their Ethnic Group from the list held at the desk.

If any of the above details have changed or are incorrect, PAS must be updated immediately. The casenote front sheet should also be updated as appropriate.

Doncaster & Bassetlaw Hospitals NHS Foundation Trust's score for 2010/11 for Information Quality & Records Management, assessed using the information Governance Toolkit, was 73%.

Clinical coding error rate

Doncaster & Bassetlaw Hospitals NHS Foundation Trust was subject to the Payment by Results clinical coding audit by the Audit Commission during the reporting period and the error rates reported in the latest published audit for that period for diagnoses and treatment coding (clinical coding) were:

- Primary Diagnoses incorrect (2.7%)
- Secondary Diagnoses incorrect (2%)
- Primary Procedures incorrect (2.7%)
- Secondary Procedures incorrect (2.8%).

Review of Quality Performance

National targets and regulatory requirements	2008/09	2009/10	2010/11	National target or trajectory 2010/11
Screening all elective inpatients for MRSA	**		100%	100%
MRSA – maintaining the annual number of MRSA bloodstream, infections at less than half the 2003/04 level	13	12	1	5
***Clostridium difficile* year-on-year reduction**	147	67	67	141

Maximum waiting time of four hours in A&E from arrival to admission, transfer or discharge	98.5%	98.16%	97.3%	98%
A two-week maximum wait from urgent referral to first outpatient appointment for all urgent suspected cancer referrals	99.1%	95.2%	96.1%	93%
A maximum wait of 31 days from diagnosis to treatment of all cancers	99.8%	98.3%	97.9%	96%
A maximum wait of 62 days from urgent GP referral to treatment of all cancers	97.3%	90.8%	91.9%	85%
A maximum waiting time of 31 days for subsequent treatments for all cancers:	**			
■ Surgery		97.5	97.7	94%
■ Drugs		100%	100%	98%
■ Radiotherapy and other		100%	100%	94%
■ 62 day - screening *(this figure includes the Rare Tumours, which are managed on a 31-day referral to treatment pathway)*		95.7%	92.2%	90%
18-week maximum wait from referral to treatment (admitted patients)	94.8%	96.6%	95.8%	90%
18-week maximum wait from referral to treatment (non-admitted patients)	98%	99.2%	99.1%	95%
A maximum two-week wait standard for Rapid Access Chest Pain Clinics	100%	100%	99.9%	98%
People suffering heart attack to receive thrombolysis within 60 minutes of call	88.9%	95.5%	100%	68%
Guaranteed access to a genito-urinary medicine clinic within 48 hours of contacting a service	90.82%	100%	99.9%	98%
100% of people with diabetes to be offered screening for early detection (and treatment if needed) of diabetic retinopathy	100%	100%	100%	100%
Breastfeeding Initiation	60.64%	68.63%	65.13%	68% - Local Trajectory
Breastfeeding at transfer to Health Visitor		*	33.99%	40% - Local Trajectory
Patients admitted with Stroke spend 90% of their stay on a stroke unit	**	68.5%	71.4%	90%
All patients who have operations cancelled for non clinical reasons to be offered another date within 28 days	1.14%	0.64%	1.40%	CQC target – local stretch target to be agreed for 2010/2011
Readmission rates within 14 days with associated condition (not part of pathway of care)	5.4%	5.1%	5.2%	5.1%
Staff sickness rates	5%	4.30%	3.89%	4%
Number of staff who have had a PDA within the last 12 months	46%	81%	77%	N/A

** Data collection changed mid year from breast feeding at 10 days post delivery to at the time of transfer to Health Visitor and from just those women who initiated breast feeding to all women who gave birth to a live baby.*

*** This indicator was not measured in 2008/2009*

The following comments on the Quality Account were received.

Nottinghamshire County LINk

Nottinghamshire County LINk believes that this Quality Account is a fair reflection of the healthcare services provided by Doncaster & Bassetlaw Hospitals NHS Foundation Trust. On the most part, there are clear indicators throughout the document demonstrating that improvements have been made in many areas, for example, the reduction in 'never events' and in cases of MRSA. However, the Quality Account also highlights that there are areas that still require attention, for example reducing the number of patients contracting *Clostridium difficile*. As a LINk, we do acknowledge that where further improvement is required, sufficient action plans are in place for the coming year.

In some areas of the Quality Account data is missing, in particular, when discussing 'trigger incidents' and pressure ulcers. The lack of data makes it hard for the LINk to comment and makes it unclear whether overall performance has improved, remained the same or worsened. As a LINk, we feel this demonstrates a lack of confidence on the part of Doncaster & Bassetlaw Hospitals and would like to see these included in the future, fully reflecting the high quality of the service they deliver.

NB The draft copy of the Quality Account, which was commented upon by LINks, did have some data missing, as a 30-day consultation period was required and an earlier draft was given to LINk. The data in the Quality Account is now complete. LINks were invited to comment again, however were unable to do so within the timeframe.

NHS Doncaster and NHS Bassetlaw

As the Chief Operating Officers for NHS Doncaster and NHS Bassetlaw, we are pleased to have been given the opportunity to comment on Doncaster & Bassetlaw Hospitals NHS Foundation Trust's Quality Account.

NHS Doncaster and NHS Bassetlaw are committed to ensuring that the residents of Doncaster and Bassetlaw receive high-quality, safe, and effective care and we have been able to work as partners with the Trust to achieve this goal.

We would like to acknowledge the importance that the Trust has placed on delivering high-quality, safe, and clinically effective care, and the progress on striving to continually improve services. We also recognise there are areas in which we would like to see improvement. As good commissioners, we will continue to monitor the number of pressure sores that patients acquire in hospital and the instances of *Clostridium difficile* infections. We will also be reviewing with the Trust the number of complaints and the views of the patients regarding their experience of the Trust.

The Commissioning for Quality & Innovation (CQUIN) indicators, which were developed to drive forward the quality of care delivered, were mostly achieved by the Trust. The local indicators had a strong focus towards care and near real-time patient experience and the attainment of these indicators is specifically acknowledged.

Other achievements include:

- work in relation to eliminating mixed sex accommodation
- CQC registration with no conditions.

The coming year will bring more challenges to the NHS and we look forward to continuing to work together with the Trust to deliver high quality services.

Board of Governors

The Board of Governors has had the opportunity to discuss the 2010/11 Quality Account at a meeting attended by the Director of Nursing & Quality. Governors discussed a number of issues and queries regarding the report, including:

- the report was clear and easy to read
- whether the content of the report would be comparable across all Trusts
- whether there was evidence to suggest that monitoring performance would lead to improved performance
- it was confirmed that the MRSA ceiling of five was set externally by the Department of Health
- the target of a 30% reduction in grade 3 pressure ulcers was acknowledged as being challenging
- the targeted 40% reduction in patient falls was queried, and it was confirmed that this figure related to only those patient falls that resulted in harm
- the reasons for the Trust's decision to cease using incident forms listing Trigger Incidents
- complaints relating to staff attitude. Although the overall numbers were small, governors felt it was unacceptable for patients to have a bad experience due to staff attitude
- the sources of patient experience data
- the final outturn for the stroke indicator, and the challenging nature of the 2011/12 target.

Governors noted their satisfaction with the rigour of quality governance and monitoring, and the Board of Directors' focus on quality at its meetings, which governors are now invited to observe.

Annex

Statement of directors' responsibilities in respect of the Quality Report

The directors are required under the Health Act 2009 and the National Heath Service (Quality Accounts) Regulations 2010 to prepare a Quality Account for each financial year.

Monitor has issued guidance to NHS foundation trust boards on the form and content of annual quality reports (which incorporate the above legal requirements) and on the arrangements that foundation thrust boards should put in place to support the data quality for the preparation for the quality report.

In preparing the quality report, directors are required to take steps to satisfy themselves that:

- the content of the Quality Report meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual 2010/11
- the content of the Quality Report is not inconsistent with internal and external sources of information including:
  - Board minutes and papers for the period April 2010 to June 2011
  - papers relating to quality reported to the Board over the period April 2010 to June 2011
  - feedback from the commissioners, dated 7 June 2011
  - feedback from governors dated 7 June 2011
  - feedback from LINks dated 7 June 2011
  - the Trust's complaints report published under regulation 18 of the Local Authority Social Services & NHS Complaints Regulations 2009, dated 7 June 2011
  - the 2010 national patient survey, 3 May 2011
  - the 2010 national staff survey, 5 April 2011
  - the Head of Internal Audit's annual opinion over the Trust's control environment, dated 7 June 2011
  - CQC quality and risk profiles, dated 3 May 2011
- the Quality Report presents a balanced picture of the NHS foundation trust's performance over the period covered
- the performance information reported in the Quality Report is reliable and accurate
- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice
- the data underpinning the measure of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review, and the Quality Report has been prepared in accordance with Monitor's annual reporting guidance (which incorporated the Quality Accounts regulations) (published at www.monitor-nhsft.gov.uk/annualreportingmanual) as well as the standards to support data quality for the preparation of the Quality Report (available at www.monitor-nhsft.gov.uk/annualreportingmanual).

The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the Quality Report.

By order of the Board

Chris Scholey
Chairman
6 June 2011

Dr Peter Reading
Interim Chief Executive
6 June 2011

Independent Auditor's Report to the Board of Governors of Doncaster & Bassetlaw Hospitals NHS Foundation Trust on the Annual Quality Report

We have been engaged by the Board of Governors of Doncaster & Bassetlaw Hospitals NHS Foundation Trust ('the Trust') to perform an independent assurance engagement in respect of the content of Doncaster & Bassetlaw Hospitals NHS Foundation Trust's Quality Report for the year ended 31 March 2011 (the 'Quality Report').

Scope and subject matter

We read the Quality Report and considered whether it addresses the content requirements of the *NHS Foundation Trust Annual Reporting Manual*, and consider the implications for our report if we become aware of any material omissions.

Respective responsibilities of the directors and auditors

The directors are responsible for the content and the preparation of the Quality Report in accordance with the criteria set out in the *NHS Foundation Trust Annual Reporting Manual 2010/11* issued by the Independent Regulator of NHS Foundation Trusts ('Monitor').

Our responsibility is to form a conclusion, based on limited assurance procedures, on whether anything has come to our attention that causes us to believe that the content of the Quality Report is not in accordance with the *NHS Foundation Trust Annual Reporting Manual* or is inconsistent with the documents.

We read the other information contained in the Quality Report and considered whether it is inconsistent with

- Board minutes for the period April 2010 to May 2011
- papers relating to quality reported to the Board over the period April 2010 to May 2011
- feedback from the commissioners dated 12 May 2011
- feedback from LINks dated 26 May 2011
- the Trust's Quarterly Complaints reports for the period April 2010 to December 2010
- the 2010 national patient survey
- the 2010 national staff survey
- the Head of Internal Audit's annual opinion over the Trust's controls environment dated 23 May 2011; and
- CQC quality and risk profiles dated March 2011.

We considered the implications for our report if we became aware of any apparent misstatements or material inconsistencies with those documents (collectively, the 'documents'). Our responsibilities do not extend to any other information.

This report, including the conclusion, has been prepared solely for the Board of Governors of Doncaster & Bassetlaw Hospitals NHS Foundation Trust as a body, to assist the Board of Governors in reporting Doncaster & Bassetlaw Hospitals NHS Foundation Trust's quality agenda, performance, and activities. We permit the disclosure of this report within the Annual Report for the year ended 31 March 2011, to enable the Board of Governors to demonstrate they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the Quality Report. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Board of Governors as a body and Doncaster & Bassetlaw Hospitals NHS Foundation Trust for our work or this report save where terms are expressly agreed and with our prior consent in writing.

Assurance work performed

We conducted this limited assurance engagement in accordance with International Standard on Assurance Engagements 3000 (Revised) – *Assurance Engagements other than Audits or Reviews of Historical Financial Information* – issued by the International Auditing and Assurance Standards Board ('ISAE 3000'). Our limited assurance procedures included:

- making enquiries of management
- comparing the content requirements of the *NHS Foundation Trust Annual Reporting Manual* to the categories reported in the Quality Report; and
- reading the documents.

A limited assurance engagement is less in scope than a reasonable assurance engagement. The nature, timing, and extent of procedures for gathering sufficient appropriate evidence are deliberately limited relative to a reasonable assurance engagement.

Limitations

It is important to read the Quality Report in the context of the criteria set out in the *NHS Foundation Trust Annual Reporting Manual*.

Conclusion

Based on the results of our procedures, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2011, the content of the Quality Report is not in accordance with the *NHS Foundation Trust Annual Reporting Manual*.

PricewaterhouseCoopers LLP

PricewaterhouseCoopers LLP
Chartered Accountants
Leeds
6 June 2011

12 ANNUAL ACCOUNTS

Statement of the Chief Executive's responsibilities as the Accounting Officer of Doncaster & Bassetlaw Hospitals NHS Foundation Trust

The NHS Act 2006 states that the Chief Executive is the accounting officer of the NHS foundation trust. The relevant responsibilities of the accounting officer, including their responsibility for the propriety and regularity of public finances for which they are answerable, and for the keeping of proper accounts, are set out in the *NHS Foundation Trust Accounting Officer Memorandum* issued by the Independent Regulator of NHS Foundation Trusts ("Monitor").

Under the NHS Act 2006, Monitor has directed Doncaster & Bassetlaw Hospitals NHS Foundation Trust to prepare for each financial year a statement of accounts in the form and on the basis set out in the Accounts Direction. The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of Doncaster & Bassetlaw Hospitals NHS Foundation Trust and of its income and expenditure, total recognised gains and losses and cash flows for the financial year.

In preparing the accounts, the Accounting Officer is required to comply with the requirements of the *NHS Foundation Trust Annual Reporting Manual* and in particular to:

- observe the Accounts Direction issued by Monitor, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis
- make judgements and estimates on a reasonable basis
- state whether applicable accounting standards as set out in the *NHS Foundation Trust Annual Reporting Manual* have been followed, and disclose and explain any material departures in the financial statements; and
- prepare the financial statements on a going concern basis.

The accounting officer is responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the NHS foundation trust and to enable him/her to ensure that the accounts comply with requirements outlined in the above mentioned Act. The Accounting Officer is also responsible for safeguarding the assets of the NHS foundation trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

To the best of my knowledge and belief, I have properly discharged the responsibilities set out in Monitor's *NHS Foundation Trust Accounting Officer Memorandum.*

Dr Peter Reading
Interim Chief Executive
6 June 2011

STATEMENT ON INTERNAL CONTROL

Scope of responsibility

As Accounting Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the NHS Foundation Trust's policies, aims and objectives, while safeguarding the public funds and departmental assets for which I am personally responsible, in accordance with the responsibilities assigned to me. I am also responsible for ensuring that the NHS Foundation Trust is administered prudently and economically and that resources are applied efficiently and effectively. I also acknowledge my responsibilities as set out in the *NHS Foundation Trust Accounting Officer Memorandum.*

The Trust works closely with a range of partner organisations, both within and outside the NHS, locally and nationally, including:

- membership of the Foundation Trust Network and the NHS Confederation
- routine meetings with the chief executives of other NHS organisations in Doncaster and Bassetlaw
- meetings with local authority Overview & Scrutiny Committees
- attendance of the chief executive and other executives at Yorkshire and the Humber meetings
- representation on Local Strategic Partnerships
- chairman's attendance at the East Midlands and Yorkshire and the Humber SHAs' Chairman's forums
- LINks and other patient groups.

