Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

The meeting of the Board of Directors

To be held on Tuesday, 30 January 2018 at 9.00am
in the Boardroom, Doncaster Royal Infirmary

AGENDA
Part I

		Enclosures	Time
1.	Apologies for absence	(Verbal)	9:00am
2.	Declarations of Interest	(Verbal)	
3.	Actions from the previous meeting	Enclosure A	
4.	Freedom to Speak Up Lynn Goy – Lead Freedom to Speak Up Guardian	Presentation	9:10am
Reports for decision			
5.	Standing Orders, Scheme of Delegation and Standing Financial Instructions Jon Sargeant – Director of Finance Matthew Kane – Trust Board Secretary	Enclosure B	9:25am
6.	Review of Constitution Matthew Kane – Trust Board Secretary	Enclosure C	9:35am
Reports for assurance			
7.	Chairs Assurance Logs for Board Committees Linn Phipps – Chair of Quality & Effectiveness Committee Neil Rhodes – Chair of Finance and Performance Committee Philippe Serna – Chair of Audit and Non-clinical Risk Committee	Enclosure D	9:45am
8.	Finance Report as at 31 December 2017 Jon Sargeant – Director of Finance	Enclosure E	10:15am
9.	Performance Report as at 31 December 2017 Led by David Purdue – Chief Operating Officer	Enclosure F	10:45am
BREAK			**11:15am**
10.	Nursing Workforce Report Moira Hardy – Director of Nursing, Midwifery and Allied Health Professionals	Enclosure G	11:25am
11.	Draft National Workforce Strategy Karen Barnard – Director of People and Organisational Development	Enclosure H	11:40am
12.	Board Assurance Framework and Corporate Risk Register Q3 Matthew Kane – Trust Board Secretary	Enclosure J	12:00pm

Reports for information

13.	Chair and NEDs' Report Suzy Brain England – Chair	Enclosure K	12:10pm
14.	Chief Executive's Report including Corporate objectives Q3 Richard Parker –Chief Executive	Enclosure L	
15.	Minutes of Finance and Performance Committee, 14 December 2017 Neil Rhodes – Chair of Finance and Performance Committee	Enclosure M	
16.	Minutes of Management Board, 11 December 2017 Richard Parker – Chief Executive	Enclosure N	
17.	Guardian for Safe Working Report Dr Jay Duggar – Guardian for Safe Working	Enclosure O	
18.	Working Together Partnership Vanguard Briefing Richard Parker – Chief Executive	Enclosure P	
19.	**To note:** Board of Directors Agenda Calendar Matthew Kane – Trust Board Secretary	Enclosure Q	

Minutes

20.	To approve the minutes of the previous meeting held 19 December 2017	Enclosure R	12:35pm

21. Any other business (to be agreed with the Chair prior to the meeting)

22. Governor questions regarding the business of the meeting

23. Date and time of next meeting

Date: 27 February 2018
Time: 9.00am
Venue: Boardroom, BDGH

24. Withdrawal of Press and Public

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

Suzy Brain England
Chair of the Board

24 January 2018

NOTICE FOR THE PUBLIC

DBTH is committed to ensuring its Part 1 Board meetings are open and accessible. If any adjustments need to be made in order for you to access this meeting, please contact us.

If you are Deaf and need a BSL interpreter, or would like to request information in Braille, you can contact us at matthew.kane1@nhs.net or text 0799 9924276.

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Action Notes

Meeting: Board of Directors

Date of meeting: 19 December 2017

Location: Boardroom, Montagu Hospital

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

Apologies: None.

No.	Minute No	Action	Responsibility	Target Date	Update
1.	**17/01/13**	Director of Education to share the Teaching Hospital phase two development plan at a future Board.	**MK**	**Following discussions at QEC**	Partially complete. Research and development discussions at QEC ongoing.
2.	**17/05/30**	Once the Emergency Planning Officer had considered the existing business continuity plans, a presentation would be brought to Board and the plans would be tested by internal audit.	**DP**	**To be confirmed**	Partially complete. Presentation given at November meeting. Policy review by internal audit to be scheduled.
3.	**17/06/34**	Board to meet with care group directors regarding EEPs.	**MK**	**January 2018**	To be arranged.

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

No.	Minute No	Action	Responsibility	Target Date	Update
4.	**17/10/42**	Hold Board workshop on System Perfect involving partners.	**DP**	**Spring 2018**	To be arranged as part of Board development programme.
5.	**C/17/11/7**	Establish priority list for strategies.	**KEJ**	**February 2018 (updated)**	Priority list currently being formulated and will be presented to Board in due course.
6.	**17/12/21**	To provide assurance that risks relating to the IM&T Strategy are being managed appropriately.	**SM**	**February 2018**	Action not yet due.
7.	**17/12/26**	To report back on progress on veteran friendly hospital.	**RP**	**December 2018**	Not yet due.

Date of next meeting: 31 January 2018
Action notes prepared by: M Kane
Circulation: SBE, AA, NR, KB, DJ, MH, RA, DP, JS, SS, JP, RP, LP, PS

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Title	**Review of Standing Orders (SOs), Standing Financial Instructions (SFIs) and Scheme of Delegation (SoD)**		
Report to	**Board of Directors**	**Date**	**30 January 2017**
Author	**Jon Sargeant, Director of Finance** **Matthew Kane, Trust Board Secretary**		
Purpose			Tick one as appropriate
	Decision		X
	Assurance		
	Information		

Executive summary containing key messages and issues
The attached Standing Orders (SOs), Standing Financial Instructions (SFIs) and Scheme of Delegation (SoD) form the core suite of governance documents which, along with the Constitution, govern how the Trust operates and does business. They were reviewed and considered by ANCR and recommended to the Board of Directors on 4 January 2018. The attached documents have been reviewed by the Director of Finance and the Trust Board Secretary and a schedule of the proposed changes are attached as **Appendix A**. The tracked documents are attached as **Appendix B**.
Key questions posed by the report
Is Board content to approve the revised governance documents?
How this report contributes to the delivery of the strategic objectives
The documents support the delivery of the strategic aims by providing a clear, accountable and transparent platform through which decisions may be made.

How this report impacts on current risks or highlights new risks
The report mitigates risks relating to sound and effective corporate governance.
Recommendation(s) and next steps
Board is asked to approve the attached documents.

Appendix A - Amendments to Standing Orders

Page No.	Section	Proposed change
6	1.1 Introduction	To reflect the change of Trust name.
6 15	1.8 Delegation of Powers 6.1 Arrangements for the exercise of functions by delegation	To reflect the statutory position in Schedule 7 to the National Health Service Act 2006 that Board of Directors' functions may only be delegated to an executive director or committee of directors. This does not inhibit executive directors authorising other staff to undertake work on their behalf.
11/12	5.15 Quorum	To reflect the change agreed by Board of Directors in January 2017 to allow directors to join Board and committee meetings via telephone or video link and for such participation to count towards the quorum of the meeting.
14	14.2 Standing orders implied by SFIs	To reflect the change in regulatory position.
15	6.2 Emergency Powers	To reflect the legislative position outlined in Schedule 7. There is no provision for functions of the Board to be exercised by a non-executive acting alone or by an executive and non-executive acting jointly, unless they are part of a committee.
17	7.8 Committees	To reflect the new Board committee names.
18	8.6 Declaration of interests	For avoidance of doubt.
22	10.13 Relatives of Directors or Officers	To reflect the new Standards of Business Conduct Policy agreed by ANCR in July 2017 and based on NHS England's new Conflicts of Interest guidance.

Amendments to Scheme of Delegation

Page No.	Section	Proposed change
Throughout	Throughout	To reflect the statutory position in Schedule 7 to the National Health Service Act 2006 that Board of Directors' functions may only be delegated to an executive director or a committee of directors. This does not inhibit executive directors authorising other staff to undertake work on their behalf.
4	A) Role of CEO	To amend a typographical error. Chief executives in NHS Foundation Trusts are known as accounting officers. In CCGs they are accountable officers.
5	Absence of Directors or Officer to Whom Powers have been Delegated	To reflect the legislative position outlined in Schedule 7 above. There is no provision for functions of the Board to be exercised by a non-executive acting alone or by an executive and non-executive acting jointly, unless they are part of a committee.
7	1.3.13 Regulation and control	To align with the amended standing order.
7	1.4, 1.5, 1.6	For avoidance of doubt.
8 12	1.9 Audit arrangements Scheme of delegation implied by SFIs	For clarity.
9	3.1 Scheme of delegation to officers	To make a distinction between functions of the Board that are delegated to executive directors and those matters that executive directors may authorise staff to undertake within their departments.
12/14	Scheme of Delegation implied by SFIs	To reflect the legislative position that functions cannot be delegated to a group of staff. Usually such issues would be reported by staff through their director and then on to the Director of Finance.

16 17 18	Non Pay Expenditure/ Requisitioning/ Ordering/ Payment of Goods & Services Non Pay Expenditure/Requisitioning/Ordering/ Payment of Goods & Services Expenditure on Charitable and Endowment Funds	To reflect the new financial limits approved by Board of Directors in March 2017.
19	Receiving hospitality	To reflect the new Standards of Business Conduct Policy agreed by ANCR in July 2017 and based on NHS England's new Conflicts of Interest guidance.
24	46. Committee in common	To reflect the delegation arrangements for the committee in common arrangements.
Throughout	Throughout	DoNMQ changed to DoNM&AHP to reflect new structure

Amendments to Standing Financial Instructions

Page No.	Section	Proposed change
Throughout	Throughout	To align with the Delegation of Powers.
4	Contents Page	To reflect correct page numbers.
10, 11 and 34	Relating to NHS Protect	To reflect the change in regulatory position.
9	All directors and employees, severally and collectively, are responsible for:	For avoidance of doubt.
12	External Audit	

Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

Standing Orders
Board of Directors
20186

NHS Foundation Trusts must agree Standing Orders (SOs) for the regulation of their proceedings and business. The Board of Directors are also required to adopt schedules of reservation of powers and delegation of powers. These documents, together with Standing Financial Instructions, provide a regulatory framework for the business conduct of the Trust. They fulfil the dual role of protecting the Trust's interests and protecting staff from any possible accusation that they have acted less than properly.

The Standing Orders, Scheme of Delegation and Standing Financial Instructions provide a comprehensive business framework. All executive and non-executive directors, and all members of staff, should be aware of the existence of these documents and, where necessary, be familiar with the detailed provisions.

Provisions within the Standing Orders which are not subject to suspension under SO 5.40 are indicated in italics.

Did you print this document yourself?
The Trust discourages the retention of hard copies of policies and can only guarantee that the policy on the Trust website is the most up-to-date version. **If, for exceptional reasons, you need to print a policy off, it is only valid for 24 hours.**

Name and title of author/reviewer:	~~Andrew Thomas, Finance Programme Director~~Jon Sargeant and Matthew Kane
Date written/revised:	~~July 2016~~September 2017
Approved by (Committee/Group):	Board of Directors
Date of approval:	~~26 July 2016~~TBC

Date issued:	~~August 2016~~TBC
Next review date:	~~July 2017~~TBC
Target audience:	Trust-wide

CONTENTS

1 INTRODUCTION

1.1 Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust is a Public Benefit Corporation that was established by the granting of Authorisation by Monitor (now NHS Improvement).

1.2 The principal purpose of the Trust is set out in the 2012 Act, and the Trust Constitution.

1.3 The Trust is required to adopt Standing Orders (SOs) for the regulation of its proceedings and business.

1.4 The powers of the Trust are set out in section 4 of the Constitution.

1.5 The Trust has specific powers to contract in its own name and to act as a corporate trustee. In the latter role it is accountable to the Charity Commission for those funds deemed to be charitable as well as to NHS Improvement. The Trust also has a common law duty as a bailee for patients' property held by the Trust on behalf of patients.

1.6 Failure to comply with SFIs and SOs is a disciplinary matter which could result in dismissal.

1.7 **Delegation of Powers**
The Trust has resolved that certain powers and decisions may only be exercised or made by the Board of Directors in formal session. These powers and decisions are set out in the Scheme of Delegation.

1.8 Under the Standing Orders relating to the Arrangements for the Exercise of Functions (SO 6) the Board of Directors may exercise its powers to make arrangements for the exercise, on behalf of the Trust, of any of its functions by a committee or sub-committee appointed by virtue of SO 7 or by an ~~officer~~ executive director~~of the Trust~~, in each case subject to such restrictions and conditions as the Board of Directors thinks fit or as NHS Improvement may direct.

1.9 Delegated Powers are covered in the Scheme of Delegation, which has effect as if incorporated into the Standing Orders.

2 INTERPRETATION AND DEFINITIONS

2.1 Save as permitted by law, at any meeting the Chair of the Trust, advised by the Chief Executive, shall be the final authority on the interpretation of Standing Orders.

2.2 These Standing Orders shall only be applied in accordance with the Constitution. Where any provision in these Standing Orders contradicts any provision in the Constitution, the Constitution shall be paramount.

2.3 In these Standing Orders:

"the 2006 Act"	means the National Health Service Act 2006 as amended from time to time;
"the 2012 Act"	means the Health and Social Care Act 2012 as amended from time to time;
"Accounting Officer"	means the person who from time to time discharges the functions specified in paragraph 25(5) of Schedule 7 to the 2006 Act;
"Board of Directors"	means the board of directors as constituted in accordance with the Trust Constitution;
"Chair"	means the Chair of the Trust appointed in accordance with the Trust Constitution;
"Chief Executive"	means the Chief Executive Officer of the Trust appointed in accordance with the terms of the Trust Constitution;
"Committee"	means a committee appointed by the Board of Directors;
"Committee members"	means those persons formally appointed by the Board of Directors to sit on or to chair specific committees;
"Constitution"	means the Trust Constitution and all annexes to it;
"Corporate Director"	A non-voting director with executive responsibilities, appointed by the Board of Directors;
"Director"	means a director on the Board of Directors;
"Director of Finance"	means the chief finance officer of the Trust;
"Executive Director"	means an executive director of the Trust appointed in accordance with the Trust Constitution;
"Funds held on Trust"	means those funds which the Trust holds at its date of incorporation, receives on distribution by statutory instrument or chooses to accept under powers derived under S.90 of the 2006 Act;
"Member"	means a member of the Trust;
"NHS Improvement"	means the body corporate known as NHS Improvement.
"Motion"	means a formal proposition to be discussed and voted on during the course of a meeting;

"Nominated Officer"	means an officer charged with the responsibility for discharging specific tasks within the SOs and SFIs;
"Non-Executive Director"	means a non-executive director of the Trust appointed in accordance with the Trust Constitution;
"Officer"	means an employee of the Trust;
"Secretary"	means the Trust Board Secretary or any other person appointed to perform the duties of the secretary of the Trust, including a joint, assistant or deputy secretary;
"SFIs"	means Standing Financial Instructions;
"SOs"	means Standing Orders;
"the Trust"	means Doncaster & Bassetlaw Hospitals NHS Foundation Trust.

3 THE BOARD OF DIRECTORS

3.1 All business of the Board of Directors shall be conducted in the name of the Trust.

3.2 All funds received in trust shall be in the name of the Trust as corporate trustee. In relation to funds held on trust, powers exercised by the Trust as corporate trustee shall be exercised separately and distinctly from those powers exercised as a Trust.

3.3 Directors acting on behalf of the Trust as a corporate trustee are acting as quasi-trustees. Accountability for charitable funds held on trust is to the Charity Commission and to NHS Improvement. Accountability for non-charitable funds held on trust is only to NHS Improvement.

3.4 **Composition of the Board of Directors**
In accordance with the 2006 Act, the 2012 Act, and the Constitution, the composition of the Board of Directors of the Trust shall be:

(a) The Chair of the Trust

(b) 6 non-executive directors

(c) 6 executive directors including:

- the Chief Executive (the Accounting Officer)
- the Director of Finance (the Chief Finance Officer)
- the Medical Director
- the Director of Nursing

3.5 The Board of Directors may appoint corporate directors in addition to the six executive directors described above. Non-voting Corporate directors shall attend meetings of the Board of Directors but shall not have a vote (see SO 5.19).

3.6 **Non-executive Directors**
Non-executive Directors are appointed by the Board of Governors. The appointment shall be in accordance with the Constitution.

3.7 The regulations governing the tenure of office of the Non-executive Directors shall be in accordance with the Constitution.

3.8 **Joint Directors**
Where more than one person is appointed jointly to a post in the Trust which qualifies the holder for executive directorship or in relation to which an executive director is to be appointed, those persons shall become appointed as an executive director jointly, and shall count for the purpose of Standing Order 3.4 as one person.

4 CHAIR OF THE BOARD OF DIRECTORS

4.1 The Chair of the Trust is the Chair of the Board of Directors.

4.2 The Chair is appointed by the Board of Governors. The appointment shall be in accordance with the Constitution.

4.3 The regulations governing the tenure of office of the Chair shall be in accordance with the Constitution.

4.4 At any meeting of the Board of Directors, the Chair, if present, shall preside. If the Chair is absent from the meeting, the Deputy Chair shall preside.

4.5 If the Chair is absent from a meeting temporarily on the grounds of a declared conflict of interest the Deputy Chair, if present, shall preside.

4.6 **Deputy Chair**
Where the Chair of the Trust has died or has otherwise ceased to hold office or where he has been unable to perform his duties as Chair owing to illness, absence from England and Wales or any other cause, references to the Chair in the Schedule to these Regulations shall, so long as there is no Chair able to perform his duties, be taken to include references to the Deputy Chair. In such cases the Deputy Chair shall act as Chair of the Board of Directors.

4.7 The appointment of the Deputy Chair shall be as prescribed in the Constitution.

4.8 The regulations governing the tenure of office of the Deputy Chair shall be in accordance with the Constitution.

5 PRACTICE AND PROCEDURE OF MEETINGS

5.1 All business at meetings of the Board of Directors shall be conducted in the name of the Trust.

5.2 **Annual Members Meeting**
The Trust will publicise and hold an annual meeting of its members in accordance with the constitution and the 2012 Act.

5.3 **Admission of the Public and Press**
The public and representatives of the press shall be afforded facilities to attend all formal meetings of the Board of Directors but shall be required to withdraw upon the Board of Directors resolving as follows:

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

5.4 The Chair (or Deputy Chair when acting as Chair) shall give such directions as he thinks fit in regard to the arrangements for meetings and accommodation of the public and representatives of the press such as to ensure that the Board of Directors business shall be conducted without interruption and disruption and, without prejudice to the power to exclude on the grounds of the confidential nature of the business to be transacted, the public will be required to withdraw upon the Board of Directors resolving as follows:

"That in the interests of public order the meeting adjourns for (the period to be specified) to enable the Board of Directors to complete business without the presence of the public."

5.5 Members of the public or representatives of the press are not permitted to record proceedings in any manner unless with the express prior agreement of the Chair (or Deputy Chair when acting as Chair). Where permission has been granted, the Chair (or Deputy Chair) retains the right to give directions to halt recording of proceedings at any point during the meeting. For the avoidance of doubt, "recording" refers to any audio or visual recording, including still photography.

5.6 **Calling Meetings**
Ordinary meetings of the Board of Directors shall be held at such times and places as the Board of Directors may determine.

5.7 The Chair may call a meeting of the Board of Directors at any time. If the Chair refuses to call a meeting after a requisition for that purpose, signed by at least one-third of the whole number of directors, has been presented to him, or if, without so refusing, the Chair does not call a meeting within seven days after such requisition has been presented to him such one third or more directors may forthwith call a meeting. In such cases meetings shall be held at the Trust's designated headquarters.

5.8 **Notice of Meetings**
Save in the case of emergencies or the need to conduct urgent business, the Secretary shall give at least fourteen days written notice of the date and place of every meeting of the Board of Directors to all Directors.

5.9 The notice of the meeting, specifying the business proposed to be transacted at it, and signed by the Chair or by an officer of the Trust authorised by the Chair to sign on his behalf shall be delivered to every director, or sent by post to the usual place of residence of such director, so as to be available to him at least three clear days before the meeting.

5.10 Lack of service of the notice on any director shall not affect the validity of a meeting.

5.11 In the case of a meeting called by directors in default of the Chair, the notice shall be signed by those directors and no business shall be transacted at the meeting other than that specified in the notice.

5.12 Failure to serve such a notice on more than three directors will invalidate the meeting. A notice shall be presumed to have been served at the time at which the notice would be delivered in the ordinary course of the post.

5.13 **Chair of Meeting**
At any meeting of the Board of Directors, the Chair, if present, shall preside. If the Chair is absent from the meeting the Deputy Chair, if there is one and he is present, shall preside. If the Chair and Deputy Chair are absent such non-executive director as the directors present shall choose shall preside.

5.14 If the Chair is absent from a meeting temporarily on the grounds of a declared conflict of interest the Deputy Chair, if present, shall preside. If the Chair and Deputy Chair are absent, or are disqualified from participating, such non-executive director as the directors present shall choose shall preside.

5.15 **Quorum**
No business shall be transacted at a meeting of the Board of Directors unless at least one-third of the whole number of the directors are present including at least one executive director and one non-executive director.

Directors can participate in meetings by telephone or through the use of video conferencing

facilities, where such facilities are available. Participation in a meeting through any of these methods shall be deemed to constitute presence in person at the meeting.

5.16 An officer in attendance for an executive director but without formal acting up status may not count towards the quorum.

5.17 If a director has been disqualified from participating in the discussion on any matter and/or from voting on any resolution by reason of the declaration of a conflict of interest, he shall no longer count towards the quorum. If a quorum is then not available for the discussion and/or the passing of a resolution on any matter, that matter may not be discussed further or voted upon at that meeting. Such a position shall be recorded in the minutes of the meeting. The meeting must then proceed to the next business i.e. lack of a quorum for specific items will not invalidate the whole meeting.

5.18 The requirement for at least one executive director to form part of the quorum shall not apply where the executive directors are excluded from a meeting.

5.19 **Voting**
Each executive and non-executive director shall be entitled to exercise one vote. Corporate directors who are not executive directors (as described in SOs 3.4 and 3.5) shall not have a vote.

5.20 Every question at a meeting shall be determined by a majority of the votes of the directors present and voting on the question and, in the case of any equality of votes, the person presiding shall have a second or casting vote.

5.21 All questions put to the vote shall, at the discretion of the Chair of the meeting, be determined by oral expression or by a show of hands. A paper ballot may also be used if a majority of the directors present so request.

5.22 If at least one-third of the directors present so request, the voting (other than by paper ballot) on any question may be recorded to show how each director present voted or abstained.

5.23 If a director so requests, his vote shall be recorded by name upon any vote (other than by paper ballot).

5.24 In no circumstances may an absent director vote by proxy. Absence is defined as being absent at the time of the vote.

5.25 An officer who has been appointed formally by the Board of Directors to act up for an executive director during a period of incapacity or temporarily to fill an executive director vacancy, shall be entitled to exercise the voting rights of the executive director. An officer attending the Board of Directors to represent an executive director during a period of

incapacity or temporary absence without formal acting up status may not exercise the voting rights of the executive director. An officer's status when attending a meeting shall be recorded in the minutes.

5.26 **Setting the Agenda**
The Board of Directors may determine that certain matters shall appear on every agenda for a meeting of the Board of Directors and shall be addressed prior to any other business being conducted.

5.27 A director desiring a matter to be included on an agenda shall make his request in writing to the Chair at least ten clear days before the meeting. Requests made less than ten days before a meeting may be included on the agenda at the discretion of the Chair.

5.28 **Minutes**
The minutes of the proceedings of a meeting shall be drawn up and submitted for agreement at the next ensuing meeting where they will be signed by the person presiding at it.

5.29 No discussion shall take place upon the minutes except upon their accuracy or where the Chair considers discussion appropriate. Any amendment to the minutes shall be agreed and recorded at the next meeting.

5.30 Minutes shall be circulated in accordance with directors' wishes. Where providing a record of a public meeting the minutes shall be made available to the public.

5.31 **Record of Attendance**
The names of the directors present at the meeting shall be recorded in the minutes.

5.32 **Notices of Motion**
A director of the Trust desiring to move or amend a motion shall send a written notice thereof at least ten clear days before the meeting to the Chair, who shall insert in the agenda for the meeting all notices so received subject to the notice being permissible under the appropriate regulations. This paragraph shall not prevent any motion being moved during the meeting, without notice on any business mentioned on the agenda subject to SO 5.11.

5.33 **Withdrawal of Motion or Amendments**
A motion or amendment once moved and seconded may be withdrawn by the proposer with the concurrence of the seconder and the consent of the Chair.

5.34 **Motion to Rescind a Resolution**
Notice of motion to amend or rescind any resolution (or the general substance of any resolution) which has been passed within the preceding six calendar months shall bear the signature of the director who gives it and also the signature of four other directors. When

any such motion has been disposed of by the Board of Directors, it shall not be competent for any director other than the Chair to propose a motion to the same effect within six months; however the Chair may do so if he considers it appropriate.

5.35 **Motions**
The mover of a motion shall have a right of reply at the close of any discussion on the motion or any amendment thereto.

5.36 When a motion is under discussion or immediately prior to discussion it shall be open to a Director to move:

(i) An amendment to the motion.

(ii) The adjournment of the discussion or the meeting.

(iii) The appointment of an ad hoc committee to deal with a specific item of business.

(iv) That the meeting proceed to the next business.*

(v) The appointment of an ad hoc committee to deal with a specific item of business.

(vi) That the motion be now put to a vote.*

In the case of sub-paragraphs denoted by * above, to ensure objectivity motions may only be put by a Director who has not previously taken part in the debate.

5.37 No amendment to the motion shall be admitted if, in the opinion of the Chair of the meeting, the amendment negates the substance of the motion.

5.38 **Chair's Ruling**
Statements of directors made at meetings of the Board of Directors shall be relevant to the matter under discussion at the material time and the decision of the Chair of the meeting on questions of order, relevancy, regularity and any other matters shall be observed at the meeting.

5.39 **Joint Directors**
Where a post of executive director is shared by more than one person:

(a) both persons shall be entitled to attend meetings of the Trust:

(b) either of those persons shall be eligible to vote in the case of agreement between them:

(c) in the case of disagreement between them no vote should be cast;

(d) the presence of either or both of those persons shall count as one person for the purposes of SO 5.15 (Quorum).

5.40 **Suspension of Standing Orders**

Any one or more of the Standing Orders may be suspended at any duly constituted meeting, provided that:

(i) at least two-thirds of the Board of Directors are present, including one executive director and one non-executive director;

(ii) a majority of those present vote in favour of suspension; and

(iii) the variation proposed does not contravene any statutory provision or direction made by NHS Improvement.

5.41 A decision to suspend SOs shall be recorded in the minutes of the meeting.

5.42 A separate record of matters discussed during the suspension of SOs shall be made and shall be available to the directors.

5.43 No formal business may be transacted while SOs are suspended.

5.44 The Audit Committee shall review every decision to suspend SOs.

6 ARRANGEMENTS FOR THE EXERCISE OF FUNCTIONS BY DELEGATION

6.1 Subject to SO 1.5 and such directions as may be given by NHS Improvement, the Board of Directors may make arrangements for the exercise, on behalf of the Trust, of any of its functions by a committee or sub-committee, appointed by virtue of SO 1.5 or 6.3 or by a executive director ~~or an officer~~ of the Trust in each case subject to such restrictions and conditions as the Board of Directors thinks fit.

6.2 **Emergency Powers**

Those powers of the Trust which the Board of Directors has retained to itself may in ~~emergency~~ urgent circumstances be exercised by the Chief Executive ~~and the Chair~~ after having consulted ~~at least two non-executive directors~~ the Chair. A decision is urgent where any delay would seriously prejudice the Trust's or the public's interests. The exercise of such powers by the Chief Executive ~~and the Chair~~ shall be reported to the next formal meeting of the Board of Directors for ratification.

6.3 **Delegation to Committees**

The Board of Directors shall agree from time to time to the delegation of executive powers to be exercised by committees or sub-committees, which it has formally constituted. The

constitution and terms of reference of these committees, or sub-committees, and their specific executive powers shall be approved by the Board of Directors.

6.4 **Delegation to Officers**
Those functions of the Trust which have not been retained as reserved by the Board of Directors or delegated to an executive committee or sub-committee shall be exercised on behalf of the Board of Directors by the Chief Executive. The Chief Executive shall determine which functions he will perform personally and shall nominate officers to undertake the remaining functions for which he will still retain an accountability to the Board of Directors.

6.5 The Chief Executive shall prepare a Scheme of Delegation identifying his proposals, which shall be considered and approved by the Board of Directors, subject to any amendment, agreed during the discussion. The Chief Executive may periodically propose amendment to the Scheme of Delegation, which shall be considered and approved by the Board of Directors as indicated above.

6.6 Nothing in the Scheme of Delegation shall impair the discharge of the direct accountability to the Board of Directors of the Director of Finance or other executive director to provide information and advise the Board of Directors in accordance with any statutory requirements.

6.7 The arrangements made by the Board of Directors as set out in the Scheme of Delegation shall have effect as if incorporated in these Standing Orders.

7 COMMITTEES

7.1 **Appointment of Committees**
Subject to SO 1.5 and such directions as may be given by NHS Improvement, the Board of Directors may and, if directed to, shall appoint committees of the Board of Directors, consisting wholly or partly of directors of the Trust or wholly of persons who are not directors of the Trust.

7.2 *A committee appointed under SO 7.1 may, subject to such directions as may be given by NHS Improvement or the Board of Directors appoint sub-committees consisting wholly or partly of members of the committee (whether or not they include directors of the Trust or wholly of persons who are not members of the Trust committee).*

7.3 The Standing Orders of the Board of Directors, as far as they are applicable, shall apply with appropriate alteration to meetings of any committees or sub-committee established by the Board of Directors.

7.4 Each such committee or sub-committee shall have such terms of reference and powers and be subject to such conditions (as to reporting back to the Board of Directors), as the Board of Directors shall decide. Such terms of reference shall have effect as if incorporated

into the Standing Orders.

7.5 Committees may not delegate their executive powers to a sub-committee unless expressly authorised by the Board of Directors.

7.6 The Board of Directors shall approve the appointments to each of the committees, which it has formally constituted. Where the Board of Directors determines that persons, who are neither directors nor officers, shall be appointed to a committee, the terms of such appointment shall be determined by the Board of Directors subject to the payment of travelling and other allowances being in accordance with such sum as may be determined.

7.7 Where the Board of Directors is required to appoint persons to a committee and/or to undertake statutory functions as required by NHS Improvement, and where such appointments are to operate independently of the Board of Directors such appointment shall be made in accordance with the regulations laid down by NHS Improvement.

7.8 The committees and sub-committees established by the Board of Directors are:

(a) Audit and Non-clinical Risk

~~(b) Clinical Governance Oversight~~ Quality and Effectiveness

~~(c)~~(b) Nominations and Remuneration

(c) Charitable Funds

(d) Finance and Performance

~~(d)~~(e) Working Together Partnership Committee in Common

~~(e) Fred and Ann Green Legacy~~

~~(f) Financial Oversight~~

7.9 **Confidentiality**
A member of a committee shall not disclose a matter dealt with by, or brought before, the committee without its permission until the committee shall have reported to the Board of Directors or shall otherwise have concluded on that matter.

7.10 A Director of the Trust or a member of a committee shall not disclose any matter reported to the Board of Directors or otherwise dealt with by the committee, notwithstanding that the matter has been reported or action has been concluded, if the Board of Directors or committee shall resolve that it is confidential.

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8 DECLARATION OF INTERESTS AND REGISTER OF INTERESTS

8.1 Pursuant to Section 20 of Schedule 7 of the 2006 Act, a register of Directors' interests must be kept by the Trust.

8.2 Pursuant to Section 152 of the 2012 Act, Directors have a duty:

a) to avoid a situation in which the director has (or can have) a direct or indirect interest that conflicts (or possibly may conflict) with the interests of the Trust.

b) not to accept a benefit from a third party by reason of being a director or doing (or not doing) anything in that capacity.

8.3 **Declaration of Interests**
Directors are required to declare interests, which are relevant and material. All existing Directors should declare relevant and material interests. Any Directors appointed subsequently should do so on appointment.

8.4 Interests which should be regarded as "relevant and material" and which, for the guidance of doubt, should be included in the register, are:

a) Directorships, including non-executive directorships held in private companies or PLCs (with the exception of those of dormant companies).

b) Ownership or part-ownership of private companies, businesses or consultancies likely or possibly seeking to do business with the NHS.

c) Majority or controlling share holdings in organisations likely or possibly seeking to do business with the NHS.

d) A position of authority in any organisation, including charity or voluntary organisations, in the field of health and social care.

e) Any connection with a voluntary or other organisation contracting for NHS services.

f) Any connection with an organisation, entity or company considering entering into or having entered into a financial arrangement with the NHS Foundation Trust, including but not limited to, lenders or banks.

8.5 If directors have any doubt about the relevance of an interest, this should be discussed with the Chair.

8.6 At the time the interests are declared, they should be recorded as appropriate. Any changes in interests should be declared at the next Board of Directors meeting as

appropriate following the change occurring. It is the obligation of the Director to inform the Trust Board Secretary in writing within 7 days of becoming aware of the existence of a relevant or material interest. The Secretary will amend the Register upon receipt within 3 working days.