The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of Doncaster & Bassetlaw Hospitals NHS Foundation Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place in Doncaster & Bassetlaw Hospitals NHS Foundation Trust for the year ended 31 March 2011 and up to the date of approval of the Annual Report & Accounts.

Capacity to handle risk

The Chief Executive has overall responsibility for risk management. There is a designated lead executive director for each area of risk, described in the Risk Management Strategy.

Staff at all levels of the organisation are trained in the identification and management of risk. Training provided is appropriate to the level of responsibility. The training needs of staff are identified through annual performance and development appraisals. The Trust makes the management and minimisation of risk a top priority, so staff are trained appropriately through:

- Risk Management and Adverse Incident Reporting training
- Risk Identification, Assessment & Treatment training
- Root Cause Analysis training.

The Trust has well-developed guidelines, policies, and procedures to help managers in the assessment, control, and investigation of risks. The documents (below) set out levels of acceptable risks and identify where each type of risk should be managed:

- Risk Assessment policy
- Guidelines on the Investigation of Complaints, Claims & Adverse Incidents
- Claims Management Policy
- Complaints Procedure.

Trust policies are publicly available on the website. Examples of policies concerning just one category, patient safety, are Missing Patient Policy, Policy for Operation Site Marking and Verification, The Safe Use of Safety Sides, Policy for Emollient & Moisturiser Use, Patient Identification Policy, Safeguarding Adults Policy, Safeguarding and Promoting the Welfare of Children, Patient Falls and Injuries Prevention Guidelines, and Safeguarding Children Supervision Policy. All relate to areas where there are, or have been, identified risks.

Learning from complaints and serious incidents, and from other opportunities, is taken into clinical service units by the management team (clinical director, general manager, and matron) and disseminated to all appropriate staff.

The Clinical Governance Standards Committee and the Audit & Non-clinical Risk Sub-committee are the main vehicles for the Trust Board to be assured about the management of risk. Structures within clinical service units and corporate directorates were established to ensure that risks are identified, recorded, and controlled as part of the overall risk infrastructure.

The Trust Executive Team (Management Board from June 2011) formally reviews corporate risks monthly, and the corporate risk register is routinely reviewed by the Audit & Non-clinical Risk Sub-committee. Amendments to the Trust's risk register are brought to the Board of Directors.

The risk and control framework

An Assurance Framework is in place, as reviewed and amended by the Audit & Non-clinical Risk Sub-committee in 2010/11. The Assurance Framework details the Trust's strategic objectives and for each of the objectives, identifies the key risks to their achievement. The Framework clarifies how the Trust obtains its assurances, quantifies each risk, and outlines any mitigating action plans. The risk assessment is linked to the Trust's corporate risk register, which in itself links to clinical service unit and directorate risk registers.

The Audit & Non-clinical Risk Sub-committee oversees the effective functioning of the Assurance Framework and related compliance.

The Trust registered with the Care Quality Commission (CQC), and was granted an unconditional licence to provide services under the new scheme of regulating the NHS. We were compliant with 18 essential standards of quality and safety, and with other standards concerning management and governance arrangements. The standards were divided into the following key areas:

- involvement and information
- personalised care, treatment, and support
- safeguarding and safety
- suitability of staffing
- quality of care.

The CQC has developed a Quality & Risk Profile for each provider of NHS care, using many sources of data to rate organisations across the whole range of standards. The position for this Trust was assessed as mainly green.

The Trust has in place an effective structure for public stakeholder involvement, predominantly through the Trust's Board of Governors and its sub-committees. In addition, the Board of Governors nominates two public governors to participate in the Clinical Governance Standards Committee and the Audit & Non-clinical Risk Sub-committee. The Board of Governors receives a report from these governors at each of its formal meetings. The Board of Governors meets four times a year in public and reviews updates from executive directors on performance and associated risks to delivery.

A range of risk assessments is undertaken. In the Trust's Risk Management Strategy, individual responsibilities of the executive leads, Head of Risk & Legal Services, clinical service units, directorate managers, departmental managers, and all staff within the organisation, on the management and minimisation of risk are identified.

Control measures are in place to ensure compliance with all the organisation's obligations under equality and diversity and human rights legislation.

The Trust routinely tests its emergency response and contingency plans and undergoes emergency response training with its staff.

The Trust is committed to learning and development – a learning rather than punitive environment when things go wrong - and has established systems to achieve this. Risk management is recognised as an integral part of this process. The Risk Management Strategy makes everyone responsible for managing risk:

- personal responsibility for risk
- collaborative approaches to work - across disciplinary, service and organisational boundaries
- team working.

Risks are identified and assessed at clinical service unit and corporate directorate levels; these assessments form part of the overall action plan for the management and treatment of risks within the Trust. Risks may be identified through routine risk assessments, matrons' rounds, complaints, concerns raised by staff or patients/visitors, clinical incidents, etc. Through the Board of Governors, public stakeholders are involved in understanding and managing the risks that impact on them with membership of groups such as the Clinical Governance Standards Sub-committee and Patient Environment Assessment Team, as well as through the work of the Board of Governors' sub-committees (listed in section 7).

Analysing risks is handled through internal and external arrangements:

- Internal: this is how the Trust will identify the root causes of incidents and near misses for further analysis. To support this, the Trust has developed an Adverse Incident & Near Miss Reporting system. There is a single reporting document for all occurrences; details of incidents are transferred to a secure incident reporting computer system that facilitates trend and other analyses. Equality Impact Assessments are carried out for all new policies and new developments

The Trust is subject to a wide variety of quality targets set in association with our commissioners.

- External: there are systems in place to manage and handle a risk/hazard notified by external bodies, such as the National Patient Safety Agency (NPSA), Medicines & Healthcare Products Regulatory Agency, and Safety Alert Broadcast System.

Identified risks/hazards are reviewed to see if existing controls are adequate, and to analyse risks in terms of their consequences and likelihood. A consistent approach is ensured through analysis and assessment of risk, using a Risk Assessment policy and documentation to assess and develop control mechanisms.

As an employer with staff entitled to membership of the NHS Pension Scheme, control measures are in place to ensure all employer obligations contained within the Scheme regulations are complied with. This includes ensuring that deductions from salary, employer's contributions, and payments into the Scheme are in accordance with the Scheme rules, and that member Pension Scheme records are accurately updated in accordance with the timescales detailed in the regulations.

We have undertaken risk assessments and Carbon Reduction Delivery Plans are in place in accordance with emergency preparedness and civil contingency requirements, as based on UKCIP 2009 weather projects, to ensure that this organisation's obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with.

The Chief Executive, as Accounting Officer, and the Board of Directors have overall responsibility for the management of governance and risk issues. They have identified the actions required to address these risks and the resulting action plans are being monitored by the Board of Directors, supported by relevant groups.

Data security has been enhanced following a comprehensive review of information governance arrangements with particular focus on how risks to data security are being managed and controlled. Increasingly new IT systems include a Smartcard front end medium, to ensure a greater level of:

- service user identification
- relevant and auditable access controls
- appropriate reassurance – for the patient – concerning the Care Records Guarantee and the 'legitimate relationships' between themselves and those NHS staff accessing their personal data records.

The Trust is fully compliant with the requirements of registration with the Care Quality Commission.

Review of economy, efficiency and effectiveness of the use of resources

For 2010/11, detailed service delivery and operational plans were produced; they incorporated financial as well as quality, efficiency, and productivity targets. The overall plans were disaggregated to clinical service unit/corporate directorate level and assigned to individual budget holders.

These plans are subject to scrutiny by and approval from the Board of Directors. The Annual Plan, submitted to Monitor, covers finance, mandatory services, and governance. Monitor assigns risk ratings for each aspect of the Annual Plan.

Management accountants led in-year financial monitoring, involving budget holders. Regular reports were made to the Management Board, Board of Directors, and to Monitor on the current position against the budget.

Financial procedure notes have been set up and, with the Standing Orders, Standing Financial Instructions and Scheme of Delegation, they form clear guidance to all staff. They ensure appropriate controls are in place. These controls are further supported by internal and external audit. The work of the auditors is reported to the Audit & Non-clinical Risk Sub-committee. Staff are informed of key changes through monthly staff briefings; training on financial governance is provided for budget holders.

Finance policies are publicly available on the Trust's website. Also included is our Fraud Policy and Response Plan.

Annual Quality Report

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 to prepare Quality Accounts for each financial year. Monitor has issued guidance to NHS foundation trust boards on the form and content of annual Quality Reports which incorporate the legal requirements in the *NHS Foundation Trust Annual Reporting Manual*.

The Board of Directors has received and adopted a Quality Report that has been widely consulted upon to ensure balance and accuracy. The draft report has been subject to consultation with local PCTs and Local Involvement Networks, Foundation Trust Governors, Trust Executives (including lead clinicians), and the Clinical Governance Standards Committee. Details of the consultation process are to be found in the Annex to the report. Where possible, suggested changes have been incorporated into the report.

The report has been prepared and validated in conjunction with relevant senior managers within the Trust. The quality data reflects that which has generally been available in summary to the Trust Board or, in more detail, to Board committees and sub-committees such as the Clinical Governance Standards Committee. The Quality Report has been set out in the format required by Monitor and incorporates the Quality Report information required by the Department of Health.

The Trust is subject to a wide variety of quality targets set in association with our commissioners. The quality of performance data is also reviewed within the internal committee structures and is subject to internal and external audit.

The above steps ensure the Quality Report is produced with the requisite underpinning:

- governance and leadership (including processes to ensure the Quality Report presents a balanced view)
- policies
- systems and processes
- people and skills
- data use and reporting.

Review of effectiveness

As Accounting Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, and the executive managers within the NHS Foundation Trust, who have responsibility for the development and maintenance of the internal control framework. I have drawn on the content of the Quality Report within this Annual Report and other performance information available to me. My review is also informed by comments made by the external auditors in their management letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Board, the Audit & Non-clinical Risk Sub-committee, and a plan to address weaknesses and ensure continuous improvement of the system is in place.

The role of each body reviewing the effectiveness of the system of internal control is described in the table opposite:

Body	Role
Board of Directors	Monitor internal controls; receive exception reports; receive minutes of key committees, ie Audit & Non-clinical Risk Sub-committee and Clinical Governance Standards Committee; non-executive director (NED) membership of key committees; NEDs bring external perspective and rigour to the Board
Board of Governors	Appoint or remove the Trust's external auditors. For further responsibilities, see section 7
Audit & Non-clinical Risk Sub-committee	Ensure compliance with the law and regulations; ensure effective internal control and systems are set up and maintained; ensure value for money. For further responsibilities, see section 9. Minutes of meetings go to Board of Directors
Internal Audit	Systematic analysis of business processes, procedures and activities
Head of Risk Management & Legal Services	Monitor compliance with systems for investigating patient safety incidents. Manage serious incidents system
Clinical Governance Standards Committee	Monitor improvements in patient care; ensure patient safety; improve clinical outcomes; assess and anticipate risk; eliminate or reduce risk or harm. Minutes of meetings go to Board of Directors
Patient Safety Review Group	Operational aspects of clinical risk management

During 2010/11, the Audit & Non-clinical Risk Sub-committee kept a focus on weaknesses identified in payroll processes, highlighted in 2009/10. Steps were taken to address deficiencies, including the introduction of a new timesheet and training on the correct completion of timesheets, in conjunction with the Local Counter Fraud Service. This process will continue in 2011/12.

The Trust broadened the scope of internal audit work during 2010/11 undertaking more reviews beyond core financial systems. This resulted in a number of recommendations to enable enhancement of key controls. Of particular focus were improvement points arising from audits of serious incidents, business continuity, and back-up of IT systems. The Trust has made progress in implementing the recommendations and the Audit & Non-clinical Risk Sub-committee will again monitor completion in 2011/12.

The Trust carried out a comprehensive review of its information governance arrangements using Connecting for Health's Information Governance Tool Kit. The Trust achieved compliance with Monitor's Assurance Framework: a minimum of level 2 for all key standards or an achievable action plan agreed with Internal Audit; in many areas, level 3 was reached. Overall, the Trust achieved 73% compliance with CfH's IG Toolkit. There was one serious untoward incident involving data loss in 2010/11, which related to the theft of a laptop control processor, which held *de minimus* patient data. The Information Commissioner's office was informed, and concluded that the actions taken by the Trust, after the incident, were appropriate and satisfactory.

Looking forward to 2011/12, business and financial transformation remain a key objective, to which risk is heightened given the context of the broader economic climate. The Trust's Annual Plan for 2011/12 will identify the key components of this and other risks, as well as related management action, to ensure continued delivery of objectives, building on the successful delivery of key operational targets and a 1% financial surplus in 2011/12.

Conclusion

During the year, no further significant internal control issues were identified.

Dr Peter Reading
Interim Chief Executive
6 June 2011

Annual accounts 2010/11

FOREWORD TO THE ACCOUNTS

DONCASTER & BASSETLAW HOSPITALS NHS FOUNDATION TRUST

These accounts for the year ended 31 March 2011 have been prepared by the Doncaster & Bassetlaw Hospitals NHS Foundation Trust in accordance with paragraphs 24 and 25, schedule 7 of the National Health Service Act 2006 in the form Monitor has, with the approval of the Treasury, directed.

Dr Peter Reading
Interim Chief Executive
6 June 2011

STATEMENT OF COMPREHENSIVE INCOME FOR THE YEAR ENDED 31 March 2011

	NOTE	2010/11 £000	Restated 2009/10 £000
Operating income	4	**330,178**	320,997
Operating expenses	6	**(322,207)**	(314,298)
Operating surplus		**7,971**	6,699
Finance costs:			
Finance income	13	**319**	243
Finance expense	14	**(177)**	(187)
Unwinding of discount on provisions	25	**(45)**	(31)
Public dividend capital dividends payable		**(4,826)**	(5,425)
Net finance costs		**(4,729)**	(5,400)
Surplus for the year		**3,242**	1,299
Other comprehensive income and expense			
Revaluation gains/(losses) on property, plant and equipment		**1,978**	(18,450)
Impairments on property, plant and equipment		**0**	0
Increase in the donated asset reserve due to receipt of donated assets		**316**	711
Reduction in the donated asset reserve in respect of depreciation, impairment, and/or disposal of donated assets		**(277)**	(1,067)
Other recognised gains and losses		**0**	0
Total comprehensive expense for the year		**5,259**	(17,507)

The notes on pages 66 to 89 form part of these accounts.