8.7 During the course of a Board of Directors meeting, if a conflict of interest is established, the director concerned should withdraw from the meeting and play no part in the relevant discussion or decision. For the avoidance of doubt, this includes voting on such an issue where a conflict is established. If there is a dispute as to whether a conflict of interest does exist,- majority will resolve the issue with the Chair having the casting vote.

8.8 There is no requirement for the interests of directors' spouses or partners to be declared.

8.9 **Authorisation of Conflict of Interest**
Where a director has a direct or indirect interest that conflicts (or possibly may conflict) with the interests of the Tt~~t~~rust (in contravention of the duty outlined at SO 8.2), this may be authorised if a majority of directors vote in favour of authorisation. If there is a dispute as to whether a conflict or potential conflict of interest exists, majority will resolve the issue with the Chair having the casting vote.

8.10 If a director has a direct or indirect interest that conflicts (or possibly may conflict) with the interests of the Trust that is not authorised by the Board of Directors, the director in question will be deemed to be in breach of the statutory duty outlined at SO 8.2.

8.11 **Register of Interests**
The details of directors' interests recorded in the Register will be kept up to date by means of a monthly review of the Register by the Secretary, during which any changes of interests declared during the preceding month will be incorporated.

8.12 Subject to contrary regulations being passed, the Register will be available for inspection by the public free of charge. The Chair will take reasonable steps to bring the existence of the Register to the attention of the local population and to publicise arrangements for viewing it. Copies or extracts of the Register must be provided to members of the Trust free of charge and within a reasonable time period of the request. A reasonable charge may be imposed on non-members for copies or extracts of the Register.

9 DISABILITY OF DIRECTORS IN PROCEEDINGS ON ACCOUNT OF PECUNIARY INTEREST

9.1 *If a director of the Trust has any pecuniary interest, direct or indirect, in any contract, proposed contract or other matter and is present at a meeting of the Board of Directors at which the contract or other matter is the subject of consideration, he shall at the meeting and as soon as practicable after its commencement disclose the fact and shall not take part in the consideration or discussion of the contract or other matter or vote on any question with respect to it.*

9.2 *The Trust shall exclude a director from a meeting of the Board of Directors while any contract, proposed contract or other matter in which he has a pecuniary interest, is under consideration.*

9.3 *For the purpose of this Standing Order directors shall be treated as having indirectly a pecuniary interest in a contract, proposed contract or other matter, if:*

(a) he, or a nominee of his, is a director of a company or other body, not being a public body, with which the contract was made or is proposed to be made or which has a direct pecuniary interest in the other matter under consideration;

or

(b) he is a partner of, or is in the employment of a person with whom the contract was made or is proposed to be made or who has a direct pecuniary interest in the other matter under consideration;

and in the case of married persons, persons in a civil partnership, or unmarried persons living together as partners, the interest of one spouse or partner shall, if known to the other, be deemed for the purposes of this Standing Order to be also an interest of the other.

9.4 *A director shall not be treated as having a pecuniary interest in any contract, proposed contract or other matter by reason only:*

(a) of his membership of a company or other body, if he has no beneficial interest in any securities of that company or other body;

(b) of an interest in any company, body or person with which he is connected as mentioned in SO 9.3 above which is so remote or insignificant that it cannot reasonably be regarded as likely to influence a director in the consideration or discussion of or in voting on, any question with respect to that contract or matter.

9.5 *Where a director:*

(a) has an indirect pecuniary interest in a contract, proposed contract or other matter by reason only of a beneficial interest in securities of a company or other body, and

(b) the total nominal value of those securities does not exceed £5,000 or one-hundredth of the total nominal value of the issued share capital of the company or body, whichever is the less, and

(c) if the share capital is of more than one class, the total nominal value of shares of any one class in which he has a beneficial interest does not exceed one-hundredth

of the total issued share capital of that class,

this Standing Order shall not prohibit him from taking part in the consideration or discussion of the contract or other matter or from voting on any question with respect to it without prejudice however to his duty to disclose his interest.

9.6 *SO 9 applies to a committee or sub-committee of the Board of Directors as it applies to the Board of Directors and applies to any member of any such committee or sub-committee (whether or not he is also a director of the Trust) as it applies to a director of the Trust.*

10 STANDARDS OF BUSINESS CONDUCT

10.1 **Policy**
Directors shall act in accordance with the Nolan Principles Governing Conduct of Public Office Holders at all times.

10.2 The Trust has adopted as good practice the national guidance contained in HSG(93)5 `Standards of Business Conduct for NHS staff' and staff must comply with this guidance. The following provisions should be read in conjunction with this document.

10.3 **Interest of Officers in Contracts**
If it comes to the knowledge of a director or an officer of the Trust that a contract in which he has any pecuniary interest not being a contract to which he is himself a party, has been, or is proposed to be, entered into by the Trust he shall, at once, give notice in writing to the Chief Executive of the fact that he is interested therein. In the case of married persons, or persons living together as partners, the interest of one partner shall, if known to the other, be deemed to be also the interest of that partner.

10.4 An officer must also declare to the Chief Executive any other employment or business or other relationship of his, or of a cohabiting spouse, that conflicts, or might reasonably be predicted could conflict with the interests of the Trust.

10.5 The Trust shall require interests, employment or relationships so declared by staff to be entered in a register of interests of staff.

10.6 **Canvassing of, and Recommendations by, Directors in Relation to Appointments**
Canvassing of directors of the Trust or members of any committee of the Trust directly or indirectly for any appointment under the Trust shall disqualify the candidate for such appointment. The contents of this paragraph of the Standing Order shall be included in application forms or otherwise brought to the attention of candidates.

10.7 A director of the Trust shall not solicit for any person any appointment under the Trust or recommend any person for such appointment: but this paragraph of this Standing Order shall not preclude a director from giving written testimonial of a candidate's ability,

experience or character for submission to the Trust.

10.8 Informal discussions outside appointments panels or committees, whether solicited or unsolicited, should be declared to the panel or committee.

10.9 **Relatives of Directors or Officers**
Candidates for any staff appointment shall when making application disclose in writing whether they are related to any director or the holder of any office under the Trust. Failure to disclose such a relationship shall disqualify a candidate and, if appointed, render him liable to instant dismissal.

10.10 The directors and every officer of the Trust shall disclose to the Chief Executive any relationship with a candidate of whose candidature that director or officer is aware. It shall be the duty of the Chief Executive to report to the Board of Directors any such disclosure made.

10.11 On appointment, directors (and prior to acceptance of an appointment in the case of executive directors) should disclose to the Trust whether they are related to any other director or holder of any office under the Trust.

10.12 Where the relationship of an officer or another director to a director of the Trust is disclosed, the Standing Order headed `Disability of directors in proceedings on account of pecuniary interest' (SO 9) shall apply.

10.13 In accordance with paragraph 1.1.2 of the Trust's Standards of Business Conduct and Employees Declarations of Interest Policy, any Board member or member of staff who receives or is offered and declines hospitality in excess of £5025.00 is required to enter the details of the hospitality in the Trust's Hospitality Register.

11 TENDERING AND CONTRACT PROCEDURES

11.1 **Duty to comply with Standing Orders**
The procedure for making all contracts by or on behalf of the Trust shall comply with these Standing Orders (except where SO 5.40 (Suspension of SOs) is applied).

11.2 **EU Directives Governing Public Procurement**
Directives by the Council of the European Union promulgated by the Department of Health (DoH) prescribing procedures for awarding all forms of contracts shall have effect as if incorporated in these Standing Orders.

11.3 The Trust shall comply as far as is practicable with the requirements of the Capital Investment Manual and with guidance contained in "The Procurement and Management of Consultants within the NHS".

11.4 Financial Thresholds

The Trust shall set financial thresholds above which competitive quotations and tenders are to be invited. The value to be compared to the threshold is the estimated full amount of the goods and/or services to be paid during the life of the contract exclusive of vat.

11.5 The estimated value of the requirement is calculated with reference to the following:

a) all possible options under the contract need are included;

b) where volumes and prices are known in advance, then the value of the contract is the full amount which will be paid during the life of the contract;

c) where the contract is for an indefinite period, or for a period of time which is uncertain when the contract is entered into, or the volumes are uncertain, then the estimated amount to be paid is the estimated monthly value multiplied by 24;

d) where it is proposed to enter into two or more contracts for goods or services of a particular type, then the estimated value of each of the contracts must be added together. This aggregate value is the one which must be applied and assessed against the threshold. Where the aggregate value is above the threshold, each contract has to be put to competition, even if the estimated value of each individual contract is below the threshold;

e) for building or engineering works this is the estimated value of the whole works project, irrespective of whether or not it comprises a number of separate contracts for different activities. For example if the construction of a new building is divided into three phases, site clearance, construction and fitting out, the threshold must be applied to the value of all three phases, even though the activities are different and different contractors may be used.

11.6 If the estimate proves to have been flawed, for example, because bids or the eventual contract value are significantly higher than estimated, there may be a breach of the Regulations and the competition may have to be stopped and started again. There may, for example, be unfairness to contractors who relied upon a flawed estimate in reaching a decision not to bid for a particular contract.

11.7 The current thresholds (exclusive of vat) are 3 written quotes up to £25,000, formal quotes up to £50,000; local tenders £50,000 to EU Threshold and measured term contract for works £250,000.

11.8 **Formal Competitive Tendering and Quotations**

The Trust shall ensure that competitive tenders are invited for the supply of goods, materials and manufactured articles and for the rendering of services including all forms of management consultancy services (other than specialised services sought from or provided

by the DoH); for the design, construction and maintenance of building and engineering works (including construction and maintenance of grounds and gardens); where the value is expected to exceed the financial threshold (11.7)and for disposals.

11.9 Formal tendering procedures may be waived by officers to whom powers have been delegated by the Chief Executive without reference to the Chief Executive where:

(a) the estimated expenditure or income does not, or is not reasonably expected to, exceed the financial threshold (11.7); or

(b) where the supply is proposed under special arrangements negotiated by the DoH in which event the said special arrangements must be complied with.

11.10 Formal tendering procedures are not required where:

(a) the requirement is covered by an existing contract;

(b) the requirement is covered by an existing framework

11.11 Formal tendering procedures may be waived by the Chief Executive where:

(a) where a consortium arrangement is in place and a lead organisation has been appointed to carry out tendering activity on behalf of the consortium members;

(d) the timescale genuinely precludes competitive tendering. Failure to plan the work properly is not a justification for single tender; or

(e) specialist expertise is required and is available from only one source; or

(f) the task is essential to complete the project, AND arises as a consequence of a recently completed assignment and engaging different consultants for the new task would be inappropriate; or

(g) there is a clear benefit to be gained from maintaining continuity with an earlier project. However in such cases the benefits of such continuity must outweigh any potential financial advantage to be gained by competitive tendering; or

(h) where provided for in the Capital Investment Manual.

Where it is decided that competitive tendering is not applicable and should be waived by virtue of (d) to (g) above the fact of the waiver and the reasons should be documented and reported by the Chief Executive to the Audit and Non Clinical Risk Sub-Committee in the next formal meeting.

11.12 The limited application of the single tender rules (11.9 and 11.10 above) should not be used to avoid competition or for administrative convenience or to award further work to a consultant originally appointed through a competitive procedure.

11.13 Quotations are required from at least three suppliers where formal tendering procedures are waived under SO 11.9 (a) and where the intended expenditure or income exceeds, or is reasonably expected to exceed the financial threshold (11.7).

11.14 If a framework agreement is to be used, the selection of the best supplier for the particular need is to be made on the basis of either:

(a) the supplier offering the most economically advantageous offer (using the original award criteria) for the particular need where the terms of the agreement are precise enough; or

(b) through mini competition between those suppliers on the framework capable of meeting the particular need using the terms of the original terms, supplemented or refined as necessary.

11.15 Works requirements falling below the MTC financial threshold (11.7) can be placed with the measured term contract supplier, following the process set out in that contract.

11.16 Except where SOs 11.10 and 11.11, or a requirement under SO 11.2, applies, the Board of Directors shall ensure that invitations to tender are sent to a sufficient number of suppliers to provide fair and adequate competition as appropriate, and in no case less than three written competitive tenders must be obtained, having regard to suppliers capacity to supply the goods or materials or to undertake the services or works required.

11.17 The number of suppliers to be invited to tender for building and engineering schemes valued above the financial threshold (11.7)will be a minimum of six, of which four written competitive tenders must be obtained, unless the requirement is waived in writing by the Chief Executive or Director of Finance.

11.18 The Board of Directors shall ensure that normally the suppliers invited to tender (and where appropriate, quote) for building and engineering schemes are among those on approved lists (see Annex Section 5). Where in the opinion of the Director of Finance it is desirable to seek tenders from firms not on the approved lists, the reason shall be recorded in writing to the Chief Executive.

11.19 Tendering procedures are set out in the Annex.

11.20 Quotations should be in writing or via the e-tendering system for quotes above £25,000 unless the Chief Executive or his nominated officer determines that it is impractical to do so in which case quotations may be obtained by telephone. Confirmation of telephone

quotation should be obtained as soon as possible and the reasons why the telephone quotation was obtained should be set out in a permanent record.

11.21 All quotations should be treated as confidential and should be retained for inspection.

11.22 The Chief Executive or his nominated officer should evaluate the quotations and select the one that is either the lowest cost or is the most economically advantages to the Trust taking into account quality. If this is not the lowest or economically advantages then this fact and the reasons why should be in a permanent record.

11.23 **Where tendering or competitive quotation is not required**
Where tenders or quotations are not required, because expenditure is below the financial threshold (11.7), the Trust shall procure goods and services in accordance with procurement procedures approved by the Board of Directors.

11.24 The Chief Executive shall be responsible for ensuring that best value for money can be demonstrated for all services provided under contract or in-house. The Board of Directors may also determine from time to time that in-house services should be market tested by competitive tendering (SO 11.8).

11.25 **Private Finance**
When the Board of Directors proposes, or is required, to use finance provided by the private sector the following should apply:

(a) The Chief Executive shall demonstrate that the use of private finance represents value for money and genuinely transfers risk to the private sector.

(b) The proposal must be specifically agreed by the Board of Directors in the light of such professional advice as should reasonably be sought in particular with regard to vires.

(c) The selection of a private sector partner must be on the basis of competitive tendering or quotations.

11.26 **Contracts**
The Trust may only enter into contracts within its statutory powers and shall comply with:

(a) these Standing Orders;

(b) the Trust's SFIs;

(c) EU Directives and other statutory provisions.

(d) any relevant directions including the Capital Investment Manual and guidance on

the Procurement and Management of Consultants;

Where appropriate contracts shall be in or embody the same terms and conditions of contract as was the basis on which tenders or quotations were invited.

11.27 In all contracts made by the Trust, the Board of Directors shall endeavour to obtain best value for money. The Chief Executive shall nominate an officer who shall oversee and manage each contract on behalf of the Trust.

11.28 **Personnel and Temporary Staff Contracts**
The Chief Executive shall nominate officers with delegated authority to enter into contracts for the employment of other officers, to authorise regrading of staff, and enter into contracts for the employment of temporary staff.

11.29 **Healthcare Services Contracts**
Healthcare Services Contracts made between two NHS organisations are subject to the provisions of the 2006 Act.

11.30 The Chief Executive shall nominate officers with power to negotiate for the provision of healthcare services with commissioners of healthcare.

11.31 **Contracts Involving Funds Held on Trust**
Contracts Involving Funds Held on Trust shall do so individually to a specific named fund. Such contracts involving charitable funds shall comply with the requirements of the Charities Acts.

11.32 **Legality of Payments**
It is the responsibility of the Director of Finance to ensure that all payments made by the Trust fall within its powers.

12 DISPOSALS

12.1 Competitive Tendering or Quotation procedures shall not apply to the disposal of:

(a) any matter in respect of which a fair price can be obtained only by negotiation or sale by auction as determined (or pre-determined in a reserve) by the Chief Executive or his nominated officer;

(b) obsolete or condemned articles and stores, which may be disposed of in accordance with the Trust's condemnation policy;

(c) items to be disposed of with an estimated sale value of less than £5,000;

(d) items arising from works of construction, demolition or site clearance, which

should be dealt with in accordance with the relevant contract;

(e) land or buildings concerning which DoH guidance has been issued but subject to compliance with such guidance.

13 IN HOUSE SERVICES

13.1 In all cases where the Board of Directors determines that in-house services should be subject to competitive tendering the following groups shall be set up:

(a) Specification group, comprising the Chief Executive or nominated officer(s) and specialist(s).

(b) In-house tender group, comprising representatives of the in-house team, a nominee of the Chief Executive and technical support.

(c) Evaluation group, comprising normally a specialist officer, a supplies officer and a Director of Finance representative. For services having a likely annual expenditure exceeding £250,000, a non-executive director should be a member of the evaluation team.

13.2 All groups should work independently of each other but individual officers may be a member of more than one group. No member of the in-house tender group may, however, participate in the evaluation of tenders.

13.3 The evaluation group shall make recommendations to the Board of Directors.

13.4 The Chief Executive shall nominate an officer to oversee and manage the contract.

14 CUSTODY OF SEAL AND SEALING OF DOCUMENTS

14.1 **Custody of Seal**
The Common Seal of the Trust shall be kept by the Secretary in a secure place.

14.2 **Sealing of Documents**
The Seal of the Trust shall not be fixed to any documents unless the sealing has been authorised by a resolution of the Board of Directors or of a committee, thereof or where the Board of Directors has delegated its powers.

14.3 The legal requirement to "seal" documents executed as a deed has been removed. The Board of Directors' may however, choose to continue to use the seal.

14.4 Before any building, engineering, property or capital document is sealed it must be approved and signed by the Director of Finance (or an officer nominated by him) and

authorised and countersigned by the Chief Executive (or an officer nominated by him). Officers nominated to approve the use of the seal on behalf of either the Director of Finance or Chief Executive shall not be within the originating directorate.

14.5 **Register of Sealing**
An entry of every sealing shall be made and numbered consecutively in a book provided for that purpose, and shall be signed by the persons who shall have approved and authorised the document and those who attested the seal. A report of all sealing shall be made to the Board of Directors at least quarterly. (The report shall contain details of the seal number, description of the document, date of sealing, and the directors authorising the use of the seal).

15 SIGNATURE OF DOCUMENTS

15.1 Where the signature of any document will be a necessary step in legal proceedings involving the Trust, it shall be signed by the Chief Executive, unless any enactment otherwise requires or authorises, or the Board of Directors shall have given the necessary authority to some other person for the purpose of such proceedings.

15.2 The Chief Executive or nominated officers shall be authorised, by resolution of the Board of Directors, to sign on behalf of the Trust any agreement or other document (not required to be executed as a deed) the subject matter of which has been approved by the Board of Directors or committee or sub-committee to which the Board of Directors has delegated appropriate authority.

16 MISCELLANEOUS

16.1 **Standing Orders to be given to Directors and Officers**
It is the duty of the Chair to ensure that existing Governors and all new Directors are notified of and understand their responsibilities within SOs and SFIs. Updated copies shall be issued to Directors designated by the Chair. New Directors shall be informed in writing and shall receive copies where appropriate of SOs.

16.2 **Documents having the standing of Standing Orders**
Standing Financial Instructions shall have effect as if incorporated into SOs.

16.3 **Review of Standing Orders**
Standing Orders shall be reviewed annually by the Board of Directors. The requirement for review extends to all documents having the effect as if incorporated in SOs.

17 VARIATION AND AMENDMENT OF STANDING ORDERS

17.1 These Standing Orders shall be amended only if:

(i) at least two-thirds of the Board of Directors are present; and

(ii) a majority of those present, including no fewer than half the total of the Trust's non-executive directors, vote in favour of amendment; and

(iii) the variation proposed does not contravene any statutory provision or direction made by NHS Improvement.

Annex - TENDERING PROCEDURE

1 INVITATION TO TENDER

1.1 All invitations to submit a tender on a formal competitive basis by utilising the E-Tender Portal and shall include:

(a) clear instructions of documentation to complete, including pricing information, technical specifications and business continuity plans

(b) details of the closing date, time and place of receipt of submission with a named lead of who to contact should there be submission problems.

1.2 Extensions of time for the period allowed for receipt of tenders shall only be considered where no tenders have been received or, if tenders have been received, on the basis that all parties are notified and all agreed to the proposed extension . Suppliers may re-submit if they wish by the new deadline.

1.3 Each invitation shall include as a minimum (where appropriate) the following:

(a) Instructions to Offer
(b) Terms of offer including Evaluation Criteria
(c) Specification of goods/service
(d) Terms and conditions of contract as appropriate.
(e) Offer schedule(s)
(f) Form of offer

1.4 Other than in exceptional circumstances, all preparation in relation to the specification and the evaluation of product should be conducted prior to invitation to tender.

1.5 Other than in exceptional circumstances, all preparation in relation to the specification and the evaluation of product should be conducted prior to invitation to tender.

1.6 There shall normally be no contact between Officers of the Trust and the candidates invited to tender in relation to the tender or the proposed contract between the issue of the tender documentation and the award of the contract other than via the use of the Electronic Portal to:-

(a) clarify questions relating to the specification, or
(b) clarify questions relating to the completion of the tender documents, or
(c) offer all parties invited to tender a briefing on the Trust's requirements with the opportunity for the Officers of the Trust and such persons as deemed appropriate and parties invited to tender representatives to ask questions of each other at a meeting arranged by the Trust specifically for this purpose:

where this happens an electronic record should be made and retained for future inspection, or

(d) arrange trials of supplies and/or equipment.

No clarification by Officers of the Trust shall be sought with candidates in relation to financial matters including pricing until after tenders have been opened.

2 RECEIPT, SAFE CUSTODY AND RECORD OF FORMAL TENDERS

2.1 All communicating with candidates between invitation to tender and receipt of tender by the Trust shall be channelled through the e-tendering portal.

2.1.1 Unsuccessful tenderers will be notified via the e-tendering portal.

2.1.3 All tenders received and associated documents (or copies of) will be retained by those seeking the tender and stored on the E-Tendering Portal against the unique Contract reference number for future reference, inspection and audit where required along with the evaluation scoring and details of the evaluation team.

2.1.4 By utilising the E-Tendering Portal procedures shall be adopted to ensure that all tenders received are retained in the secure electronic Portal and remain unopened until such time as they are officially opened which shall be as soon as is reasonably practicable following the latest date and time set for receipt of tenders.

2.2 The tenders will be opened and recorded electronically in the e-tendering portal by two Procurement officers.

2.3 Where examination of tenders reveals errors which would affect the tender figure, the tenderer is to be given details of such errors and afforded the opportunity of confirming or withdrawing his offer.

2.4 Where the lowest tender submitted is so much below the estimate it prompts doubts as to whether an error has been made in tendering, especially where it differs substantially from the other tenders, confirmation of price may be sought from the tenderer via the e-tendering portal without disclosing that it is the lowest tenderer, and an assurance that the contractual arrangements and technical documentation have been fully understood. If the tenderer has made an error, he may withdraw his tender. If he stands by his original price, it must be decided whether acceptance would carry too great a risk of subsequent failure before establishing an order of preference.

2.5 Where only one tender/quotation is received the Trust shall, as far as practicable, ensure that the price to be paid is fair and reasonable.

2.6 Wherever the invitation to tender does not demonstrate sufficient competition by reason of an inadequate response to the invitation, the supervising officer/project manager concerned shall set up a fresh competition, and all tenderers submitting a tender from the original invitation shall be invited to re-tender.

3 WORKS TENDERS

3.1 Every tender for building and engineering works, except for maintenance work only where Estmancode guidance should be followed, shall embody or be in the terms of the current edition of either the appropriate Joint Contracts Tribunal (JCT) or Department of the Environment (GC/Wks) standard forms of contract or NEC3 form of contract amended to comply with Concode. When the content of the works is primarily engineering, tenders shall embody or be in the terms of the General Conditions of Contract recommended by the Institutions of Mechanical Engineers, Electrical Engineers and the Association of Consulting Engineers (Form A) or, in the case of civil engineering work, the General Conditions of Contract recommended by the Institution of Civil Engineers. The standard documents should be amended to comply with Concode and, in minor respects, to cover special features of individual projects. Tendering based on other forms of contract may be used only after prior consultation with the DoH.

3.2 Works to a maximum value of £250,000 may alternatively be procured through an agreed Measured Term Contract, based on the provisions of the Joint Contracts Tribunal (JCT) contract form. The current Measured Term Contract award should be renewed in February 2017.

3.3 Works of value greater than £1m may be procured under an EU Public Procurement compliant Procure 21+ process. This process will be reviewed in April 2016 (as P22_and is likely to be of similar form to P21+ and will be a route available for procurement of works greater than £1m.

4 LISTS OF APPROVED FIRMS

4.1 A manager nominated by the Chief Executive shall on behalf of the Trust maintain lists of approved firms from whom tenders and quotations may be invited. These shall be kept under frequent review. The lists shall include all firms who have applied for permission to tender and as to whose technical and financial competence the Trust is satisfied. All suppliers must be made aware of the Trust's terms and conditions of contract and their selection for invitation to tender or quote, must be effectively rotated.

(a) **Building and Engineering Construction Works**

(i) Invitations to tender shall be made only to firms included on the approved list of tenderers compiled in accordance with this Instruction or on the separate

maintenance lists compiled in accordance with Estmancode guidance (Health Notice HN(78)147).

(ii) Firms included on the approved list of tenderers shall ensure that when engaging, training, promoting or dismissing employees or in any conditions of employment, shall not discriminate against any person because of colour, race, ethnic or national origins, religion or sex, and will comply with the provisions of current legislation and regulations.

(iii) Firms shall conform at least with the requirements of the Health and Safety at Work Act and any amending and/or other related legislation concerned with the health, safety and welfare of workers and other persons, and to any relevant British Standard Code of Practice issued by the British Standard Institution and CDM2007. Firms must provide to the appropriate manager a copy of its safety policy and evidence of the safety of plant and equipment, when requested.

(b) **Financial Standing and Technical Competence of Contractors**
The Director of Finance may make or institute any enquiries he deems appropriate concerning the financial standing and financial suitability of approved contractors. The Director of Facilities and Commercial Development will similarly make such enquiries as is felt appropriate to be satisfied as to their technical competence.

4.2 The Trust shall arrange for advertisements to be issued as may be necessary, and not less frequently than every third year, in trade journals and national newspapers inviting applications from firms for inclusion in the prescribed lists.

4.3 If in the opinion of the Chief Executive or the Director of Finance it is impractical to use a list of approved suppliers (for example where specialist services or skills are required and there are insufficient suitable potential contractors on the list), the Chief Executive should ensure that appropriate checks are carried out as to the technical and financial capability of firms invited to tender or quote.

4.4 A permanent record should be made of the reasons for inviting a tender or quote other than from an approved list.

5 NEGOTIATED TENDERS

5.1 The use of a negotiated tender leading to a 'continuation' or 'run-on' contract may be appropriate where the need arises for additional work which, if authorised as variation on the existing contract or let to another contractor would be undesirable or unduly disruptive and expensive. This situation can arise in two circumstances:

(a) when the need is for further work of a similar nature to that already being

executed and normally on the same or a closely adjoining site; and

(b) when the need is for alteration to the works executed in the original contract which it is important should be carried out by the same contractor in order to safeguard the Trust's rights with regard to defects in the works.

5.2 The following criteria must be observed when considering the use of negotiated tender procedure:

(a) The initial contract must have been awarded as a result of competitive tendering.

(b) The new work must not be of a disproportionately high value (i.e. as a general rule not more than 50%) in relation to the value of the initial contract.

(c) For further work of a similar nature a high proportion (at least 60%) of the value of the new work must be covered by rates included in the initial contract that can be used as basis of negotiation of new rates.

(d) For alteration works, the rates must be based as far as practicable on the same fundamental costing data used for rates in the initial contract.

(e) The aggregate value of contracts awarded for additional works may not exceed 50% of the value of the original contract.

(f) During the negotiations the contractor's agreement must be obtained that the addition of further work will not later be raised by him as a ground for a claim for disruption of the initial contract. (The costs of any necessary reorganisation of the initial contract so as to accommodate the further work must be raised during the negotiations and, if agreed, included in the negotiated amount).

(g) At the conclusion of the negotiations the Trust must have reasonable evidence to show that the negotiated amount is no less favourable than a freshly obtained competitive tender would be.

(h) The procedure must not be used simply to recover time lost during the initial contract or as a means of bringing forward a later scheme, or as a substitute for good planning.

(i) The details of the further work should be fully prepared and meet the normal requirements of readiness to proceed to tender.

(j) The timetable for the negotiations should be linked with the planning of capital expenditure so that this does not place any additional constraint on the Trust's

freedom of action.

6 TENDERS NOT STRICTLY IN ACCORDANCE WITH SPECIFICATION

6.1 Tenders not strictly in accordance with the specification may be considered if a marked financial advantage to the Trust would otherwise be lost. A marked financial advantage is a saving in excess of £1000 or 1% of the tender price, whichever is the greater.

6.2 Provided there is no reason to doubt the bona fides of the tenderer, the lowest tenderer to specification may be asked to revise his tender to conform to the revised specification.

6.3 If he is willing to do so but refuses to abide by his original price, his tender must be rejected.

6.4 If he declines to revise his tender to conform with the specification then, in the case of professional Services Contracts or Supplies Contracts, post tender negotiations may be undertaken in accordance with the procedures below. Otherwise his tender should be rejected and the second lowest (or second highest in the case of a sale) should be considered.

6.5 If so many of the tenderers fail to conform with the specification that the whole basis of the competition is invalidated or post tender negotiations do not take place then consideration should be given to re-commencing competition and inviting further tenders.

7 POST TENDER NEGOTIATION

7.1 At any time prior to acceptance of a tender by the Trust the Chief Executive or any officer authorised by him, may authorise post tender negotiations if it appears that a marked financial advantage as defined above may accrue to the Trust, or, if subsequently there has been a bona fide change in specification which is not so significant as to warrant abandonment of the procedure and the invitation of further tenders.

7.2 Where the negotiation is carried out by officers of the Trust each tenderer shall be notified that the Trust wishes to enter into post tender negotiations, and at least each of the three lowest (or highest in the case of a sale) tenderers, or all the tenderers if less than three submitted valid tenders, shall be invited to attend a separate meeting at the Trust's offices (unless an adverse financial report has been received from the Director of Finance in respect of any tenderer, in which case that tenderer shall be excluded from the invitation). At each such meeting the Trust shall be represented by at least two officers, one of whom shall write a minute of the meeting, which, as soon as practicable thereafter, shall be confirmed as correct by the other officer and each tenderer shall be

given equal opportunity on an equal footing insofar as it is reasonably practicable to negotiate his tender, whether as to price, quality or in any other respect. Negotiations with each tenderer may continue over a series of meetings and any amendment finally negotiated shall be confirmed by the tenderer in writing to the Trust.

7.3 The time during which all negotiations shall be completed by receipt of written confirmation of any amendments shall be specified in the invitation referred to in 8.2 above and may be extended by notice in writing from the Trust to all tenderers at any time.

7.4 Post tender negotiation in relation to Estates contracts shall only take place in accordance with the guidance given in the current edition of the Code of Procedure Single Stage Selective Tendering issued by the National Joint Consultative Committee for Building.

7.5 Upon the expiration of the time for negotiation, or any extended period, any amended tender shall be considered in accordance Section 4 on the Acceptance of Tenders.

8 PRESERVATION AND DESTRUCTION OF DOCUMENTS

8.1 **Estates' Tenders**
Documents relating to the successful tender shall not be destroyed. Documents relating to unsuccessful tenders will be destroyed after six successive financial years following the financial year of origin.

8.2 **Supply of Goods and Services**
Documents relating to the successful tender shall not be destroyed. Documents relating to unsuccessful tenders will be destroyed six years after the end of the financial year of origin.

9 FORMS OF CONTRACT

9.1 Supplies contracts may be executed under hand.

9.2 An Official Order or Letter of Acceptance will be sent to the successful tenderer in respect of contracts for estates services up to and including £250,000 in value. In the case of estates services which exceed £250,000 in value but do not exceed £500,000, contracts may be executed underhand.

9.3 Those exceeding £500,000 in value will be executed under the Common Seal of the Trust.

9.4 Every contract for building and engineering works (except contracts for maintenance work only, where Estmancode guidance should be followed) shall embody or be in the

same terms and conditions of contract as those on the basis of which tenders were invited.

9.5 In the case of Consultants' commissioning agreements relating to building and engineering works, to which a professional service contract for consultant design services relates, the contract shall be evidenced in writing, so far as is possible having regard to the custom and practice of the profession concerned.

APPENDIX 1 - EQUALITY IMPACT ASSESSMENT PART 1 INITIAL SCREENING

Service/Function/Policy/Project/ Strategy	CSU/Executive Directorate and Department	Assessor (s)	New or Existing Service or Policy?	Date of Assessment
Standing Orders Board of Directors 2016 – CORP/FIN 1 (A) v.8~~7~~	CE/Finance	~~Maria Dixon /Andrew Thomas~~Jon Sargeant and Matthew Kane	Existing Policy	~~May 2016~~September 2017

1) Who is responsible for this policy? Name of CSU/Directorate – Finance Department

2) Describe the purpose of the service / function / policy / project/ strategy? Who is it intended to benefit? What are the intended outcomes? To provide standing orders for the Board and a framework for the delegation of powers from the Board.