STATEMENT OF FINANCIAL POSITION AS AT 31 March 2011

	NOTE	31 March 2011 £000	Restated 31 March 2010 £000	Restated 1 April 2009 £000
Non-current assets				
Intangible assets	15	**2,351**	2,161	2,109
Property, plant and equipment	16	**168,112**	166,417	184,562
Trade and other receivables	19	**1,383**	1,141	1,159
Total non-current assets		**171,846**	169,719	187,830
Current assets				
Inventories	18	**3,650**	3,083	2,906
Trade and other receivables	19	**12,162**	13,878	10,696
Cash and cash equivalents	28	**23,268**	24,292	23,965
		39,080	41,253	37,567
Non-current assets held for sale	20	**1,815**	0	0
Total current assets		**40,895**	41,253	37,567
Total assets		**212,741**	210,972	225,397
Current liabilities				
Trade and other payables	21	**(28,161)**	(28,583)	(26,101)
Borrowings	23	**(427)**	(427)	(227)
Provisions	25	**(3,981)**	(5,239)	(3,250)
Tax payable	22	**(4,253)**	(4,114)	(3,897)
Other liabilities	26	**(1,683)**	(1,916)	(2,734)
Total current liabilities		**(38,505)**	(40,279)	(36,209)
Total assets less current liabilities		**174,236**	170,693	189,188
Non-current liabilities				
Borrowings	23	**(3,767)**	(4,194)	(2,720)
Provisions	25	**(1,191)**	(2,410)	(5,074)
Other liabilities	26	**(1,501)**	(1,571)	(1,869)
Total non-current liabilities		**(6,459)**	(8,175)	(9,663)
Total assets employed		**167,777**	162,518	179,525
Financed by taxpayers' equity:				
Public dividend capital		**122,632**	122,632	122,132
Revaluation reserve		**36,688**	34,904	53,714
Donated asset reserve		**3,412**	3,373	3,729
Income and expenditure reserve		**5,045**	1,609	(50)
Total taxpayers' equity		**167,777**	162,518	179,525

The financial statements and associated notes on pages 66 to 89 were approved by the Board of Directors on 23 May and signed on its behalf by:

Dr Peter Reading
Interim Chief Executive

STATEMENT OF CHANGES IN TAXPAYERS' EQUITY

	Public dividend capital (PDC)	Revaluation reserve	Donated asset reserve	Income and expenditure reserve	Total
£000	**£000**	**£000**	**£000**	**£000**	
Balance at 1 April 2009	122,132	46,821	3,729	6,843	179,525
Prior period adjustment - impairments charged to operating expenses	0	6,893	0	(6,893)	0
Restated balance at 1 April 2009	122,132	53,714	3,729	(50)	179,525
Changes in taxpayers' equity for 2009-10					
Surplus for the year	0	0	0	1,299	1,299
Revaluation gains/(losses) on property, plant and equipment	0	(18,450)	0	0	(18,450)
Impairments on property, plant and equipment	0	0	0	0	0
Increase in the donated asset reserve due to receipt of donated assets	0	0	711	0	711
Reduction in the donated asset reserve in respect of depreciation, impairment, and/or disposal of donated assets	0	0	(1,067)	0	(1,067)
Transfer of the excess of current cost depreciation over historical cost depreciation to the Income and Expenditure Reserve	0	(360)	0	360	0
New PDC received	500	0	0	0	500
Balance at 31 March 2010	122,632	34,904	3,373	1,609	162,518
Changes in taxpayers' equity for 2010-11					
Surplus for the year	**0**	**0**	**0**	**3,242**	**3,242**
Revaluation gains/(losses) on property, plant and equipment	**0**	**1,978**	**0**	**0**	**1,978**
Impairments on property, plant and equipment	**0**	**0**	**0**	**0**	**0**
Increase in the donated asset reserve due to receipt of donated assets	**0**	**0**	**316**	**0**	**316**
Reduction in the donated asset reserve in respect of depreciation, impairment, and/or disposal of donated assets	**0**	**0**	**(277)**	**0**	**(277)**
Transfers to the income and expenditure account in respect of assets disposed of	**0**	**(194)**	**0**	**194**	**0**
New PDC received	**0**	**0**	**0**	**0**	**0**
Balance at 31 March 2011	**122,632**	**36,688**	**3,412**	**5,045**	**167,777**

STATEMENT OF CASH FLOWS FOR THE YEAR ENDED 31 March 2011

	NOTE	2010/11 £000	Restated 2009/10 £000
Cash flows from operating activities			
Operating surplus		**7,971**	6,699
Depreciation and amortisation		**10,857**	10,823
Impairments		**106**	3,613
Other non cash movements		**463**	0
Transfer from donated asset reserve		**(309)**	(390)
Increase in inventories		**(567)**	(177)
(Increase)/decrease in trade and other receivables		**1,295**	(2,653)
Increase/(decrease) in trade and other payables		**(2,010)**	4,332
Decrease in other current liabilities		**(375)**	(1,152)
Increase/(decrease) in provisions	25	**(2,701)**	(769)
Increase in tax payable		**139**	217
Net cash inflow from operating activities		**14,869**	20,543
Cash flows from investing activities			
Interest received		**319**	243
Purchase of intangible assets	15	**(493)**	(387)
Purchase of property, plant and equipment	16	**(10,595)**	(16,166)
Receipts from disposal of plant, property and equipment		**129**	20
Net cash outflow from investing activities		**(10,640)**	(16,290)
Net cash inflow before financing		**4,229**	4,253
Cash flows from financing activities			
Public dividend capital received		**0**	500
Loans received		**0**	2,000
Loans repaid		**(427)**	(326)
Interest paid		**(179)**	(164)
Dividends paid		**(4,647)**	(5,936)
Net cash outflow from financing		**(5,253)**	(3,926)
Net increase/(decrease) in cash and cash equivalents		**(1,024)**	327
Cash and cash equivalents at 1 April		**24,292**	23,965
Cash and cash equivalents at 31 March	28	**23,268**	24,292

NOTES TO THE ACCOUNTS

1 Accounting policies and other information

Monitor has directed that the financial statements of Foundation Trusts shall meet the accounting requirements of the *NHS Foundation Trust Annual Reporting Manual* (FT ARM), which shall be agreed with HM Treasury. Consequently, the financial statements will be prepared in accordance with the 2010/11 FT ARM issued by Monitor. The accounting policies contained in that manual follow International Financial Reporting Standards (IFRS) and HM Treasury's *Financial Reporting Manual* to the extent that they are meaningful and appropriate to NHS foundation trusts. The accounting policies will be applied consistently in dealing with items considered material in relation to the accounts.

Accounting convention

These accounts have been prepared on a going concern basis under the historical cost convention modified to account for the revaluation of property, plant and equipment, intangible assets, inventories and certain financial assets and financial liabilities.

1.1 Consolidation

Subsidiaries

Subsidiary entities are those over which the Trust has the power to exercise control or a dominant influence so as to gain economic or other benefits.

For 2009/10 and 2010/11, NHS charitable funds considered to be subsidiaries are excluded from consolidation in accordance with the accounting direction issued by Monitor. The Trust has no other subsidiaries.

1.2 Income

Income in respect of services provided is recognised when, and to the extent that, performance occurs and is measured at the fair value of the consideration receivable. The main source of income for the Trust is contracts with commissioners in respect of healthcare services.

Under the terms of the Trust's contracts, once a patient is admitted and treatment begins then the income for that treatment or spell can start to be recognised. Income relating to those spells, which are partially completed at the year end, is apportioned across the financial years on a pro rata basis, based on the costs incurred.

Where income is received for a specific activity, which is to be delivered in the following financial year, that income is deferred.

Income from the sale of non-current assets is recognised only when all material conditions of sale have been met, and is measured as the sums due under the sale contract.

1.3 Expenditure on employee benefits

Short-term employee benefits

Salaries, wages and employment-related payments are recognised in the period in which the service is received from employees. The cost of annual leave entitlement earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry forward leave into the following period.

Pension costs

NHS Pension Scheme

Past and present employees are covered by the provisions of the NHS Pensions Scheme. The scheme is an unfunded, defined benefit scheme that covers NHS employers, general practices and other bodies, allowed under the direction of Secretary of State, in England and Wales. It is not possible for the Trust to identify its share of the underlying scheme liabilities. Therefore, the scheme is accounted for as a defined contribution scheme.

Employers' pension cost contributions are charged to operating expenses as and when they become due.

Additional pension liabilities arising from early retirements are not funded by the scheme except where the retirement is due to ill-health. The full amount of the liability for the additional costs is charged to the operating expenses at the time the Trust commits itself to the retirement, regardless of the method of payment.

1.4 Expenditure on other goods and services

Expenditure on goods and services is recognised when, and to the extent that they have been received, and is measured at the fair value of those goods and services. Expenditure is recognised in operating expenses except where it results in the creation of a non-current asset such as property, plant and equipment.

1.5 Property, plant and equipment

Recognition

Property, plant and equipment is capitalised where:

- it is held for use in delivering services or for administrative purposes;
- it is probable that future economic benefits will flow to, or service potential be provided to, the Trust;
- it is expected to be used for more than one financial year;
- the cost of the item can be measured reliably; and
- individually have a cost of at least £5,000; or
- form a group of assets which individually have a cost of more than £250, collectively have a cost of at least £5,000, where the assets are functionally interdependent, they had broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control; or
- form part of the initial equipping and setting-up cost of a new building or refurbishment of a ward or unit irrespective of their individual or collective cost.

Where a large asset, for example a building, includes a number of components with significantly different asset lives, eg plant and equipment, then these components are treated as separate assets and depreciated over their own useful economic lives.

Measurement

Valuation

All property, plant and equipment assets are measured initially at cost, representing the costs directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management.

All assets are measured subsequently at fair value. All land and buildings are revalued using professional valuations when management determine there to be a material difference between carrying value and fair value as defined by IAS16 'Property, Plant and Equipment'. Operational equipment is valued at net current replacement cost as a proxy for fair value.

Subsequent expenditure

Where subsequent expenditure enhances an asset beyond its original specification, the directly attributable cost is added to the asset's carrying value. Where a component of an asset is replaced, the cost of the replacement is capitalised if it meets the criteria for recognition above. The carrying amount of the part replaced is de-recognised. Where subsequent expenditure is simply restoring the asset to the specification assumed by its economic useful life then the expenditure is charged to operating expenses.

Depreciation

Items of property, plant and equipment are depreciated over their remaining useful economic lives in a manner consistent with the consumption of economic or service delivery benefits.

	Years
Buildings excluding dwellings	34 to 60
Dwellings	34 to 40
Medical equipment and engineering plant and equipment	7 to 15
Furniture	7
Mainframe information technology installations	7
Soft furnishings	7
Office and information technology equipment	5 to 7
Vehicles	5

Freehold land is considered to have an infinite life and is not depreciated.

Property, plant and equipment which has been reclassified as 'Held for Sale' ceases to be depreciated upon the reclassification. Assets in the course of construction are not depreciated until the asset is brought into use or reverts to the Trust, respectively.

Revaluation gains and losses

Revaluation gains are recognised in the revaluation reserve, except where, and to the extent that, they reverse a revaluation decrease that has previously been recognised in operating expenses, in which case they are recognised in operating income.

Revaluation losses are charged to the revaluation reserve to the extent that there is an available balance for the asset concerned, and thereafter are charged to operating expenses.

Gains and losses recognised in the revaluation reserve are reported in the Statement of Comprehensive Income as an item of 'other comprehensive income'.

Impairments

In accordance with the FT ARM, impairments that are due to a loss of economic benefits or service potential in the asset are charged to operating expenses. A compensating transfer is made from the revaluation reserve to the income and expenditure reserve of an amount equal to the lower of the impairment charged to operating expenses and the balance in the revaluation reserve attributable to that asset before the impairment.

Other impairments are treated as revaluation losses. Reversals of 'other impairments' are treated as revaluation gains.

De-recognition

Assets intended for disposal are reclassified as 'Held for Sale' once all of the following criteria are met:

- the asset is available for immediate sale in its present condition subject only to terms which are usual and customary for such sales;
- the sale must be highly probable, ie:
  - management are committed to a plan to sell the asset
  - an active programme has begun to find a buyer and complete the sale
  - the asset is being actively marketed at a reasonable price
  - the sale is expected to be completed within 12 months of the date of classification as 'Held for Sale'; and
  - the actions needed to complete the plan indicate it is unlikely that the plan will be dropped or significant changes made to it.

Following reclassification, the assets are measured at the lower of their existing carrying amount and their 'fair value less costs to sell'. Depreciation ceases to be charged and the assets are not revalued, except where the 'fair value less costs to sell' falls below the carrying amount. Assets are de-recognised when all material sale contract conditions have been met.

Property, plant and equipment which is to be scrapped or demolished does not qualify for recognition as 'Held for Sale' and instead is retained as an operational asset and the asset's economic life is adjusted. The asset is de-recognised when scrapping or demolition occurs.

Donated assets

Donated non-current assets are capitalised at their current value on receipt and this value is credited to the donated asset reserve. Donated non-current assets are valued and depreciated as described above for purchased assets. Gains and losses on revaluations are also taken to the donated asset reserve and, each year, an amount equal to the depreciation charge on the asset is released from the donated asset reserve to the income and expenditure account. Similarly, any impairment on donated assets charged to the income and expenditure account is matched by a transfer from the donated asset reserve. On sale of donated assets, the net book value of the donated asset is transferred from the donated asset reserve to the income and expenditure reserve.

1.6 Intangible assets

Recognition

Intangible assets are non-monetary assets without physical substance which are

capable of being sold separately from the rest of the Trust's business or which arise from contractual or other legal rights. They are recognised only where it is probable that future economic benefits will flow to, or service potential be provided to, the Trust and where the cost of the asset can be measured reliably. Where internally generated assets are held for service potential, this involves a direct contribution to the delivery of services to the public.

Internally generated intangible assets

Internally generated goodwill, brands, mastheads, publishing titles, customer lists and similar items are not capitalised as intangible assets.

Expenditure on research is not capitalised.

Expenditure on development is capitalised only where all of the following can be demonstrated:

- the project is technically feasible to the point of completion and will result in an intangible asset for sale or use
- the Trust intends to complete the asset and sell or use it
- the Trust has the ability to sell or use the asset
- how the intangible asset will generate probable future economic or service delivery benefits, eg the presence of a market for it or its output, or where it is to be used for internal use, the usefulness of the asset
- adequate financial, technical and other resources are available to the Trust to complete the development and sell or use the asset, and
- the Trust can measure reliably the expenses attributable to the asset during development.

Software

Software which is integral to the operation of hardware eg an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software which is not integral to the operation of hardware eg application software, is capitalised as an intangible asset.

Measurement

Intangible assets are recognised initially at cost, comprising all directly attributable costs needed to create, produce and prepare the asset to the point that it is capable of operating in the manner intended by management.

Subsequently intangible assets are measured at fair value, net current replacement cost may be used as a proxy for fair value. Revaluation gains and losses and impairments are treated in the same manner as for Property, Plant and Equipment.

Intangible assets held for sale are measured at the lower of their carrying amount or 'fair value less costs to sell'.

Amortisation

Intangible assets are amortised over their expected useful economic lives in a manner consistent with the consumption of economic or service delivery benefits.

1.7 Government grants

Government grants are grants from Government bodies other than income from primary care trusts or NHS trusts for the provision of services. Grants from the Department of Health, including those for achieving three star status, are accounted for as Government grants as are grants from the Big Lottery Fund. Where the Government grant is used to fund revenue expenditure it is taken to the Statement of Comprehensive Income to match that expenditure.

Where the grant is used to fund capital expenditure the grant is held as deferred income and released to operating income over the life of the asset in a manner consistent with the depreciation charge for that asset.

1.8 Inventories

Inventories are valued at the lower of cost and net realisable value. The cost of inventories are measured using the First In, First Out (FIFO) method with the exception of drugs, which are measured using the weighted average cost method.

1.9 Financial instruments and financial liabilities

Recognition

Financial assets and financial liabilities which arise from contracts for the purchase or sale of non-financial items (such as goods or services), which are entered into in accordance with the Trust's normal purchase, sale or usage requirements, are recognised when, and to the extent which, performance occurs, ie when receipt or delivery of the goods or services is made.

All other financial assets and financial liabilities are recognised when the Trust becomes a party to the contractual provisions of the instrument.