3) Are there any associated objectives? Legislation, targets national expectation, standards No

4) What factors contribute or detract from achieving intended outcomes? – Compliance with the policy

5) Does the policy have an impact in terms of age, race, disability, gender, gender reassignment, sexual orientation, marriage/civil partnership, maternity/pregnancy and religion/belief? Details: [see Equality Impact Assessment Guidance] - No

- **If yes, please describe current or planned activities to address the impact** [e.g. Monitoring, consultation] – N/A

6) Is there any scope for new measures which would promote equality? [any actions to be taken] N/A

7) Are any of the following groups adversely affected by the policy? No

Protected Characteristics	Affected?	Impact
a) Age	No	
b) Disability	No	
c) Gender	No	
d) Gender Reassignment	No	
e) Marriage/Civil Partnership	No	
f) Maternity/Pregnancy	No	
g) Race	No	
h) Religion/Belief	No	
i) Sexual Orientation	No	

8) Provide the Equality Rating of the service / function /policy / project / strategy – tick (✓) outcome box

Outcome 1✓	Outcome 2	Outcome 3	Outcome 4

If you have rated the policy as having an outcome of 2, 3 or 4, it is necessary to carry out a detailed assessment and complete a* **Detailed Equality Analysis form in Appendix 4

Date for next review: ~~May 2017~~September 2018

Checked by: ~~Andrew Thomas~~ Jon Sargeant and Matthew Kane **Date:** ~~May 2016~~September 2017

Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

Reservation of Powers to the Board and Delegation of Powers

~~July 2016~~January 2018

This procedural document supersedes: CORP/FIN 1 (C) v.~~5~~ 6 - Reservation of Powers to the Board and Delegation of Powers – ~~March 2015~~July 2016

Did you print this document yourself?
The Trust discourages the retention of hard copies of policies and can only guarantee that the policy on the Trust website is the most up-to-date version. **If, for exceptional reasons, you need to print a policy off, it is only valid for 24 hours.**

Name and title of author/reviewer:	~~Andrew Thomas, Finance Programme Director~~ Jon Sargeant, Director of Finance Matthew Kane, Trust Board Secretary
Date written/revised:	~~June 2016~~ January 2018
Approved by (Committee/Group):	Board of Directors
Date of approval:	~~26 July 2016~~TBC
Date issued:	~~14 September 2016~~TBC
Next review date:	July 2017
Target audience:	Trust-wide

Reservation of Powers to the Board and Delegation of Powers

Amendment Form

Please record brief details of the changes made alongside the next version number.
If the procedural document has been reviewed **without change**, this information will still need to be recorded although the version number will remain the same.

Version	Date	Brief Summary of Changes	Author
Version 7	September 2017	Various	Jon Sargeant and Matthew Kane
Version 6	September 2016	• Update ~~t~~o ensure consistency with the SFIs • Update for consistency with new committee structure • Various changes	Maria Dixon / Andrew Thomas
Version 5	March 2015	• Updated to reflect changes to Standing Orders relating to e-tendering and Working Together Group thresholds	Andrea Smith
Version 4	November 2013	• References throughout to Director of Finance, Information and Procurement / DoFIP amended to Director of Finance and Infrastructure / DoFI; • References throughout to Director of Human Resources amended to Director of People and Organisational Development; • Updated references and amendments for consistency to revised Standing Orders section 11 and tendering annex; • Clarification added to the posts included in role of 'Senior Officer'.	Robert Paskell

CONTENTS

1. INTRODUCTION

SO 6.1 of the Standing Orders provides that "subject to such directions as may be given by NHS Improvement, the Trust may make arrangements for the exercise, on behalf of the Trust, of any of its functions by a committee or sub-committee of directors or by ~~the Chair or a~~an executive director ~~or by an officer~~ of the Trust, in each case subject to such restrictions and conditions as the Board thinks fit." The Code of Accountability also requires that there should be a formal schedule of matters specifically reserved to the Trust.

The purpose of this document is to provide details of those powers reserved to the Board - generally matters for which it is held accountable to the NHS Improvement, while at the same time delegating to the appropriate level the detailed application of Trust policies and procedures. However, the Board remains accountable for all of its functions; even those delegated ~~to the Chair, individual directors or officers~~ and would therefore expect to receive information about the exercise of delegated functions to enable it to maintain a monitoring role.

A. Role of the Chief Executive

All powers of the Trust which have not been retained as reserved by the Board or delegated to an executive committee or sub-committee shall be exercised on behalf of the Board by the Chief Executive. The Chief Executive shall prepare a Scheme of Delegation identifying which functions he shall perform personally and which functions have been delegated ~~to other directors and officers~~. ~~**Directors for the purpose of SO/SFI and Scheme of Delegation are those reporting directly to the Chief Executive, including executive board members.**~~

All powers delegated by the Chief Executive can be re-assumed by him/her should the need arise. As Accounting~~able~~ Officer the Chief Executive is accountable to NHS Improvement for the funds entrusted to the Trust.

B. Caution over the Use of Delegated Powers

Powers are delegated to directors ~~and officers~~ on the understanding that they would not exercise delegated powers in a matter which in their judgement was likely to be a cause for public concern.

C. Directors' Ability to Delegate their own Delegated Powers

The Scheme of Delegation shows only the "top level" of delegation within the Trust. The Scheme is to be used in conjunction with the system of budgetary control and other established procedures within the Trust.

D. Absence of Directors or Officer to Whom Powers have been Delegated

In the absence of a director ~~or officer~~ to whom powers have been delegated those powers shall be exercised by that director ~~or officer~~'s superior unless alternative arrangements have been approved by the Board. If the Chief Executive is absent powers delegated to him may be exercised by ~~the Chair~~ the Deputy Chief Executive after taking appropriate advice from the Director of Finance.

The Chief Executive, ~~in~~ following consultation with the Chair, may authorise any person to act on his behalf and exercise such delegated powers across the full range of duties carried out by the Chief Executive.

1. RESERVATION OF POWERS TO THE BOARD

1.1 The Code of Accountability which has been adopted by the Trust requires the Board to determine those matters on which decisions are reserved unto itself. These reserved matters are set out in paragraphs 1.2 to 1.9 below:

1.2 **General Enabling Provision**

The Board may determine any matter it wishes in full session within its statutory powers.

1.3 **Regulation and Control**

1.3.1 Approval of Standing Orders (SOs), a schedule of matters reserved to the Board and Standing Financial Instructions for the regulation of its proceedings and business.

1.3.2 Approval of a scheme of delegation of powers from the Board to officers.

1.3.3 Suspension of Standing Orders.

1.3.4 Variation or amendment of Standing Orders.

1.3.5 Requiring and receiving the declaration of directors' interests which may conflict with those of the Trust and determining the extent to which that director may remain involved with the matter under consideration.

1.3.6 Requiring and receiving the declaration of interests from officers which may conflict with those of the Trust.

1.3.7 Disciplining directors who are in breach of statutory requirements or SOs.

1.3.8 Approval of the disciplinary procedure for officers of the Trust.

1.3.9 Approval of arrangements for dealing with complaints.

1.3.10 Adoption of the organisational structures, processes and procedures to facilitate the discharge of business by the Trust and to agree modifications there to.

1.3.11 To receive reports from committees including those which the Trust is required to establish and to take appropriate action thereon.

1.3.12 To confirm the recommendations of the Trust's committees where the committees do not have executive powers. To establish terms of reference and reporting arrangements of all ~~sub-~~board committees (and other committees if required).

1.3.13 Ratification of any urgent decisions taken ~~by the Chair~~ in accordance with SO 6.2.

1.3.14 Approval of arrangements relating to the discharge of the Trust's responsibilities as a corporate trustee for funds held on trust.

1.3.15 Approval of arrangements relating to the discharge of the Trust's responsibilities as a bailee for patients' property.

1.4 **Appointments**

1.4.1 The appointment and ~~dismissal~~ disestablishment of committees.

1.4.2 The appointment and dismissal of executive directors (subject to SO 3.4).

1.4.3 The appointment of members of any committee of the Trust.

1.5 **Policy Determination**

1.5.1 To ~~receive~~ approve management policies including personnel policies incorporating the arrangements for the appointment, removal and remuneration of staff. Policies so received shall be listed.

1.6 **Strategy and Business Plans and Budgets**

1.6.1 Definition of the strategic aims and objectives of the Trust, including approval of underpinning strategies that support its delivery.

1.6.2 Approval annually of plans, including the NHS Improvement's annual plan in respect of:-

- Service delivery strategy.
- The application of available financial resources.

1.6.3 Overall approval of programmes of investment to guide the letting of contracts for the supply of clinical services.

1.6.4 Approval and monitoring of the Trust's policies and procedures for the management of risk, through the Audit and Non-clinical Risk ~~Sub~~ Committee.

1.7 **Direct Operational Decisions**

1.7.1 Acquisition, disposal or change of use of land and/or buildings.

1.7.2 The introduction or discontinuance of any significant activity or operation. An activity or operation shall be regarded as significant if it has a gross annual income or expenditure (that is before any set off) in excess of £250,000.

1.7.3 Approval of individual contracts (other than NHS contracts) of a capital or revenue nature amounting to, or likely to amount to over £500,000 over a 2 year period or the period of the contract if longer.

1.7.4 Approval of individual compensation payments over £100,000.

1.7.5 To agree action on litigation against or on behalf of the Trust.

1.8 **Financial and Performance Reporting Arrangements**

1.8.1 Continuous appraisal of the affairs of the Trust by means of the receipt of reports as it sees fit from directors, committees, associate directors and officers of the Trust as set out in management policy statements. All monitoring returns required by NHS Improvement and the Charity Commission shall be reported, at least in summary, to the Board of Directors.

1.8.2 Approval of the opening or closing of any bank or investment accounts.

1.8.3 Receipt and approval of a schedule of NHS contracts signed in accordance with arrangements approved by the Chief Executive.

1.8.4 Consideration and approval of the Trust's Annual Report including the annual accounts.

1.8.5 Receipt and approval of the Annual Report(s) for funds held on trust.

1.9 **Audit Arrangements**

1.9.1 To approve audit arrangements (including arrangements for the separate audit of funds held on trust) and to receive reports of the Audit and Non Clinical Risk ~~Sub-~~Committee meetings and take appropriate action.

1.9.2 The receipt of the annual management letter received from the external auditor and agreement of action on the recommendation where appropriate of the Audit and Non Clinical Risk ~~Sub-~~Committee.

1.9.3 The receipt of the annual report received from the internal auditor and the agreement of action on the recommendation where appropriate of the Audit and Non Clinical Risk ~~Sub-~~Committee.

2. DELEGATION OF POWERS

2.1 **Delegation to Committees**

The Board may determine that certain of its powers shall be exercised by ~~Standing Committees~~committees. The composition and terms of reference of such committees shall be that determined by the Board from time to time taking into account where necessary the requirements of NHS Improvement and or the Charity Commissioners (including the need to appoint an Audit Committee and a Remuneration and Terms of Service Committee). The Board shall determine the reporting requirements in respect of these committees. In accordance with SO 7.5 committees may not delegate executive powers to sub-committees unless expressly authorised by the Board.

3. SCHEME OF ~~DELEGATION~~ AUTHORISATION TO OFFICERS

3.1 Standing Orders and model Standing Financial Instructions set out in some detail the financial responsibilities of the Chief Executive (CE), the Director of Finance (DoF) and other directors. These responsibilities are summarised below.

> [**NOTE** It should be noted that the SFIs generally specify officers responsible for various matters whereas SOs only do this occasionally].

Certain matters needing to be covered in the scheme of delegation are not covered by SFIs or SOs or they do not specify the responsible officer. These are:

Area of responsibility	Overall responsibility
Data Protection Act Requirements	Medical Director
Health and Safety Arrangements	Chief Executive

This scheme of delegation covers only matters delegated by the Board to directors and certain other specific matters referred to in SFIs. Each director is responsible for the delegation within his area of responsibility. S/h~~H~~e should produce a scheme of ~~delegation~~ authorisation for matters. In particular the scheme of ~~delegation~~ authorisation should include how budget management and procedures for approval of expenditure are delegated.

A more detailed scheme of delegation including financial limits is given in Section 5.

SECTION 4 – SCHEME OF DELEGATION IMPLIED BY STANDING ORDERS

SCHEME OF DELEGATION IMPLIED BY STANDING ORDERS

SO REF	DELEGATED TO	DUTIES DELEGATED
2.1	CHAIR	Final authority in interpretation of SOs.
4.1	CHAIR	Chair all board meetings and associated responsibilities.
5.6	CHAIR	Calling meetings.
8.8	CE	Register(s) of interests.
11.18	CE	Demonstrate that the use of private finance represents best value for money and transfers risk to the private sector.
11.20	CE	Best value for money is demonstrated for all services provided under contract or in-house.
11.20	CE	Nominate an officer to oversee and manage the contract on behalf of the Trust.
11.21	CE	Nominate officers to enter into contracts of employment, regrading staff, agency staff or consultancy service contracts.
11.23	CE	Nominate officers with power to negotiate commissioning contracts with providers of healthcare and other authorities.
12.1(a)	CE OR NOMINATED OFFICER	Determining any items to be sold by sale or negotiation.
14.1	CE	Keep seal in safe place and maintain a register of sealing.
14.4	CE/DOF OR NOMINATED OFFICERS	Approve and sign all building, engineering, property or capital documents.
15.1	CE	Approve and sign all documents which will be necessary in legal proceedings
15.2	CE OR NOMINATED OFFICERS	Sign on behalf of the Trust any agreement or document not requested to be executed as a deed.
16.1	CHAIR	Existing Directors, Governors and employees and all new appointees are notified of and understand their responsibilities within Standing Orders and SFIs.

SCHEME OF DELEGATION IMPLIED BY STANDING ORDERS

SO REF	DELEGATED TO	DUTIES DELEGATED
Annex s2	CE	Designate an officer responsible for receipt and custody of tenders before opening.
Annex s3	TWO SENIOR OFFICERS	Open tenders.
Annex s4	CE OR NOMINATED OFFICER	Decide whether any late tenders should be considered.
Annex s5	CE OR NOMINATED OFFICER	Keep lists of approved firms for tenders.

SECTION 4 – SCHEME OF DELEGATION IMPLIED BY STANDING FINANCIAL INSTRUCTIONS

SCHEME OF DELEGATION IMPLIED BY STANDING FINANCIAL INSTRUCTIONS

SFI REF	DELEGATED TO	DUTIES DELEGATED
1.3.6	CHIEF EXECUTIVE (CE)	To ensure all employees and directors, present and future, are notified of and understand Standing Financial Instructions.
1.3.7	DIRECTOR OF FINANCE (DOF)	Responsible for implementing the Trust's financial policies and coordinating corrective action and ensuring detailed financial procedures and systems are prepared and documented.
1.3.8	~~ALL~~ DIRECTORS ~~AND EMPLOYEES~~	Responsible for security of the Trust's property, avoiding loss, exercising economy and efficiency in using resources and conforming to Standing Orders, Financial Instructions and financial procedures.
1.3.10	DOF	Form and adequacy of financial records of all departments.
2.1.1	AUDIT AND NON-CLINICAL RISK ~~SUB-~~COMMITTEE	Provide independent and objective view on internal control and probity.
2.2	DOF / CE	Monitor and ensure compliance with directions on fraud and corruption.
2.5	HEAD OF INTERNAL AUDIT	Review, appraise and report in accordance with NHS Internal Audit Manual and best practice.
2.6	BOARD OF GOVERNORS	Appoint external auditors.
3	CE DOF	Overall responsibility for Prudential Borrowing Control. Ensuring compliance with NHS Improvement's requirements, ensure loans drawn are for approved expenditure only at time of need, and ensuring adequate system of monitoring.
4	DOF DOF CE	Submit budgets. Monitor performance against budget; submit to Board financial estimates and forecasts. Delegate budget to budget holders and submit monitoring returns.
4.3	DOF	Devise and maintain systems of budgetary control.

SECTION 4 – SCHEME OF DELEGATION IMPLIED BY STANDING FINANCIAL INSTRUCTIONS

SCHEME OF DELEGATION IMPLIED BY STANDING FINANCIAL INSTRUCTIONS

SFI REF	DELEGATED TO	DUTIES DELEGATED
5	DoF	Annual accounts and reports.
6	DoF	Banking arrangements.
7	DoF	Income systems.
8	CE DoF	Negotiating contracts for provision of patient services. Regular reports of actual and forecast contract expenditure.
9.1	NOM. & REMUN. COMMITTEE	Remuneration & Terms of Service Committee
9.2	CE	Variation to funded establishment of any department.
9.3	CE	Staff, including agency staff, appointments.
9.4	DIRECTOR OF PEOPLE AND ORGANISATIONAL DEVELOPMENT	Payroll
10.1	CE DOF	Determine, and set out, level of delegation of non-pay expenditure to budget managers.
10.2.2	DoF	Prompt payment of accounts.
10.2.5	CE	Authorise the use of official orders.
10.2.7	DoF	Ensure that arrangements for financial control and financial audit of building and engineering contracts and property transactions comply with the good practice guidance.
10.3	CE	Grants for provision of patient services.
11	DoF	Advise Board on borrowing and investment needs and prepare procedural instructions.

SECTION 4 – SCHEME OF DELEGATION IMPLIED BY STANDING FINANCIAL INSTRUCTIONS

SCHEME OF DELEGATION IMPLIED BY STANDING FINANCIAL INSTRUCTIONS

SFI REF	DELEGATED TO	DUTIES DELEGATED
12	CE	Capital investment programme
12.3	CE	Maintenance of asset registers.
12.3.8	DoF	Calculate and pay capital charges in accordance with NHS Improvement requirements.
12.4.1	CE	Overall responsibility for fixed assets.
12.4.4	~~ALL SENIOR STAFF~~DIRECTORS	Responsibility for security of Trust assets including notifying discrepancies to DoF, and reporting losses in accordance with Trust procedure.
13	DoF	Responsible for systems of control over stores and receipt of goods.
13.8	CE	Identify persons authorised to requisition and accept goods from NHS Supply Chain Warehouses.
14.2	DoF	Prepare procedures for recording and accounting for losses and special payments and informing ~~NHS Protect and~~ NHS Counter Fraud Authority and the External Auditor of all frauds and informing police in cases of suspected arson or theft.
15	DoF	Responsible for accuracy and security of computerised financial data.
16	CE	Responsible for ensuring patients and guardians are informed about patients' money and property procedures on admission.
17	DoF	Shall ensure each fund held on trust is managed appropriately (subject to the discretion and approval of the Charitable Funds Committee if any).
18	CE	Retention of document procedures
19.1	CE DoF	Risk management programme Insurance arrangements

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SECTION 5 - DETAILED SCHEME OF DELEGATION & AUTHORISATION

Delegated matters in respect of decisions which may have a far reaching effect must be reported to the Chief Executive. The delegation and authorisation shown below is the lowest level to which authority is ~~delegated~~given. Delegation and authorisation to lower levels is only permitted with written approval of the Chief Executive who will, before authorising ~~such delegation~~, consult with other Directors as appropriate. All items concerning Finance must be carried out in accordance with Standing Financial Instructions and Standing Orders.

Key: CE - Chief Executive, MD - Medical Director, ~~DoNMQ~~DoNM&AHP - Director of Nursing, Midwifery & Quality, DoF - Director of Finance, DoPOD – Director of People and Organisational Development, COO - Chief Operating Officer, HoCM Head of Communications and Engagement

Directors for the purpose of SO/SFI and Scheme of Delegation are Executive Directors.

Senior officers are staff employed in the post of Care Group Director, General Manager, Deputy Director or Head of a department.

Delegated Matter	Authority Delegated To	Reference Document
1. Management of Budgets		SFIs Section 4
Responsibility of keeping expenditure within budgets		
a) At individual budget level (Pay and Non Pay)	Budget Holder	
b) At service level	Care Group Director or Executive Director	
c) For the totality of services covered by Functional Director	Executive Director or CE	
d) For all other areas:	DoF or Appropriate Delegated Manager	
Budgetary or virement limits		
a) Up to £50,000 per request	General Manager or Care Group Director	
b) Up to £100,000 per request	Executive Director	
c) Up to £250,000 per request	CE	
Approval for the carry forward of funds into a different budgetary period, after discussion with the DoF	CE	
Approval of revenue business cases		
a) Cases up to £250,000	Management Board (decisions taken outside MB by CE / Executive Team)	
b) Cases over £250,000	Board of Directors	

Delegated Matter	Authority Delegated To	Reference Document
2. Maintenance / Operation of Bank Accounts Maintenance / Operation of Bank Accounts	DoF	SFIs Section 6
3. Quotation, Tendering & Contract Procedures **Authority to obtain at least:** a) To obtain best Value for goods/services under £5,000 b) 3 written quotations for goods/services from £5,000 to £25,000 c) 3 quotations via e-tendering portal from 25,000 to £50,000 c) 4 Tenders for goods/services (non works) via e-tendering portal from £50,000 e) Competitive tenders via e-tendering portal for works goods/services from £50,000 (after seeking responses from a minimum of 6 suppliers) f) Single quotation approval up to £50,000 subject to SFIs g) Single tender approval over £50,000 subject to SFIs	 Buyers & Senior Officers (Procurement and Estates) Senior Officers (Procurement and Estates) Senior Officer (Procurement) Senior Officer (Procurement) Senior Officers (Estates) or Executive Director Head of Procurement CE or DoF	SFIs Section 10 & SOs Section 11 & Annex
4. Non Pay Expenditure/Requisitioning/Ordering/ Payment of Goods & Services ~~Authorisation of requisitions (where contract or framework already in place):~~ ~~a) Requisitions to £500~~ ~~b) Requisitions to cumulative value of agreed contract under £50,000~~ c) ~~Over £50,000~~ Authorisation of requisitions ~~(where no contract or framework already in place)~~: a) Requisitions to £2,000~~500~~ b) Requisitions to £25,000 c) Requisitions to £50,000 d) Requisitions to £100,000 e~~d~~) Requisitions to £250,000 f~~e~~) Requisitions over £250,000 Authorisation of contracts for goods & services and subsequent variations to contracts a) Contracts up to £250,000 b) Contracts over £250,000 to £500,000 c) Contracts over £500,000 to £1,000,000 d) Contracts over £1,000,000	 ~~Authorised Signatory for Budget~~ ~~General Manager, CG Director or Exec Dir~~ ~~CE~~ Authorised Signatory for Budget Head of Dept. General Manager or Care Group Director Executive Director Chief Operating Officer CE and DOF CE and Chair, after approval by the Board Senior Officers (Estates, Procurement, Pharmacy) DoF DoF or CE DoF or CE with Chair, after approval by the Board	SFIs Section 10 & SOs Section 11 & Annex

Delegated Matter	Authority Delegated To	Reference Document
Authorisation of call off contracts for goods and services covered by a pre-tendered Framework		
a) Contracts up to £~~500,000~~250,000	Senior Officers (Estates, Procurement, Pharmacy)	
b) Contracts over £~~500,000~~250,000 to £1,000,000	DoF	
c) Contracts over £1,000,000 to £2,000,000	DoF or CE	
d) Contracts over £2,000,000	DoF or CE, after approval by the board	
5. Capital Schemes		
Business Cases		SFIs Section 12
a) Production of case of need for every capital expenditure proposal	DoF	& SOs Section 11
b) Certification of costs and revenue consequences	DoF	
c) Approval of business cases to £1,000,000 and not linked to new service development	Management Board (decisions taken outside MB by CE / Executive Team)	
d) Approval of business cases over £1,000,000 or linked to new service development	Board of Directors	
Capital Programme		
a) Production of draft capital programme	DoF	
b) Confirmation of capital funds available	DoF	
c) Approval of capital programme	Board of Directors	
Capital Expenditure		
a) Issue authority to commit expenditure and proceed to tender up to budget approved in capital programme	DoF or CE	
b) Responsibility of keeping expenditure within scheme budget	Scheme Manager	
c) Responsibility of keeping expenditure within total capital budget	DoF	
d) Approval of variations to scheme budgets from plan:		
i) To 10% of original scheme budget, a maximum of £50,000	DoF	
ii) To 20% of original scheme budget, a maximum of £250,000	CE	
iii) Above £250,000 or 20% of original scheme budget	Board of Directors	
e) Selection of architects, quantity surveyors, consultant engineer and other professional advisors within EU regulations	DoF	
f) Financial reporting on all capital scheme expenditure	DoF	
g) Financial monitoring of all capital scheme expenditure	DoF	
h) Granting and termination of leases with annual rent <£100k	DoF	
i) Granting and termination of leases of >£100k	CE	
6. Setting of Fees and Charges		

Delegated Matter	Authority Delegated To	Reference Document
a) Private Patient, Overseas Visitors, Income Generation and other patient related services b) Price of all NHS Contracts	DoF DoF	SFIs Section 7 SFIs Section 8
7. Engagement of Staff Not On the Establishment (Within NHSI price caps) a) Management Consultancy b) Engagement of Trust's Solicitors c) Booking of Bank or Agency Staff i) Medical Locums ii) Nursing iii) Clerical	 Executive Director DoPOD, MD and DoF General Manager or Care Group Director General Manager General / Department Manager or Care Group /Executive Director	SFIs Section 9
8. Expenditure on Charitable and Endowment Funds ~~Up to £10~~£5,000 per request ~~Over £10,000 u~~Up to £~~50,000~~10,000 per request Unlimited	 ~~Nominated signatory (as approved by DoF)~~ DoF or CE ~~CEO following consultation with Chair after approval by BoD~~CEO or DoF after authorisation from the Charitable Funds Committee.	SFIs Section 17
9. Agreements/Licences a) Preparation and signature of all tenancy agreements/licences for all staff subject to Trust Policy on accommodation for staff b) Extensions to existing leases c) Letting of premises to outside organisations d) Approval of rent based on professional assessment	 DoF and DoPOD DoF DoF DoF	
10. Condemning & Disposal a) Items obsolete, obsolescent, redundant, irreparable or cannot be repaired cost effectively b) disposal of x-ray films c) disposal of controlled drugs	 General/Department Manager and Condemning Officer Superintendent Radiographer Chief Pharmacist	SFIs Section 14
11. Losses, Write-off & Compensation a) Losses and Cash due to theft, fraud, overpayment & others Up to £50,000 b) Fruitless Payments (including abandoned Capital Schemes) Up to £100,000 c) Bad Debts and Claims Abandoned. Private Patients, Overseas Visitors & Other Up to £50,000	 CE or Nominated Director and DoF CE or Nominated Director and DoF CE or Nominated Director and DoF	SFIs Section 14

Delegated Matter	Authority Delegated To	Reference Document
d) Damage to buildings, fittings, furniture and equipment and loss of equipment and property in stores and in use due to: Culpable causes (e.g. fraud, theft, arson) or other Up to £50,000 e) Compensation payments made under legal obligation f) Extra Contractual payments to contractors Up to £50,000 <u>Ex-Gratia Payments</u> g) Patients and staff for loss of personal effects Up to £50,000 h) For clinical negligence up to £1,000,000 (negotiated settlements) i) Negotiate settlement up to £50,000 ii) £50,000 to £100,000 i) over £100,000 iv) Authorise payment (up to £1,000,000) i) For personal injury claims involving negligence where legal advice has been obtained and guidance applied i) Negotiate settlement up to £25,000 ii) £25,000 to £100,000 iii) over £100,000 iv) Authorise payment (up to £1,000,000) j) Other, except cases of maladministration where there was no financial loss by claimant £50,000 k) Write off of Debtors	 CE or Nominated Director and DoF CE or Nominated Director and DoF CE or Nominated Director and DoF CE or Nominated Director and DoF MD CE Board of Directors CE or Nominated Director and DoF DoPOD CE Board of Directors CE or Nominated Director and DoF CE or Nominated Director and DoF CE or Nominated Director and DoF	
<u>12. Reporting of Incidents to the Police</u> a) Where a criminal offence is suspected (other than theft or fraud) b) Where a theft is involved c) Where a fraud is involved	 Director with managerial responsibility for the area DoF or DoPOD DoF	SFIs Sections 2 & 14
<u>13. Petty Cash Disbursements (not applicable to central Cashiers Office)</u> a) Expenditure up to £25 per item	 Petty Cash Holder	SFIs Section 10
<u>14. Receiving Hospitality</u> Applies to both individual and collective items of hospitality received **or offered and declined**, in excess of £<u>50</u>~~25~~.00.	 Declaration required in Trust's Hospitality Register	

Delegated Matter	Authority Delegated To	Reference Document
15. Implementation of Internal and External Audit Recommendations	DoF	SFIs Section 2
16. Maintenance & Update on Trust Financial Procedures	DoF	SFIs Section 1
17. Investment of Funds (including Charitable & Endowment Funds)	DoF	SFIs Section 17
18. Personnel & Pay		
a) Authority to fill funded post on the establishment with permanent staff.	Budget holder (after vacancy control approval or Management Board approval for Consultant posts)	
b) Authority to appoint staff to post not on the formal establishment.	CE and DoF	
c) Additional Increments		
The granting of additional increments to staff within budget	DoPOD	
d) Upgrading & Regrading		
All requests for upgrading/regrading shall be dealt with in accordance with Trust procedure	DoPOD	
e) Establishments		
i) Additional staff to the agreed establishment with specifically allocated finance	Budget holder(after vacancy control approval or Management Board approval for Consultant posts)	
ii) Additional staff to the agreed establishment without specifically allocated finance	CE and DoF	
f) Pay		
i) Authority to complete standing data forms affecting pay, new starters, variations and leavers	Senior Officer or Executive Director	
ii) Authority to authorise overtime	Senior Officer or Executive Director	
iii) Authority to complete and authorise positive reporting forms	Senior Officer or Executive Director	
iv) Authority to authorise travel & subsistence expenses	Senior Officer or Executive Director	
v) Approval of Performance Related Pay Assessment	Remuneration Committee/CE	
g) Leave		
i) Approval of annual leave	Senior Officer or Executive Director	
ii) Annual leave - approval of carry forward (up to maximum of 5 days).	Senior Officer or Executive Director	
iii) Annual leave - approval of carry over in excess of 5 days but less than 10 days.	Executive Director	
iv) Compassionate leave up to 3 days	Senior Officer or Executive Director	
v) Compassionate leave up to 6 days	Executive Director	
vi) Special leave arrangements	Executive Director	
paternity leave	Senior Officer or Executive Director	
vii) Leave without pay	Executive Director	
viii) Medical Staff Leave of Absence	MD and CE	
paid and unpaid	General Manager or Care Group Director	
ix) Time off in lieu	Automatic approval with guidance	

Delegated Matter	Authority Delegated To	Reference Document
x) Maternity Leave - paid and unpaid	Automatic approval with guidance	
h) Sick Leave		
i) Extension of sick leave on half pay up to three months	Executive Director in conjunction with DoPOD	
ii) Return to work part-time on full pay to assist recovery	Executive Director in conjunction with DoPOD	
iii) Extension of sick leave on full pay	DoPOD or CE	
i) Study Leave		
i) Study leave outside the UK	DoPOD or MD	
ii) Medical staff study leave (UK)	Care Group Director	
iii) All other study leave (UK)	Senior Officer or Executive Director	
j) Removal Expenses, Excess Rent and House Purchases		
Authorisation of payment of removal expenses incurred by Directors taking up new appointments (providing consideration was promised at interview)	DoPOD	
k) Grievance Procedure	DoPOD	
All grievances cases must be dealt with strictly in accordance with the Grievance Procedure and the advice of a the Director of People and Organisational Development must be sought when the grievance reaches the level of Associate/Dept. Manager		
l) Authorised Car & Mobile Phone Users		
Requests for new posts to be authorised as car users	DoPOD	
Requests for new posts to be authorised as mobile telephone users	DoPOD	
m) Renewal of Fixed Term Contract	Senior Officer or Executive Director	
n) Redundancy	DoPOD	
o) Ill Health Retirement		
Decision to pursue retirement on the grounds of ill-health	DoPOD	
p) Dismissal	Appointing Officers	
q) Development of personnel, industrial relations & training strategies and procedures	Executive Directors	
r) Authorisation of expenditure on recruitment advertising	DoPOD	
s) Day to day management of Consultants' contracts	MD and Care Group Directors	
t) Excellence Awards to Medical staff.	CE	
19. Authorisation of New Drugs		SFIs Section 10
Estimated total yearly cost up to £25,000	Medicines Management Group	
Estimated total yearly cost above £25,000	CE (Subject to consultation with the above)	
20. Authorisation of Sponsorship deals	CE	
21. Authorisation of Research Projects	CE or MD or ~~DoNMQ~~DoNM&AHP	
22. Authorisation of Clinical Trials	CE and MD	

Delegated Matter	Authority Delegated To	Reference Document
23. Insurance Policies and Risk Management	DoF	SFIs Section 19
24. Patients & Relatives Complaints a) Overall responsibility for ensuring that all complaints are dealt with effectively under regulations. b) Responsibility for ensuring complaints relating to a directorate are investigated thoroughly c) Medico - Legal Complaints Co-ordination of their management.	 CE Senior Officer and PALS Rep. MD	
25. Relationships with Press a) Non-Urgent General Enquiries Within Hours Outside Hours b) Urgent Within Hours Outside Hours	 HoCM Executive Director on call HoCM Executive Director on call	
26. Infectious Diseases & Notifiable Outbreaks	MD or Consultant Microbiologist or Control of Infection Nurse	
27. Extended Role Activities Approval of any professions to undertake duties / procedures which can properly be described as beyond the normal scope of practice.	Clinical Governance ~~Quality~~ Committee	
28. Patient Services a) Variation of operating and clinic sessions within existing numbers Outpatients Theatres Other b) All proposed changes in bed allocation and use (excluding critical care) Temporary Change Permanent Change Contract monitoring & reporting c) Critical Care	 COO with General Manager or Care Group Director COO with General Manager or Care Group Director COO with General Manager or Care Group Director COO with General Manager or Care Group Director Bed Manager with advice from COO & ~~DoNMQ~~DoNM&AHP CE with advice from COO & ~~DoNMQ~~DoNM&AHP DoF CE or Executive Director on call	

Delegated Matter	Authority Delegated To	Reference Document
29. Facilities for staff not employed by the Trust to gain practical experience Professional Recognition, Honorary Contracts, & Insurance of Medical Staff, Work experience students	DoPOD	
30. Review of fire precautions	CE	
31. Review of all statutory compliance legislation and Health and Safety requirements including control of Substances Hazardous to Health Regulations	~~DoNMQ~~DoNM&AHP	
32. Review of Medicines Inspectorate Regulations	Chief Pharmacist	
33. Review of compliance with environmental regulations, for example those relating to clean air and waste disposal	CE	
34. Review of Trust's compliance with the Data Protection Act	MD	
35. Monitor proposals for contractual arrangements between the Trust and outside bodies a) Monitor proposals for contractual arrangements between the Trust and other healthcare bodies b) Monitor proposals for contractual arrangements between the Trust and non-healthcare bodies	 DoF DoF	
36. Review the Trust's compliance with the Access to Records Act	MD	
37. Review of the Trust's compliance code of Practice for handling confidential information in the contracting environment and the compliance with "safe haven" per EL 92/60	MD	
38. The keeping of a Declaration of Interests Register	Secretary to the Board	
39. Attestation of sealings in accordance with Standing Orders	CE and DoF	
40. The keeping of a register of Sealings	CE	
41. The keeping of the Hospitality Register	DoF	
42. Retention of Records	COO	
43. Clinical Audit	MD	

Delegated Matter	Authority Delegated To	Reference Document
44. Nominated Fire Director Within Hours Outside Hours	 CE Executive Director on call	
45. Agreement of Policies a) To recommend the adoption of new policies to the Board of Directors b) To approve policies where authorised to do so by the Board of Directors	The appropriate sub-committee of the Board e.g. ~~FOC~~ Finance and Performance for finance related policies	
46. Working Together Partnership Committee in Common All functions agreed to be delegated by the Board and listed in the DBTH Committee in Common terms of reference.	 Committee in common consisting of CEO and Chair or nominated deputies	 DTH CiC TORs

6. ROLES AND RESPONSIBILITIES OF GOVERNORS

The Constitution states that at general meetings, the Board of Governors shall discharge the following responsibilities:

6.1 The appointment or removal of the Chair and the other Non-Executive Directors (section 26).

6.2 Approve an appointment (made by the Non-Executive Directors) of the Chief Executive (section 28).

6.3 The appointment or removal of the Trust's auditors (section 27).

6.4 Decide the remuneration and allowances, and the other terms and conditions of office, of the Chair and the other Non-Executive Directors (section 33).