De-recognition

All financial assets are de-recognised when the rights to receive cashflows from the assets have expired or the Trust has transferred substantially all of the risks and rewards of ownership.

Financial liabilities are de-recognised when the obligation is discharged, cancelled or expires.

Classification and measurement

Financial assets are categorised as 'Fair Value through Income and Expenditure' or Loans and receivables.

Financial liabilities are classified as 'Fair value through Income and Expenditure' or as 'Other Financial liabilities'.

Financial assets and financial liabilities at 'Fair Value through Income and Expenditure'

Financial assets and financial liabilities at 'fair value through income and expenditure' are financial assets or financial liabilities held for trading. A financial asset or financial liability is classified in this category if acquired principally for the purpose of selling in the short-term. Derivatives are also categorised as held for trading unless they are designated as hedges. Derivatives which are embedded in other contracts but which are not 'closely-related' to those contracts are separated-out from those contracts and measured in this category. Assets and liabilities in this category are classified as current assets and current liabilities.

These financial assets and financial liabilities are recognised initially at fair value, with transaction costs expensed in the income and expenditure account. Subsequent movements in the fair value are recognised as gains or losses in the Statement of Comprehensive Income.

Loans and receivables

Loans and receivables are non-derivative financial assets with fixed or determinable payments, which are not quoted in an active market. They are included in current assets.

The Trust's loans and receivables comprise: cash and cash equivalents, NHS debtors, accrued income and 'other debtors'.

Loans and receivables are recognised initially at fair value, net of transactions costs, and are measured subsequently at amortised cost, using the effective interest method. The effective interest rate is the rate that discounts exactly estimated future cash receipts through the expected life of the financial asset or, when appropriate, a shorter period, to the net carrying amount of the financial asset.

Interest on loans and receivables is calculated using the effective interest method and credited to the Statement of Comprehensive Income.

Other financial liabilities

All other financial liabilities are recognised initially at fair value, net of transaction costs incurred, and measured subsequently at amortised cost using the effective interest method. The effective interest rate is the rate that discounts exactly estimated future cash payments through the expected life of the financial liability or, when appropriate, a shorter period, to the net carrying amount of the financial liability.

They are included in current liabilities except for amounts payable more than 12 months after the Statement of Financial Position date, which are classified as non-current liabilities.

Interest on financial liabilities carried at amortised cost is calculated using the effective interest method and charged to Finance Costs. Interest on financial liabilities taken out to finance property, plant and equipment or intangible assets is not capitalised as part of the cost of those assets.

Determination of fair value

For financial assets and financial liabilities carried at fair value, the carrying amounts are determined from discounted cash flow analysis.

Impairment of financial assets

At the Statement of Financial Position date, the Trust assesses whether any financial assets, other than those held at 'fair value through income and expenditure' are impaired. Financial assets are impaired and impairment losses are recognised if, and only if, there is objective evidence of impairment as a result of one or more events which occurred after the initial recognition of the asset and which has an impact on the estimated future cash flows of the asset.

For financial assets carried at amortised cost, the amount of the impairment loss is measured as the difference between the asset's carrying amount and the present value of the revised future cash flows discounted at the asset's original effective interest rate. The loss is recognised in the Statement of Comprehensive Income and the carrying amount of the asset is reduced indirectly through the use of a bad debt provision, until such time as the debt is considered to be no longer recoverable.

1.10 Leases

Finance leases

Where substantially all risks and rewards of ownership of a leased asset are borne by the Trust, the asset is recorded as Property, Plant and Equipment and a corresponding liability is recorded. The value at which both are recognised is the lower of the fair value of the asset or the present value of the minimum lease payments, discounted using the interest rate implicit in the lease. The implicit interest rate is that which produces a constant periodic rate of interest on the outstanding liability.

The asset and liability are recognised at the inception of the lease, and are de-recognised when the liability is discharged, cancelled or expired. The annual rental is split between the repayment of the liability and a finance cost. The annual finance cost is calculated by applying the implicit interest rate to the outstanding liability and is charged to Finance Costs in the Statement of Comprehensive Income.

Operating leases

Other leases are regarded as operating leases and the rentals are charged to operating expenses on a straight-line basis over the term of the lease. Operating lease incentives received are added to the lease rentals and charged to operating expenses over the life of the lease.

Leases of land and buildings

Where a lease is for land and buildings, the land component is separated from the building component and the classification for each is assessed separately.

The Trust as lessor

Amounts due from lessees under finance leases are recorded as receivables at the amount of the Trust's net investment in the leases.

Rental income from operating leases is recognised on a straight-line basis over the term of the lease. Initial direct costs incurred in negotiating and arranging an operating lease are added to the carrying amount of the leased asset and recognised on a straight-line basis over the lease term.

1.11 Provisions

The Trust provides for legal or constructive obligations that are of uncertain timing or amount at the Statement of Financial Position date on the basis of the best estimate of the expenditure required to settle the obligation. Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using HM Treasury's discount rate of 2.2% in real terms, except for early retirement provisions and injury benefit provisions which both use the HM Treasury's pension discount rate of 2.9% in real terms.

Clinical negligence costs

The NHS Litigation Authority (NHSLA) operates a risk pooling scheme under which the Trust pays an annual contribution to the NHSLA, which, in return, settles all clinical negligence claims. Although the NHSLA is administratively responsible for all clinical negligence cases, the legal liability remains with the Trust. The total value of clinical negligence provisions carried by the NHSLA on behalf of the Trust is disclosed at note 25.

Non-clinical risk pooling

The Trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the Trust pays an annual contribution to the NHS Litigation

Authority and in return receives assistance with the costs of claims arising. The annual membership contributions, and any 'excesses' payable in respect of particular claims are charged to operating expenses when the liability arises.

1.12 Contingencies

Contingent assets (that is, assets arising from past events whose existence will only be confirmed by one or more future events not wholly within the entity's control) are not recognised as assets, but are disclosed in note 32 where an inflow of economic benefits is probable.

Contingent liabilities are not recognised, but are disclosed in note 32, unless the probability of a transfer of economic benefits is remote. Contingent liabilities are defined as:

- possible obligations arising from past events whose existence will be confirmed only by the occurrence of one or more uncertain future events not wholly within the entity's control; or
- present obligations arising from past events but for which it is not probable that a transfer of economic benefits will arise or for which the amount of the obligation cannot be measured with sufficient reliability.

1.13 Public dividend capital

Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS Trust. HM Treasury has determined that PDC is not a financial instrument within the meaning of IAS 32.

A charge, reflecting the cost of capital utilised by the Trust, is paid over as public dividend capital dividend. The charge is calculated at the rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the Trust during the financial year. Relevant net assets are calculated as the value of all assets less the value of all liabilities, except for donated assets, net cash balances held with the Government Banking Service and any PDC dividend balance receivable or payable. In accordance with the requirements laid down by the Department of Health (as the issuer of PDC), the dividend for the year is calculated on the actual average relevant net assets for the year as set out in the 'pre-audit' version of the annual accounts. The dividend thus calculated is not revised should any adjustment to net assets occur as a result of the audit of the annual accounts.

1.14 Value added tax

Most of the activities of the Trust are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of non-current assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

1.15 Corporation tax

Most of the activities of the Trust are outside the scope of corporation tax. For those activities which fall within the scope, the Trust employs a three-stage test to determine whether or not an activity is likely to be taxable:

- is the activity an authorised activity related to the provision of core healthcare
- is the activity actually or potentially in competition with the private sector or is it clearly ancillary to the Trust's core healthcare objectives and not entrepreneurial in nature; and
- are the annual profits in excess of £50,000.

The Trust has determined that it has no corporation tax liability.

1.16 Foreign exchange

The functional and presentational currencies of the Trust are sterling.

A transaction which is denominated in a foreign currency is translated into the functional currency at the spot exchange rate on the date of the transaction.

1.17 Third party assets

Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the Trust has no beneficial interest in them. However, they are disclosed in a separate note to the accounts in accordance with the requirements of HM Treasury's *Financial Reporting Manual.*

1.18 EU emissions trading scheme

EU Emission Trading Scheme allowances are accounted for as Government grant funded intangible assets if they are not expected to be realised within twelve months, and otherwise as other current assets. They are valued at open market value. As the Trust makes emissions, a provision is recognised with an offsetting transfer from Government grant deferred income. The provision is settled on surrender of the allowances. The asset, provision and Government grant deferred income are valued at fair value at the end of the reporting period.

2 Critical accounting estimates and judgements

The preparation of the financial statements requires management to make judgements, estimates and assumptions that affect the application of policies and reported amounts of assets and liabilities, income and expenses. The estimates and associated assumptions are based on historical experience and various other factors that are believed to be reasonable under the circumstances, the results of which form the basis of judgements about carrying values of assets and liabilities that are not readily apparent from other sources. Actual results may differ from these estimates.

The estimates and underlying assumptions are reviewed on an ongoing basis. Revisions to accounting estimates are recognised in the period in which the estimate is revised if the revision affects only that period, or in the period of the revision, and future periods, if the revision affects both current and future periods.

Critical estimates and assumptions are made in particular with regard to impairment reviews, classification of leases as operating leases versus finance leases and the classification of certain properties as property assets rather than non-current assets held for sale.

3 Operating segments

During the year the Trust changed its management structure from clinical divisional business units and corporate directorates to clinical service units and corporate support units (CSUs). Performance is reported at CSU level to the

Board, however this has only been reported using the revised structure for part of the 2010/11 financial year, and this is not the primary way in which financial matters are considered. As a result, the Trust has determined that full adoption of IFRS 8 'Segmental Reporting' is not appropriate for the 2010/11 accounts.

The overall surplus reported to the Board under the revised CSU-based reporting structure was £3.242 million, which agrees to the surplus reported in the Statement of Comprehensive Income.

4 Operating Income

	2010/11 £000	Restated 2009/10 £000
Income from patient care activities by activity		
NHS		
Elective income	**55,494**	53,005
Non-elective income	**92,608**	92,716
Outpatient income	**61,057**	59,151
Other types of activity	**68,268**	67,747
A&E income	**16,614**	12,009
	294,041	284,628
Non-NHS		
Private Patients	**729**	750
Overseas patients (non-reciprocal)	**52**	9
NHS Injury Scheme	**2,141**	1,670
Other	**457**	583
Total income from patient care activities	**297,420**	287,640
Other operating income		
Education, training and research	**7,842**	7,218
Charitable and other contributions to expenditure	**0**	216
Transfers from donated asset reserve	**309**	390
Transfers from Government grants	**466**	466
Non-patient care services to other bodies	**15,521**	16,946
Other income	**8,620**	8,121
Total other operating income	**32,758**	33,357
Total operating income	**330,178**	320,997

In other operating income, the 'other income' mainly income from recharges of £3,888,000 (2009/10, £4,060,000) and internal generation of £4,332,000 (2009/10, £4,030,000). The main sources of the internally generated income were the Trust's catering outlets, car parking charges, day nurseries and staff accommodation.

Income from private patients, other patient care activities and non-patient care services to other bodies for 2009/10 have been restated to reflect the revised Monitor guidance on private patient income in relation to income received indirectly by the Trust for services provided to private patients.

5 Income from patient care activities

5.1 Income from patient care activities by source

	2010/11 £000	Restated 2009/10 £000
Primary care trusts	**294,011**	284,584
NHS other	**30**	44
Non-NHS:		
Private patients	**729**	750
Overseas patients (non-reciprocal)	**52**	9
Injury costs recovery	**2,141**	1,670
Other	**457**	583
	297,420	287,640

The income from PCTs for activity covered by 'Payment by Results' is charged at national tariff, subject to a market forces factor adjustment.

Injury costs recovery income is subject to a provision for doubtful debts of 9.6% (2009/10, 7.8%) to reflect expected rates of collection.

5.2 Private Patient Income	2010/11 £000	Restated 2009/10 £000	Restated Base Year £000
Private patient income	**729**	750	866
Total Patient Related Income	**297,420**	287,640	161,516
Proportion (%)	**0.2%**	0.3%	0.5%

Under its Terms of Authorisation, the Trust must ensure that the proportion of patient related income derived from private patients does not exceed the proportion received as an NHS Trust in 2002/03 (the base year). On 10 February 2010, Monitor issued revised and updated rules in their Private Patient Cap publication. Private patient income now includes income attributable to the Trust either directly or indirectly and which has its origin in the provision of goods and services to non-NHS patients. The revised guidance increased the base year income from private patients to £866,000 which equates to revised proportion of 0.5%. In 2010/11, the Trust received 0.2% (2009/10, 0.3%) of its patient related income from private patients, which is within the revised limit set at 0.5%. The income indirectly received from private patients has been estimated based upon recorded private and non-private patient activity.

6 Operating Expenses	2010/11 £000	Restated 2009/10 £000
Services from Foundation Trusts	3,727	3,056
Services from NHS Trusts	157	2,049
Services from other NHS bodies	6,139	4,945
Purchase of healthcare from non-NHS bodies	4,987	5,041
Employee Expenses - Executive directors	1,216	1,033
Employee Expenses - Non-executive directors	108	103
Employee Expenses - Staff	218,375	214,463
Drug costs	22,003	18,874
Supplies and services - clinical	25,253	23,233
Supplies and services - general	4,213	4,159
Establishment	3,228	3,189
Transport	849	503
Premises	9,743	9,307
Provision for impairment of receivables	290	1
Depreciation on property, plant and equipment	10,314	10,358
Amortisation on intangible assets	543	465
Impairments of property, plant and equipment	106	3,613
Audit fees	54	48
Other auditor's remuneration	27	3
Clinical negligence	5,893	5,550
Loss on disposal of intangible fixed assets	11	0
Loss on disposal of plant and equipment	452	20
Legal fees	479	317
Consultancy costs	449	943
Training, courses and conferences	711	768
Patient travel	23	23
Security	180	165
Redundancy	500	0
Early retirement	100	268
Insurance	206	206
Other services	1,135	1,122
Losses, ex gratia & special payments	8	63
Other	728	410
	322,207	314,298

7 Operating leases

7.1 Operating lease income

The Trust has a number of leasing arrangements for the use of land and buildings, mainly with other NHS organisations. The only significant leasing arrangement not with another NHS organisation is with Parkhill Hospital at Doncaster Royal Infirmary.

Rental income	**2010/11**	2009/10
	£000	£000
Rents recognised as income	**778**	783
Total rental income	**778**	783

Total future minimum lease payments due	**2010/11**	2009/10
	£000	£000
Receivable:		
Not later than one year	**777**	778
Between one and five years	**259**	170
Total	**1,036**	948

7.2 Operating lease expenditure

The Trust has a number of leasing arrangements with other NHS bodies in respect of the use of their buildings. The minimum lease payments were £457,592 (2009/10, £435,098).

In addition to this the Trust also has leasing arrangements in respect of medical equipment and staff cars, the minimum lease payments were £167,745 (2009/10, £168,618).

Payments recognised as an expense	**2010/11**	2009/10
	£000	£000
Minimum lease payments	**625**	604
	625	604

Total future minimum lease payments	**2010/11**	2009/10
	£000	£000
Payable:		
Not later than one year	**476**	471
Between one and five years	**10**	13
Total	**486**	484

8 Employee costs and numbers

8.1 Employee costs

	2010/11			2009/10		
	Total	**Permanently Employed**	**Other**	Total	Permanently Employed	Other
	£000	**£000**	**£000**	£000	£000	£000
Salaries and wages	**186,910**	**173,778**	**13,132**	184,604	173,143	11,461
Social Security Costs	**13,602**	**13,602**	**0**	12,032	12,032	0
Employer contributions to NHS Pension scheme	**19,708**	**19,708**	**0**	19,357	19,357	0
Redundancy and early retirements	**600**	**600**	**0**	268	268	0
Employee benefits expense	**220,820**	**207,688**	**13,132**	216,261	204,800	11,461

Staff costs which have been capitalised during the year total £628,884 (2009/10, £497,000).

8.2 Average number of people employed (whole time equivalents)

	2010/11 Total Wte	2010/11 Permanently Employed Wte	2010/11 Other Wte	2009/10 Total Wte	2009/10 Permanently Employed Wte	2009/10 Other Wte
Medical and dental	**581**	**510**	**71**	581	499	82
Administration and estates	**1,111**	**1,091**	**20**	1,103	1,078	25
Healthcare assistants and other support staff	**697**	**677**	**20**	701	686	15
Nursing, midwifery and health visiting staff	**2,366**	**2,356**	**10**	2,328	2,317	11
Scientific, therapeutic and technical staff	**817**	**808**	**9**	825	810	15
Total	**5,572**	**5,442**	**130**	5,538	5,390	148

8.3 Employee exit packages

Exit package cost band	2010/11 Number of Compulsory Redundancies	2010/11 Number of other agreed departures	2010/11 Total	2009/10 Number of Compulsory Redundancies	2009/10 Number of other agreed departures	2009/10 Total
Upto £10,000	6	0	**6**	0	0	0
£10,001 - £25,000	**1**	0	**1**	0	1	1
Total number of packages	**7**	**0**	**7**	0	1	1
Total cost of packages (£000)	**48**	**0**	**48**	0	19	19

During the year the Trust made seven staff compulsorily redundant as a consequence of closing the workplace nursery on the Bassetlaw Hospital site.

9 Pension costs

Past and present employees are covered by the provisions of the NHS Pensions Scheme. Details of the benefits payable under these provisions can be found on the NHS Pensions website. The scheme is an unfunded, defined benefit scheme that covers NHS employers, General Practices and other bodies, allowed under the direction of the Secretary of State, in England and Wales. The scheme is not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, the scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS Body of participating in the scheme is taken as equal to the contributions payable to the scheme for the accounting period.

The scheme is subject to a full actuarial valuation every four years (until 2004, every five years) and an accounting valuation every year. An outline of these follows:

a) Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the scheme (taking into account its recent demographic experience), and to recommend the contribution rates to be paid by employers and scheme members. The last such valuation, which determined current contribution rates was undertaken as at 31 March 2004 and covered the period from 1 April 1999 to that date.

The conclusion from the 2004 valuation was that the scheme had accumulated a notional deficit of £3.3 billion against the notional assets as at 31 March 2004. However, after taking into account the changes in the benefit and contribution structure effective from 1 April 2008, the scheme actuary reported that employer contributions could continue at the existing rate of 14% of pensionable pay. On advice from the scheme actuary, scheme contributions may be varied from time to time to reflect changes in the scheme's liabilities. Up to 31 March 2008, the vast majority of employees paid contributions at the rate of 6% of pensionable pay. From 1 April 2008, employees contributions are on a tiered scale from 5% up to 8.5% of their pensionable pay depending on total earnings.

b) Accounting valuation

A valuation of the scheme liability is carried out annually by the scheme actuary as at the end of the reporting period by updating the results of the full actuarial valuation.

Between the full actuarial valuations at a two-year midpoint, a full and detailed member data-set is provided to the scheme actuary. At this point the assumptions regarding the composition of the scheme membership are updated to allow the scheme liability to be valued.

The valuation of the scheme liability as at 31 March 2008, is based on detailed membership data as at 31 March 2006 (the latest midpoint), updated to 31 March 2008 with summary global member and accounting data.

The latest assessment of the liabilities of

the scheme is contained in the scheme actuary report, which forms part of the annual NHS Pension Scheme (England and Wales) Resource Account, published annually. These accounts can be viewed on the NHS Pensions website. Copies can also be obtained from The Stationery Office.

c) Scheme provisions

The scheme is a 'final salary' scheme. Annual pensions are normally based on 1/80th of the best of the last 3 years pensionable pay for each year of service. A lump sum normally equivalent to 3 years pension is payable on retirement. Annual increases are applied to pension payments at rates defined by the Pensions (Increase) Act 1971, and are based on changes in retail prices in the twelve months ending 30 September in the previous calendar year. On death, a pension of 50% of the member's pension is normally payable to the surviving spouse.

Early payment of a pension, with enhancement, is available to members of the scheme who are permanently incapable of fulfilling their duties effectively through illness or infirmity. A death gratuity of twice the final year's pensionable pay for death in service, and five times their annual pension for death after retirement, less pension already paid, subject to a maximum amount equal to twice the member's final year's pensionable pay less their retirement lump sum for those who die after retirement, is payable.

For early retirements other than those due to ill health, the additional pension liabilities are not funded by the scheme. The full amount of the liability for the additional costs is charged to the statement of comprehensive income at the time the Trust commits itself to the retirement, regardless of the method of payment.

The scheme provides the opportunity to members to increase their benefits through money purchase additional voluntary contributions (AVCs) provided by an approved panel of life companies. Under the arrangement the employee/member can make contributions to enhance an employee's pension benefits. The benefits payable relate directly to the value of the investments made.

10 Retirements due to ill-health

During 2010/11, there were six (2009/10, 13) early retirements from the Trust agreed on the grounds of ill-health. The estimated additional pension liabilities of these ill-health retirements will be £280,000 (2009/10, £624,000), based on information supplied by NHS Pensions. The cost of these ill-health retirements will be borne by the NHS Business Services Authority - Pensions Division. These retirements represented 0.81 (2009/10, 1.81) per 1,000 active scheme members.

11 Auditor's remuneration

	2010/11	2009/10
	£000	£000
Audit fees:		
audit services - statutory audit	**54**	48
Other auditors remuneration:		
further assurance services	**17**	3
other services	**10**	0
Total	**81**	51

The statutory audit fee includes the work on the Quality Report as required under Monitor's Audit Code for NHS Foundation Trusts. The further assurance services relate to work on the Quality Report 2009/10, carried out in June 2010.

Limitation on the external auditor's liability is set at £1,000,000.

12 Supplier payment practice

12.1 Supplier payment practice - measure of compliance

	2010/11		2009/10	
	Number	**£000**	Number	£000
Total invoices paid in the year	**94,416**	**123,282**	90,505	114,030
Total invoices paid within 30 days	**64,763**	**89,298**	58,327	80,108
Percentage of invoices paid within 30 days	**69%**	**72%**	64%	70%

The Better Payment Practice Code requires the Trust to aim to pay all undisputed invoices by the due date or within 30 days of receipt of goods or a valid invoice, whichever is later. The above analysis shows the Trust's payment performance of paying invoices within 30 days, measured from the invoice date to date of payment without any adjustment for invoices which have been in dispute.

12.2 The late payment of commercial debts (interest) Act 1998

	2010/11 £000	2009/10 £000
Amounts included in finance costs from claims made under this legislation	**0**	0
Compensation paid to cover debt recovery costs under this legislation	**0**	0
Total	**0**	0

13 Finance income

	2010/11 £000	2009/10 £000
Bank accounts	**319**	243
Total	**319**	243

14 Finance expense

	2010/11 £000	2009/10 £000
Interest on loans from Foundation Trust Financing Facility	177	187
Total	**177**	187

15 Intangible assets

15.1 Intangible assets 2010/11:

	Computer software purchased	EU emissions trading scheme allowances	Total
	£000	£000	£000
Gross cost at 1 April 2010	3,282	390	**3,672**
Additions purchased	493	0	**493**
Additions Government granted	0	124	**124**
Disposals	(28)	0	**(28)**
Revaluation surpluses	0	127	**127**
Gross cost at 31 March 2011	**3,747**	**641**	**4,388**
Amortisation at 1 April 2010	1,511	0	1,511
Disposals	(17)	0	(17)
Charged during the year	543	0	543
Amortisation at 31 March 2011	**2,037**	**0**	**2,037**
Net book value			
Purchased	1,710	0	1,710
Government granted	0	641	641
Total at 31 March 2011	**1,710**	**641**	**2,351**

Prior year:

15.2 Intangible assets 2009/10:	Computer software purchased	EU emissions trading scheme allowances	Total
	£000	£000	£000
Gross cost at 1 April 2009	3,081	260	**3,341**
Additions purchased	387	0	**387**
Additions Government granted	0	103	**103**
Disposals	(186)	0	**(186)**
Reversals of impairments	0	27	**27**
Gross cost at 31 March 2010	**3,282**	**390**	**3,672**
Amortisation at 1 April 2009	1,232	0	**1,232**
Disposals	(186)	0	**(186)**
Charged during the year	465	0	**465**
Amortisation at 31 March 2010	**1,511**	**0**	**1,511**
Net book value			
Purchased	1,771	0	**1,771**
Government granted	0	390	**390**
Total at 31 March 2010	**1,771**	**390**	**2,161**

15.3 Economic life of intangible assets	Min Life Years	Max Life Years
Computer software licences (straight line basis)	1	5
EU Emissions	1	3

16 Property, plant and equipment

16.1 Property, plant and equipment 2010/11:

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant and machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Cost or valuation at 1 April 2010	20,842	125,940	5,346	0	38,094	572	12,840	3,330	206,964
Additions purchased	0	5,421	89	187	4,234	1	1,525	608	12,065
Additions donated	0	119	0	0	197	0	0	0	316
Additions Government granted	0	12	0	0	100	0	8	0	120
Reclassifications	0	187	0	(187)	0	0	0	0	0
Reclassified as held for sale	(715)	(515)	(585)	0	0	0	0	0	(1,815)
Disposals	(35)	(193)	(379)	0	(1,784)	(49)	(838)	(64)	(3,342)
Revaluation gains/(losses)	233	(4,037)	(367)	0	0	0	0	0	(4,171)
At 31 March 2011	**20,325**	**126,934**	**4,104**	**0**	**40,841**	**524**	**13,535**	**3,874**	**210,137**
Depreciation at 1 April 2010	0	0	213	0	29,020	442	9,207	1,665	40,547
Disposals	0	(19)	(29)	0	(1,784)	(49)	(828)	(52)	(2,761)
Revaluation gains/(losses)	0	(5,688)	(493)	0	0	0	0	0	(6,181)
Impairments	0	106	0	0	0	0	0	0	106
Charged during the year	0	5,601	309	0	2,710	62	1,243	389	10,314
Depreciation at 31 March 2011	**0**	**0**	**0**	**0**	**29,946**	**455**	**9,622**	**2,002**	**42,025**
Net book value									
Purchased	20,315	123,349	4,104	0	9,939	69	3,838	1,865	163,479
Donated	10	2,619	0	0	713	0	63	7	3,412
Government granted	0	966	0	0	243	0	12	0	1,221
Total at 31 March 2011	**20,325**	**126,934**	**4,104**	**0**	**10,895**	**69**	**3,913**	**1,872**	**168,112**
Analysis of net book value									
Protected	18,935	126,196	2,691	0	0	0	0	0	147,822
Unprotected	1,390	738	1,413	0	10,895	69	3,913	1,872	20,290
Total 31 March 2011	**20,325**	**126,934**	**4,104**	**0**	**10,895**	**69**	**3,913**	**1,872**	**168,112**

Prior year:

16.2 Property, plant and equipment 2009/10:

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant and machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Cost or valuation at 1 April 2009	22,448	135,471	5,651	6,844	37,619	587	12,095	2,790	**223,505**
Additions purchased	0	7,346	1	2,546	2,231	25	1,473	624	**14,246**
Additions donated	0	215	0	0	449	0	47	0	**711**
Additions Government granted	0	13	0	0	0	0	3	0	**16**
Reclassifications	0	9,283	0	(9,283)	0	0	0	0	**0**
Disposals	0	0	0	0	(2,205)	(40)	(778)	(84)	**(3,107)**
Revaluation gains/(losses)	0	2,095	0	0	0	0	0	0	**2,095**
Impairments	(1,606)	(28,483)	(306)	(107)	0	0	0	0	**(30,502)**
At 31 March 2010	**20,842**	**125,940**	**5,346**	**0**	**38,094**	**572**	**12,840**	**3,330**	**206,964**
Depreciation at 1 April 2009	0	0	0	0	28,229	412	8,927	1,375	**38,943**
Disposals	0	0	0	0	(2,202)	(38)	(770)	(77)	**(3,087)**
Revaluation gains/(losses)	0	272	0	0	0	0	0	0	**272**
Impairments	0	(5,860)	(79)	0	0	0	0	0	**(5,939)**
Charged during the year	0	5,588	292	0	2,993	68	1,050	367	**10,358**
Depreciation at 31 March 2010	**0**	**0**	**213**	**0**	**29,020**	**442**	**9,207**	**1,665**	**40,547**
Net book value									
Purchased	20,832	122,284	5,133	0	8,029	119	3,504	1,653	**161,554**
Donated	10	2,548	0	0	698	6	99	12	**3,373**
Government granted	0	1,108	0	0	347	5	30	0	**1,490**
Total at 31 March 2010	**20,842**	**125,940**	**5,133**	**0**	**9,074**	**130**	**3,633**	**1,665**	**166,417**
Analysis of net book value									
Protected	18,938	124,950	3,065	0	0	0	0	0	**146,953**
Unprotected	1,904	990	2,068	0	9,074	130	3,633	1,665	**19,464**
Total 31 March 2010	**20,842**	**125,940**	**5,133**	**0**	**9,074**	**130**	**3,633**	**1,665**	**166,417**

16.3 Land and property held at revalued amounts

Valuations are carried out by professionally qualified valuers in accordance with the Royal Institution of Chartered Surveyors (RICS) Appraisal and Valuation Manual. The last full asset valuations were undertaken in 2011 on a Modern Equivalent Asset (MEA) basis with a valuation date of 31 March 2011. The valuation increased net book values by £1,904,000, the movements are accounted for in these accounts.

16.4 Land and property held at open market value

The totals at 31 March 2011 include land, buildings and dwellings valued at open market value of:

	31 March 2011	31 March 2010
	£000	£000
Land	**2,185**	2,590
Buildings, excluding dwellings	**1,274**	1,317
Dwellings	**4,554**	5,133
TOTAL	**8,013**	9,040

16.5 Land and property by holding

The net book values at 31 March 2011 include land, buildings and dwellings which comprise:

	Protected	Unprotected	**31 March 2011**	31 March 2010
	£000	£000	**£000**	£000
Freehold	147,489	3,541	**151,030**	151,066
Long leasehold	0	0	**0**	849
Short leasehold	337	0	**337**	0
TOTAL	147,826	3,541	**151,367**	151,915

16.6 Property, plant and equipment leased to third parties

The Trust is the lessor of a number of property assets provided under operating leases, however they are not all discrete assets in their own right, but areas within the Trust's existing buildings. The additional details below only cover those assets which are discrete and/or material.