6.5 Approve any increase of 5% or more in the proportion of the Trust's total income in any financial year attributable to activities other than the provision of goods and services for the purposes of health service in England (section 40).

6.6 Approve any significant transaction, as defined in the constitution (section 44).

6.7 Approve any merger, acquisition, separation or dissolution proposed (section 44).

APPENDIX 1 - EQUALITY IMPACT ASSESSMENT PART 1 INITIAL SCREENING

Service/Function/Policy/Project/ Strategy	CSU/Executive Directorate and Department	Assessor (s)	New or Existing Service or Policy?	Date of Assessment
Reservation of Powers to the Board and Delegation of Powers May 2016 – CORP/FIN 1 (C) v.6	CE/Finance	~~Maria Dixon/Andrew Thomas~~Jon Sargeant/ Matthew Kane	Existing Policy	~~July 2016~~September 2017

1) Who is responsible for this policy? Name of CSU/Directorate – Finance Department/Secretariat

2) Describe the purpose of the service / function / policy / project/ strategy? Who is it intended to benefit? What are the intended outcomes? To provide standing orders for the Board and a framework for the delegation of powers from the Board.

3) Are there any associated objectives? Legislation, targets national expectation, standards No

4) What factors contribute or detract from achieving intended outcomes? – Compliance with the policy

5) Does the policy have an impact in terms of age, race, disability, gender, gender reassignment, sexual orientation, marriage/civil partnership, maternity/pregnancy and religion/belief? Details: [see Equality Impact Assessment Guidance] - No

- **If yes, please describe current or planned activities to address the impact** [e.g. Monitoring, consultation] – N/A

6) Is there any scope for new measures which would promote equality? [any actions to be taken] N/A

7) Are any of the following groups adversely affected by the policy? No

Protected Characteristics	Affected?	Impact
a) Age	No	
b) Disability	No	
c) Gender	No	
d) Gender Reassignment	No	
e) Marriage/Civil Partnership	No	
f) Maternity/Pregnancy	No	
g) Race	No	
h) Religion/Belief	No	
i) Sexual Orientation	No	

8) Provide the Equality Rating of the service / function /policy / project / strategy – tick (✓) outcome box

Outcome 1✓	Outcome 2	Outcome 3	Outcome 4

If you have rated the policy as having an outcome of 2, 3 or 4, it is necessary to carry out a detailed assessment and complete a* **Detailed Equality Analysis form in Appendix 4

Date for next review: July 2017

Checked by: ~~Maria Dixon~~ Matthew Kane **Date:** ~~May 2016~~September 2017

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Standing Financial Instructions

~~July 2017~~January 2018

This procedural document supersedes: CORP/FIN 1 (B) v.5 – Standing Financial Instructions – July 2016

~~(Numerous changes made to contents shown in Red)~~

Did you print this document yourself?
The Trust discourages the retention of hard copies of policies and can only guarantee that the policy on the Trust website is the most up-to-date version. **If, for exceptional reasons, you need to print a policy off, it is only valid for 24 hours.**

Name and title of author/reviewer:	Winston Weir, Project Finance Assistant Director
Date written/revised:	~~July 2017~~December 2017
Approved by (Committee/Group):	Board of Directors
Date of approval:	
Date issued:	
Next review date:	December 2018~~July 2018~~
Target audience:	Trust-wide

Standing Financial Instructions

Amendment Form

Please record brief details of the changes made alongside the next version number. If the procedural document has been reviewed **without change**, this information will still need to be recorded although the version number will remain the same.

Version	Date Issued	Brief Summary of Changes	Author
Version 1	6 July 2017	• Updated sections on Audit, Budgets, funded/ budgeted establishment, Banking, Payment of Directors and Employees, Non Pay Expenditure, Funds Held on Trust~~,~~	Winston Weir
Version 1	6 July 2017	• ~~Purchasing~~Procurement and Tendering Appendix added	Winston Weir

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FOREWORD

NHS Foundation Trusts need to agree Standing Orders (SOs) for the regulation of their proceedings and business. The Board of Directors are also required to adopt schedules of reservation of powers and delegation of powers.

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The documents, together with Standing Financial Instructions, provide a regulatory framework for the business conduct of the Trust. They fulfil the dual role of protecting the Trust's interests and protecting staff from any possible accusation that they have acted less than properly.

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The Standing Orders, Delegated Powers and Standing Financial Instructions provide a comprehensive business framework. All executive and non-executive directors, and all members of staff, should be aware of the existence of these documents and, where necessary, be familiar with the detailed provisions.

CONTENTS

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1. INTRODUCTION

1.1. GENERAL

1.1.1. These Standing Financial Instructions (SFIs) detail the financial responsibilities, policies and procedures adopted by the Trust. They are designed to ensure that its financial transactions are carried out in accordance with the law and Government policy in order to achieve probity, accuracy, economy, efficiency and effectiveness. They should be used in conjunction with the Schedule of Decisions Reserved to the Board and the Scheme of Delegation adopted by the Trust. They shall have effect as if incorporated in the Standing Orders (SOs) of the Trust.

1.1.2. These SFIs identify the financial responsibilities which apply to everyone working for the Trust and its constituent organisations including Trading Units. They do not provide detailed procedural advice. These statements should therefore be read in conjunction with the detailed departmental and financial procedure notes. All financial procedures must be approved by the Director of Finance subject to review by the Financial Oversight Committee.

1.1.3. Should any difficulties arise regarding the interpretation or application of any of the SFIs then the advice of the Director of Finance MUST BE SOUGHT BEFORE ACTING. The user of these SFIs should also be familiar with and comply with the provisions of the Trust's SOs.

1.1.4. **Failure to comply with SFIs and SOs is a disciplinary matter which could result in dismissal.**

1.2. TERMINOLOGY

1.2.1. Any expression to which a meaning is given in Health Service Acts, or in the Financial Directions made under the Acts, shall have the same meaning in these instructions; and

“the Board”	means the board of directors as constituted in accordance with the Trust Constitution;
"Budget"	means a resource, expressed in financial terms, proposed by the Board for the purpose of carrying out, for a specific period, any or all of the functions of the Trust;
"Budget Holder"	means the director or employee with delegated authority to manage finances (Income and Expenditure) for a specific area of the organisation;
“Chairman”	means the chairman of the Trust appointed in accordance with the Trust Constitution;
“Chief Executive”	means the Chief Executive Officer of the Trust appointed in accordance with the terms of the Trust Constitution;
"Constitution"	means the Trust Constitution and all annexes to it;

"Director"	means a director on the Board of Directors;
"Director of Finance"	means the chief finance officer of the Trust;
"Executive Director"	means an executive director of the Trust appointed in accordance with the Trust Constitution;
"Funds held on Trust"	means those funds which the Trust holds at its date of incorporation, receives on distribution by statutory instrument or chooses to accept under powers derived under S.90 of the 2006 Act;
"Legal Adviser"	means the properly qualified person appointed by the Trust to provide legal advice;
"NHS Improvement"	means the body corporate known as NHS Improvement;
"Nominated Officer"	means an officer charged with the responsibility for discharging specific tasks within the SOs and SFIs;
"Officer"	means an employee of the Trust;
"SOs"	means Standing Orders;
"the Trust"	means Doncaster & Bassetlaw Hospitals NHS Foundation Trust.

1.2.2. Wherever the title Chief Executive, Director of Finance, or other nominated officer is used in these instructions, it shall be deemed to include such other director or employees who have been duly authorised to represent them.

1.2.3. Wherever the term "employee" is used and where the context permits it shall be deemed to include employees of third parties contracted to the Trust when acting on behalf of the Trust.

1.3. RESPONSIBILITIES AND DELEGATION

1.3.1. The Board exercises financial supervision and control by:

(a) formulating the financial strategy;

(b) requiring the submission and approval of budgets within approved overall income;

(c) defining and approving essential features in respect of important procedures and financial systems (including the need to obtain value for money); and

(d) defining specific responsibilities placed on directors and employees as indicated in the Scheme of Delegation document.

1.3.2. The Board has resolved that certain powers and decisions may only be exercised by the Board in formal session. These are set out in the 'Reservation of Powers to the Board' document.

1.3.3. The Board will delegate responsibility for the performance of its functions in accordance with the Scheme of Delegation document adopted by the Trust.

1.3.4. Within the SFIs, it is acknowledged that the Chief Executive is ultimately accountable to the Board and as Accountable Officer to NHS Improvement, for ensuring that the Board meets its obligation to perform its functions within the available financial resources. The Chief Executive has overall executive responsibility for the Trust's activities, is responsible to the Board for ensuring that its financial obligations and targets are met and has overall responsibility for the Trust's system of internal control.

1.3.5. The Chief Executive and Director of Finance will, as far as possible, delegate their detailed responsibilities but they remain accountable for financial control.

1.3.6. It is a duty of the Chief Executive to ensure that existing directors and employees and all new appointees are notified of and understand their responsibilities within these Instructions.

1.3.7. <u>The Director of Finance is responsible for:</u>

(a) implementing the Trust's financial policies and for co-ordinating any corrective action necessary to further these policies;

(b) maintaining an effective system of internal financial control including ensuring that detailed financial procedures and systems incorporating the principles of separation of duties and internal checks are prepared, documented and maintained to supplement these instructions;

(c) ensuring that sufficient records are maintained to show and explain the Trust's transactions, in order to disclose, with reasonable accuracy, the financial position of the Trust at any time;

And, without prejudice to any other functions of directors and employees to the Trust, the duties of the Director of Finance include:

(d) the provision of financial advice to the Trust and its directors and employees;

(e) the design, implementation and supervision of systems of internal financial control; and

(f) the preparation and maintenance of such accounts, certificates, estimates, records and reports as the Trust may require for the purpose of carrying out its statutory duties.

1.3.8. All directors and employees, severally and collectively, are responsible for:

(a) the security of the property of the Trust;

(b) avoiding loss;

(c) exercising economy and efficiency in the use of resources; and

(d) conforming with the requirements of Standing Orders, Standing Financial Instructions, Financial Procedures and the Scheme of Delegation.

1.3.9 Any contractor or employee of a contractor who is empowered by the Trust to commit the Trust to expenditure or who is authorised to obtain income shall be covered by these instructions. It is the responsibility of the Chief Executive to ensure that such persons are made aware of this.

1.3.10 For any and all directors and employees who carry out a financial function, the form in which financial records are kept and the manner in which directors and employees discharge their duties must be to the satisfaction of the Director of Finance.

2. AUDIT

2.1 AUDIT AND NON CLINICAL RISK SUB-COMMITTEE

2.1.1 In accordance with Standing Orders and the Audit Code for Foundation Trusts, the Board shall formally establish an Audit Committee, with clearly defined terms of reference and following guidance from the NHS Audit Committee Handbook.

The Board has established the Audit and Non Clinical Risk Sub-Committee to perform the role of the Audit Committee along with additional responsibilities in relation to non-clinical risk management and assurance. The sub-committee will provide an independent and objective view of internal controls and risk management by:

(a) overseeing Internal and External Audit services;

(b) reviewing all internal audit reports;

(c) reviewing financial and information systems and monitoring the integrity of the financial statements and reviewing significant financial reporting judgments;

(d) monitoring compliance with Standing Orders and Standing Financial Instructions;

(e) ensuring that there are adequate arrangements in place for countering fraud and reviewing the outcomes of counter fraud work;

(f) assessing and providing assurance to the Board on the validity of the control environment within the Trust

(g) reviewing schedules of losses and compensations and making recommendations to the Board;

(h) reviewing non clinical controls assurance systems, including information to governors; and

(i) reviewing non clinical risk management arrangements.

The Board shall satisfy itself that at least one member of the committee has recent and relevant financial experience.

2.1.2 Where the committee feel there is evidence of ultra vires transactions, evidence of improper acts, or if there are other important matters that the committee wish to raise, the chairman of the committee should raise the matter at a full meeting of the Board. Exceptionally, the matter may need to be referred to NHS Improvement. (To the Director of Finance in the first instance.)

2.1.3 It is the responsibility of the Director of Finance to ensure an adequate internal audit service is provided and the committee shall be involved in the selection process when an internal audit service provider is changed.

2.2 FRAUD AND CORRUPTION

2.2.1 In line with their responsibilities, the Chief Executive and Director of Finance shall monitor and ensure compliance with directions on fraud and corruption.

2.2.2 The Trust shall nominate a suitable person to carry out the duties of the Local Counter Fraud Specialist (LCFS) ~~as specified by the NHS Protect Anti-Fraud Manual~~.

2.2.3 The LCFS shall report to the Director of Finance and shall work with staff in the NHS ~~Protect in accordance with the Department of Health Fraud and Corruption Manual~~Counter Fraud Authority.

2.2.4 The Local Counter Fraud Specialist will provide a written report to the ANCR Committee, at least annually, on counter fraud work within the Trust and national context.

2.3 SECURITY MANAGEMENT

2.3.1 The Chief Executive will monitor and ensure compliance with directions on NHS security management.

2.3.2 The Board shall nominate a suitable person to carry out the duties of the Local Security Management Specialist (LSMS) as specified by the Secretary of State for Health guidance on NHS security management.

2.3.3 The Chief Executive has overall responsibility for controlling and coordinating security. However, key tasks are delegated by the Chief Executive to the Director responsible for Security Management (SMD) and the appointed Local Security Management Specialist

(LSMS).

2.3.4 The LSMS shall work with the staff in NHS ~~Protect in accordance with the Department of Health Security Management Manual.~~Counter Fraud Authority.

2.3.5 The LSMS will provide a written report, at least annually, to the Audit and Non-Clinical Risk Sub-Committee on security management work within the Trust.

2.4 DIRECTOR OF FINANCE

2.4.1 The Director of Finance is responsible for:

(a) ensuring there are arrangements to review, evaluate and report on the effectiveness of internal financial control including the establishment of an effective internal audit function;

(b) ensuring that the internal audit is adequate and meets the mandatory audit standards;

(c) deciding at what stage to involve the police in cases of fraud, misappropriation, and other irregularities;

(d) ensuring that an annual internal audit report is prepared for the consideration of the Audit and Non Clinical Risk Sub-Committee and the Board. The report must cover:

(i) a clear statement on the effectiveness of internal control,
(ii) major internal financial control weaknesses discovered,
(iii) progress on the implementation of internal audit recommendations,
(iv) progress against plan over the previous year,
(v) strategic audit plan covering the coming three years,
(vi) a detailed plan for the coming year.

2.4.2 The Director of Finance or designated auditors are entitled without necessarily giving prior notice to require and receive:

(a) access to all records, documents and correspondence relating to any financial or other relevant transactions, including documents of a confidential nature;

(b) access at all reasonable times to any land, premises or employee of the Trust;

(c) the production of any cash, stores or other property of the Trust under an employee's control; and

(d) explanations concerning any matter under investigation.

2.5 ROLE OF INTERNAL AUDIT

2.5.1 Internal audit will provide an independent and objective opinion on risk management, control and governance arrangements by measuring and evaluating their effectiveness. The Head of Internal Audit will provide an annual opinion on the whole system of internal control.

2.5.2 Internal audit will review, appraise and report upon:

(a) the extent of compliance with, and the financial effect of, relevant established policies, plans and procedures;

(b) the adequacy and application of financial and other related management controls;

(c) the integrity, reliability and suitability of financial and other related management data;

(d) the extent to which the Trust's assets and interests are accounted for and safeguarded from loss of any kind, arising from:

(i) fraud and other offences,
(ii) waste, extravagance, inefficient administration,
(iii) poor value for money or other causes.

2.5.3 Whenever any matter arises which involves, or is thought to involve, irregularities concerning cash, stores, or other property or any suspected irregularity in the exercise of any function of a pecuniary nature, the Director of Finance must be notified immediately.

2.5.4 The Head of Internal Audit will normally attend Audit and Non Clinical Risk Sub-Committee meetings and has a right of access to all committee members, the Chairman and Chief Executive of the Trust.

2.5.5 The Head of Internal Audit shall be accountable to the Audit and Non-clinical Risk Committee. The reporting system for internal audit shall be agreed between the Director of Finance, the Audit and Non Clinical Risk Sub-Committee and the Head of Internal Audit. The agreement shall be in writing and shall comply with the best practice guidance on reporting contained in the NHS Internal Audit Manual. The reporting system shall be reviewed at least every 3 years.

2.6 EXTERNAL AUDIT

2.6.1 The external auditor is appointed by the Board of Governors and paid for by the Trust, in accordance with paragraph 32 of the Constitution. The auditor must be a member of one or more of the bodies referred to in paragraph 12, Annex 7 of the Constitution.

2.6.2 The Board of Governors must ensure that the auditor meets the criteria included by the -Code of Audit Practice issued by the National Audit Office (NAO) on behalf of the Comptroller and Auditor General at the date of appointment and on an ongoing basis throughout the term of their appointment.

3. PRUDENTIAL BORROWING REQUIREMENT CONTROL

3.1 The Trust is required by statutory provisions not to exceed its Prudential Borrowing Requirement (PBR). The Chief Executive has overall executive responsibility for the Trust's activities and is responsible for ensuring that it stays within its PBR.

3.2 The definition of the Prudential Borrowing Code is set out by NHS Improvement for NHS Foundation Trusts.

3.3 The Director of Finance will:

(a) provide reports in the form required by NHS Improvement;

(b) ensure loans and Public Dividend Capital drawn against the PBR is required for approved expenditure only, and is drawn down only at the time of need; and

(c) be responsible for ensuring that an adequate system of monitoring financial performance is in place to enable the Trust to fulfil its statutory responsibility not to exceed its PBR.

4. BUSINESS PLANNING, BUDGETS, BUDGETARY CONTROL, AND MONITORING

4.1 **PREPARATION AND APPROVAL OF BUSINESS PLANS AND BUDGETS**

4.1.1 The Chief Executive will compile and submit to the Board an annual business plan which takes into account financial targets and forecast limits of available resources. The annual business plan will contain:

(a) a statement of the significant assumptions on which the plan is based;

(b) details of major changes in workload, delivery of services or resources required to achieve the plan.

4.1.2 In addition the Director of Finance will annually compile, and submit to the Board, such financial plans as required by NHS Improvement

4.1.3 Prior to the start of the financial year the Director of Finance will, on behalf of the Chief Executive, prepare and submit budgets for approval by the Board. Such budgets will:

(a) be in accordance with the aims and objectives set out in the annual business plan;

(b) accord with workload and staffing plans;

(c) be produced following discussion with appropriate budget holders;

(d) be prepared within the limits of available funds;

(e) identify potential risks; and

(f) Comply with NHS Improvement requirements and other regulations

4.1.4 The Director of Finance shall monitor financial performance against budget and business plan monthly and report to the Board and Financial Oversight Committee appropriately.

4.1.5 All budget holders must provide information in a timely manner as required by the Director

of Finance to enable budgets to be compiled.

4.1.6 All Budget Holders will sign up to their allocated Budgets at the commencement of each financial year.

4.1.7 The Director of Finance has a responsibility to ensure that adequate training is delivered on an on-going basis to budget holders to help them manage successfully.

4.2 BUDGETARY DELEGATION

4.2.1 The Chief Executive may delegate the management of a budget to permit the performance of a defined range of activities. This delegation must be in writing and be accompanied by a clear definition of:

(a) the amount of the budget;
(b) the purpose(s) of each budget heading;
(c) individual and group responsibilities;
(d) authority to exercise virement;
(e) achievement of planned levels of service; and
(f) the provision of regular reports.

4.2.2 The Chief Executive and delegated budget holders must not exceed the budgetary total or virement limits set by the Board.

4.2.3 Any budgeted funds not required for their designated purpose(s) revert to the immediate control of the Chief Executive, subject to any authorised use of virement.

4.2.4 Non-recurring budgets should not be used to finance recurring expenditure without the authority in writing of the Chief Executive, as advised by the Director of Finance. In defining what is either non-recurring or recurring the Director of Finance will have the final decision.

4.3 BUDGETARY CONTROL AND REPORTING

4.3.1 The Director of Finance will devise and maintain systems of budgetary control. These will include:

(a) monthly financial reports to the Board in a form approved by the Board containing:

(i) income and expenditure to date showing trends, forecast year-end position, and variances against budget;
(ii) balance sheet;
(iii) cashflow;
(iv) movements in working capital;
(v) capital project spend and projected outturn against plan;
(vi) explanations of any material variances from plan;
(vii) movements in reserves;

(viii) details of any corrective action where necessary and the Chief Executive's and/or Director of Finance's view of whether such actions are sufficient to correct the situation;

(b) the issue of timely, accurate and comprehensible advice and financial reports to each budget holder, covering the areas for which they are responsible;

(c) investigation and reporting of variances from financial, workload and staffing budgets;

(d) monitoring of management action to correct variances; and

(e) arrangements for the authorisation of budget transfers or virements.

4.3.2 Each Budget Holder is responsible for ensuring that:

(a) any likely overspending or reduction of income which cannot be met by virement is not incurred without the prior consent of the Board;

(b) the amount provided in the approved budget is not used in whole or in part for any purpose other than that specifically authorised subject to the rules of virement; and

(c) no permanent employees are appointed without the approval of the Chief Executive other than those provided for in the budgeted establishment as approved by the Board.

4.3.3 Detailed rules relating to budgetary virement are set out in Appendix 3.

4.3.4 The Chief Executive is responsible for identifying and implementing cost improvements and income generation initiatives in accordance with the requirements of the Annual Business Plan and a balanced budget.

4.4 CAPITAL EXPENDITURE

4.4.1 The general rules applying to delegation and reporting shall also apply to capital expenditure. (The particular applications relating to capital are contained in Chapter 12.)

4.5 MONITORING RETURNS

4.5.1 The Chief Executive is responsible for ensuring that the appropriate monitoring forms are submitted to NHS Improvement and other parties as required.

5. ANNUAL ACCOUNTS AND REPORTS

5.1 The Director of Finance, on behalf of the Trust, will:

(a) prepare financial returns in accordance with the accounting policies and guidance given by NHS Improvement, the Trust's accounting policies, and international financial reporting standards (IFRS);

(b) prepare and submit annual financial reports in accordance with current guidelines; and

(c) submit financial returns for each financial year in accordance with the guidance and timetable prescribed by NHS Improvement.

5.2 The Trust's audited annual accounts and auditor's report and Quality Accounts must be presented to the Board of Directors for approval or to ANCR by delegation from the Board and to a general meeting of the Board of Governors.

5.3 The Trust will publish an annual report, in accordance with guidelines on local accountability, and present it at the Annual Members' Meeting. The document will comply with NHS Improvement's Annual Reporting Manual (ARM).

6. BANK AND GOVERNMENT BANKING SERVICE ACCOUNTS

6.1 GENERAL

6.1.1 The Director of Finance is responsible for managing the Trust's banking arrangements and for advising the Trust on the provision of banking services and operation of accounts. This advice will take into account guidance/Directions issued from time to time by NHS Improvement.

6.1.2 The Board shall approve the banking arrangements.

6.2 BANK AND GOVERNMENT BANKING SERVICE ACCOUNTS

6.2.1 The Director of Finance is responsible for:

(a) Setting arrangements in place that NHS Shared Business Service compiles with its contract with the organisation for bank and banking services

(b) Commercial bank accounts and accounts operated through the Government Banking Service (GBS);

(b) establishing separate bank accounts for the Trust's non-exchequer funds;

(c) ensuring payments made from commercial banks or GBS accounts do not exceed the amount credited to the account except where arrangements have been made; and

(d) reporting to the Board all arrangements made with the Trust's bankers for accounts to be overdrawn.

6.3 BANKING PROCEDURES

6.3.1 The Director of Finance will prepare detailed instructions (agreed with NHS Shared Business Services) on the operation of commercial bank and GBS accounts which must include:

(a) the conditions under which each commercial bank and GBS account is to be operated;

(b) the limit to be applied to any overdraft; and

(c) those authorised to sign cheques or other orders drawn on the Trust's accounts.

6.3.2 The Director of Finance must advise the Trust's bankers in writing of the conditions under which each account will be operated.

6.3.3 Payments over £10,000 shall be supported by more than one authorised signature on the cheque or authority to pay as appropriate.

6.3.4 The Director of Finance shall nominate members of his staff who are authorised to act as signatories in respect of commercial bank and GBS accounts.

6.4 TENDERING AND REVIEW

6.4.1 The Director of Finance will review the banking arrangements of the Trust at regular intervals to ensure they reflect best practice and represent best value for money by periodically seeking competitive tenders for the Trust's banking business.

6.4.2 Competitive tenders should be sought at least every 5 years. The results of the tendering exercise should be reported to the Board. This review is not necessary for GBS accounts.

7. INCOME, FEES AND CHARGES AND SECURITY OF CASH, CHEQUES AND OTHER NEGOTIABLE INSTRUMENTS

7.1 INCOME SYSTEMS

7.1.1 The Director of Finance is responsible for designing, maintaining and ensuring compliance with systems for the proper recording, invoicing, collection and coding of all monies due.

7.1.2 The Director of Finance is also responsible for the prompt banking of all monies received.

7.2 FEES AND CHARGES

7.2.1 The Director of Finance is responsible for approving and regularly reviewing the level of all fees and charges other than those determined by the Department of Health or by Statute. Independent professional advice on matters of valuation shall be taken as necessary.

7.2.2 All employees must inform the Director of Finance promptly of money due arising from transactions which they initiate/deal with, including all contracts, leases, tenancy agreements, private patient undertakings and other transactions.

7.2.3 The Director of Finance shall be responsible for implementing any such guidance issued by NHS Improvement in relation to the costing and pricing of services, and in particular services provided to NHS Commissioning bodies.

7.3 DEBT RECOVERY

7.3.1 The Director of Finance is responsible for the appropriate recovery action on all outstanding debts.

7.3.2 Income not received should be dealt with in accordance with losses procedures.

7.3.3 Overpayments should be detected (or preferably prevented) and recovery initiated.

7.4 SECURITY OF CASH, CHEQUES AND OTHER NEGOTIABLE INSTRUMENTS

7.4.1 The Director of Finance is responsible for:

(a) approving the form of all receipt books, agreement forms, or other means of officially acknowledging or recording monies received or receivable;

(b) ordering and securely controlling any such stationery;

(c) the provision of adequate facilities and systems for employees whose duties include collecting and holding cash, including the provision of safes or lockable cash boxes, the procedures for keys, and for coin operated machines; and

(d) prescribing systems and procedures for handling cash and negotiable securities on behalf of the Trust.

7.4.2 Official money shall not under any circumstances be used for the encashment of private cheques.

7.4.3 All cheques, postal orders, cash etc., shall be banked intact. Disbursements shall not be made from cash received.

7.4.4 The holders of safe keys shall not accept unofficial funds for depositing in their safes unless such deposits are in special sealed envelopes or locked containers. It shall be made clear to the depositors that the Trust is not to be held liable for any loss, and written indemnities must be obtained from the organisation or individuals absolving the Trust from responsibility for any loss. Where receipt of such indemnities is problematic or unclear no such items shall be held in Trust safes.

7.4.5 A cheque and payable order register shall be kept in which all cheque and payable order stocks ordered, received and issued shall be recorded and signed for by nominated officers.

8. CONTRACTING FOR PROVISION OF SERVICES

8.1 The Chief Executive is responsible for negotiating contracts for the provision of services to patients in accordance with the Business Plan, and for establishing the arrangements for providing extra-contractual services. In carrying out these functions, the Chief Executive should take into account the advice of the Director of Finance regarding:

(a) costing and pricing of services;

(b) payment terms and conditions; and

(c) amendments to contracts and extra-contractual arrangements.

8.2 Contracts should be so devised as to minimise risk whilst maximising the Trust's opportunity to generate income.

8.3 The Director of Finance shall produce regular reports detailing actual and forecast contract income (linked to contract activity) with a detailed assessment of the impact of the variable elements of income and an assessment of any significant risks faced.

8.4 This also includes both partnership and provision of facilities arrangements to private healthcare providers in their provision of health care and diagnostic services to patients.

9. TERMS OF SERVICE AND PAYMENT OF DIRECTORS AND EMPLOYEES

9.1 REMUNERATION AND TERMS OF SERVICE

9.1.1 In accordance with Standing Orders the Board shall establish a Nominations and Remuneration Committee, with clearly defined terms of reference, specifying which posts fall within its area of responsibility, its composition, and the arrangements for reporting.

9.1.2 The Committee will:

(i) Identify and appoint candidates to fill Executive Director positions when they arise.

(ii) Identify and nominate a candidate, for approval by the Board of Governors, to fill the position of Chief Executive.

(iii) Decide any matter relating to the disciplining or the continuation in office of any Executive Director at any time including the suspension or termination of service of an individual as an employee of the Trust.

(iv) Monitor and evaluate the performance of individual Executive Directors on an annual basis.

(v) Decide and review the terms and conditions of office of Executive Directors and senior managers on locally-determined pay in accordance with relevant Trust policies, including:

a. Salary, including any performance-related pay or bonus;
b. Provisions for other benefits, including pensions and cars; and
c. Other allowances.

(vi) Decide all contractual arrangements for Executive Directors, including, but not limited to, termination payments.

9.1.3 The Committee shall report to the Board regarding its recommendations.

9.1.4 The Trust will remunerate the Chairman and Non-executive Directors in accordance with instructions issued by the Board of Governors.

9.2 FUNDED/ BUDGETED ESTABLISHMENT

9.2.1 The staffing plans incorporated within the annual budget will form the funded / budgeted establishment. The funded/ budgeted establishment will list out the grade, amount, whole time equivalent for the relevant department(s) and must be set out and agreed each financial year.