	31 March 2011	31 March 2010
	£000	£000
Gross carrying amount	**7,067**	6,941
Accumulated depreciation	**198**	218
Depreciation charge for the period	**198**	165
Impairment losses recognised for the period	**16**	2,866

16.7 Economic life of property, plant and equipment

	Min Life	Max Life
	Years	Years
Buildings excluding dwellings	1	61
Dwellings	5	34
Assets under Construction & POA		
Plant & Machinery	1	7
Transport Equipment	1	5
Information Technology	1	5
Furniture & Fittings	1	7

17 Impairments

	31 March 2011	Restated 31 March 2010
	£000	£000
Impairment of assets due to:		
Changes in market price	**106**	24,563
Impairments charged to:		
Operating expenses	**106**	3,613
Revaluation reserve	**0**	20,273
Donated asset reserve	**0**	677
	106	24,563

18 Inventories

18.1 Inventories

	31 March 2011 £000	31 March 2010 £000
Drugs	**2,262**	2,163
Theatre consumables	**1,115**	623
Building and engineering consumables	**141**	143
Other consumables	**132**	154
Total	**3,650**	3,083

18.2 Inventories recognised in expenses

	31 March 2011 £000	31 March 2010 £000
Inventories recognised as an expense in the period	23,340	21,022
Total	**23,340**	21,022

19 Trade and other receivables

19.1 Trade and other receivables

	31 March 2011 £000	31 March 2010 £000
Current		
NHS receivables	**9,438**	10,438
Accrued income	**154**	135
Provision for the impairment of receivables - NHS	**(803)**	(600)
Provision for the impairment of receivables - Non-NHS	**(280)**	(312)
Prepayments	**594**	675
PDC dividend receivable	**332**	511
Other receivables	**2,727**	3,031
Total	**12,162**	13,878
Non-current		
Provision for the impairment of receivables	**(147)**	(97)
Other receivables	**1,530**	1,238
Total	**1,383**	1,141
Total	**13,545**	15,019

The great majority of trade is with primary care trusts, as commissioners for NHS patient care services. As primary care trusts are funded by the Government to buy NHS patient care services, no credit scoring of them is considered necessary.

19.2 Provision for impairment of receivables

	31 March 2011 £000	31 March 2010 £000
Balance at 1 April	**1,009**	1,008
Arising during the year	**290**	359
Utilised during the year	**(69)**	0
Reversed unused	**0**	(358)
Balance at 31 March	**1,230**	1,009

19.3 Ageing of impaired receivables past their due date

	31 March 2011 £000	31 March 2010 £000
By up to three months	**5,019**	4,157
By three to six months	**74**	187
By more than six months	**1,145**	912
Total	**6,238**	5,256

19.4 Ageing of non-impaired receivables past their due date

	31 March 2011 £000	31 March 2010 £000
By up to three months	**5,938**	9,371
By three to six months	**802**	56
By more than six months	**717**	24
Total	**7,457**	9,451

20 Non-current assets held for sale

	31 March 2011 £000	31 March 2010 £000
Net Book Value of non-current assets for sale and assets in disposal groups at 1 April	**0**	0
Plus assets classified as available for sale in the year	**1,815**	0
Net Book Value of non-current assets for sale and assets in disposal groups at 31 March	**1,815**	0

The Trust has placed off-site properties on Thorne Road, Bruce Crescent, Victoria Residences and Barrowby House for sale along with land adjacent to the Montagu Hospital site, as part of the Estates Strategy.

21 Trade and other payables

	31 March 2011 £000	31 March 2010 £000
Current		
Interest payable	**21**	23
NHS payables	**7,445**	9,947
Other trade payables - capital	**4,363**	2,773
Other trade payables - revenue	**10,447**	7,911
Other payables	**439**	359
Accruals	**5,446**	7,570
Total	**28,161**	28,583

22 Tax payable

	31 March 2011 £000	31 March 2010 £000
Tax and social security costs	**4,253**	4,114
Total	**4,253**	4,114

23 Borrowings

	31 March 2011 £000	31 March 2010 £000
Current		
Loans from Foundation Trust Financing Facility	**427**	427
Total	**427**	427
Non-current		
Loans from Foundation Trust Financing Facility	**3,767**	4,194
Total	**3,767**	4,194
Total	**4,194**	4,621

The Trust has the following loans from the Foundation Trust Financing Facility:

	31 March 2011	31 March 2010
	£000	£000
Loan 1 - 5.05% fixed interest, repayable over 15 years, with an expected settlement date of 15 March 2022.	**2,495**	2,721
Loan 2 - 2.45% fixed interest, repayable over 10 years, with an expected settlement date of 15 May 2019.	**1,700**	1,900
	4,195	4,621

24 Prudential Borrowing Limit

	2010/11	2009/10
	£000	£000
Long term borrowing limit set by Monitor	**59,100**	62,500
Borrowing as at 1 April	**4,621**	2,947
Actual borrowing in year	**(427)**	1,674
Borrowing as at 31 March	**4,194**	4,621
Working capital limit set by Monitor	**15,000**	15,000
Actual working capital facility in place	**15,000**	15,000
Facility used in year	**0**	0

	Limit	**Actual**	Actual
Minimum dividend cover (at least once)	1.00	**3.96**	3.90
Minimum interest cover (at least 3 times)	3.00	**107.92**	113.20
Minimum debt service cover (at least twice)	2.00	**31.63**	41.18
Maximum debt asset ratio (less than 10%)	10.00%	**2.50%**	2.84%
Maximum debt service to revenue (less than 3%)	3.00%	**0.18%**	0.16%

The Trust is required to comply and remain within a prudential borrowing limit. This is made up of two elements:

- the maximum cumulative amount of long-term borrowing. This is set by reference to the five ratio tests set out in Monitor's Prudential Borrowing Code. The financial risk rating set under Monitor's Compliance Framework determines one of the ratios and therefore can impact on the long term borrowing limit
- the amount of any working capital facility approved by Monitor.

Further information on the NHS Foundation Trust Prudential Borrowing Code and Compliance Framework can be found on the website of Monitor, the Independent Regulator of Foundation Trusts.

25 Provisions

	Current		Non-current		Total	
	31 March 2011	31 March 2010	**31 March 2011**	31 March 2010	**31 March 2011**	31 March 2010
	£000	£000	**£000**	£000	**£000**	£000
Early retirement pensions	**154**	158	**597**	626	**751**	784
Legal claims	**199**	251	**0**	0	**199**	251
Injury benefits (NHS Pensions)	**69**	65	**594**	720	**663**	785
Agenda for change	**0**	1,862	**0**	1,064	**0**	2,926
Medical career reform	**2,188**	2,370	**0**	0	**2,188**	2,370
Other pay items	**682**	344	**0**	0	**682**	344
Patient re-admissions	**321**	0	**0**	0	**321**	0
EU emissions trading scheme	**368**	189	**0**	0	**368**	189
Total	**3,981**	5,239	**1,191**	2,410	**5,172**	7,649

	Early retirement pensions	Legal claims	Injury benefits (NHS Pensions)	Agenda for Change	Medical career reform	Other pay items	Patient Re-admissions	EU emissions trading scheme	Total
	£000	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**
At 1 April 2010	784	251	785	2,926	2,370	344	0	189	**7,649**
Arising during the year	99	224	0	0	2	667	321	179	**1,492**
Used during the year	(155)	(231)	(74)	(130)	(184)	(176)	0	0	**(950)**
Reversed unused	0	(45)	(70)	(2,796)	0	(153)	0	0	**(3,064)**
Unwinding of discount	23	0	22	0	0	0	0	0	**45**
At 31 March 2011	**751**	**199**	**663**	**0**	**2,188**	**682**	**321**	**368**	**5,172**
Expected timing of cash flows:									
Within one year	154	199	69	0	2,188	682	321	368	**3,981**
Between one and five years	597	0	278	0	0	0	0	0	**875**
After five years	0	0	316	0	0	0	0	0	**316**

Pensions costs relating to the early retirements of employees are not funded by the NHS Pension Scheme, the full amount of the liability for the additional costs is charged to the income and expenditure account at the time the Trust commits itself to the retirement, regardless of the method or timing of payment.

Legal claims (which excludes clinical negligence claims) includes personal injury claims made against the Trust. These claims are covered under the Trust's commercial insurance policies for incidents arising pre 1 April 2000 or the NHSLA Pooling Arrangement Scheme for incidents post 1 April 2000.

Other provisions include provisions made for the cost of injury benefits based on information provided by the NHS Pension Agency and provisions for the cost of back pay as a consequence of implementing consultant contracts, medical career reform and agenda for change, restructuring and appeals in relation to clinical excellence, employment tribunals and equal pay.

Patient re-admission provisions are made for the cost of the Trust providing treatment for patients readmitted within 30 days of discharge under the terms of its patient care contracts in respect of activity provided during 2010/11.

The timing of payments in relation to any of these is unclear, however, with the exception of the pension and injury benefit provisions, it is expected that the vast majority will be completed in the 2011/12 financial year.

£59,479,000 is included in the provisions of the NHS Litigation Authority at 31 March 2011 in respect of clinical negligence liabilities of the Trust (31 March 2010, £59,083,000).

26 Other liabilities

	31 March 2011 £000	31 March 2010 £000
Current		
Deferred Income	**1,213**	1,418
Deferred Government Grant	**470**	498
Total	**1,683**	1,916
Non-current		
Deferred Government Grant	**1,501**	1,571
Total	**1,501**	1,571
Total	**3,184**	3,487

27 Revaluation reserves

27.1 Revaluation reserves 2010/11

	Property, plant and equipment £000
Revaluation reserve at 1 April 2010	34,904
Total Comprehensive Income for the year	1,978
Transfers to the income and expenditure account in respect of assets disposed of	(194)
Revaluation reserve at 31 March 2011	**36,688**

27.2 Revaluation reserves 2009/10

	Restated Property, plant and equipment £000
Revaluation reserve at 1 April 2009	46,821
Prior period adjustment - impairments charged to operating expenses	6,893
Restated Revaluation reserve at 1 April 2009	53,714
Total Comprehensive Income for the year	(18,450)
Transfers to the income and expenditure account in respect of assets disposed of	(360)
Revaluation reserve at 31 March 2010	**34,904**

Prior period adjustment

A prior period adjustment has been made to transfer impairments arising in 2009/10 and previous periods from the revaluation reserve. This eliminates negative revaluation reserve balances in respect of some elements of the estate.

The effect of this was to restate the surplus for 2009/10 from £4.733m to £1.299m with an equivalent change to the revaluation reserve, taking it from £46.821m to £53.714m. Retained earnings on 1 April 2009 changed from £6.843m to (£0.050m).

The effects of this adjustment are reflected in the Statement of Comprehensive Income, Statement of Financial Position, Statement of Changes in Tax Payers' Equity, Statement of Cash Flows and notes 6 and 27.2.

28 Cash and cash equivalents

	31 March 2011 £000	31 March 2010 £000
Balance at 1 April	**24,292**	23,965
Net change in year	**(1,024)**	327
Balance at 31 March	**23,268**	24,292
Made up of		
Commercial banks and cash in hand	382	264
Cash with the Government Banking Service	22,886	24,028
Cash and cash equivalents as in statement of financial position	**23,268**	24,292
Cash and cash equivalents as in statement of cash flows	**23,268**	24,292

29 Financial Instruments

29.1 Financial assets

	Loans and receivables £000	Total £000
Receivables	10,853	10,853
Cash at bank and in hand	24,292	24,292
Total at 31 March 2010	35,145	35,145
Receivables	**9,497**	**9,497**
Cash at bank and in hand	**23,268**	**23,268**
Total at 31 March 2011	**32,765**	**32,765**

29.2 Financial liabilities

	Other £000	Total £000
Payables	28,583	28,583
Borrowings	4,621	4,621
Provisions	7,649	7,649
Total at 31 March 2010	40,853	40,853
Payables	**28,161**	**28,161**
Borrowings	**4,194**	**4,194**
Provisions	**5,172**	**5,172**
Total at 31 March 2011	**37,527**	**37,527**

29.3 Financial risk management

Financial reporting standard IFRS 7 'Financial Instruments: Disclosures' requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities. Because of the continuing service provider relationship that the Trust has with primary care trusts, and the way those primary care trusts are financed, the Trust is not exposed to the degree of financial risk faced by business entities. Also, financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which the financial reporting standards mainly apply. The Trust has limited powers to borrow or invest surplus funds and financial assets, and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the Trust in undertaking its activities.

The Trust's treasury management operations are carried out by the finance department, within parameters defined formally within the Trust's Standing Financial Instructions and policies agreed by the Board of Directors. Trust treasury activity is subject to review by the Trust's internal auditors.

Market risk

IFRS7 defines three components of Market Risk; Currency risk, Interest Rate Risk, and Price Risk. The Trust's assessment of its exposure to these risks is as follows;

Currency risk

This is the risk that the Trust's income and expenditure could be affected materially by foreign exchange rate gains and losses.

The Trust is principally a domestic organisation with the great majority of transactions, assets and liabilities being in the UK and sterling based. The Trust has no overseas operations. The Trust therefore has low exposure to currency rate fluctuations.

Interest rate risk

This is the risk that the Trust's income and expenditure could be affected materially by changes in interest rates on financial liabilities (eg Borrowing).

The Trust borrows from the Government for capital expenditure, subject to Monitor's prudential borrowing limit. The borrowings are for 1 – 25 years, in line with the life of the associated assets, and interest is charged at the National Loans Fund rate, fixed for the life of the loan. The Trust therefore has low exposure to interest rate fluctuations.

Price risk

Price risk arises on financial instruments as a result of changes in, for example, commodity or equity prices. The Trust does not consider itself to be exposed to this form of risk as it holds no such financial assets or liabilities.

Credit risk

This is the risk that other parties may not pay amounts due from them to the Trust. The principle sources of credit risk are trade and other receivables and cash investments.

Because the majority of the Trust's income comes from contracts with other public sector bodies, the Trust has low exposure to credit risk. Amounts receivable from NHS Trusts and other NHS bodies are statutorily backed by the Secretary of State for Health. Consequently the risk of non-receipt of such sums is low. The maximum exposures as at 31 March 2011 are in receivables from customers, as disclosed in the Trade and other receivables note, which can be found in Note 19.

Liquidity risk

The Trust's operating costs are incurred under contracts with primary care trusts, which are financed from resources voted annually by Parliament. The Trust funds its capital expenditure from resources obtained within its prudential borrowing limit. In addition to this the Trust has access to a £15 million working capital facility and is not, therefore, exposed to significant liquidity risks.

29.4 Fair Values

The fair values of the Trust's financial assets and liabilities as at 31 March 2011 are the same as the book values.

30 Capital commitments

Contracted capital commitments at 31 March not otherwise included in these financial statements:

	31 March 2011 £000	31 March 2010 £000
Property, plant and equipment	**1,278**	904
Intangible assets	**0**	0
Total	**0**	904

£286,512 relates to medical imaging equipment (mammomats) funded from the Bassetlaw Breastcare Appeal. The remainder relates to building work funded from internal resources.

31 Events after the reporting period

There are no events after the reporting date which the Trust is aware which should be reported within these accounts.

32 Contingencies

32.1 Contingent liabilities

	31 March 2011 £000	31 March 2010 £000
Legal claims	**89**	93
Total	**89**	93

The contingent liability relates to personal injury claims made against the Trust which are covered under the NHSLA Pooling Arrangement Scheme, but for which no provision has been made due to the low probability of settlement.

33 Related party transactions

Doncaster & Bassetlaw Hospitals NHS Foundation Trust is a public benefit corporation which was established under the granting of authority by the Independent Regulator for NHS Foundation Trusts, Monitor.

During the year none of the governors, Board members or Management Board members or parties related to them, or entities controlled, jointly controlled or significantly influenced by them or a close family member, had undertaken any material transactions with the Trust.