9.2.2 The funded / budgeted establishment of any department may not be varied without the approval of the Chief Executive and Director of People & OD.

9.2.3 The funded/ budgeted establishment of any clinical department will take account of the required safe levels of clinical staff as necessary for the running of those services.

9.3 STAFF APPOINTMENTS

9.3.1 No director or employee may engage, re-engage, or regrade employees, either on a permanent or temporary nature, or hire agency staff, or agree to changes in any aspect of remuneration:

(a) unless authorised to do so by the Chief Executive; and

(b) within the limit of his approved budget and funded establishment.

9.3.2 The Board will approve procedures presented by the Chief Executive for the determination of commencing pay rates, condition of service, etc, for employees.

9.4 PROCESSING OF PAYROLL

9.4.1 The Director of People and Organisational Development is responsible for:

(a) ensuring that arrangements in place so that NHS Shared Business Services provide an effective and efficient payroll service

(b) specifying timetables for submission of properly authorised time records and other notifications;

(c) the final determination of pay;

(c) making payment on agreed dates; and

(d) agreeing method of payment.

9.4.2 The Director of People and Organisational Development will issue instructions regarding:

(a) verification and documentation of data;

(b) the timetable for receipt and preparation of payroll data and the payment of employees;

(c) maintenance of subsidiary records for pension, income tax, social security and other authorised deductions from pay;

(d) security and confidentiality of payroll information;

(e) checks to be applied to completed payroll before and after payment;

(f) authority to release payroll data under the provisions of the Data Protection Act;

(g) methods of payment available to various categories of employee;

(h) procedures for payments to employees;

(i) procedures for the recall of bank credits

(j) pay advances and their recovery;

(k) maintenance of regular and independent reconciliation of pay control accounts;

(l) system to ensure the recovery from leavers of sums of money and property due by them to the Trust.

9.4.3 Appropriately nominated managers have delegated responsibility for:

(a) submitting time records, and other notifications in accordance with agreed timetables;

(b) completing time records and other notifications in accordance with the Director of People and Organisational Development's instructions and in the form prescribed by the Director of People and Organisational Development.

(c) submitting termination forms in the prescribed form immediately upon knowing the effective date of an employee's resignation, termination or retirement. Where an employee fails to report for duty in circumstances that suggest they have left without notice, the Director of People and Organisational Development must be informed immediately.

9.4.4 Where the Director of People and Organisational Development has contracted with another

body to administer the Trust's payroll service responsibility for compliance with the above requirements remain with the Director of People and Organisational Development.

9.4.5 Regardless of the arrangements for providing the payroll service, the Director of Finance shall ensure that the chosen method is supported by appropriate (contracted) terms and conditions, adequate internal controls and audit review procedures and that suitable arrangements are made for the collection of payroll deductions and payment of these to appropriate bodies.

9.5 CONTRACTS OF EMPLOYMENT

9.5.1 The Board shall delegate responsibility to a manager for:

(a) ensuring that all employees are issued with a Contract of Employment in a form approved by the Board and which complies with employment legislation; and

(b) dealing with variations to, or termination of, contracts of employment.

9.6 DIRECTORS AND STAFF EXPENSES

9.6.1 Claims for expenses should be submitted in accordance with the Director of People and Organisational Development's instructions and in the form prescribed by the Director of People and Organisational Development.

9.6.2 All claims should be submitted for authorisation, along with any accompanying receipts, as soon as possible after the end of the month concerned. However all claims must be submitted within three months of the month in which the claim arose. Any claim periods in excess of this deadline will not usually be paid.

9.6.3 Once authorised, claims will be paid in accordance with current guidelines and regulations.

9.6.4 Claimants must not make duplicate claims for expenses from any other body in addition to that from the Trust.

10. NON-PAY EXPENDITURE

10.1 DELEGATION OF AUTHORITY

10.1.1 The Board will approve the level of non-pay expenditure on an annual basis and the Chief Executive will determine the level of delegation to budget managers.

10.1.2 The Chief Executive will set out:

(a) the list of managers who are authorised to place requisitions for the supply of goods and services; and

(b) the maximum level of each requisition and the system for authorisation above that level.

10.1.3 The Chief Executive shall set out procedures on the seeking of professional advice regarding the supply of goods and services.

10.2 CHOICE, REQUISITIONING, ORDERING, RECEIPT AND PAYMENT FOR GOODS AND SERVICES

10.2.1 The requisitioner, in choosing the item to be supplied (or the service to be performed) shall always obtain the best value for money for the Trust. In so doing, the advice of the Trust's ~~Associate Director of~~ Procurement Director shall be sought. ~~Where this advice is not acceptable to the requisitioner, the Director of Finance (and/or the Chief Executive) shall be consulted.~~ Wherever appropriate, the supply of goods and services shall be covered by a contract following a ~~tender~~ competitive exercise.

10.2.2 The Trust's ~~Associate Director of~~ Procurement Director shall be responsible for ensuring that the Trust complies with all applicable laws in relation to choice, requisitioning, ordering and receipt for goods and services. The Director of Finance shall be responsible for the prompt payment of accounts and claims. Payment of contract invoices shall be in accordance with contract terms.

10.2.3 The Director of Finance will:

(a) advise the Board regarding the setting of thresholds above which quotations (competitive or otherwise) or formal tenders must be obtained; and, once approved, the thresholds (whole life costs) should be incorporated in standing orders and regularly reviewed (see Appendix 4);

(b) prepare procedural instructions where not already provided in the Scheme of Delegation or procedure notes for budget holders on the obtaining of goods, works and services incorporating the thresholds;

(c) be responsible for the prompt payment of all properly authorised accounts and claims;

(d) be responsible for designing and maintaining a system of verification, recording and payment of all amounts payable. The system shall provide for:

(i) A list of directors/employees (including specimens of their signatures) authorised to certify invoices.

(ii) Certification that:

- goods have been duly received, examined and are in accordance with specification and the prices are correct;
- work done or services rendered have been satisfactorily carried out in accordance with the order, and, where applicable, the materials used are of the requisite standard and the charges are correct;
- in the case of contracts based on the measurement of time, materials or expenses, the time charged is in accordance with the time sheets, the

rates of labour are in accordance with the appropriate rates, the materials have been checked as regards quantity, quality, and price and the charges for the use of vehicles, plant and machinery have been examined;

- where appropriate, the expenditure is in accordance with regulations and all necessary authorisations have been obtained;
- the account is arithmetically correct;
- the account is in order for payment.

(iii) A timetable and system for submission to the Director of Finance of accounts for payment; provision shall be made for the early submission of accounts subject to cash discounts or otherwise requiring early payment.

(iv) Instructions to employees regarding the handling and payment of accounts within the Finance Department.

(e) be responsible for ensuring that payment for goods and services is only made once the goods and services are received, (except as below).

(f) be responsible for ensuring that all payments made by the Trust fall within its powers.

10.2.4 Prepayments are only permitted where exceptional circumstances apply. In such instances:

(a) Prepayments are only permitted where the financial advantages outweigh the disadvantages (i.e. cash flows must be discounted to NPV) and the intention is not to circumvent cash limits;

(b) the appropriate Director must provide, in the form of a written report, a case setting out all relevant circumstances of the purchase. The report must set out the effects on the Trust if the supplier is at some time during the course of the prepayment agreement unable to meet his commitments;

(c) the Director of Finance will need to be satisfied with the proposed arrangements before contractual arrangements proceed; and

(d) the budget holder is responsible for ensuring that all items due under a prepayment contract are received and he/she must immediately inform the appropriate Director or Chief Executive if problems are encountered.

10.2.5 Official Orders must:

(a) be consecutively numbered, even where electronically generated;

(b) be in a form approved by the Director of Finance;

(c) state the Trust's terms and conditions of trade; and

(d) only be issued to, and used by, those duly authorised by the Chief Executive.

10.2.6 Managers must ensure that they comply fully with the guidance and limits specified by the Director of Finance and that:

(a) all contracts (other than for a simple purchase permitted within the Scheme of Delegation or delegated budget), leases, tenancy agreements and other commitments which may result in a liability are notified to the Director of Finance in advance of any commitment being made;

(b) contracts above specified thresholds are advertised and awarded in accordance with ~~EU and GATT rules on~~ public procurement regulations);

(c) where consultancy advice is being obtained, the procurement of such advice must be in accordance with guidance issued by the Department of Health and NHS Improvement;

(d) no order shall be issued for any item or items to any firm which has made an offer of gifts, reward or benefit to directors or employees, other than:

(i) isolated gifts of a trivial character or inexpensive seasonal gifts, such as calendars;

(ii) conventional hospitality, such as lunches in the course of working visits;

(e) no requisition/order is placed for any item or items for which there is no budget provision unless authorised by the Director of Finance on behalf of the Chief Executive;

(f) all goods, services, or works are ordered in advance on an official order as outlined in the Procurement Policy. ~~except where the need for an order is specifically excluded for certain categories of items by agreement of the Financial Oversight Committee (e.g. rates, monthly utility bills, etc.).~~ All invoices received where an order is not already in place will be returned;

(g) verbal orders must only be issued very exceptionally - by an employee designated by the Chief Executive and only in cases of emergency or urgent necessity. All such instances shall be reported to the Director of Finance and followed up with an official purchase order;

(h) No orders shall be issued retrospectively of the items being received or the service being delivered;

(i) orders are not split or otherwise placed in a manner devised so as to avoid the financial thresholds;

(j) goods are not taken on trial or loan in circumstances that could commit the Trust to a future uncompetitive purchase;

(k) changes to the list of directors/employees authorised to certify invoices are notified to the Director of Finance;

(l) purchases from petty cash are restricted in value and by type of purchase in accordance with instructions issued by the Director of Finance; and

(m) petty cash records are maintained in a form as determined by the Director of Finance.

10.2.7 The Director of Finance shall ensure that the arrangements for financial control and financial audit of building and engineering contracts and property transactions comply with the good practice guidance. The technical audit of these contracts shall be the responsibility of the relevant Director.

10.3 **LEGALLY BINDING AGREEMENTS (e.g. leases)**

10.3.1 Any leases or rental agreements must be vetted by the Director of Finance prior to final agreement, to enable insurance issues and technical accounting treatment to be determined. In addition, all leases entered into on behalf of the Trust should represent value for money.

10.3.2 All lease agreements must be signed on behalf of the Trust by the Director of Finance (or his deputy) in addition to being accompanied by the usual order and duly authorised in accordance with these SFIs.

10.4 GRANTS TO LOCAL AUTHORITIES AND VOLUNTARY BODIES

10.4.1 Grants to local authorities and voluntary organisations made under the powers of section 28A of the NHS Act 2006 or section 64 of the Health Service and Public Health Act 1968 shall comply with procedures laid down by the Director of Finance which shall be in accordance with these Acts.

10.4.2 The financial limits for officers' approval of grants are set out in the Scheme of Delegation.

11. EXTERNAL BORROWING AND INVESTMENTS

11.1 EXTERNAL BORROWING

11.1.1 The Director of Finance will advise the Board concerning the Trust's ability to pay interest on, and repay, both the originating capital debt and any proposed new borrowing, within the limits set by NHS Improvement for NHS Foundation Trusts. The Director of Finance is also responsible for reporting periodically to the Board concerning Public Dividend Capital debt and all loans and overdrafts.

11.1.2 Any application for PDC, a loan or overdraft will only be made by the Director of Finance or by an employee so delegated by him. Also such applications must however first be authorised by the Board.

11.1.3 The Director of Finance must prepare detailed procedural instructions concerning applications for PDC, loans and overdrafts.

11.1.4 All borrowings should be kept to the minimum period of time possible, consistent with the

overall cash flow position. Any short term borrowing requirement in excess of one month must be authorised by the Director of Finance.

11.1.5 All long term borrowing must be consistent with the plans outlined in the current Business Plan. Where there is a need to vary from this principle due to unforeseen in year events a revised business plan will be prepared and provided to the Board to support its deliberations when considering the need to borrow.

11.2 INVESTMENTS

11.2.1 Temporary cash surpluses must be held only in such public or private sector investments as authorised by the Board and within such government guidance as may be in place from time to time. The need to prudently manage public funds from unnecessary risk will be a key factor in any decision making regarding what bodies to deposit such funds with.

11.2.2 The Director of Finance is responsible for advising the Board on investments and shall report periodically to the Board concerning the performance of investments held.

11.2.3 The Director of Finance will prepare detailed procedural instructions on the operation of investment accounts and on the records to be maintained.

12. CAPITAL INVESTMENT, PRIVATE FINANCING, FIXED ASSET REGISTERS AND SECURITY OF ASSETS

12.1 CAPITAL INVESTMENT

12.1.1 The Chief Executive:

(a) shall ensure that there is an adequate appraisal and approval process in place for determining capital expenditure priorities and the effect of each proposal upon business plans;

(b) is responsible for the management of all stages of capital schemes and for ensuring that schemes are delivered on time and to cost; and

(c) shall ensure that the capital investment is not undertaken without the availability of resources to finance all revenue consequences, including capital charges.

(d) shall ensure that processes and procedures are in place to monitor, record and report spend against each element of the Capital programme.

12.1.2 For every capital expenditure proposal the Chief Executive shall ensure:

(a) that a business case (in line with the guidance contained within the *Capital Investment Manual*) is produced setting out:

(i) an option appraisal of potential benefits compared with known costs to determine the option with the highest ratio of benefits to costs; and

(ii) appropriate project management and control arrangements; and

(b) that the Director of Finance has certified professionally to the costs and revenue consequences detailed in the business case.

12.1.3 For capital schemes where the contracts stipulate stage payments, the Chief Executive will issue procedures for their management, incorporating the recommendations of "Estatecode" and other official guidance that may become available from time to time.

The Director of Finance shall assess on an annual basis the requirement for the operation of the construction industry tax deduction scheme in accordance with Inland Revenue guidance.

The Director of Finance shall issue procedures for the regular reporting of expenditure and commitment against authorised expenditure.

12.1.4 The approval of a capital programme shall not constitute approval for expenditure on any scheme.

The Chief Executive shall issue to the manager responsible for any scheme:

(a) specific authority to commit expenditure;

(b) authority to proceed to tender;

(c) approval to accept a successful tender.

The Chief Executive will issue a scheme of delegation for capital investment management in accordance with "Estatecode" guidance and the Trust's Standing Orders.

12.1.5 The Director of Finance shall issue procedures governing the financial management, including variations to contract, of capital investment projects and valuation for accounting purposes.

12.2 PRIVATE FINANCE

12.2.1 Where appropriate the possibility of attracting private finance will be investigated for capital expenditure proposals.

12.2.2 The Chief Executive will consider such proposals along with all other bids received, in line with the Trust's priorities.

12.2.3 Where the proposal is approved the private sector will be invited to submit their bids based upon clear, high level, service based objectives.

12.2.4 Once the private sector bids have been received the Director of Finance will provide or commission any specialist assistance to allow the bids to be appraised on a like for like basis.

12.2.5 The Chief Executive shall be responsible for deciding upon the preferred shape of the

proposed contract and inviting the bidders to tender.

12.2.6 The Director of Finance shall ensure that all privately financed proposals represent value for money and genuinely transfer risk to the private sector.

12.2.7 Proposals which include the lease of equipment and/or buildings will be tested for Value for Money and the Transfer of Risk by the Capital Accountant.

12.2.8 To allow this appraisal of the lease to take place the following financial details shall be obtained:

(a) Capital value of asset(s) supplied;

(b) Minimum lease period;

(c) Minimum lease payment;

(d) Frequency of lease payment, including details as to whether required in arrears or advance;

(e) Premium for payment by non-direct debit method if applicable;

(f) Interest rate implicit in the lease (if available).

12.2.9 Figures shall be requested for a number of different lease periods, to identify the option, which gives the best returns for the Trust, and be exclusive of VAT.

12.2.10 For comparative purposes the capital value of the asset supplied will be the value at the start of the contract plus the discounted value of any enhancements during the minimum lease term less the discounted value of any disposal proceeds at the end of the lease term.

12.2.11 The fundamental requirements of a PFI proposal with regards risk are that it is allocated to the party which is best able to manage it and that it is genuinely transferred to the private sector.

12.2.12 By achieving optimum risk transfer between the parties to the PFI proposal there is a greater likelihood that value for money will also be achieved.

12.2.13 The risks associated with a project typically fall under the following headings:

(a) Design and Construction Risks;

(b) Commissioning and Operating Risks;

(c) Demand, Volume or Usage Risks;

(d) Technology and Obsolescence Risks;

(e) Regulation and Other Risks;

(f) Project Financing Risks.

12.2.14 The Value for Money attributable to a project is tested by comparing the net present value (or cost) of the estimated annual cash flows over an appraisal period equivalent to the PFI contract term.

12.2.15 In addition the PFI proposal shall be assessed for its affordability. This will show whether the proposal is affordable to the Trust and that the impact on prices can be afforded by the Trust's main commissioner.

12.2.16 The Director of Finance will be notified in advance of all lease and PFI agreements before any commitment is made.

12.2.17 The Chief Executive will ensure that all proposed agreements are scrutinised by either in-house experts or the Trust's Solicitors to ensure that the agreements are comprehensive and are not disadvantageous to the Trust.

12.2.18 The Board must specifically agree all PFI proposals before any contracts are signed.

12.2.19 When comparing the financials of the various options VAT shall be included within the calculation in so far as it is irrecoverable. The Director of Finance shall engage professional VAT advisers to facilitate this where it is felt necessary.

12.3 ASSET REGISTERS

12.3.1 The Chief Executive is responsible for the maintenance of registers of assets, taking account of the advice of the Director of Finance concerning the form of any register and the method of updating, and arranging for a physical check of assets against the asset register to be conducted once a year. Where systems are in place to monitor these on an ongoing basis a rolling programme of checks and/or sampling will be acceptable.

12.3.2 Each Trust shall maintain an asset register recording fixed assets. The minimum data set to be held within these registers shall be based on good accounting practice.

12.3.3 Additions to the fixed asset register must be clearly identified to an appropriate budget holder and be validated by reference to:

(a) properly authorised and approved agreements, architect's certificates, supplier's invoices and other documentary evidence in respect of purchases from third parties;

(b) stores, requisitions and wages records for own materials and labour including appropriate overheads; and

(c) lease agreements in respect of assets held under a finance lease and capitalised.

12.3.4 Where capital assets are sold, scrapped, lost or otherwise disposed of, their value must be removed from the accounting records and each disposal must be validated by reference to authorisation documents and invoices (where appropriate).

12.3.5 The Director of Finance shall approve procedures for reconciling balances on fixed assets accounts in ledgers against balances on fixed asset registers.

12.3.6 The value of each asset shall be indexed to current values in accordance with good accounting practice and NHS Improvement guidelines. A periodic revaluation of land and buildings will be undertaken, by an independent professional valuer, as required by accounting guidelines.

12.3.7 The value of each asset shall be depreciated using methods and rates as specified in accounting standards.

12.3.8 The Director of Finance shall calculate capital charges.

12.4 SECURITY OF ASSETS

12.4.1 The overall control of fixed assets is the responsibility of the Chief Executive.

12.4.2 Asset control procedures (including fixed assets, cash, cheques and negotiable instruments, and also including donated assets) must be approved by the Director of Finance. This procedure shall make provision for:

(a) recording managerial responsibility for each asset;

(b) identification of additions and disposals;

(c) identification of all repairs and maintenance expenses;

(d) physical security of assets;

(e) periodic verification of the existence of, condition of, and title to, assets recorded;

(f) identification and reporting of all costs associated with the retention of an asset; and

(g) reporting, recording and safekeeping of cash, cheques, and negotiable instruments.

12.4.3 All discrepancies revealed by verification of physical assets to fixed asset register shall be notified to the Director of Finance.

12.4.4 Whilst each employee has a responsibility for the security of property of the Trust, it is the responsibility of directors and senior employees in all disciplines to apply such appropriate routine security practices in relation to property as may be determined by the Board. Any breach of agreed security practices must be reported in accordance with instructions.

12.4.5 Any damage to the Trust's premises, vehicles and equipment, or any loss of equipment, stores or supplies must be reported by directors and employees in accordance with the procedure for reporting losses.

12.4.6 Where practical, assets should be marked as Trust property.

13. STORES AND RECEIPT OF GOODS

13.1 Stores, defined in terms of controlled stores and departmental stores (for immediate use) should be:

(a) kept to a minimum;

(b) subjected to annual stock take;

(c) valued at the lower of cost and net realisable value.

13.2 Subject to the responsibility of the Director of Finance for the systems of control, overall responsibility for the control of stores shall be delegated to an employee by the Chief Executive. The day-to-day responsibility may be delegated by him/her to departmental employees and stores managers/keepers, subject to such delegation being entered in a record available to the Director of Finance. The control of Pharmaceutical stocks shall be the responsibility of a designated Pharmaceutical Officer; the control of fuel oil and similar items of a designated estates manager.

13.3 The responsibility for security arrangements and the custody of keys for all stores and locations shall be clearly defined in writing by the designated manager/Pharmaceutical Officer. Wherever practicable, stocks should be marked as health service property.

13.4 The Director of Finance shall set out procedures and systems to regulate the stores including records for receipt of goods, issues, and returns to stores, and losses.

13.5 Stocktaking arrangements shall be agreed with the Director of Finance and there shall be a physical check covering all items in store at least once a year. Where stock control systems allow this may be undertaken on a rolling or sample basis as is felt best to ensure the accurate control and recording of stock.

13.6 Where a complete system of stores control is not justified, alternative arrangements shall require the approval of the Director of Finance.

13.7 The designated Manager/Pharmaceutical Officer shall be responsible for a system approved by the Director of Finance for a review of slow moving and obsolete items and for condemnation, disposal, and replacement of all unserviceable articles. The designated Officer shall report to the Director of Finance any evidence of significant overstocking and of any negligence or malpractice (see also Chapter 14, Disposals and Condemnations, Losses and Special Payments). Procedures for the disposal of obsolete stock shall follow the procedures set out for disposal of all surplus and obsolete goods.

13.8 For goods supplied via the NHS Logistics central warehouses, the Chief Executive shall identify those authorised to requisition and accept goods from the store. The authorised person shall check receipt against the delivery note before forwarding this to the Director of

Finance who shall satisfy himself that the goods have been received before accepting the recharge.

13.9 All goods received shall be checked as regards quantity and/or weight and inspected as to quality and specification.

13.10 The issue of stores shall be supported by an authorised requisition note and a receipt for the stores issued shall be returned to the ~~Supplies~~ Procurement Department, Issuing Department, or Director of Finance.

13.11 Where a 'topping up' system is used a record shall be maintained as approved by the Director of Finance. Regular comparisons shall be made of the quantities issued to wards/departments etc. and explanations recorded of significant variances.

13.12 All transfers and returns shall be recorded on forms provided for the purpose and approved by the Director of Finance.

13.13 Breakages and other losses of goods in stores shall be recorded as they occur and a summary shall be presented to the Director of Finance at regular intervals. Tolerance limits shall be established for all stores subject to unavoidable loss, e.g. shrinkage in the case of certain food stuffs and natural deterioration of certain goods.

14. DISPOSALS AND CONDEMNATIONS, LOSSES AND SPECIAL PAYMENTS

14.1 DISPOSALS AND CONDEMNATIONS

14.1.1 The Director of Finance must prepare detailed procedures for the disposal of assets including condemnations, and ensure that these are notified to managers.

The Trust may not dispose of any protected property without the approval of NHS Improvement.

14.1.2 When it is decided to dispose of a Trust asset, the head of department or authorised deputy will determine and advise the Director of Finance of the estimated market value of the item, taking account of professional advice where appropriate.

14.1.3 All unserviceable articles shall be:

(a) condemned or otherwise disposed of by an employee authorised for that purpose by the Director of Finance;

(b) recorded by the Condemning Officer in a form approved by the Director of Finance which will indicate whether the articles are to be converted, destroyed or otherwise disposed of. All entries shall be confirmed by the countersignature of a second employee authorised for the purpose by the Director of Finance.

14.1.4 The Condemning Officer shall satisfy himself as to whether or not there is evidence of negligence in use and shall report any such evidence to the Director of Finance who will take

the appropriate action.

14.2 LOSSES AND SPECIAL PAYMENTS

14.2.1 The Director of Finance must prepare procedural instructions on the recording of and accounting for condemnations, losses, and special payments. The Director of Finance must also prepare a 'fraud response plan' that sets out the action to be taken both by persons detecting a suspected fraud and those persons responsible for investigating it.

14.2.2 Any employee discovering or suspecting a loss of any kind must either immediately inform their head of department, who must immediately inform the Chief Executive and the Director of Finance or inform an officer charged with responsibility for responding to concerns involving loss or fraud confidentially. This officer will then appropriately inform the Director of Finance and/or Chief Executive. Where a criminal offence is suspected, the Director of Finance must immediately inform the police if theft or arson is involved. In cases of fraud and corruption or of anomalies which may indicate fraud or corruption, the Director of Finance must inform the relevant LCFS, who will then inform NHS ~~Protect~~ Counter Fraud Authority in accordance with Secretary of State for Health's Directions.

The Director of Finance must ensure that NHS ~~Protect~~ Counter Fraud Authority and the External Auditor are notified of all frauds.

14.2.3 For losses apparently caused by theft, fraud, arson, neglect of duty or gross carelessness, except if trivial and where fraud is not suspected, the Director of Finance must immediately notify:

(a) the Board, and

(b) the External Auditor.

14.2.4 The Board shall approve the writing-off of losses. The level of delegation to Senior Officers of the Trust are set out in the Reservation of Powers to the Board and Delegation of Powers section 5, paragraph 11.

14.2.5 The Director of Finance shall be authorised to take any necessary steps to safeguard the Trust's interests in bankruptcies and company liquidations.

14.2.6 For any loss, the Director of Finance should consider whether any insurance claim can be made.

14.2.7 The Director of Finance shall maintain a Losses and Special Payments Register in which write-off action is recorded.

14.2.8 All losses and special payments must be reported to the Audit and Non Clinical Risk Sub-Committee at every meeting although the identities of individuals should not be reported unless requested.

15. INFORMATION TECHNOLOGY

15.1 The Director of Finance, who is responsible for the accuracy and security of the computerised financial data of the Trust, shall:

(a) devise and implement any necessary procedures to ensure adequate (reasonable) protection of the Trust's data, programs and computer hardware for which he/she is responsible from accidental or intentional disclosure to unauthorised persons, deletion or modification, theft or damage, having due regard for the Data Protection Act 1998;

(b) ensure that adequate (reasonable) controls exist over data entry, processing, storage, transmission and output to ensure security, privacy, accuracy, completeness, and timeliness of the data, as well as the efficient and effective operation of the system;

(c) ensure that adequate controls exist such that the computer operation is separated from development, maintenance and amendment;

(d) ensure that an adequate management (audit) trail exists through the computerised system and that such computer audit reviews as he may consider necessary are being carried out.

15.2 The Director of Finance shall satisfy himself that new financial systems and amendments to current financial systems are developed in a controlled manner and thoroughly tested prior to implementation. Where this is undertaken by another organisation, assurances of adequacy will be obtained from them prior to implementation.

15.3 In the case of computer systems which are proposed General Applications, all responsible directors and employees will send to the Director of Finance:

(a) details of the outline design of the system;

(b) in the case of packages acquired either from a commercial organisation, from the NHS, or from another public sector organisation, the operational requirement.

15.4 The Director of Finance shall ensure that contracts for computer services for financial applications with another health organisation or any other agency shall clearly define the responsibility of all parties for the security, privacy, accuracy, completeness, and timeliness of data during processing, transmission and storage. The contract should also ensure rights of access for audit purposes.

15.5 Where another health organisation or any other agency provides a computer service for financial applications, the Director of Finance shall periodically seek assurances that adequate controls are in operation.

15.6 Where computer systems have an impact on corporate financial systems the Director of Finance shall satisfy himself that:

(a) systems acquisition, development and maintenance are in line with corporate policies such as an Information Technology Strategy;

(b) data produced for use with financial systems is adequate, accurate, complete and timely, and that a management (audit) trail exists;

(c) Director of Finance staff have access to such data; and

(d) such computer audit reviews as are considered necessary are being carried out.

15.7 The Medical Director shall publish and maintain a Freedom of Information (FOI) Publication Scheme, or adopt a model Publication Scheme approved by the information Commissioner. A Publication Scheme is a complete guide to the information routinely published by a public authority. It describes the classes or types of information about the Trust that is made publicly available.

16. PATIENTS' PROPERTY

16.1 The Trust has a responsibility to provide safe custody for money and other personal property (hereafter referred to as "property") handed in by patients, in the possession of unconscious or confused patients, or found in the possession of patients dying in hospital or dead on arrival.

16.2 The Chief Executive is responsible for ensuring that patients or their guardians, as appropriate, are informed before or at admission by:

- notices and information booklets,
- hospital admission documentation and property records,
- the oral advice of administrative and nursing staff responsible for admissions,

that the Trust will not accept responsibility or liability for patients' property brought into Health Service premises, unless it is handed in for safe custody and a copy of an official patients' property record is obtained as a receipt.

16.3 The Director of Finance must provide detailed written instructions on the collection, custody, investment, recording, safekeeping, and disposal of patients' property (including instructions on the disposal of the property of deceased patients and of patients transferred to other premises) for all staff whose duty is to administer, in any way, the property of patients. Due care should be exercised in the management of a patient's money in order to maximise the benefits to the patient.

16.4 Where it is a requirement for the opening of separate accounts for patients' moneys, these shall be opened and operated under arrangements agreed by the Director of Finance.

16.5 In all cases where property of a deceased patient is of a total value in excess of £5,000 (or such other amount as may be prescribed by any amendment to the Administration of

Estates, Small Payments, Act 1965) or other statue, the production of Probate or Letters of Administration shall be required before any of the property is released. Where the total value of property is £5,000 or less, forms of indemnity shall be obtained.

16.6 Staff should be informed, on appointment, by the appropriate departmental or senior manager of their responsibilities and duties for the administration of the property of patients.

16.7 Where patients' property or income is received for specific purposes and held for safekeeping the property or income shall be used only for that purpose, unless any variation is approved by the donor or patient in writing.

17. FUNDS HELD ON TRUST

17.1 INTRODUCTION

17.1.1 Standing Orders (SOs) identify the Trust's responsibilities as a corporate trustee for the management of funds it holds on trust and define how those responsibilities are to be discharged. They explain that although the management processes may overlap with those of the organisation of the Trust, the trustee responsibilities must be discharged separately and full recognition given to the duel accountabilities to the Charity Commission for charitable funds held on trust and to NHS Improvement for all funds held on trust.

17.1.2 The reserved powers of the Board and the Scheme of Delegation make clear where decisions regarding the exercise of dispositive discretion are to be taken and by whom. Directors and officers must take account of that guidance before taking action. SFIs are intended to provide guidance to persons who have been delegated to act on behalf of the corporate trustee.

17.1.3 As management processes overlap most of the sections of these SFIs will apply to the management of funds held on trust. This section covers those instructions which are specific to the management of funds held on trust. Any further guidance is set out in the Charitable Funds Policy (approved by Board of Directors in June 2017).

17.1.4 The over-riding principle is that the integrity of each trust must be maintained and statutory and trust obligations met. Materiality must be assessed separately from Exchequer activities and funds.

17.1.5 The Director of Finance shall maintain such accounts and records, including an investment register, as may be necessary to record and protect all transactions and funds of the Trust as trustees of funds held on trust.

17.2 EXISTING TRUSTS

17.2.1 The Director of Finance shall make arrangements for the administration of all existing funds held on trust and shall produce instructions covering every aspect of the financial management of the funds.

17.2.2 The Director of Finance shall periodically review the funds in existence and shall make recommendations to the Board regarding the potential for rationalisation, within statutory guidelines.

17.3 NEW TRUSTS

17.3.1 The Director of Finance shall arrange for the creation of a new trust where funds and/or other assets are received and cannot be adequately managed as part of an existing trust.

17.3.2 When making such as assessment as outlined in 17.3.1 above the needs for simplicity of administration and therefore downward pressure on costs shall also be considered.

17.4 SOURCES OF NEW FUNDS

17.4.1 In respect of Donations, the Director of Finance shall:

(a) provide guidelines to officers of this Body as to how to proceed when offered funds. These to include:

(i) the identification of the donor's intentions;
(ii) where possible, the avoidance of new trusts;
(iii) the avoidance of impossible, undesirable or administratively difficult objects;
(iv) sources of immediate further advice; and
(v) treatment of offers for personal gifts; and

(b) provide secure and appropriate receipting arrangements which will indicate that funds have been accepted directly into this Body's trust funds and that the donor's intentions have been noted and accepted.

17.4.2 The Director of Finance shall deal with all Legacies and Bequests.

17.4.3 In respect of Fund-raising, the Director of Finance shall:

(a) deal with all arrangements for fund-raising by and/or on behalf of this Body and ensure compliance with all statutes and regulations;

(b) be empowered to liaise with other organisations/persons raising funds for this Body and provide them with an adequate discharge. The Director of Finance shall be the only officer empowered to give approval for such fund-raising subject to the overriding direction of the Board;

(c) for alerting the Board to any irregularities regarding the use of this Body's name or its registration numbers; and

(d) be responsible for the appropriate treatment of all funds received from this source.