The Trust has received revenue and capital payments from the charitable fund, for which the Trust is the Corporate Trustee. Included in the accounts as at 31 March 2011 are debtors of £63,565 (31 March 2010, £103,506) and creditors of £10,807 (31 March 2010, £87,910). Copies of the audited accounts of the charitable fund are available separately by contacting the Trust's Communications Manager (see page 3 for contact details).

Other NHS and Government bodies are also regarded as a related party. During the year the Trust had transactions as follows:

	Income	Expenditure	Debtors	Creditors
	£000	£000	£000	£000
Department of Health	141	937	6	7
Other NHS Bodies	318,982	51,285	9,432	7,438
Other Government Bodies	0	21,757	0	4,253
	319,123	**73,979**	**9,438**	**11,698**

During the year the Trust has had a significant number of material transactions with the following:

	Income	Expenditure	Debtors	Creditors
	£000	£000	£000	£000
Rotherham Doncaster and South Humber Mental Health NHS Foundation Trust	526	1,519	3	66
Sheffield Children's Hospital NHS Foundation Trust	62	1,384	0	160
Sheffield Teaching Hospitals NHS Foundation Trust	7,300	6,722	2,195	3,167
The Rotherham NHS Foundation Trust	1,443	713	834	178
Nottinghamshire Healthcare NHS Trust	1,474	0	49	0
Yorkshire and the Humber Strategic Health Authority	6,442	48	160	1
Barnsley PCT	14,175	13	4	0
Bassetlaw PCT	63,996	271	722	329
Derbyshire County PCT	5,330	0	0	47
Doncaster PCT	190,275	4,718	3,957	147
North Lincolnshire PCT	3,016	0	0	6
Nottinghamshire County PCT	4,865	0	116	0
Rotherham PCT	12,054	0	83	0
Wakefield District PCT	2,419	0	335	0
NHS Litigation Authority	0	6,105	0	0
National Blood Authority	0	2,022	24	0
NHS Business Services Authority	0	13,808	0	666
NHS Pension Service	0	13,065	0	2,420
HMRC	0	19,708	0	4,253
	313,377	**70,096**	**8,482**	**11,440**

During 2009/10 the Trust had a significant number of material transactions with the following:

	Income	Expenditure	Debtors	Creditors
	£000	£000	£000	£000
Rotherham Doncaster and South Humber				
Mental Health NHS Foundation Trust	621	1,490	1	84
Sheffield Children's Hospital NHS Foundation Trust	43	1,574	0	645
Sheffield Teaching Hospitals NHS Foundation Trust	6,801	6,202	1,435	2,818
The Rotherham NHS Foundation Trust	1,579	348	367	126
Nottinghamshire Healthcare NHS Trust	1,637	0	56	0
Yorkshire Ambulance Service NHS Trust	33	1,497	6	362
Yorkshire and the Humber Strategic Health Authority	7,147	24	133	27
Barnsley PCT	12,086	108	0	90
Bassetlaw PCT	63,297	637	1,422	239
Derbyshire County PCT	5,745	0	278	0
Doncaster PCT	184,909	1,824	4,686	1,819
North Lincolnshire PCT	2,742	0	180	0
Nottinghamshire County PCT	4,546	0	43	0
Rotherham PCT	12,063	0	82	1
Wakefield District PCT	2,016	0	154	0
NHS Litigation Authority	0	5,750	0	0
National Blood Authority	16	2,235	0	82
National Heath Service Logistics Authority	0	11,877	0	0
NHS Pension Service	0	12,040	0	2,602
HMRC	0	19,357	138	4,114
	305,281	**64,963**	**8,981**	**13,009**

34 Third Party Assets

The Trust held £3,858 cash and cash equivalents at 31 March 2011 (£2,510 at 31 March 2010) which relates to monies held by the Trust on behalf of patients. This has been excluded from the cash and cash equivalents figure reported in the accounts.

35 Losses and Special Payments

There were 160 cases of losses and special payments (2009/10, 79 cases) totalling £326,000 (2009/10, £205,000) charged to expenditure during 2010/11. None of the cases exceeded £100,000.

These amounts are reported on an accruals basis but excluding provisions for future losses.

Independent Auditor's report to the Board of Governors of Doncaster & Bassetlaw Hospitals NHS Foundation Trust

We have audited the financial statements of Doncaster & Bassetlaw Hospitals NHS Foundation Trust for the year ended 31 March 2011, which comprise the Statement of Comprehensive Income, the Statement of Financial Position, the Statement of Cash Flows, the Statement of Changes in Taxpayers' Equity, and the related notes. The financial reporting framework that has been applied in their preparation is the *NHS Foundation Trust Annual Reporting Manual* issued by the Independent Regulator of NHS Foundation Trusts ("Monitor").

Respective responsibilities of directors and auditors

As explained more fully in the Directors' Responsibilities Statement, the directors are responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view. Our responsibility is to audit and express an opinion on the financial statements in accordance with the NHS Act 2006, the Audit Code for NHS Foundation Trusts issued by Monitor, and International Standards on Auditing (ISAs) (UK and Ireland). Those standards require us to comply with the Auditing Practices Board's Ethical Standards for Auditors.

This report, including the opinions, has been prepared for and only for the Board of Governors of Doncaster & Bassetlaw Hospitals NHS Foundation Trust in accordance with paragraph 24(5) of Schedule 7 of the National Health Service Act 2006 and for no other purpose. We do not, in giving these opinions, accept or assume responsibility for any other purpose or to any other person to whom this report is shown or into whose hands it may come save where expressly agreed by our prior consent in writing.

Scope of the audit of the financial statements

An audit involves obtaining evidence about the amounts and disclosures in the financial statements sufficient to give reasonable assurance that the financial statements are free from material misstatement, whether caused by fraud or error. This includes an assessment of: whether the accounting policies are appropriate to the NHS Foundation Trust's circumstances and have been consistently applied and adequately disclosed; the reasonableness of significant accounting estimates made by the NHS Foundation Trust; and the overall presentation of the financial statements. In addition, we read all the financial and non-financial information in the Annual Report & Accounts to identify material inconsistencies with the audited financial statements. If we become aware of any apparent material misstatements or inconsistencies we consider the implications for our report.

Opinion on financial statements

In our opinion the financial statements:

- give a true and fair view, in accordance with the *NHS Foundation Trust Annual Reporting Manual*, of the state of the NHS Foundation Trust's affairs as at 31 March 2011 and of its income and expenditure and cash flows for the year then ended to 31 March 2011; and
- have been properly prepared in accordance with the *NHS Foundation Trust Annual Reporting Manual*.

Opinion on other matters prescribed by the Audit Code for NHS Foundation Trusts

In our opinion:

- the part of the Directors' Remuneration Report to be audited has been properly prepared in accordance with the *NHS Foundation Trust Annual Reporting Manual*; and
- the information given in the Directors' Report for the financial year for which the financial statements are prepared is consistent with the financial statements.

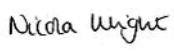
Matters on which we are required to report by exception

We have nothing to report in respect of the following matters where the Audit Code for NHS Foundation Trusts requires us to report to you if:

- in our opinion the Statement on Internal Control does not meet the disclosure requirements set out in the *NHS Foundation Trust Annual Reporting Manual* or is misleading or inconsistent with information of which we are aware from our audit. We are not required to consider, nor have we considered, whether the Accounting Officer's Statement on Internal Control addresses all risks and controls or that risks are satisfactorily addressed by internal controls;
- we have not been able to satisfy ourselves that the NHS Foundation Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources; or
- we have qualified our report on any aspects of the Quality Report.

Certificate

We certify that we have completed the audit of the accounts in accordance with the requirements of Chapter 5 of Part 2 to the National Health Service Act 2006 and the Audit Code for NHS Foundation Trusts issued by Monitor.



Nicola Wright
Senior Statutory Auditor
For and on behalf of
PricewaterhouseCoopers LLP
Chartered Accountants and
Statutory Auditors
Leeds
6 June 2011

APPENDIX 1

Membership of Key Committees and Sub-Committees

Membership of the Clinical Governance Standards Sub-committee (at 11 March 2011)

Joe Barnes (Chair)	Non-executive Director
Dr Robin Bolton (Vice Chair)	Medical Director
Hilary Bond	Director of Nursing & Quality
Mr Ray Cuschieri	Deputy Medical Director for Clinical Standards
Dr Christine Hoy	Director of Infection Prevention & Control
Mandy Dalton	Head of Risk & Legal Services
Denise Gardiner	Patient Advice & Liaison Service Manager
Nicola Atkin	Non-executive Director

Clinical Governance Lead from each Clinical Service Unit

Dr G Shah	Accident & Emergency
Dr P Smith	Anaesthetics & Critical Care
Dr Nigel Brooke	Children's Services
Sylvia Banbury	Clinical Therapies
Mr Ullas Raghavan	ENT (Special Surgery)
Dr Claire Ryan	GU Medicine
Wendy Lee	Medical Imaging
Dr Mahmoud Al-Khoffash	Medicine
Ms Ann Holmes	OMFS
Mr Subramanian Dinakaran	Ophthalmology (Special Surgery)
Mr Hari Kumar	Orthopaedics
Dr Richard Stott	Pathology
Julie Kay	Pharmacy
Miss Clare Rogers	Surgery
Linda McLoughlin	Theatres
Mr Eki Emovon	Women's Services

In attendance

Karen Humphries	Clinical Governance Co-ordinator
Maureen Young	Governor Observer
John Plant	Governor Observer
Dr Eric Kelly	Clinical Governance Lead, NHS Doncaster
Dr Phil Foster	Clinical Governance Lead, NHS Bassetlaw

Audit & Non Clinical Risk Committee (at 31 March 2011)

Name	Position	Attendance
John Parker	Chair & Non-executive Director	5 out of 5
Geraldine Broderick	Vice Chair & Non-executive Director	5 out of 5
David Crowe	Non-executive Director	5 out of 5
In attendance		
Joe Brayford	Director of Human Resources	5 out of 5
Jonathan Idle	Head of Internal Audit	5 out of 5
Kate Pilling	Internal Audit Manager	5 out of 5
Ian Roberts	Auditor, PricewaterhouseCoopers	4 out of 5
Nicola Wright	Auditor, PricewaterhouseCoopers	3 out of 5
Ian Looker	Auditor, PricewaterhouseCoopers (standing in for Nicola Wright)	1 out of 5
Jon Goodison	Local Counter Fraud Specialist	3 out of 5
Kevin Turner	Director of Finance & Information (to 5 January 2011)	4 out of 4
David Pratt	Director of Finance, Information & Procurement (commenced 7 March 2011)	1 out of 1
Robert Paskell	Deputy Director of Finance – Financial Accounts	5 out of 5
Sue Michael	Trust Minute Secretary	5 out of 5
George Webb	Governor Observer	3 out of 5
Nic Davison	Governor Observer (for John Weston)	1 out of 5

Membership of Charitable Funds Sub Committee (at 31 March 2011)

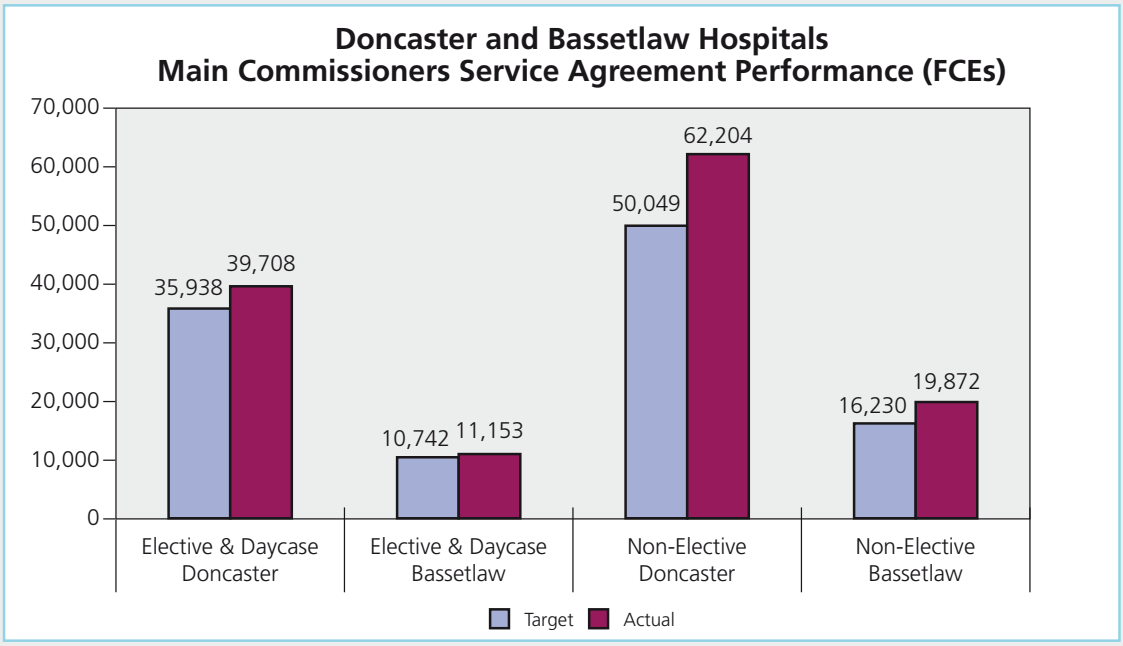
Name	Position
Chris Scholey	Chair
David Crowe	Non-executive Director
Joe Barnes	Non-executive Director
Dr Robin Bolton	Medical Director
Hilary Bond	Director of Nursing & Quality
Kevin Turner	Director of Finance & Information (to 5 January 2011)
David Pratt	Director of Finance, Information & Procurement (from 7 March 2011)
In attendance	
Peter Reading	Interim Chief Executive
David Richardson	Rensburg Investment Management
Robert Paskell	Deputy Director of Finance – Financial Accounts

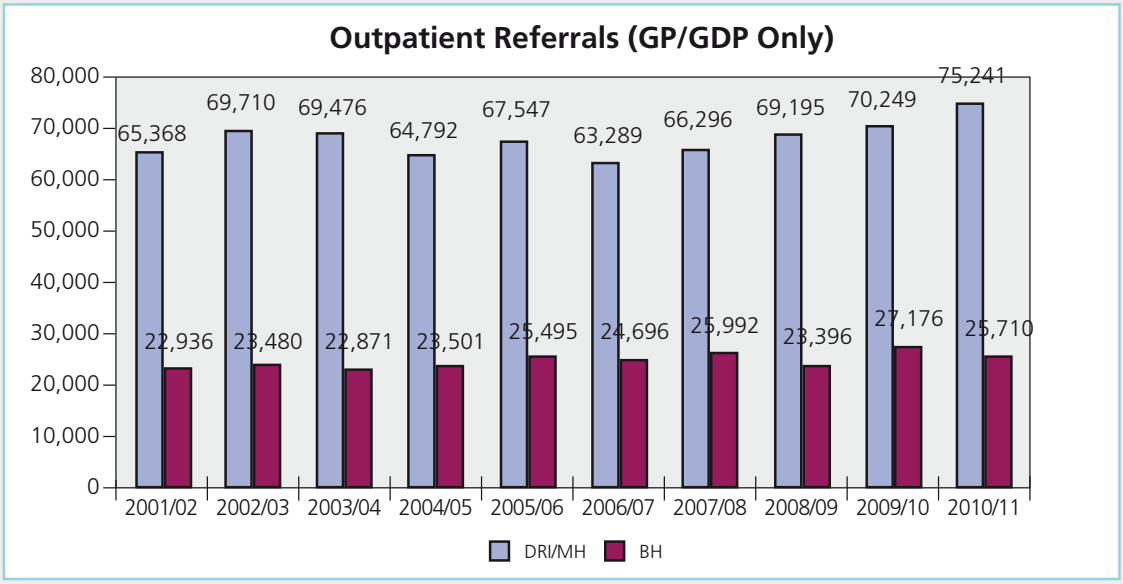
Membership of Fred & Ann Green Sub Committee (at 31 March 2011)