17.4.4 In respect of Trading Income, the Director of Finance shall:

(a) be primarily responsible with other designated officers, for any trading undertaken by

this Body as corporate trustee; and

(b) be primarily responsible for the appropriate treatment of all funds received from this source.

17.4.5 In respect of Investment Income, the Director of Finance shall be responsible for the appropriate treatment of all dividends, interest and other receipts from this source (see below).

17.5 INVESTMENT MANAGEMENT

17.5.1 The Director of Finance shall be responsible for all aspects of the management of the investment of funds held on trust. The issues on which he shall be required to provide advice to the Board shall include:-

(a) the formulation of investment policy within the powers of this Body under statute and within governing instruments to meet its requirements with regard to income generation and the enhancement of capital value;

(b) the appointment of advisers, brokers, and, where appropriate, fund managers and:

(i) the Director of Finance shall agree the terms of such appointments; and for which

(ii) written agreements shall be signed by the Chief Executive;

(c) pooling of investment resources and the preparation of a submission to the Charity Commission for them to approve;

(d) the participation by this Body in common investment funds and the agreement of terms of entry and withdrawal from such funds;

(e) that the use of Trust assets shall be appropriately authorised in writing and charges raised within policy guidelines;

(f) the review of the performance of brokers and fund managers;

(g) the reporting of investment performance.

17.6 DISPOSITION MANAGEMENT

17.6.1 The exercise of this Body's dispositive discretion shall be managed by the Director of Finance in conjunction with the Board. In so doing he shall be aware of the following:

(a) The objects of various funds and the designated objectives;

(b) the availability of liquid funds within each trust;

(c) the powers of delegation available to commit resources;

(d) the avoidance of the use of exchequer funds to discharge trust fund liabilities (except where administratively unavoidable), and to ensure that any indebtedness to the

Exchequer shall be discharged by trust funds at the earliest possible time;

(e) that funds are to be spent rather than preserved, subject to the wishes of the donor and the needs of this Body; and

(f) the definitions of "charitable purposes" as agreed by the Charity Commission.

17.7 BANKING SERVICES

17.7.1 The Director of Finance shall advise the Board and, with its approval, shall ensure that appropriate banking services are available to this Body as corporate trustee. These bank accounts should permit the separate identification of liquid funds to each trust where this is deemed necessary by the Charity Commission.

17.8 ASSET MANAGEMENT

17.8.1 Assets in the ownership of or used by this Body as corporate trustee, shall be maintained along with the general estate and inventory of assets of the Body. The Director of Finance shall ensure:

(a) that appropriate records of all assets owned by this Body as corporate trustee are maintained, and that all assets, at agreed valuations, are brought to account;

(b) that appropriate measures are taken to protect and/or to replace assets. These to include decisions regarding insurance, inventory control, and the reporting of losses;

(c) that donated assets received on trust are accounted for appropriately;

(d) that all assets acquired from funds held on trust which are intended to be retained within the trust funds are appropriately accounted for;

(e) all share and stock certificates and property deeds shall be deposited either with the Trust's bankers or, where this is not practicable, held securely at trust premises.

17.9 REPORTING

17.9.1 The Director of Finance shall ensure that regular reports are made to the Board with regard to, inter alia, the receipt of funds, investments, and the disposition of resources.

17.9.2 The Director of Finance shall prepare annual accounts in the required manner which shall be submitted to the Board within agreed timescales.

17.9.3 The Director of Finance shall prepare an annual trustees' report and the required returns to the Charity Commission for adoption by the Board.

17.10 ACCOUNTING AND AUDIT

17.10.1 The Director of Finance shall maintain all financial records to enable the production of reports as above and to the satisfaction of internal and external audit.

17.10.2 The Director of Finance shall ensure that the records, accounts and returns receive

adequate scrutiny by internal audit during the year. He will liaise with external audit and provide them with all necessary information.

17.10.3 The Board shall be advised by the Director of Finance on the outcome of the annual audit. The Chief Executive shall submit the Management Letter to the Board.

17.11 ADMINISTRATION COSTS

17.11.1 The Director of Finance shall identify all costs directly incurred in the administration of funds held on trust and, in agreement with the Board, shall charge such costs to the appropriate trust accounts.

17.12 TAXATION AND EXCISE DUTY

17.12.1 The Director of Finance shall ensure that this Body's liability to taxation, duties and other such charges is managed appropriately, taking full advantage of available concessions, through the maintenance of appropriate records, the preparation and submission of the required returns and the recovery of deductions at source.

17.13 AUTHORISATION LEVELS OF EXPENDITURE FROM TRUST FUNDS

17.13.1 The Board has established levels of authorisation necessary for expenditure from the funds held on trust, these are set out in the Reservation of Powers to the Board and Delegation of Powers section 5, paragraph 8.

These will be reviewed on a regular basis to ensure that they remain at an appropriate financial level.

18. RETENTION OF DOCUMENTS

18.1 The Chief Executive shall be responsible for maintaining archives for all documents required to be retained following good practice under the direction contained in Department of Health guidelines.

18.2 The documents held in archives shall be capable of retrieval by authorised persons.

18.3 Documents held in accordance with the latest Department of Health guidance shall only be destroyed at the express instigation of the Chief Executive, records shall be maintained of documents so destroyed.

19. RISK MANAGEMENT & INSURANCE

19.1 PROGRAMME OF RISK MANAGEMENT

19.1.1 The Chief Executive shall ensure that the Trust has a programme of risk management which will be approved and monitored by the Board.

19.1.2 The programme of risk management shall include:

(a) a process for identifying and quantifying risks and potential liabilities;

(b) engendering among all levels of staff a positive attitude towards the control of risk;

(c) management processes to ensure all significant risks and potential liabilities are addressed including effective systems of internal control, cost effective insurance cover, and decisions on the acceptable level of retained risk;

(d) contingency plans to offset the impact of adverse events;

(e) audit arrangements including; internal audit, clinical audit, health and safety review;

(f) a clear indication of which risks shall be insured;

(g) arrangements to review the risk management programme.

The existence, integration and evaluation of the above elements will provide a basis to complete the annual governance statement within the Annual Report and Accounts.

19.1.3 The Director of Finance shall ensure that insurance arrangements exist in accordance with the risk management programme.

19.2 INSURANCE: RISK POOLING SCHEMES ADMINISTERED BY NHSLA

19.2.1 The Board shall decide if the Trust will insure through the risk pooling schemes administered by the NHS Litigation Authority or self insure for some or all of the risks covered by the risk pooling schemes. If the Board decides not to use the risk pooling schemes for any of the risk areas (clinical, property and employers/third party liability) covered by the scheme this decision shall be reviewed annually.

19.3 INSURANCE ARRANGEMENTS WITH COMMERCIAL INSURERS

19.3.1 The Board shall decide if the Trust will insure with commercial insurers to supplement or replace the cover available through the risk pooling schemes. If the Board decides to use commercial insurers this decision shall be reviewed annually.

19.4 ARRANGEMENTS TO BE FOLLOWED BY THE BOARD IN AGREEING INSURANCE COVER

19.4.1 Where the Board decides to use the risk pooling schemes administered by the NHS Litigation Authority the Director of Finance shall ensure that the arrangements entered into are appropriate and complementary to the risk management programme. The Director of Finance shall ensure that documented procedures cover these arrangements.

19.4.2 Where the Board decides not to use the risk pooling schemes administered by the NHS Litigation Authority for one or other of the risks covered by the schemes, the Director of Finance shall ensure that the Board is informed of the nature and extent of the risks that are self insured as a result of this decision.

19.4.3 The Director of Finance will draw up formal documented procedures for the management of any claims arising from third parties and payments in respect of losses which will not be reimbursed.

19.4.4 All the risk pooling schemes require Scheme members to make some contribution to the settlement of claims (the 'deductible'). The Director of Finance should ensure documented procedures also cover the management of claims and payments below the deductible in each case.

20. ACCEPTANCE OF GIFTS BY STAFF AND LINK TO STANDARDS OF BUSINESS CONDUCT

20.1 The ~~Director of Finance~~~~Company~~Board Secretary shall ensure that all staff are made aware of the Trust Policy on acceptance of gifts and other benefits in kind by staff. This policy follows the guidance contained in the department of health standards of business conduct for NHS staff set out in "Code of Conduct for Directors and employees".

APPENDIX 1 - INVESTMENTS

INVESTMENTS

1. The Director of Finance shall ensure that all funds are invested in the name of the Trust. No officer other than the Director of Finance shall open accounts to invest funds on behalf of the Trust.

2. The Director of Finance shall advise bankers and other approved deposit facilities in writing of the conditions under which each account shall be operated.

3. Transfers of funds from bank and GBS accounts to investment accounts must be authorised by two signatories.

APPENDIX 2 – SECURITY OF CASH, CHEQUES AND OTHER NEGOTIABLE INSTRUMENTS

SECURITY OF CASH, CHEQUES AND OTHER NEGOTIABLE INSTRUMENTS

1. All cash, cheques postal orders and other forms of payments received by an officer other than a cashier shall be entered immediately on an approved form. All cheques and postal orders shall be crossed immediately "Not negotiable -A/c Doncaster and Bassetlaw Hospitals NHS Foundation Trust". The remittances shall be passed to the cashier from whom a signature shall be obtained.

2. The opening of coin operated machines and the counting and recording of the takings shall be undertaken by two officers together, except as may be authorised in writing by the Director of Finance and the coin box keys shall be held by a nominated officer.

3. Where amounts of cash have to be transported, special arrangements shall be made by the Director of Finance with a specialist security firm. Under no circumstances shall cash in excess of (£500) be transported by only one officer and the route travelled and times of collection shall be varied as far as practicable.

4. During the absence (e.g. on holiday) of the holder of a safe or cash box key, the officer who acts in his place shall be subject to the same controls as the normal holder of the key. There shall be written discharge for the safe/or cash box contents on the transfer of responsibilities and the discharge document must be retained for inspection.

5. All unused cheques and other orders shall be subject to the same security precautions as are applied to cash.

6. Staff shall be informed on appointment, by the appropriate departmental or senior officers, of their responsibilities and duties for the collection, handling or disbursement or cash, cheques, etc, in line with appropriate financial procedures. This must be in writing, acknowledged, and acknowledgement retained.

7. Any loss or shortfall of cash, cheques, or other negotiable instruments, however occasioned shall be reported immediately to the Director of Finance

APPENDIX 3 – BUDGETARY VIREMENT

BUDGETARY VIREMENT

1. Virement is the term used to define the movement of funds from one budget heading to another.

2. Virement within Individual Budgets:

2.1 Where a budget holder is expected to be under spent at the year-end, the budget holder may be allowed to offset this under spending against overspendings elsewhere in his/her budget, subject to the criteria itemised below.

2.2 Budget holders are not allowed to use non-recurrent savings for recurrent commitments, for example, savings on equipment purchased cannot be used to appoint new permanent staff.

2.3 Subject to the overall financial position of the individual Care Group and the Trust, virement will be allowed using the following criteria:

(a) Efficiency/CIP targets are being achieved;
(b) The predicted year end expenditure will be within budget;
(c) The predicted year end income will at least achieve the target;
(d) The proposed expenditure is within overall policy, i.e. virement cannot be used to initiate a development of a new / existing service, which is not policy;
(e) All other targets are being achieved;
(f) Approval has been obtained from the Director of Finance.

2.4 Virement between Care Groups:

Expected underspendings can be transferred to another CSU subject to the agreement of both budget holders and the same constraints as above.

2.5 Virement between Revenue and Capital:

This can only be done in exceptional circumstances when approved in advance by the Director of Finance.

2.6 Budgetary and Virement Limits of the Chief Executive:

Budgetary or virement limits of the Chief Executive delegated by the Board are outlined in the Scheme of Delegation

APPENDIX 4 ~~PURCHASING~~ PROCUREMENT AND TENDERING

1.0 INTRODUCTION

1.1 The Trust's Standing Financial Instructions (SFI's) set out procedures to be adopted in obtaining goods and services.

1.2 This supplementary procedure note deals with the setting of thresholds above which quotations (competitive or otherwise) or formal tenders must be obtained and detailed procedures in relation to ~~purchasing~~ procurement and tendering.

1.3 The Director of Finance (or Deputy in his absence) must personally authorise any order or contract which commits the Trust to expenditure up to £100,000 as determined by the scheme of delegation. The Chief Executive (or Director of Finance in his absence) must authorise all expenditure from £100,000 to £500,000.

~~1.4~~ 1.4 Any commitment on behalf of the Trust in respect of all capital projects and financial commitments, including leases, costing between £0.5m and £1.5m, in their entirety if included in the Trust's Annual Plan or Capital Plan must be approved by the Trust's ~~Commercial Development and Investment~~ Corporate Investment Group ~~Committee~~ (CIG) ~~(CDIC)~~. Any proposals above £0.5m and below £1.5m which have not already been approved in the Trust's Annual Plan or Capital Plan must be submitted to ~~CDI~~ CIIG~~C~~ for review and recommendation to the Board. The costs are whole life costs. All expenditure in excess of £1.5m requires approval of the Board.

1.5 In addition to the Trust delegated tendering limits, attention must be paid to the regulations governing procurement within the European Union. In all cases advice should be sought from ~~the Supplies/Purchasing Manager~~Procurement Director to ensure compliance with appropriate thresholds.

2.0 COMPETITIVE TENDERING (Over £50,000)

2.1 The Trust must ensure that goods and services are procured in an efficient manner and are purchased at the most competitive price. The standard method of procurement will be by competitive tender for goods or services expected to cost in excess of £50,000; this may be waived under the following circumstances:

- W~~w~~here the requirements are ordered under existing contracts or where in the opinion of the ~~relevant~~ Finance D~~d~~irector:

- there is only one supplier and no reasonably satisfactory alternative product/service;

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- competition would be impractical, impossible or not beneficial;
- the requirement is to be ordered under existing contracts;
- the work for practical reasons must be of the same manufacture, for instance repairs/spare parts for existing equipment;
- where it is known that a marked financial advantage will accrue to the Trust from making a spot purchase of products subject to quickly changing market conditions.

2.2 In any of these circumstances the detail should be documented and the authorisation counter-signed by the ~~Supplies/Purchasing Manager~~Procurement Director in confirmation of such circumstances.

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3.0 COMPETITIVE AND NON-COMPETITIVE QUOTATIONS (£50,000 and under)

3.1 Three competitive quotations must be obtained for all contracts and services where the value is not expected to exceed £50,000 but is above £5,000.

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3.2 Non-competitive quotations in writing, or electronically via the e-tendering portal if the value is expected to exceed £25,000, may be obtained for the following purposes:

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(a) where the supply of goods (or related goods) is of a special character and does not exceed £5,000;

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or where in the opinion of the ~~relevant~~ Finance D~~d~~irector:

(b) there being only one supplier and no reasonably satisfactory alternative product/service;

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(c) competition would be impractical, impossible or not beneficial;

(d) the requirement is to be ordered under existing contracts;

(e) the work for practical reasons must be of the same manufacture, for instance, repairs/spare parts for existing equipment;

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(f) where it is known that a marked financial advantage will accrue to the Trust from making a spot purchase of products subject to quickly changing market conditions.

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In any of these circumstances the detail should be documented and the authorisation counter-signed by the ~~Supplies/Purchasing Manager~~Procurement Director in confirmation of such circumstances.

3.3 Officers should involve the ~~Supplies/Purchasing Manager~~Procurement Director in choice of supplier, price negotiation and in the procurement process for all goods and services.

3.4 Where the supplier being used is nationally or regionally approved, and/or they are providing a continuous supply in operational terms, it may be appropriate to use annual orders duly authorised as appropriate. Annual orders must include a clear schedule of the items being ordered, their agreed individual prices, an estimate of the volumes required of each item for the period of the order and hence an agreed total cost which must not be exceeded. The advice of the ~~Supplies/Purchasing Manager~~ Procurement Director should be sought when establishing such annual orders to ensure that the correct format is applied and that value for money is obtained.

3.5 No single supplier or single annual order should be used for a period in excess of 12 months., ~~where the costs incurred during that period exceed £25,000, without the requisitioner demonstrating value for money~~. The advice of ~~the Supplies /Purchasing Manager~~Procurement Director should be sought. Where this advice is not sought or not acted upon the requisitioner must advise the Chief Executive in writing seeking waiver of this rule.

4.0 TENDERING PROCEDURES

4.1 The basic procedures to be followed in relation to competitive tenders are set out below. ~~In addition, the Board has agreed further procedures concerning the arrangements for tendering as follows:~~

~~- Where tenders for goods and services exceed £100,000 (whole life costs), a Sub-committee of the Board should be formed comprising, as a minimum, two Executive Directors, which would have responsibility for adjudicating the tenders.~~

4.2 In all cases the ~~lowest tender/quotation~~tender that provides the best value for money must be accepted using a defined combination of cost and quality. Any proposal to waive this rule would need the approval of:

- goods/services between £50,000 and £100,000 — ~~Director of Finance~~Procurement Director
- goods/services in excess of £100,000 and up to £500,000 — ~~Chief Executive~~Director of Finance
- goods/services in excess of £500,000 and up to £1m — ~~Board~~Chief Executuve
- Goods/services in excess of £1m — Board

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4.3 Officers with any doubts concerning the appropriateness of competitive tendering in particular circumstances must seek formal clarification from the Director of Finance. The Trust will not be responsible for officers committing costs other than in accordance with the above procedures.

4.4 ~~Wherever possible t~~Tenders shall be advertised, issued and submitted on the Trust's e-tendering system.

4.5 ~~All written tenders shall be addressed to the Chief Executive.~~

~~4.6 All invitations to tender on a competitive basis shall state that no written tender will be accepted unless submitted in either:~~

~~a) A plain, sealed package bearing a pre-printed label supplied by the Trust (or the word "Tender", followed by the subject to which it relates and the latest date and time for the receipt of such tender); or~~

~~b) in a special envelope supplied by the Trust to prospective tenders, and that tender envelopes/packages shall not bear the names or marks indicating the sender.~~

4.7 Every tender for building and engineering works, except any tender for maintenance work only, where Estmancode guidance should be followed, shall embody or be in the terms of the current Edition of the Standard Form of Building Contract Local Authorities Edition with (or, where appropriate, without) quantities or the Agreement for Minor Building Works issued by the Joint Contract Tribunal as appropriate or (when the contents of the works is primarily engineering) the General Conditions of Contracts recommended by the Institute of Mechanical and Electrical Engineers and the Association of Consulting Engineers (Form A), or (in the case of civil engineering work) the General Conditions of Contract recommended by the Institution of Civil Engineers, the Association of Consulting Engineers and the Federation of Civil Engineering Contractors. These base documents should be modified and amplified to accord with current Departmental guidance forms of contract may be used after prior consultation with the Department.

4.8 ~~The date and time of receipt of each tender shall be endorsed on the unopened tender envelope/package.~~ Tenders submitted via e-tendering will be electronically date and time stamped.

4.9 ~~The Trust shall designate an officer or officers, not from the originating department, to be responsible for the receipt, endorsement and safe custody of tenders received until the time appointed for their opening.~~ Tenders submitted via e-tendering will remain electronically locked to all Trust staff until the end time for receipt of tenders has passed.

4.10 ~~As soon as practicable after the date and time stated as being the latest time for the receipt of tenders they shall be opened in the presence of two officers at least one of which must~~

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~~be an Executive member of the Board. Tenders submitted via e-tendering shall be opened by officers as above though these officers need not be geographically co-located.~~

4.11 ~~Every tender received shall be recorded to show for each set of competitive tender invitations despatched: -~~

~~(a) the names of all firms invited;~~

~~(b) the names of and the number of firms from which tenders have been received, and the amount for each tender;~~

~~(c) the date the tenders were opened; and~~

~~(a) the record shall be signed by the persons present at the opening.~~

~~For tenders received via e-tendering this information will be electronically recorded.~~

4.12 ~~Except as in paragraph 4.14 below a record shall be maintained of all price alterations on tenders, i.e. where a price has apparently been altered, the final price shown shall be recorded. The record shall be initialled by two of those present at the opening.~~ Alterations to tenders submitted via e-tendering will be electronically marked.

4.13 ~~A report shall be made in the record if on any one tender price alterations are so numerous as to render the procedure at paragraph 4.12 above unreasonable.~~

4.14 Tenders received after the due time and date may be considered only if the Chief Executive decides that there are exceptional circumstances, e.g. where marked financial, technical or delivery advantages would accrue, and is satisfied that there is no reason to doubt the bona fides of the tenderers concerned. The Chief Executive shall decide whether such tenders are admissible and where re-tendering is desirable.

4.15 Technically late tenders (i.e. those ~~despatched~~ uploaded in good time but delayed through no fault of the tenderer) may be regarded as having arrived in due time.

4.16 Incomplete tenders (i.e. those from which information necessary for the adjudication of the tender is missing) and amended tenders (i.e. those amended by the tenderer upon his own initiative either orally or in writing after the due time for receipt) should be dealt with in the same way as late tenders.

4.17 Necessary discussion with a tenderer of the contents of his tender, in order to elucidate technical, etc, points before the award of a contract, need not disqualify the tender.

4.18 While decisions as to the admissibility of late, incomplete, or amended tenders are under consideration and while re-tenders are being obtained, the ~~tender documents shall~~

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~~be kept strictly confidential and held in safe custody by an officer designated by the Chief Executive. For tenders submitted via e-tendering, the~~ tenders will remain electronically unopened.

4.19 ~~———~~Where only one tender/quotation is sought and/or received, the Trust shall, as far as is practicable, ensure that the price to be paid is fair and reasonable.

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4.20 ~~———The lowest tender/quotation, if payment is to be made by the Trust, or the highest, if payment is to be received by the Trust, shall be accepted unless there are good and sufficient reasons to the contrary; such reasons shall be set out in a permanent record.~~

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4.21 ~~———~~Every contract for building and engineering works, except measured term contracts where Estmancode guidance should be followed, should be embodied in a formal contract document which should conform to these Standing Financial Instructions. These formal contract documents should reflect any change in the terms and conditions of contract agreed following receipt of tenders.

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4.22 ~~———~~No goods, services or works other than works and services, executed in accordance with a contract and purchases from petty cash shall be ordered except on an official order, which may be in hard copy or electronic media. Contractors shall be notified that they should not accept orders unless in an official format. Verbal orders shall be issued only in specific instances, the first being by an officer designated by the Chief Executive in cases of emergency or urgent necessity. These must be confirmed by an official order and clearly marked "Confirmation Order". The second being by the use of official purchasing cards, by those designated to do so by the Chief Executive, and in accordance with the detailed guidance and limitations for the use of such cards as issued by the Director of Finance.

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APPENDIX 4 - EQUALITY IMPACT ASSESSMENT PART 1 INITIAL SCREENING

Service/Function/Policy/Project/ Strategy	CSU/Executive Directorate and Department	Assessor (s)	New or Existing Service or Policy?	Date of Assessment
Standing Financial instructions – July 2016 - CORP/FIN 1 (B) v.5	CE/Finance	Maria Dixon /Andrew Thomas	Existing Policy	May 2016

1) Who is responsible for this policy? Name of CSU/Directorate – Finance Department

2) Describe the purpose of the service / function / policy / project/ strategy? Who is it intended to benefit? What are the intended outcomes? To provide a framework within which the Trust can properly conduct its financial affairs and transactions.

3) Are there any associated objectives? Legislation, targets national expectation, standards No

4) What factors contribute or detract from achieving intended outcomes? – Compliance with the policy

5) Does the policy have an impact in terms of age, race, disability, gender, gender reassignment, sexual orientation, marriage/civil partnership, maternity/pregnancy and religion/belief? Details: [see Equality Impact Assessment Guidance] - No

- **If yes, please describe current or planned activities to address the impact** [e.g. Monitoring, consultation] – N/A

6) Is there any scope for new measures which would promote equality? [any actions to be taken] N/A

7) Are any of the following groups adversely affected by the policy? No

Protected Characteristics	Affected?	Impact
a) Age	No	
b) Disability	No	
c) Gender	No	
d) Gender Reassignment	No	
e) Marriage/Civil Partnership	No	
f) Maternity/Pregnancy	No	
g) Race	No	
h) Religion/Belief	No	
i) Sexual Orientation	No	

8) Provide the Equality Rating of the service / function /policy / project / strategy – tick (✓) outcome box

Outcome 1✓	Outcome 2	Outcome 3	Outcome 4

If you have rated the policy as having an outcome of 2, 3 or 4, it is necessary to carry out a detailed assessment and complete a* **Detailed Equality Analysis form in Appendix 4

Date for next review: **May 2017**

Checked by: **Andrew Thomas** **Date: May 2016**

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Title	**Review of Constitution**		
Report to	**Board of Governors** **Board of Directors**	**Date**	**31 January 2018** **30 January 2018**
Author	**Matthew Kane, Trust Board Secretary**		

Purpose		Tick one as appropriate
	Decision	X
	Assurance	
	Information	

Executive summary containing key messages and issues

The Trust is required to have a constitution which sets out how it is constituted, how it makes decisions and to whom it is accountable. It is based on Monitor's core constitution statutory guidance issued in 2014. Some of the provisions are required by law while some are discretionary.

The Constitution is required to be reviewed in full every three years although a partial review took place in December 2016 to insert the word "Teaching" into the Trust's name. Since then, a number of changes have been discussed in various fora including informal and formal governors meetings and at Board of Directors.

A full list of the proposed changes is attached to this report as **Appendix A**. The changes were considered by a meeting of the Audit and Non-clinical Risk Committee on 4 January 2018 and recommended to Board of Directors.

A tracked version of the constitution is at **Appendix B**.

Amendments to the Constitution are required to be approved by both Board of Directors (on 30 January) and by Board of Governors (on 31 January 2018) and then notified to NHSI.

Key questions posed by the report
Will the Board of Directors and Board of Governors approve the changes proposed to the Constitution?
How this report contributes to the delivery of the strategic objectives
The documents support the delivery of the strategic aims by providing a clear, accountable and transparent governance platform through which decisions can be made.
How this report impacts on current risks or highlights new risks
The report mitigates risks relating to sound and effective corporate governance.
Recommendation(s) and next steps
Board of Directors and Board of Governors are asked to APPROVE the proposed amendments to the Constitution outlined in Appendix A to this report and shown as tracked changes in Appendix B.

Appendix A - Amendments to Constitution

Page No.	Section	Proposed change
Throughout	Throughout	Words for chair, deputy chair and vice chair have been made gender neutral to align with the Standing Orders. The word 'trust' where it refers to DBTH has been capitalised.
Throughout	Throughout	Amend Board of Governors to Council of Governors to reflect the current legislative position. This was discussed at the recent NHS Providers' training.
5	Interpretation – Secretary	For avoidance of doubt.
10/11 69	Board of Governors – Tenure Board of Governors – Terms of Office	To reflect the decision made by Board of Governors on 26 October 2017.
12	Board of Governors – Referral to Panel	To delete. The Panel was quietly disbanded in January 2017 having had no questions referred to it in its three-year existence.
13	Board of Directors - Composition	To add "registered pharmacist" to further expand pool of possible clinical NEDs.
26-28	Partnership Organisations	To delete Doncaster CVS which has closed. To add partner governors for Doncaster College and Doncaster Deaf Trust to express closer partnership working with these organisations. This change will be dependent upon the organisations wishing to take up partner roles.

29-68	Annex 4 - Model Election Rules	To reflect the Trust's use of Single Transferable Vote as its system for electing governors to the Board of Governors. All references to the First Past the Post system have been deleted.
66	Information about candidates for inclusion with voting information	To reflect the decision made by Board of Governors in December 2016 and Board of Directors in February 2017 to not require candidate photographs to be submitted for use in election processes. BOD and BOG deemed the inclusion of photographs may lead to unconscious bias.
76	Annex 6 – Further Provisions	To reflect a discussion at the Board of Directors to consider deleting a provision which disqualifies a person who is an existing executive or non-executive director at another foundation trust or a governor, executive or non-executive director of a body whose business includes provision or commissioning of goods and services for the health service in Doncaster and Bassetlaw from being a director at this Trust. Such a provision is no longer contained within the core constitution and is now felt to be outdated, given the large scale partnership working operating throughout the region and the potential benefits of experience that such an arrangement might bring.
77	Non-Executive Directors: Terms of Office	To reflect a recommendation from Appointments and Remuneration Committee in September 2017 to increase the term of office for a non-executive director who is seeking reappointment to three years, in line with most other trusts.

DONCASTER AND BASSETLAW TEACHING HOSPITALS
NHS FOUNDATION TRUST

CONSTITUTION

Approved by ~~Board of Governors~~Council of Governors: ~~12 December 2016~~
Approved by Board of Directors: ~~20 December 2016~~
Review date: January 2021 ~~2018~~

TABLE OF CONTENTS

1. INTERPRETATION AND DEFINITIONS

In this Constitution:

“the 2006 Act”	means the National Health Service Act 2006 as amended from time to time;
“the 2012 Act”	means the Health and Social Care Act 2012 as amended from time to time;
"Accounting Officer"	means the person who from time to time discharges the functions specified in paragraph 25(5) of Schedule 7 to the 2006 Act;
“Annual Members Meeting”	means the annual members meeting of the Trust as defined in paragraph 10 of this Constitution.
"Appointed Governors"	means the Partner Governors;
“Area of the Trust”	means the areas of Bassetlaw District and Metropolitan Doncaster (specified in Annex 1 as areas of the public constituency);
“Board of Directors”	means the board of directors as constituted in accordance with this Constitution;
“~~Board of Governors~~Council of Governors”	means the ~~board of governors~~Council of Governors as constituted in accordance with this Constitution, which has the same meaning as the council of governors in the 2006 Act and the 2012 Act;
“Chair~~man~~”	means the chair~~man~~ of the Trust appointed in accordance with paragraph 25 of this Constitution;
“Chief Executive”	means the chief executive officer of the Trust appointed in accordance with the terms of this Constitution;
"Constitution"	means this Constitution and all annexes to it;
"Deputy Chair~~man~~"	means the Non-Executive Director appointed as deputy chair~~man~~ of the Trust in accordance with paragraph 26 of this Constitution;
“Director”	means an Executive Director or a Non-Executive Director on the Board of Directors;
"Elected Governor"	means the Public Governors and the Staff Governors;
“Election Scheme”	means the election scheme set out in Annex 4;
“Executive Director”	means an executive director of the Trust;
“Financial Year”	means a period of 12 months beginning on 1st April in a calendar year and ending on 31st March in the following calendar year;

“Governor”	means a Governor on the ~~Board of Governors~~Council of Governors and being either an Elected Governor or an Appointed Governor;
“Health Service Body”	means a body which is a health service body for the purpose of section 9(4) of the 2006 Act;
"Local Authority"	means the local authorities specified in Annex 3, which are local authorities for an area which includes the whole or part of the area of the Trust;
“Local Authority Governor”	means a member of the ~~Board of Governors~~Council of Governors appointed by a Local Authority in accordance with the provisions of this Constitution and as specified in Annex 3;
“Member”	means a member of the Trust;
"Membership	means membership of the Trust as determined in accordance with the provisions of this Constitution and as specified in Annex 3;
“Monitor”	means the body corporate known as Monitor, as provided by Section 61 of the 2012 Act;
"Model Election Rules"	means the model form rules for the conduct of elections published from time to time by the Department of Health and as currently set out in Annex 4;
“Non-Executive Director”	means a non-executive director of the Trust;
“CCG Governor”	means each member of the ~~Board of Governors~~Council of Governors appointed in accordance with the provisions of this Constitution by each of the Clinical Commissioning Groups specified in Annex 3;
"Partnership Governor"	means a member of the ~~Board of Governors~~Council of Governors appointed by a Partnership Organisation specified in Annex 3;
"Partnership Organisation"	means those organisations designated as partnership organisations for the purposes of this Constitution specified in Annex 3;
“Public Constituencies”	means a public constituency as defined in Annex 1;
“Public Governor”	means a member of the ~~Board of Governors~~Council of Governors elected by the Members of the Public Constituency;
"Secretary"	means the Trust Board Secretary ~~to the Board~~ or any other person appointed to perform the duties of the secretary to the Board, including a joint, assistant or deputy secretary;
"Senior Independent Director"	means the Non-Executive Director elected by the ~~Board of Governors~~Council of Governors as the senior independent director of the Trust;
“Staff Class”	means a class of Membership within the Staff Constituency as

provided for in Schedule 7 to the 2006 Act and as set out in Annex 2;

"Staff Constituency"	means the part of the Trust's Membership consisting of the staff of the Trust and which is divided into the classes as specified in Annex 2;
"Staff Governor"	means a member of the ~~Board of Governors~~Council of Governors elected by a Staff Class in accordance with the provisions of this Constitution;
"the Trust"	means Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust;
"Vice Chair~~man~~"	means a Governor appointed as vice chair~~man~~ in accordance with the provisions of this Constitution;

1.1 Unless the contrary intention appears or the context otherwise requires, words or expressions contained in this Constitution bear the same meaning as in the 2006 Act as amended by the Health and Social Care Act 2012.

1.2 References in this Constitution to legislation include all amendments, replacements, or re-enactments made, and all regulations, statutory guidance or directions.

1.3 Headings are for ease of reference only and are not to affect interpretation.

1.4 Words importing the masculine gender shall include the feminine gender and words importing the singular shall include the plural and vice-versa.

1.5 References in this Constitution to paragraphs are to paragraphs in the Constitution.

2. NAME

2.1 The name of the foundation trust is Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust.

3. PRINCIPAL PURPOSE

3.1 The principal purpose of the ~~t~~Trust is the provision of goods and services for the purposes of the health service in England.

3.2 The T~~t~~rust does not fulfil its principal purpose unless, in each financial year, its total income from the provision of goods and services for the purposes of the health service in England is greater than its total income from the provision of goods and services for any other purposes.

3.3 The T~~t~~rust may provide goods and services for any purposes related to:

3.3.1 the provision of services provided to individuals for or in connection with the prevention, diagnosis or treatment of illness, and

3.3.2 the promotion and protection of public health.

3.4 The T~~t~~rust may also carry on activities other than those mentioned in the above paragraph for the purpose of making additional income available in order better to carry on its principal purpose.

4. **POWERS**

4.1 The powers of the Trust are set out in the 2006 Act.

4.2 All the powers of the Trust shall be exercised by the Board of Directors on behalf of the Trust.

4.3 Any of these powers may be delegated to a committee of directors or to an executive director.

4.4 Without prejudice to the generality of paragraph 4.1, the Trust may:

4.4.1 provide hospital and other accommodation for the purposes of any of its activities;

4.4.2 provide the services of medical, dental, midwifery and nursing staff, other health care professionals, other staff and volunteers;

4.4.3 provide such other facilities for the care of expectant and nursing mothers and young children as it considers appropriate;

4.4.4 provide such facilities for the prevention of illness, the care of persons suffering from illness and the aftercare of persons who have suffered from illness as it considers appropriate;

4.4.5 provide such other services as it considers are required for the diagnosis and treatment of illness and the care of those suffering from illness;

4.4.6 conduct, or assist by grants or otherwise any person to conduct, research into any matters relating to the causation, prevention, diagnosis or treatment of illness and into any such other matters connected with any service provided by the Trust as it considers appropriate and publish the results of such research;

4.4.7 educate and train its own staff and students and those from other organisations or educational establishments in any trade, profession or other occupation relevant or related to any part of the Trust's functions and collaborate with other organisations in the provision of such education and training;

4.4.8 in fulfilling its statutory duty to co-operate with another body, provide to that body, and receive from it, goods and services on such terms as the Trust considers appropriate, including terms under which the goods or services are provided for received free of charge;

4.4.9 provide goods and services outside England;

4.4.10 provide, or assist in providing, information, training and support to voluntary and community bodies within the area of the Trust or providing services within the area of the Trust;

4.4.11 raise charitable funds and, in so doing, appeal for any contributions, donation, grant or gift of money or property;

4.4.12 insure the property of the Trust against any foreseeable risk and take out other insurance policies to protect the Trust when required or enter into arrangements which have a similar effect;

4.4.13 insure the Governors and Directors and any employee of the Trust against the cost of a defence to a criminal prosecution brought against them in their capacity as such or against personal liability incurred in respect of any act or omission which is, or is alleged to be, a breach of trust or a breach of duty, unless the Governor, Director or employee concerned knew that, or was reckless whether, the act or omission was a breach of trust or a breach of duty or enter into arrangements which have a similar effect;

4.4.14 provide and participate in external quality assurance schemes; and

4.4.15 carry out investigations into any aspect of the activities of the Trust.

5. MEMBERSHIP AND CONSTITUENCIES

5.1 The Trust shall have Members, each of whom shall be a Member of one of the following constituencies:

5.1.1 a Public Constituency; or

5.1.2 a Staff Constituency.

5.2 An individual who is eligible to become a Member of the Trust may do so on application to the Trust.

6. PUBLIC CONSTITUENCY

6.1 The Public Constituency comprises three areas as set out in Annex 1. Each area of the Public Constituency is to be known by the name listed in Annex 1.

6.2 An individual who lives in an area specified in Annex 1 as an area for a public constituency may become or continue as a Member of the Trust provided that:

6.2.1 they have made an application for Membership to the Trust; and

6.2.2 they are not eligible to become a Member of the Staff Constituency; and

6.2.3 they are not otherwise disqualified from Membership under paragraph 4 or paragraph 2 of Annex 6.

6.3 Those individuals who live in an area specified for a Public Constituency are referred to collectively as the Public Constituency.

6.4 The minimum number of Members in each area for the Public Constituency is specified in Annex 1.

7. STAFF CONSTITUENCY

7.1 An individual who is employed by the Trust under a contract of employment with the Trust may become or continue as a Member of the Trust provided that:

7.1.1 they are employed by the Trust under a contract of employment which has no fixed term or has a fixed term of at least 12 months; or

7.1.2 they have been continuously employed by the Trust under a contract of employment for at least 12 months.

7.2 Those individuals who are eligible for Membership of the Trust by reason of paragraph 7.1 are referred to collectively as the Staff Constituency.

7.3 The Staff Constituency shall be divided into four classes of individuals who are eligible for Membership of the Staff Constituency, each class of individuals being specified within Annex 2 and being referred to as a class within the Staff Constituency.

7.4 The minimum number of Members in each class of the Staff Constituency is specified in Annex 2.

8. **AUTOMATIC MEMBERSHIP BY DEFAULT AND BY APPLICATION – STAFF**

8.1 An individual who:

8.1.1 is eligible to become a Member of the Staff Constituency pursuant to paragraph 7.1 above, and

8.1.2 invited by the Trust to become a Member of the Staff Constituency and a Member of the appropriate Staff Class within the Staff Constituency,

shall become a Member of the Trust as a Member of the Staff Constituency and appropriate Staff Class within the Staff Constituency without an application being made, unless he informs the Trust that he does not wish to do so.

8.2 The process by which an individual shall be invited or shall apply to become a Member of the Staff Constituency shall be in accordance with the provisions of Annex 6.

9. **RESTRICTION ON MEMBERSHIP**

9.1 An individual who is a Member of a constituency, or of a class within a constituency, may not while Membership of that constituency or class continues, be a Member of any other constituency or class.

9.2 An individual who satisfies the criteria for Membership of the Staff Constituency may not become or continue as a Member of any constituency other than the Staff Constituency.

9.3 An individual must be at least 16 years old at the date of his application or invitation (as the case may be) to become a Member of the Trust.

9.4 Further provisions as to the circumstances in which an individual may not become or continue as a Member of the Trust are set out in Annex 6.

10. **ANNUAL MEMBERS MEETING**

10.1 The Trust shall hold an annual meeting of its members ('Annual Members' Meeting'). The Annual Members' Meeting shall be open to members of the public.

10.2 Further provisions about the Annual Members' Meeting are set out in Annex 7 – Annual Members' Meeting.

11. ~~BOARD OF GOVERNORS~~COUNCIL OF GOVERNORS - **COMPOSITION**

11.1 The Trust is to have a ~~Board of Governors~~Council of Governors, which shall comprise both Elected and Appointed Governors and the Chair~~man~~ of the Trust.

11.2 The composition of the ~~Board of Governors~~Council of Governors is specified in Annex 3.

11.3 The members of the ~~Board of Governors~~Council of Governors, other than the appointed members, shall be chosen by election by their Constituency or, where there are classes within a constituency, by their class within that Constituency. The number of Governors to be elected by each Constituency, or, where appropriate, by each class of each Constituency, is specified in Annex 3.

12. ~~BOARD OF GOVERNORS~~COUNCIL OF GOVERNORS - **ELECTION OF GOVERNORS**

12.1 Elections for elected members of the ~~Board of Governors~~Council of Governors shall be conducted in accordance with the Model Election Rules.

12.2 The Model Election Rules as may be varied from time to time, form part of this Constitution and are attached at Annex 4.

12.3 A subsequent variation of the Model Election Rules by the Department of Health shall not constitute a variation of the terms of this Constitution for the purposes of paragraph 42 of the Constitution (amendment of the Constitution).

12.4 An election, if contested, shall be by secret ballot.

13. ~~BOARD OF GOVERNORS~~COUNCIL OF GOVERNORS - **TENURE**

13.1 An Elected Governor may hold office for a period of up to 3 years.

13.2 An Elected Governor shall cease to hold office if he ceases to be a Member of the Constituency or class by which he was elected.

13.3 An Elected Governor shall be eligible for re-election at the end of his term but no Elected Governor may hold office for more than nine years.~~.~~

13.4 An Appointed Governor may hold office for a period of 3 years.

13.5 An Appointed Governor shall cease to hold office if the appointing organisation withdraws its sponsorship of him.

13.6 An Appointed Governor shall be eligible for re-appointment at the end of his term~~.~~ but no Appointed Governor may hold office for more than nine years.

13.7 Service by a current or previous governor as at 26 October 2017 will count towards the maximum time period specified in paragraphs 13.3 and 13.6 above.

13.8 Governors in post on 26 October 2017 that have exceeded nine years' service may complete the remaining portion of their existing term but are not eligible for re-election or re-appointment.

14. ~~BOARD OF GOVERNORS~~COUNCIL OF GOVERNORS – DISQUALIFICATION AND REMOVAL

14.1 The following may not become or continue as a member of the ~~Board of Governors~~Council of Governors:

14.1.1 a person who has been adjudged bankrupt or whose estate has been sequestrated and (in either case) has not been discharged;

14.1.2 a person who has made a composition or arrangement with, or granted a trust deed for, his creditors and has not been discharged in respect of it;

14.1.3 a person who within the preceding five years has been convicted in the British Islands of any offence if a sentence of imprisonment (whether suspended or not) for a period of not less than three months (without the option of a fine) was imposed on him.

14.2 Governors must be at least 16 years of age at the date they are nominated for election or appointment.

14.3 Further provisions as to the circumstances in which an individual may not become or continue as a member of the ~~Board of Governors~~Council of Governors are set out in Annex 5.

14.4 Provisions for the removal of governors are set out in Annex 5 and the Standing Orders of the ~~Board of Governors~~Council of Governors.

15. ~~BOARD OF GOVERNORS~~COUNCIL OF GOVERNORS – DUTIES OF GOVERNORS

15.1 The general duties of the ~~Board of Governors~~Council of Governors are:

15.1.1 to hold the non-executive directors individually and collectively to account for the performance of the Board of Directors; and

15.1.2 to represent the interests of the members of the T~~t~~rust as a whole and the interests of the public.

15.2 The Trust must take steps to secure that the governors are equipped with the skills and knowledge they require in their capacity as such.

16. ~~BOARD OF GOVERNORS~~COUNCIL OF GOVERNORS – MEETINGS OF GOVERNORS

16.1 The Chair~~man~~ of the Trust (i.e. the Chair~~man~~ of the Board of Directors, appointed in accordance with the provisions of paragraph 25 below) or, in his absence, the Deputy Chair~~man~~ (appointed in accordance with the provisions of paragraph 26 below), shall preside at meetings of the ~~Board of Governors~~Council of Governors save that if the Chair~~man~~ and Deputy Chair~~man~~ are unable to preside whether for reasons of absence, conflict of interest or otherwise the Vice Chair~~man~~ shall preside.

16.2 The Vice Chair~~man~~ shall be a Public Governor and shall be elected by a majority of the ~~Board of Governors~~Council of Governors in a general meeting for a term of up to 3 years. The provisions of paragraph 8 of Annex 5 shall also apply.

16.3 Meetings of the ~~Board of Governors~~Council of Governors shall be open to members of the public save that members of the public may be excluded from a meeting on the grounds set out in paragraph 6.2 of Annex 5.

16.4 For the purposes of obtaining information about the ~~trust's~~ Trust's performance of its functions or the directors' performance of their duties (and deciding whether to propose a vote on the Trust's or directors' performance), the ~~Board of Governors~~Council of Governors may require one or more of the directors to attend a meeting.

17. ~~BOARD OF GOVERNORS~~COUNCIL OF GOVERNORS – STANDING ORDERS

17.1 The ~~Board of Governors~~Council of Governors shall adopt its own standing orders, as may be varied from time to time, for its practice and procedure, in particular for its procedure at meetings.

~~18. BOARD OF GOVERNORS~~COUNCIL OF GOVERNORS ~~– REFERRAL TO THE PANEL~~

~~18.1 In this paragraph, the Panel means a panel of persons appointed by Monitor to which a governor of an NHS foundation trust may refer a question as to whether the trust has failed or is failing:~~

~~18.1.1 to act in accordance with its constitution; or~~

~~18.1.2 to act in accordance with provision made by or under Chapter 5 of the 2006 Act.~~

~~18.2 A governor may refer a question to the Panel only if more than half of the members of the Board of Governors~~Council of Governors ~~voting approve the referral.~~

~~19.~~18. ~~BOARD OF GOVERNORS~~COUNCIL OF GOVERNORS - CONFLICTS OF INTEREST OF GOVERNORS

~~19.1~~18.1 If a Governor has a pecuniary, personal or family interest, whether that interest is actual or potential and whether that interest is direct or indirect, in any proposed contract or other matter which is under consideration or is to be considered by the ~~Board of Governors~~Council of Governors, the Governor shall disclose that interest to the members of the ~~Board of Governors~~Council of Governors as soon as he becomes aware of it.

~~19.2~~18.2 The Standing Orders for the ~~Board of Governors~~Council of Governors shall make provision for the disclosure of interests and arrangements for the exclusion of a Governor declaring any interest from any discussion or consideration of the matter in respect of which an interest has been disclosed.

~~20.~~19. ~~BOARD OF GOVERNORS~~COUNCIL OF GOVERNORS – TRAVEL EXPENSES

~~20.1~~19.1 The Trust may pay travelling and other expenses to members of the ~~Board of Governors~~Council of Governors at rates determined by the Trust.

~~21.~~20. ~~**BOARD OF GOVERNORS**~~**COUNCIL OF GOVERNORS – FURTHER PROVISIONS**

~~21.1~~20.1 Further provisions with respect to the ~~Board of Governors~~Council of Governors are set out in Annex 5.

~~22.~~21. **BOARD OF DIRECTORS – COMPOSITION**

~~22.1~~21.1 The Trust is to have a Board of Directors, which shall comprise both Executive and Non-Executive Directors.

~~22.2~~21.2 The Board of Directors is to comprise:

~~22.2.1~~21.2.1 a non-executive Chair~~man~~

~~22.2.2~~21.2.2 6 other Non-Executive Directors (one of which may be elected by the ~~Board of Governors~~Council of Governors as the Senior Independent Director); and

~~22.2.3~~21.2.3 6 Executive Directors.

~~22.3~~21.3 One of the Executive Directors shall be the Chief Executive.

~~22.4~~21.4 The Chief Executive shall be the Accounting Officer.

~~22.5~~21.5 One of the Executive Directors shall be the Finance Director.

~~22.6~~21.6 One of the Executive Directors is to be a registered medical practitioner or a registered dentist (within the meaning of the Dentists Act 1984).

~~22.7~~21.7 One of the Executive Directors is to be a registered nurse or a registered midwife.

~~22.8~~21.8 One of the Non-executive Directors is to be, or have been in the past, a registered medical practitioner, registered dentist, registered nurse, registered midwife, registered pharmacist or other healthcare professional registered with the Health and Care Professions Council.

~~23.~~22. **BOARD OF DIRECTORS –GENERAL DUTY**

~~23.1~~22.1 The general duty of the Board of Directors and of each director individually, is to act with a view to promoting the success of the T~~t~~rust so as to maximise the benefits for the members of the T~~t~~rust as a whole and for the public.

~~24.~~23. **BOARD OF DIRECTORS – QUALIFICATION FOR APPOINTMENT AS A NON-EXECUTIVE DIRECTOR**

~~24.1~~23.1 A person may be appointed as a Non-Executive Director only if:

~~24.1.1~~23.1.1 he is a Member of the Public Constituency; and

~~24.1.2~~23.1.2 he is not disqualified by virtue of paragraph 28 below.

~~25.~~24. **BOARD OF DIRECTORS – APPOINTMENT AND REMOVAL OF CHAIR~~MAN~~ AND OTHER NON-EXECUTIVE DIRECTORS**

~~25.1~~24.1 The ~~Board of Governors~~Council of Governors at a general meeting of the ~~Board of Governors~~Council of Governors shall appoint or remove the Chair~~man~~ and the other Non-Executive Directors.

~~25.2~~24.2 Removal of the Chair~~man~~ or another Non-Executive Director shall require the approval of three-quarters of the members of the ~~Board of Governors~~Council of Governors.

~~25.3~~24.3 The provisions of paragraph 9 of Annex 5 and paragraph 6 of Annex 6 shall also apply.

~~26.~~25. **BOARD OF DIRECTORS – APPOINTMENT OF DEPUTY CHAIR~~MAN~~**

~~26.1~~25.1 The ~~Board of Governors~~Council of Governors at a general meeting of the ~~Board of Governors~~Council of Governors shall appoint one of the Non-Executive Directors as a Deputy Chair~~man~~.

~~26.2~~25.2 The Deputy Chair~~man~~ shall be appointed for a term of 3 years and shall be eligible for re-appointment at the end of that term but may not serve as Deputy Chair~~man~~ for more than a total of 6 years.

~~27.~~26. **BOARD OF DIRECTORS - APPOINTMENT AND REMOVAL OF THE CHIEF EXECUTIVE AND OTHER EXECUTIVE DIRECTORS**

~~27.1~~26.1 The Non-Executive Directors shall appoint or remove the Chief Executive.

~~27.2~~26.2 The appointment of the Chief Executive shall require the approval of the ~~Board of Governors~~Council of Governors.

~~27.3~~26.3 A committee consisting of the Chair~~man~~, the Chief Executive and the other Non-Executive Directors shall appoint or remove the other Executive Directors.

~~28.~~27. **BOARD OF DIRECTORS – DISQUALIFICATION**

~~28.1~~27.1 The following may not become or continue as a member of the Board of Directors:

~~28.1.1~~27.1.1 a person who has been adjudged bankrupt or whose estate has been sequestrated and (in either case) has not been discharged;

~~28.1.2~~27.1.2 a person who has made a composition or arrangement with, or granted a trust deed for, his creditors and has not been discharged in respect of it;

~~28.1.3~~27.1.3 a person who within the preceding five years has been convicted in the British Islands of any offence if a sentence of imprisonment (whether suspended or not) for a period of not less than three months (without the option of a fine) was imposed on him;

~~28.1.4~~27.1.4 a person who does not satisfy all of the 'fit and proper person' requirements set out in regulation 5(3) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014; or

~~28.1.5~~27.1.5 a person who falls within the further grounds for disqualification set out in Annex 6.

~~29.~~28. BOARD OF DIRECTORS – MEETINGS

~~29.1~~28.1 Meetings of the Board of Directors shall be open to members of the public. Members of the public may be excluded from a meeting for special reasons.

~~29.2~~28.2 Before holding a meeting, the Board of Directors must send a copy of the agenda of the meeting to the ~~Board of Governors~~Council of Governors. As soon as practicable after holding a meeting, the Board of Directors must send a copy of the minutes of the meeting to the ~~Board of Governors~~Council of Governors.

~~29.3~~28.3 The Chair~~man~~ (or Deputy Chair~~man~~) shall give such directions as he thinks fit in regard to the arrangements for meetings and accommodation of the public such as to ensure that business shall be conducted without interruption and disruption.

~~29.4~~28.4 Members of the public or representatives of the press are not permitted to record proceedings in any manner unless with the express prior agreement of the Chair~~man~~ (or Deputy Chair~~man~~). Where permission has been granted, the Chair~~man~~ (or Deputy Chair~~man~~) retains the right to give directions to halt recording of proceedings at any point during the meeting. For the avoidance of doubt, "recording" refers to any audio or visual recording, including still photography.

~~30.~~29. BOARD OF DIRECTORS – STANDING ORDERS

~~30.1~~29.1 The Board of Directors shall adopt its own standing orders, as may be varied from time to time, for its practice and procedure, in particular for its procedure at meetings

~~31.~~30. BOARD OF DIRECTORS - CONFLICTS OF INTEREST OF DIRECTORS

~~31.1~~30.1 The duties that a director of the T~~t~~rust has by virtue of being a director include in particular:

~~31.1.1~~30.1.1 A duty to avoid a situation in which the director has (or can have) a direct or indirect interest that conflicts (or possibly may conflict) with the interests of the T~~t~~rust.

~~31.1.2~~30.1.2 A duty not to accept a benefit from a third party by reason of being a director or doing (or not doing) anything in that capacity.

~~31.2~~30.2 The duty referred to in sub-paragraph 31.1.1 is not infringed if:

~~31.2.1~~30.2.1 The situation cannot reasonably be regarded as likely to give rise to a conflict of interest, or

~~31.2.2~~30.2.2 The matter has been authorized in accordance with the constitution, as specified in paragraph 31.12.

~~31.3~~30.3 The duty referred to in sub-paragraph 31.1.2 is not infringed if acceptance of the benefit cannot reasonably be regarded as likely to give rise to a conflict of interest.

~~31.4~~30.4 In sub-paragraph 31.1.2, "third party" means a person other than –

~~31.4.1~~30.4.1 The ~~t~~Trust, or

~~31.4.2~~30.4.2 A person acting on its behalf.

~~31.5~~30.5 If a director of the T~~t~~rust has in any way a direct or indirect interest in a proposed transaction or arrangement with the T~~t~~rust, the director must declare the nature and extent of that interest to the other directors.

~~31.6~~30.6 If a declaration under this paragraph proves to be, or becomes, inaccurate, incomplete, a further declaration must be made.

~~31.7~~30.7 Any declaration required by this paragraph must be made before the ~~trust~~ Trust enters into the transaction or arrangement.

~~31.8~~30.8 This paragraph does not require a declaration of an interest of which the director is not aware or where the director is not aware of the transaction or arrangement in question.

~~31.9~~30.9 A director need not declare an interest –

~~31.9.1~~30.9.1 If it cannot reasonably be regarded as likely to give rise to a conflict of interest;

~~31.9.2~~30.9.2 If, or to the extent that, the directors are already aware of it;

~~31.9.3~~30.9.3 If, or to the extent that, it concerns terms of the director's appointment that have been or are to be considered –

(a) By a meeting of the Board of Directors, or

(b) By a committee of the directors appointed for the purpose under the constitution.

~~31.10~~30.10 The Standing Orders for the Board of Directors shall make provision for the disclosure of interests and arrangements for the exclusion of a director declaring any interest from any discussion or consideration of the matter in respect of which an interest has been disclosed.

~~31.11~~30.11 The Standing Orders for the Board of Directors shall make provision for the Board of Directors to determine whether a situation may reasonably be regarded as likely to give rise to a conflict of interest.

~~31.12~~30.12 The Standing Orders for the Board of Directors shall make provision for the authorisation of a direct or indirect interest that conflicts (or possibly may conflict) with the interests of the ~~trust~~Trust.

~~31.13~~30.13 Where a Non-executive Director has declared a direct or indirect interest that conflicts (or possibly may conflict) with the interests of the ~~trust~~Trust, the Board of Directors will disclose details of this to the ~~Board of Governors~~Council of Governors following any action it takes in accordance with paragraphs 31.11 and 31.12. The ~~Board of Governors~~Council of Governors may then take further action in accordance with its powers under this constitution.

~~32.~~31. BOARD OF DIRECTORS – REMUNERATION AND TERMS OF OFFICE

~~32.1~~31.1 The ~~Board of Governors~~Council of Governors at a general meeting of the ~~Board of Governors~~Council of Governors shall decide the remuneration and allowances, and the other terms and conditions of office, of the Chair~~man~~ and the

other Non-Executive Directors. The provisions of paragraph 6 of Annex 6 shall also apply.

~~32.2~~31.2 A committee of Non-Executive Directors shall be established to decide the remuneration and allowances, and the other terms and conditions of office, of the Chief Executive and other Executive Directors.

~~33.~~32. **REGISTERS**

~~33.1~~32.1 The Trust shall have:

~~33.1.1~~32.1.1 a register of Members showing, in respect of each Member, the constituency to which he belongs and, where there are classes within it, the class to which he belongs;

~~33.1.2~~32.1.2 a register of members of the ~~Board of Governors~~Council of Governors;

~~33.1.3~~32.1.3 a register of interests of Governors;

~~33.1.4~~32.1.4 a register of Directors; and

~~33.1.5~~32.1.5 a register of interests of the Directors.

~~33.2~~32.2 The process of admission to and removal from the registers shall be as set out in Annex 6.

~~34.~~33. **REGISTERS – INSPECTION AND COPIES**

~~34.1~~33.1 The Trust shall make the registers specified in paragraph 33 above available for inspection by members of the public, except in the circumstances set out below or as otherwise prescribed by regulations.

~~34.2~~33.2 The Trust shall not make any part of its registers available for inspection by members of the public which shows details of any Member of the Trust, if he so requests.

~~34.3~~33.3 So far as the registers are required to be made available:

~~34.3.1~~33.3.1 they are to be available for inspection free of charge at all reasonable times; and

~~34.3.2~~33.3.2 a person who requests a copy of or extract from the registers is to be provided with a copy or extract.

~~34.4~~33.4 If the person requesting a copy or extract is not a Member of the Trust, the Trust may impose a reasonable charge for doing so.

~~35.~~34. **DOCUMENTS AVAILABLE FOR PUBLIC INSPECTION**

~~35.1~~34.1 The Trust shall make the following documents available for inspection by members of the public free of charge at all reasonable times:

~~35.1.1~~34.1.1 a copy of the current Constitution;

~~35.1.2~~34.1.2 a copy of the latest annual accounts and of any report of the auditor on them;

~~35.1.3~~34.1.3 a copy of the latest annual report;

~~35.2~~34.2 The Trust shall also make the following documents relating to a special administration of the Trust available for inspection by members of the public free of charge at all reasonable times:

~~35.2.1~~34.2.1 a copy of any order made under section 65D (appointment of trust special administrator), 65J (power to extend time), 65KC (action following Secretary of State's rejection of final report), 65L(trusts coming out of administration) or 65LA (trusts to be dissolved) of the 2006 Act.

~~35.2.2~~34.2.2 a copy of any report laid under section 65D (appointment of trust special administrator) of the 2006 Act.

~~35.2.3~~34.2.3 a copy of any information published under section 65D (appointment of trust special administrator) of the 2006 Act.

~~35.2.4~~34.2.4 a copy of any draft report published under section 65F (administrator's draft report) of the 2006 Act.

~~35.2.5~~34.2.5 a copy of any statement provided under section 65F(administrator's draft report) of the 2006 Act.

~~35.2.6~~34.2.6 a copy of any notice published under section 65F(administrator's draft report), 65G (consultation plan), 65H (consultation requirements), 65J (power to extend time), 65KA(Monitor's decision), 65KB (Secretary of State's response to Monitor's decision), 65KC (action following Secretary of State's rejection of final report) or 65KD (Secretary of State's response to re-submitted final report) of the 2006 Act.

~~35.2.7~~34.2.7 a copy of any statement published or provided under section 65G (consultation plan) of the 2006 Act.

~~35.2.8~~34.2.8 a copy of any final report published under section 65I (administrator's final report),

~~35.2.9~~34.2.9 a copy of any statement published under section 65J (power to extend time) or 65KC (action following Secretary of State's rejection of final report) of the 2006 Act.

~~35.2.10~~34.2.10 a copy of any information published under section 65M (replacement of trust special administrator) of the 2006 Act.

~~35.3~~34.3 Any person who requests a copy of or extract from any of the above documents is to be provided with a copy.

~~35.4~~34.4 If the person requesting a copy or extract is not a Member of the Trust, the Trust may impose a reasonable charge for doing so.

~~36.~~35. AUDITOR

~~36.1~~35.1 The Trust shall have an auditor.

~~36.2~~35.2 The ~~Board of Governors~~Council of Governors shall appoint or remove the auditor at a general meeting of the ~~Board of Governors~~Council of Governors.

~~36.3~~35.3 The provisions of paragraph 11 of Annex 6 shall apply.

~~37.~~36. AUDIT COMMITTEE

~~37.1~~36.1 The Trust shall establish a committee of Non-Executive Directors as an audit committee to perform such monitoring, reviewing and other functions as are appropriate.

~~38.~~37. ACCOUNTS

~~38.1~~37.1 The Trust must keep proper accounts and proper records in relation to the accounts.

~~38.2~~37.2 Monitor may with the approval of the Secretary of State give directions to the Trust as to the content and form of its accounts.

~~38.3~~37.3 The accounts are to be audited by the ~~trust's~~ Trust's auditor.

~~38.4~~37.4 The ~~trust~~ Trust shall prepare in respect of each financial year annual accounts in such form as Monitor may with the approval of the Secretary of State direct.

~~38.5~~37.5 The functions of the T~~t~~rust with respect to the preparation of the annual accounts shall be delegated to the Accounting Officer.

~~38.6~~37.6 The provisions of paragraph 12 of Annex 6 shall apply.

~~39.~~38. ANNUAL REPORT, FORWARD PLANS AND NON-NHS WORK

~~39.1~~38.1 The T~~t~~rust shall prepare an Annual Report and send it to Monitor.

~~39.2~~38.2 The ~~t~~Trust shall give information as to its forward planning in respect of each financial year to Monitor.

~~39.3~~38.3 The document containing the information with respect to forward planning (referred to above) shall be prepared by the directors.

~~39.4~~38.4 In preparing the document, the directors shall have regard to the views of the ~~Board of Governors~~Council of Governors.

~~39.5~~38.5 Each forward plan must include information about:

~~39.5.1~~38.5.1 the activities other than the provision of goods and services for the purposes of the health service in England that the T~~t~~rust proposes to carry on, and

~~39.5.2~~38.5.2 the income it expects to receive from doing so.

~~39.6~~38.6 Where a forward plan contains a proposal that the ~~t~~Trust carry on an activity of a kind mentioned in sub-paragraph 39.5.1 the ~~Board of Governors~~Council of Governors must:

~~39.6.1~~38.6.1 determine whether it is satisfied that the carrying on of the activity will not to any significant extent interfere with the fulfilment by the trust of its principal purpose or the performance of its other functions, and

~~39.6.2~~38.6.2 notify the directors of the T~~t~~rust and its determination.

~~39.7~~38.7 A trust which proposes to increase by 5% or more the proportion of its total income in any financial year attributable to activities other than the provision of goods and services for the purposes of health service in England may implement the proposal only if more than half of the members of the ~~Board of Governors~~Council of Governors of the T~~t~~rust voting approve its implementation.

~~40.~~39. **PRESENTATION OF THE ANNUAL ACCOUNTS AND REPORTS TO THE GOVERNORS AND MEMBERS**

~~40.1~~39.1 The following documents are to be presented to the ~~Board of Governors~~Council of Governors at a general meeting of the ~~Board of Governors~~Council of Governors.

~~40.1.1~~39.1.1 the annual accounts;

~~40.1.2~~39.1.2 any report of the auditor on them; and

~~40.1.3~~39.1.3 the annual report.

~~40.2~~39.2 The documents shall also be presented to the members of the Trust at the Annual Members' Meeting by at least one member of the Board of Directors in attendance.

~~40.3~~39.3 The Trust may combine a meeting of the ~~Board of Governors~~Council of Governors convened for the purposes of sub-paragraph 40.1 with the Annual Members' Meeting.

~~41.~~40. **INSTRUMENTS**

~~41.1~~40.1 The Trust shall have a seal.

~~41.2~~40.2 The seal shall not be affixed except under the authority of the Board of Directors.

~~42.~~41. **AMENDMENT OF THE CONSTITUTION**

~~42.1~~41.1 The T~~t~~rust may make amendments of its constitution only if:

~~42.1.1~~41.1.1 More than half of the members of the ~~Board of Governors~~Council of Governors voting approve the amendments; and

~~42.1.2~~41.1.2 More than half of the members of the Board of Directors voting approve the amendments.

~~42.2~~41.2 The Constitution shall be formally reviewed by the ~~Board of Governors~~Council of Governors and Board of Directors every 3 years.

~~42.3~~41.3 Amendments made under paragraph 42.1 take effect as soon as the conditions in that paragraph are satisfied, but the amendment has no effect in so far as the constitution would, as a result of the amendment, not accord with schedule 7 of the 2006 Act.

~~42.4~~41.4 Where an amendment is made to the constitution in relation to the powers or duties of the ~~Board of Governors~~Council of Governors (or otherwise with

respect to the role that the ~~Board of Governors~~Council of Governors has as part of the T~~t~~rust):

~~42.4.1~~41.4.1 At least one member of the ~~Board of Governors~~Council of Governors must attend the next Annual Members' Meeting and present the amendment, and

~~42.4.2~~41.4.2 The T~~t~~rust must give the members an opportunity to vote on whether they approve the amendment.

~~42.5~~41.5 If more than half of the members present and voting approve the amendment, the amendment continues to have effect; otherwise, it ceases to have effect and the T~~t~~rust must take such steps as are necessary as a result.

~~42.6~~41.6 Amendments by the T~~t~~rust of its constitution are to be notified to Monitor. For the avoidance of doubt, Monitor's functions do not include a power or duty to determine whether or not the constitution, as a result of the amendments, accords with Schedule 7 of the 2006 Act.