Name	Position
Chris Scholey	Chair
Peter Reading	Interim Chief Executive
Peter Brindley	Executor of Fred Green's Estate
David Crowe	Non-executive Director
Dr Robin Bolton	Medical Director
Hilary Bond	Director of Nursing & Quality
Kevin Turner	Director of Finance & Information (to 5 January 2011)
David Pratt	Director of Finance, Information & Procurement (from 7 March 2011)
In attendance:	
Roy Tyson	Director of Facilities & Commercial Development
Mike Rhodes	Project Manager, Fred & Ann Green Legacy

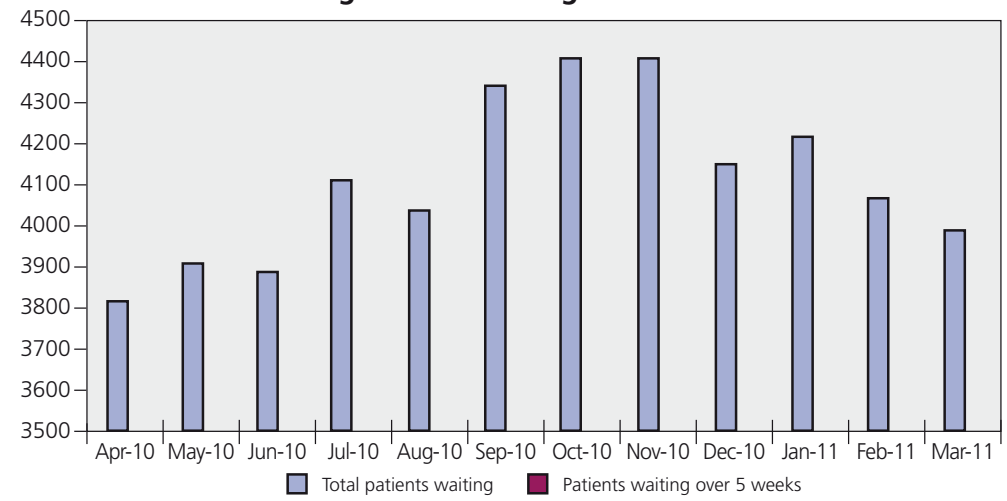
APPENDIX 2

Performance charts

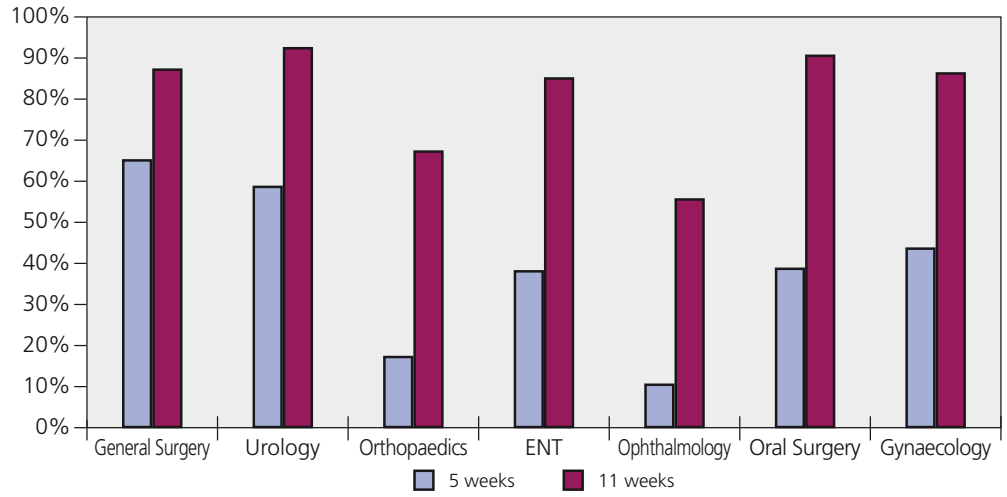




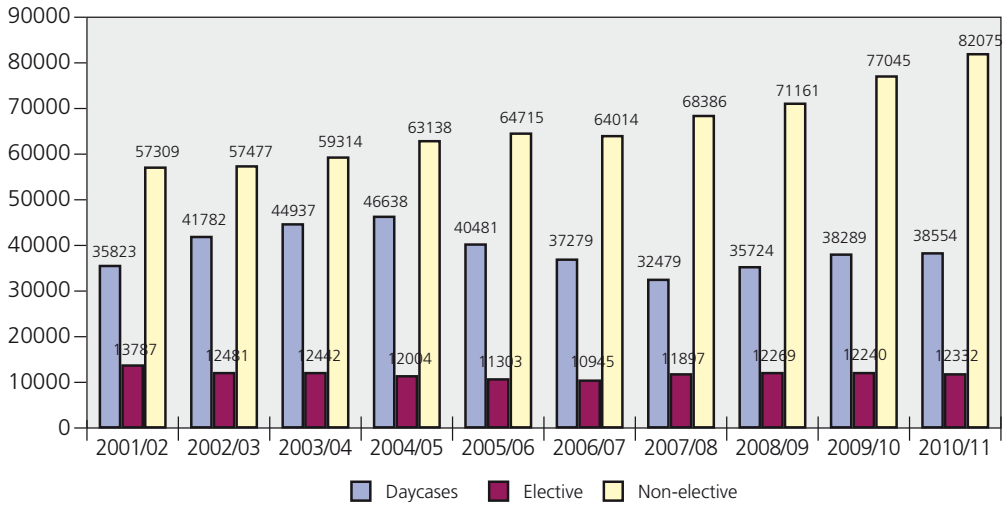
Inpatient and daycase waiting lists: total number of patients waiting & total waiting more than 5 weeks



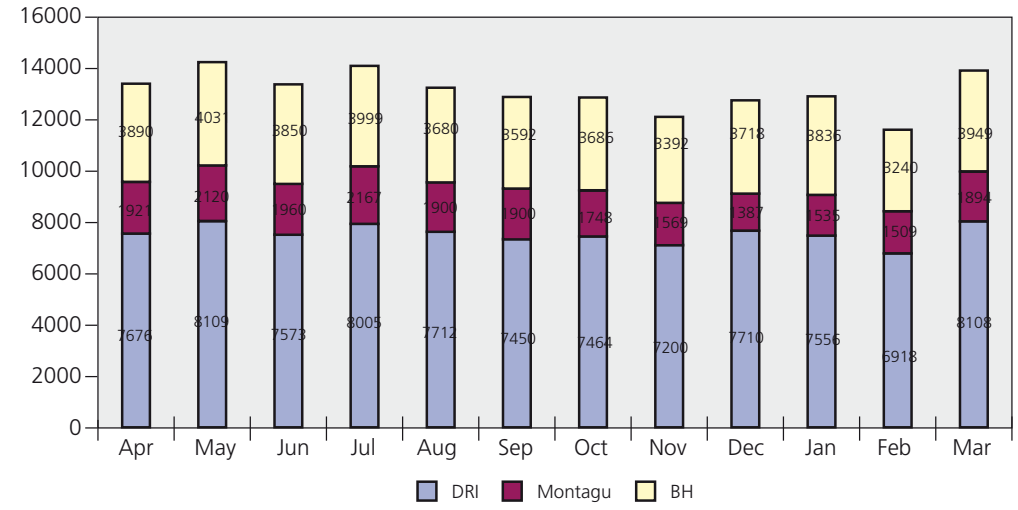
% Elective admissions seen within 5 and 11 weeks



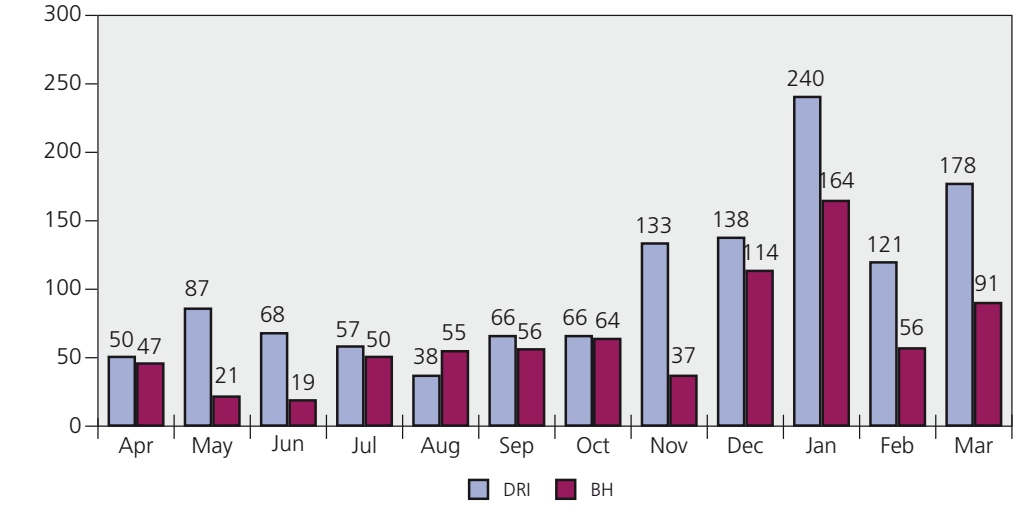
Consultant Episodes (FCEs) 2001/02 to 2010/11



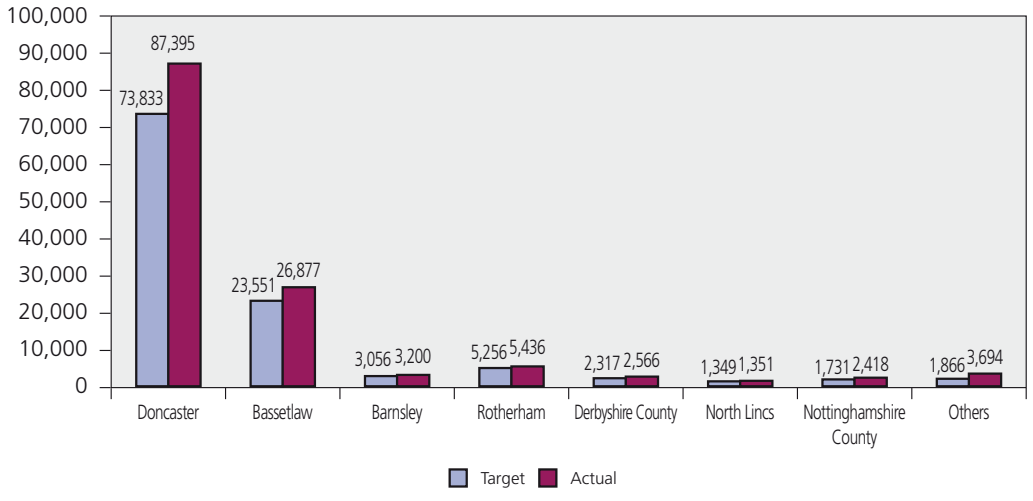
Accident & Emergency Attendances: 2010/11

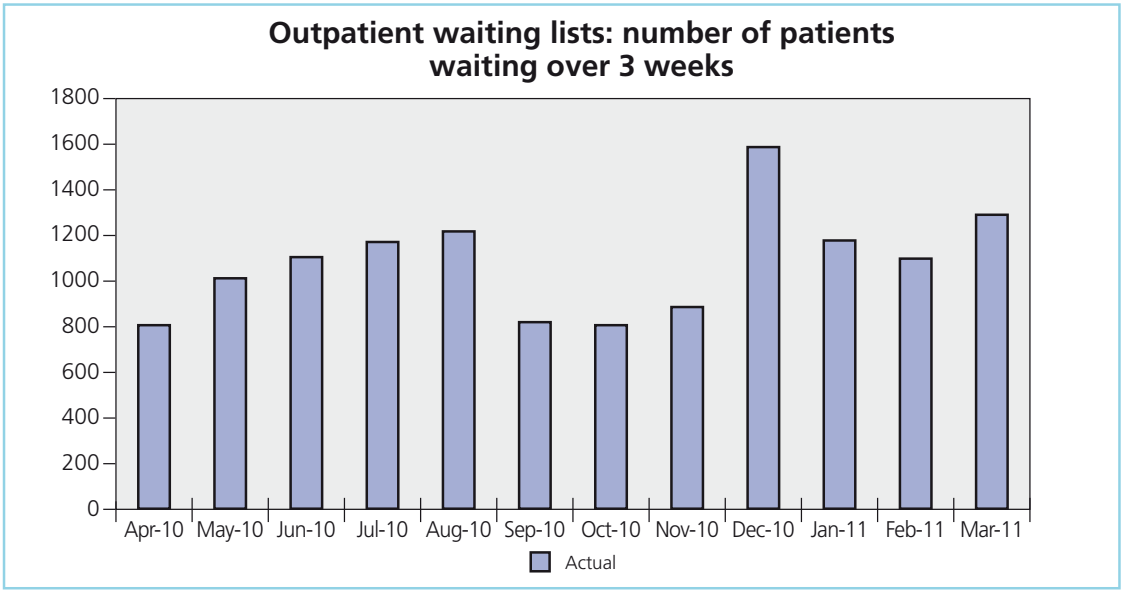


Accident & Emergency Services: Patients waiting over 2 hours for admission: 2010/11



Service Agreement Performance 2010/11 (FCEs)





APPENDIX 3

Sustainability Reporting

Area		Non-financial data (appropriate metric)	Non-financial data (applicable metric)	Non-financial data (applicable metric)		Financial data (£k)	Financial data (£k)	Financial data (£k)
		2008/09	2009/10	2010/11		2008/09	2009/10	2010/11
Waste minimisation and management	■ Absolute values for total amount of waste produced by the Trust ■ Methods of disposal (optional)	2099 tonnes Incineration Alternative treatment Landfill Recycling	2182 tonnes	2014 tonnes ■ Incineration ■ Alternative treatment ■ Landfill ■ Recycling	■ Expenditure on waste disposal	£571,964.23 (ERIC figures)	£543,671.48 Incineration Alternative treatment Landfill Recycling	£644,742.80 ■ Incineration ■ Alternative treatment ■ Landfill ■ Recycling
Finite Resources	■ Water ■ Electricity ■ Gas ■ Other energy consumption	■ 250,000m³ ■ 54,000 Gj ■ 194,267 Gj ■ None	■ 299,852 m³ ■ 62,780 Gj ■ 223,841 Gj ■ None	■ 254515m³ ■ 76712Gj ■ 229160Gj ■ None	■ Water ■ Electricity ■ Gas ■ other energy consumption	Total cost of energy and utilities ERIC £3,341.39	£3,101,101	£2,975,275

Doncaster and Bassetlaw Hospitals NHS
NHS Foundation Trust

This Annual Report & Accounts has been produced by Doncaster and Bassetlaw Hospitals NHS Foundation Trust.
For further information on this report or enquiries regarding our services, please visit www.dbh.nhs.uk or write to:

Communications Office, Doncaster Royal Infirmary, Armthorpe Road, Doncaster DN2 5LT

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