~~43.~~42. MERGERS ETC. AND SIGNIFICANT TRANSACTIONS

~~43.1~~42.1 The ~~t~~Trust may only apply for a merger, acquisition, separation or dissolution with the approval of more than half of the members of the ~~Board of Governors~~Council of Governors.

~~43.2~~42.2 The Trust may enter into a significant transaction only if more than half of the members of the ~~Board of Governors~~Council of Governors of the Trust voting approve entering into the transaction.

~~43.3~~42.3 For the purpose of paragraph 43.2, "significant transaction" means a transaction which meets any one of the following criteria:

~~43.3.1~~42.3.1 Where the gross assets subject to the transaction are greater than or equal to 25% of the gross assets of the Trust.

~~43.3.2~~42.3.2 Where the income attributable to the assets or the contract associated with the transaction is greater than or equal to 25% of the income of the Trust.

~~43.3.3~~42.3.3 Where the gross capital of the company or business being acquired or divested, or the effects on the total capital of the Trust resulting from a transaction, is greater than or equal to 25% of the total capital of the Trust following completion of the transaction,

ANNEX 1 – THE PUBLIC CONSTITUENCY

Table 1

1	2	3	4
Name of the Public Constituency	**Area of the Public Constituency (as defined by Local Authority boundaries)**	**Minimum Number of Members**	**Number of Governors to be Elected**
Bassetlaw District	Bassetlaw District Council	300	5
Metropolitan Doncaster	Doncaster Metropolitan Borough Council	470	13
Rest of England & Wales	Any other electoral area in England and Wales with the exception of the above	50	2

ANNEX 2 – THE STAFF CONSTITUENCY

Table 1

Staff Class	**Minimum Number of Members**	**Number of Governors to be elected**
Medical and Dental Practitioners Staff Class	75	1
Nurses and Midwives Staff Class	450	2
Other Healthcare Professionals Staff Class	100	1
Non Clinical Staff Class	375	2
TOTAL	1000	6

1. **CLASSES OF THE STAFF CONSTITUENCY**

1.1 The Staff Constituency shall be divided into four classes as follows:

1.1.1 Medical and Dental Practitioners Staff Class;

1.1.2 Nurses and Midwives Staff Class;

1.1.3 Other Healthcare Professionals Staff Class; and

1.1.4 Non Clinical Staff Class.

1.2 Medical and Dental Practitioners Staff Class

1.2.1 The Members of the Medical and Dental Staff Class are individuals who are Members of Staff Constituency who:

(a) are fully registered persons within the meaning of the Medicines Act 1956 or the Dentists Act 1984 (as the case may be) and who are otherwise fully authorised and licensed to practise in England and Wales or who are otherwise designated by the Trust from time to time as eligible to be Members of this Staff Class for the purposes of this paragraph having regard to the usual definitions applicable at that time for persons carrying on the professions of medical practitioner or dentist; and

(b) who are employed by the Trust in that capacity at the date of their invitation or application under paragraph 7 of the Constitution to become a Member in accordance with the provisions of Annex 6 and at all times thereafter remain employed by the Trust in that capacity.

1.3 Nurses and Midwives Staff Class

1.3.1 The Members of the Nurses and Midwives Staff Class are individuals who:

(a) are registered under the Nurses, Midwifes and Health Visitors Act 1997 and who are otherwise fully authorised and licensed to practise in England and Wales or are otherwise designated by the Trust from time to time as eligible to be Members of the Staff Class for the purposes of this paragraph, having regard to the usual definitions applicable at that time for persons carrying on the profession of registered nurse or registered midwife and individuals who are health care assistants; and

(b) who are employed by the Trust in that capacity at the date of their invitation or application under paragraph 7 of the Constitution to become a Member in accordance with the provisions of Annex 6 and at all times thereafter remain employed by the Trust in that capacity.

1.4 Other Healthcare Professionals Staff Class

Members of the Other Healthcare Professionals Staff Class are clinical staff who do not fall within paragraphs 1.2 or 1.3 of this Annex 2, including clinical therapists, scientists and technical staff, who are employed by the Trust in that capacity at the date of their invitation or application under paragraph 7 of the Constitution to become a Member in accordance with the provisions of Annex 6 and at all times thereafter remain employed by the Trust in that capacity.

1.5 Non Clinical Staff Class

Members of the Non Clinical Staff Class are Members of the Staff Constituency who do not come within paragraphs 1.2, 1.3 or 1.4 of this Annex 2.

2. **MINIMUM NUMBERS AND NUMBERS OF GOVERNORS**

2.1 The minimum number of Members in each Staff Class shall be as set out in column 3 of Table 1 to this Annex and the number of Governors to be elected by each such Staff Class is given in the corresponding entry in Column 4 of that Table.

3. **CONTINUOUS EMPLOYMENT**

3.1 For the purposes of paragraph 7.1.2 of the Constitution, Chapter 1 of Part 14 of the Employment Rights Act 1996 shall apply for the purposes of determining whether an individual has been continuously employed by the Trust or has continuously exercised functions for the purposes of the Trust.

ANNEX 3 – COMPOSITION OF ~~BOARD OF GOVERNORS~~COUNCIL OF GOVERNORS

1. **INTRODUCTION**

1.1 The ~~Board of Governors~~Council of Governors shall comprise:

1.1.1 The Chair~~man~~ of the Trust

1.1.2 Governors who are:

(a) elected by the respective Constituencies in accordance with the provisions of this Constitution; or

(b) appointed in accordance with paragraph 2 below.

1.2 The ~~Board of Governors~~Council of Governors shall at all times be constituted so that more than half the ~~Board of Governors~~Council of Governors shall consist of Governors who are elected by Members of the Public Constituency.

2. **BODIES ENTITLED TO APPOINT A MEMBER OF THE ~~BOARD OF GOVERNORS~~COUNCIL OF GOVERNORS**

2.1 The following bodies in this paragraph 2 shall be entitled to appoint a Governor or Governors (as the case may be) to the ~~Board of Governors~~Council of Governors as provided for in this paragraph 2.

2.2 Clinical Commissioning Group Governors

2.2.1 Bassetlaw Clinical Commissioning Group and Doncaster Clinical Commissioning Group shall each be entitled to appoint a Governor in accordance with a process of appointment agreed by each of them with the Trust. The absence of any such agreed process shall not preclude the said Clinical Commissioning Group from appointing its Governors provided the appointment is duly made in accordance with the Clinical Commissioning Group 's own internal processes.

2.2.2 If a Clinical Commissioning Group named in paragraphs 2.2.1 above declines or fails to appoint its Governors within three months of being requested to do so by the Trust, the Trust shall in its absolute discretion be entitled to extend an invitation to any of those other Clinical Commissioning Groups to whom it provides goods and services to appoint Governors in substitution for the Clinical Commissioning Group which has failed or declined to do so. The Trust shall give notice of that invitation to Monitor.

2.2.3 If the invitation referred to in paragraph 2.2.2 above is accepted by a Clinical Commissioning Group, that Clinical Commissioning Group shall appoint a Governor and the Clinical Commissioning Group which has previously failed to appoint a Governor shall cease to be entitled to do so, subject to the provisions of paragraph 2.2.7 below.

2.2.4 Subject to paragraph 2.2.6 below, if the invitation is not accepted within a reasonable period or such period as may have been specified in the invitation the Trust shall extend an invitation to any other such Clinical

Commissioning Group until the invitation, is accepted and a Governor is appointed.

2.2.5 The Trust shall give notice forthwith to Monitor of all invitations the Trust may extend under the preceding paragraph and of any acceptances.

2.2.6 Any Governor appointed under paragraphs 2.2.3 and 2.2.4 above shall serve on the ~~Board of Governors~~Council of Governors for the period stipulated in Annex 5. At the end of that period the Trust shall in its absolute discretion decide whether to permit that Clinical Commissioning Group which had first failed or declined to appoint a Governor to do so for the next period of office or to invite that Clinical Commissioning Group which had appointed a Governor in substitution to do so.

2.3 Local Authority Governors

2.3.1 Doncaster Metropolitan Borough Council shall be entitled to appoint two Governors in accordance with a process of appointment agreed by it with the Trust.

2.3.2 Bassetlaw District Council and Nottinghamshire County Council shall each be entitled to appoint a Governor in accordance with a process of appointment agreed by each of them with the Trust.

2.3.3 The absence of any agreed process of appointment as referred to in paragraphs 2.3.1 and 2.3.2 above shall not preclude the said local authority from appointing its Governor(s).

2.3.4 If the local authority named in paragraphs 2.3.1 or 2.3.2 above declines or fails to appoint a Governor within three months of being requested to do so by the Trust, the Trust shall consult each local authority whose area includes the whole or part of the area of the Trust and the Trust in its absolute discretion may extend an invitation to any of those local authorities to appoint a Governor in substitution for the local authority which has failed or declined to do so.

2.3.5 A Governor appointed under this paragraph 2.3 shall then serve on the ~~Board of Governors~~Council of Governors for the period stipulated in Annex 5. At the end of that period the Trust shall in its absolute discretion decide whether to permit the local authority which had failed or declined to appoint a Governor to appoint a Governor for the next period of office (provided it remains eligible to do so) or to invite the local authority which had appointed a Governor in substitution to do so.

2.4 Partnership Governors

2.4.1 The organisations designated as Partnership Organisations by the Trust for the purposes of this Constitution are:

~~(a) Doncaster Council for Voluntary Service;~~

~~(b)~~(a) Bassetlaw Council for Voluntary Service;

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~~(c)~~(b) University of Sheffield; ~~and~~

(c) Sheffield Hallam University~~;~~

(d) Doncaster College;

(e) Doncaster Deaf Trust;

~~(d)~~

~~2.4.2 Each of the above organisations shall be entitled to appoint 1 Governor each, save for Doncaster Council for Voluntary Service and Bassetlaw Council for Voluntary Service which shall be entitled to appoint 1 Governor between them, in accordance with a process of appointment agreed by it with the Trust. The absence of any such agreed process of appointment shall not preclude that Partnership Organisation from appointing its Governor provided the appointment is duly made in accordance with its own internal processes.~~

3. **COMPOSITION OF THE ~~BOARD OF GOVERNORS~~COUNCIL OF GOVERNORS**

	Electing / Appointing Body	Number of Governors	Total
1.	**Public Constituencies**		**20**
	1.1 Bassetlaw District	5	
	1.2 Metropolitan Doncaster	13	
	1.3 Rest of England and Wales	2	
2.	**Staff Constituency**		**6**
	2.1 Medical and Dental Practitioners Staff Class	1	
	2.2 Nurses and Midwives Staff Class	2	
	2.3 Other Healthcare Professionals Staff Class	1	
	2.4 Non-Clinical Staff Class	2	
3.	**Appointed Governors**		**11~~9~~**
	3.1 Doncaster Clinical Commissioning Group	1	
	3.2 Bassetlaw Clinical Commissioning Group	1	
	3.3 Doncaster Metropolitan Borough Council	2	
	3.4 Bassetlaw District Council	1	
	3.5 Nottinghamshire County Council	1	
	3.6 University of Sheffield	1	
	3.7 Sheffield Hallam University	1	
	3.8 Bassetlaw Council for Voluntary Service ~~and Doncaster Council for Voluntary Service~~	1	
	3.9 Doncaster College	1	
	3.10 Doncaster Deaf Trust	1	
	Total Number of Governors		**3~~7~~5**

4. **FURTHER PROVISIONS**

4.1 Further provisions relating to the composition of the ~~Board of Governors~~Council of Governors are at Annex 6.

ANNEX 4 –THE MODEL ELECTION RULES

PART 1: INTERPRETATION

1. Interpretation

PART 2: TIMETABLE FOR ELECTION

2. Timetable
3. Computation of time

PART 3: RETURNING OFFICER

4. Returning officer
5. Staff
6. Expenditure
7. Duty of co-operation

PART 4: STAGES COMMON TO CONTESTED AND UNCONTESTED ELECTIONS

8. Notice of election
9. Nomination of candidates
10. Candidate's particulars
11. Declaration of interests
12. Declaration of eligibility
13. Signature of candidate
14. Decisions as to validity of nomination forms
15. Publication of statement of nominated candidates
16. Inspection of statement of nominated candidates and nomination forms
17. Withdrawal of candidates
18. Method of election

PART 5: CONTESTED ELECTIONS

19. Poll to be taken by ballot
20. The ballot paper
21. The declaration of identity (public constituency)

Action to be taken before the poll

22. List of eligible voters
23. Notice of poll
24. Issue of voting information by returning officer
25. Ballot paper envelope and covering envelope
26. E-voting systems

The poll

27. Eligibility to vote
28. Voting by persons who require assistance

PART 1: INTERPRETATION

1. Interpretation

1.1 In these rules, unless the context otherwise requires:

"*2006 Act*" means the National Health Service Act 2006;

"*corporation*" means the public benefit corporation subject to this constitution;

"~~*board of governors*~~*Council of Governors*" means the ~~board of governors~~Council of Governors of the corporation;

"*declaration of identity*" has the meaning set out in rule 21.1;

"*election*" means an election by a constituency, or by a class within a constituency, to fill a vacancy among one or more posts on the ~~board of governors~~Council of Governors;

"*e-voting*" means voting using either the internet, telephone or text message;

"*e-voting information*" has the meaning set out in rule 24.2;

"*ID declaration form*" has the meaning set out in Rule 21.1; "internet voting record" has the meaning set out in rule 26.4(d);

"*internet voting system*" means such computer hardware and software, data other equipment and services as may be provided by the returning officer for the purpose of enabling voters to cast their votes using the internet;

"*lead governor*" means the governor nominated by the corporation to fulfil the role described in Appendix B to The NHS Foundation Trust Code of Governance (Monitor, December 2013) or any later version of such code.

"*list of eligible voters*" means the list referred to in rule 22.1, containing the information in rule 22.2;

"*method of polling*" means a method of casting a vote in a poll, which may be by post, internet, text message or telephone;

"*Monitor*" means the corporate body known as Monitor as provided by section 61 of the 2012 Act;

"*numerical voting code*" has the meaning set out in rule 64.2(b)

"*polling website*" has the meaning set out in rule 26.1;

"*postal voting information*" has the meaning set out in rule 24.1;

"*telephone short code"* means a short telephone number used for the purposes of submitting a vote by text message;

"*telephone voting facility*" has the meaning set out in rule 26.2;

"*telephone voting record*" has the meaning set out in rule 26.5 (d);

"*text message voting facility*" has the meaning set out in rule 26.3;

"*text voting record*" has the meaning set out in rule 26.6 (d);

"*the telephone voting system*" means such telephone voting facility as may be provided by the returning officer for the purpose of enabling voters to cast their votes by telephone;

"*the text message voting system*" means such text messaging voting facility as may be provided by the returning officer for the purpose of enabling voters to cast their votes by text message;

"*voter ID number*" means a unique, randomly generated numeric identifier allocated to each voter by the Returning Officer for the purpose of e-voting,

"*voting information*" means postal voting information and/or e-voting information

1.2 Other expressions used in these rules and in Schedule 7 to the NHS Act 2006 have the same meaning in these rules as in that Schedule.

PART 2: TIMETABLE FOR ELECTION

2. Timetable

2.1 The proceedings at an election shall be conducted in accordance with the following timetable:

Proceeding	**Time**
Publication of notice of election	Not later than the fortieth day before the day of the close of the poll.
Final day for delivery of nomination forms to returning officer	Not later than the twenty eighth day before the day of the close of the poll.
Publication of statement of nominated candidates	Not later than the twenty seventh day before the day of the close of the poll.
Final day for delivery of notices of withdrawals by candidates from election	Not later than twenty fifth day before the day of the close of the poll.
Notice of the poll	Not later than the fifteenth day before the day of the close of the poll.
Close of the poll	By 5.00pm on the final day of the election.

3. Computation of time

3.1 In computing any period of time for the purposes of the timetable:

(a) a Saturday or Sunday;
(b) Christmas day, Good Friday, or a bank holiday, or
(c) a day appointed for public thanksgiving or mourning,

shall be disregarded, and any such day shall not be treated as a day for the purpose of any proceedings up to the completion of the poll, nor shall the returning officer be obliged to proceed with the counting of votes on such a day.

3.2 In this rule, "bank holiday" means a day which is a bank holiday under the Banking and Financial Dealings Act 1971 in England and Wales.

PART 3: RETURNING OFFICER

4. Returning Officer

4.1 Subject to rule 69, the returning officer for an election is to be appointed by the corporation.

4.2 Where two or more elections are to be held concurrently, the same returning officer may be appointed for all those elections.

5. Staff

5.1 Subject to rule 69, the returning officer may appoint and pay such staff, including such technical advisers, as he or she considers necessary for the purposes of the election.

6. Expenditure

6.1 The corporation is to pay the returning officer:

(a) any expenses incurred by that officer in the exercise of his or her functions under these rules,
(b) such remuneration and other expenses as the corporation may determine.

7. Duty of co-operation

7.1 The corporation is to co-operate with the returning officer in the exercise of his or her functions under these rules.

PART 4: STAGES COMMON TO CONTESTED AND UNCONTESTED ELECTIONS

8. Notice of election

8.1 The returning officer is to publish a notice of the election stating:

(a) the constituency, or class within a constituency, for which the election is being held,

(b) the number of members of the ~~board of governors~~Council of Governors to be elected from that constituency, or class within that constituency,

(c) the details of any nomination committee that has been established by the corporation,

(d) the address and times at which nomination forms may be obtained;

(e) the address for return of nomination forms (including, where the return of nomination forms in an electronic format will be permitted, the e-mail address for such return) and the date and time by which they must be received by the returning officer,

(f) the date and time by which any notice of withdrawal must be received by the returning officer

(g) the contact details of the returning officer

(h) the date and time of the close of the poll in the event of a contest.

9. Nomination of candidates

9.1 Subject to rule 9.2, each candidate must nominate themselves on a single nomination form.

9.2 The returning officer:

(a) is to supply any member of the corporation with a nomination form, and
(b) is to prepare a nomination form for signature at the request of any member of the corporation,

but it is not necessary for a nomination to be on a form supplied by the returning officer and a nomination can, subject to rule 13, be in an electronic format.

10. Candidate's particulars

10.1 The nomination form must state the candidate's:

(a) full name,
(b) contact address in full (which should be a postal address although an e-mail address may also be provided for the purposes of electronic communication), and
(c) constituency, or class within a constituency, of which the candidate is a member.

11. Declaration of interests

11.1 The nomination form must state:

(a) any financial interest that the candidate has in the corporation, and
(b) whether the candidate is a member of a political party, and if so, which party, and if the candidate has no such interests, the paper must include a statement to that effect.

12. Declaration of eligibility

12.1 The nomination form must include a declaration made by the candidate:

(a) that he or she is not prevented from being a member of the ~~board of governors~~Council of Governors by paragraph 8 of Schedule 7 of the 2006 Act or by any provision of the constitution; and,
(b) for a member of the public constituency, of the particulars of his or her qualification to vote as a member of that constituency, or class within that constituency, for which the election is being held.

13. Signature of candidate

13.1 The nomination form must be signed and dated by the candidate, in a manner

prescribed by the returning officer, indicating that:

(a) they wish to stand as a candidate,
(b) their declaration of interests as required under rule 11, is true and correct, and
(c) their declaration of eligibility, as required under rule 12, is true and correct.

13.2 Where the return of nomination forms in an electronic format is permitted, the returning officer shall specify the particular signature formalities (if any) that will need to be complied with by the candidate.

14. Decisions as to the validity of nomination

14.1 Where a nomination form is received by the returning officer in accordance with these rules, the candidate is deemed to stand for election unless and until the returning officer:

(a) decides that the candidate is not eligible to stand,
(b) decides that the nomination form is invalid,
(c) receives satisfactory proof that the candidate has died, or
(d) receives a written request by the candidate of their withdrawal from candidacy.

14.2 The returning officer is entitled to decide that a nomination form is invalid only on one of the following grounds:

(a) that the paper is not received on or before the final time and date for return of nomination forms, as specified in the notice of the election,
(b) that the paper does not contain the candidate's particulars, as required by rule 10;
(c) that the paper does not contain a declaration of the interests of the candidate, as required by rule 11,
(d) that the paper does not include a declaration of eligibility as required by rule 12, or
(e) that the paper is not signed and dated by the candidate, if required by rule 13.

14.3 The returning officer is to examine each nomination form as soon as is practicable after he or she has received it, and decide whether the candidate has been validly nominated.

14.4 Where the returning officer decides that a nomination is invalid, the returning officer must endorse this on the nomination form, stating the reasons for their decision.

14.5 The returning officer is to send notice of the decision as to whether a nomination is valid or invalid to the candidate at the contact address given in the candidate's nomination form. If an e-mail address has been given in the candidate's nomination form (in addition to the candidate's postal address), the returning officer may send notice of the decision to that address.

15. Publication of statement of candidates

15.1 The returning officer is to prepare and publish a statement showing the candidates

who are standing for election.

15.2 The statement must show:

(a) the name, contact address (which shall be the candidate's postal address), and constituency or class within a constituency of each candidate standing, and
(b) the declared interests of each candidate standing,

as given in their nomination form.

15.3 The statement must list the candidates standing for election in alphabetical order by surname.

15.4 The returning officer must send a copy of the statement of candidates and copies of the nomination forms to the corporation as soon as is practicable after publishing the statement.

16. Inspection of statement of nominated candidates and nomination forms

16.1 The corporation is to make the statement of the candidates and the nomination forms supplied by the returning officer under rule 15.4 available for inspection by members of the corporation free of charge at all reasonable times.

16.2 If a member of the corporation requests a copy or extract of the statement of candidates or their nomination forms, the corporation is to provide that member with the copy or extract free of charge.

17. Withdrawal of candidates

17.1 A candidate may withdraw from election on or before the date and time for withdrawal by candidates, by providing to the returning officer a written notice of withdrawal which is signed by the candidate and attested by a witness.

18. Method of election

18.1 If the number of candidates remaining validly nominated for an election after any withdrawals under these rules is greater than the number of members to be elected to the ~~board of governors~~Council of Governors, a poll is to be taken in accordance with Parts 5 and 6 of these rules.

18.2 If the number of candidates remaining validly nominated for an election after any withdrawals under these rules is equal to the number of members to be elected to the ~~board of governors~~Council of Governors, those candidates are to be declared elected in accordance with Part 7 of these rules.

18.3 If the number of candidates remaining validly nominated for an election after any withdrawals under these rules is less than the number of members to be elected to be ~~board of governors~~Council of Governors, then:

(a) the candidates who remain validly nominated are to be declared elected in accordance with Part 7 of these rules, and

(b) the returning officer is to order a new election to fill any vacancy which remains unfilled, on a day appointed by him or her in consultation with the corporation.

PART 5: CONTESTED ELECTIONS

19. Poll to be taken by ballot

19.1 The votes at the poll must be given by secret ballot.

19.2 The votes are to be counted and the result of the poll determined in accordance with Part 6 of these rules.

19.3 The corporation may decide that voters within a constituency or class within a constituency, may, subject to rule 19.4, cast their votes at the poll using such different methods of polling in any combination as the corporation may determine.

19.4 The corporation may decide that voters within a constituency or class within a constituency for whom an e-mail address is included in the list of eligible voters may only cast their votes at the poll using an e-voting method of polling.

19.5 Before the corporation decides, in accordance with rule 19.3 that one or more e-voting methods of polling will be made available for the purposes of the poll, the corporation must satisfy itself that:

(a) if internet voting is to be a method of polling, the internet voting system to be used for the purpose of the election is:

(i) configured in accordance with these rules; and
(ii) will create an accurate internet voting record in respect of any voter who casts his or her vote using the internet voting system;

(b) if telephone voting to be a method of polling, the telephone voting system to be used for the purpose of the election is:

(i) configured in accordance with these rules; and
(ii) will create an accurate telephone voting record in respect of any voter who casts his or her vote using the telephone voting system;

(c) if text message voting is to be a method of polling, the text message voting system to be used for the purpose of the election is:

(i) configured in accordance with these rules; and
(ii) will create an accurate text voting record in respect of any voter who casts his or her vote using the text message voting system.

20. The ballot paper

20.1 The ballot of each voter (other than a voter who casts his or her ballot by an e-voting method of polling) is to consist of a ballot paper with the persons remaining validly nominated for an election after any withdrawals under these rules, and no others,

inserted in the paper.

20.2 Every ballot paper must specify:

(a) the name of the corporation,
(b) the constituency, or class within a constituency, for which the election is being held,
(c) the number of members of the ~~board of governors~~Council of Governors to be elected from that constituency, or class within that constituency,
(d) the names and other particulars of the candidates standing for election, with the details and order being the same as in the statement of nominated candidates,
(e) instructions on how to vote by all available methods of polling, including the relevant voter's voter ID number if one or more e-voting methods of polling are available,
(f) if the ballot paper is to be returned by post, the address for its return and the date and time of the close of the poll, and
(g) the contact details of the returning officer.

20.3 Each ballot paper must have a unique identifier.

20.4 Each ballot paper must have features incorporated into it to prevent it from being reproduced.

21. The declaration of identity (public constituency)

21.1 The corporation shall require each voter who participates in an election for a public constituency to make a declaration confirming:

(a) that the voter is the person:
(i) to whom the ballot paper was addressed, and/or

(ii) to whom the voter ID number contained within the e-voting information was allocated,

(b) that he or she has not marked or returned any other voting information in the election, and

(c) the particulars of his or her qualification to vote as a member of the constituency or class within the constituency for which the election is being held,

("declaration of identity")

and the corporation shall make such arrangements as it considers appropriate to facilitate the making and the return of a declaration of identity by each voter, whether by the completion of a paper form ("ID declaration form") or the use of an electronic method.

21.2 The voter must be required to return his or her declaration of identity with his or her ballot.

21.3 The voting information shall caution the voter that if the declaration of identity is not duly returned or is returned without having been made correctly, any vote cast by the voter may be declared invalid.

Action to be taken before the poll

22. List of eligible voters

22.1 The corporation is to provide the returning officer with a list of the members of the constituency or class within a constituency for which the election is being held who are eligible to vote by virtue of rule 27 as soon as is reasonably practicable after the final date for the delivery of notices of withdrawals by candidates from an election.

22.2 The list is to include, for each member:

(a) a postal address; and,

(b) the member's e-mail address, if this has been provided

to which his or her voting information may, subject to rule 22.3, be sent.

22.3 The corporation may decide that the e-voting information is to be sent only by e-mail to those members in the list of eligible voters for whom an e-mail address is included in that list.

23. Notice of poll

23.1 The returning officer is to publish a notice of the poll stating:

(a) the name of the corporation,
(b) the constituency, or class within a constituency, for which the election is being held,
(c) the number of members of the ~~board of governors~~Council of Governors to be elected from that constituency, or class with that constituency,
(d) the names, contact addresses, and other particulars of the candidates standing for election, with the details and order being the same as in the statement of nominated candidates,
(e) that the ballot papers for the election are to be issued and returned, if appropriate, by post,
(f) the methods of polling by which votes may be cast at the election by voters in a constituency or class within a constituency, as determined by the corporation in accordance with rule 19.3,
(g) the address for return of the ballot papers,
(h) the uniform resource locator (url) where, if internet voting is a method of polling, the polling website is located;
(i) the telephone number where, if telephone voting is a method of polling, the telephone voting facility is located,
(j) the telephone number or telephone short code where, if text message voting is a method of polling, the text message voting facility is located,
(k) the date and time of the close of the poll,

(l) the address and final dates for applications for replacement voting information, and
(m) the contact details of the returning officer.

24. Issue of voting information by returning officer

24.1 Subject to rule 24.3, as soon as is reasonably practicable on or after the publication of the notice of the poll, the returning officer is to send the following information by post to each member of the corporation named in the list of eligible voters:

(a) a ballot paper and ballot paper envelope,
(b) the ID declaration form (if required),
(c) information about each candidate standing for election, pursuant to rule 61 of these rules, and
(d) a covering envelope;

("postal voting information").

24.2 Subject to rules 24.3 and 24.4, as soon as is reasonably practicable on or after the publication of the notice of the poll, the returning officer is to send the following information by e-mail and/ or by post to each member of the corporation named in the list of eligible voters whom the corporation determines in accordance with rule 19.3 and/ or rule 19.4 may cast his or her vote by an e-voting method of polling:

(a) instructions on how to vote and how to make a declaration of identity (if required),
(b) the voter's voter ID number,
(c) information about each candidate standing for election, pursuant to rule 64 of these rules, or details of where this information is readily available on the internet or available in such other formats as the Returning Officer thinks appropriate, (d) contact details of the returning officer,

("e-voting information").

24.3 The corporation may determine that any member of the corporation shall:

(a) only be sent postal voting information; or
(b) only be sent e-voting information; or
(c) be sent both postal voting information and e-voting information;

for the purposes of the poll.

24.4 If the corporation determines, in accordance with rule 22.3, that the e-voting information is to be sent only by e-mail to those members in the list of eligible voters for whom an e-mail address is included in that list, then the returning officer shall only send that information by e-mail.

24.5 The voting information is to be sent to the postal address and/ or e-mail address for each member, as specified in the list of eligible voters.

25. Ballot paper envelope and covering envelope

25.1 The ballot paper envelope must have clear instructions to the voter printed on it, instructing the voter to seal the ballot paper inside the envelope once the ballot paper has been marked.

25.2 The covering envelope is to have:

(a) the address for return of the ballot paper printed on it, and
(b) pre-paid postage for return to that address.

25.3 There should be clear instructions, either printed on the covering envelope or elsewhere, instructing the voter to seal the following documents inside the covering envelope and return it to the returning officer –
(a) the completed ID declaration form if required, and
(b) the ballot paper envelope, with the ballot paper sealed inside it.

26. E-voting systems

26.1 If internet voting is a method of polling for the relevant election then the returning officer must provide a website for the purpose of voting over the internet (in these rules referred to as "the polling website").

26.2 If telephone voting is a method of polling for the relevant election then the returning officer must provide an automated telephone system for the purpose of voting by the use of a touch-tone telephone (in these rules referred to as "the telephone voting facility").

26.3 If text message voting is a method of polling for the relevant election then the returning officer must provide an automated text messaging system for the purpose of voting by text message (in these rules referred to as "the text message voting facility").

26.4 The returning officer shall ensure that the polling website and internet voting system provided will:

(a) require a voter to:
  (i) enter his or her voter ID number; and
  (ii) where the election is for a public constituency, make a declaration of identity;
  in order to be able to cast his or her vote;

(b) specify:
  (i) the name of the corporation,
  (ii) the constituency, or class within a constituency, for which the election is being held,
  (iii) the number of members of the ~~board of governors~~Council of Governors to be elected from that constituency, or class within that constituency,
  (iv) the names and other particulars of the candidates standing for election, with the details and order being the same as in the statement of nominated candidates,

(v) instructions on how to vote and how to make a declaration of identity,
(vi) the date and time of the close of the poll, and
(vii) the contact details of the returning officer;

(c) prevent a voter from voting for more candidates than he or she is entitled to at the election;

(d) create a record ("internet voting record") that is stored in the internet voting system in respect of each vote cast by a voter using the internet that comprises of-
(i) the voter's voter ID number;
(ii) the voter's declaration of identity (where required);
(iii) the candidate or candidates for whom the voter has voted; and
(iv) the date and time of the voter's vote,

(e) if the voter's vote has been duly cast and recorded, provide the voter with confirmation of this; and

(f) prevent any voter from voting after the close of poll.

26.5 The returning officer shall ensure that the telephone voting facility and telephone voting system provided will:

(a) require a voter to
(i) enter his or her voter ID number in order to be able to cast his or her vote; and
(ii) where the election is for a public constituency, make a declaration of identity;

(b) specify:
(i) the name of the corporation,
(ii) the constituency, or class within a constituency, for which the election is being held,
(iii) the number of members of the ~~board of governors~~Council of Governors to be elected from that constituency, or class within that constituency,
(iv) instructions on how to vote and how to make a declaration of identity,
(v) the date and time of the close of the poll, and
(vi) the contact details of the returning officer;

(c) prevent a voter from voting for more candidates than he or she is entitled to at the election;

(d) create a record ("telephone voting record") that is stored in the telephone voting system in respect of each vote cast by a voter using the telephone that comprises of:
(i) the voter's voter ID number;
(ii) the voter's declaration of identity (where required);
(iii) the candidate or candidates for whom the voter has voted; and
(iv) the date and time of the voter's vote

(e) if the voter's vote has been duly cast and recorded, provide the voter with confirmation of this;

(f) prevent any voter from voting after the close of poll.

26.6 The returning officer shall ensure that the text message voting facility and text messaging voting system provided will:

(a) require a voter to:
(i) provide his or her voter ID number; and
(ii) where the election is for a public constituency, make a declaration of identity;

in order to be able to cast his or her vote;

(b) prevent a voter from voting for more candidates than he or she is entitled to at the election;

(c) create a record ("text voting record") that is stored in the text messaging voting system in respect of each vote cast by a voter by text message that comprises of:
(i) the voter's voter ID number;
(ii) the voter's declaration of identity (where required);
(ii) the candidate or candidates for whom the voter has voted; and
(iii) the date and time of the voter's vote

(d) if the voter's vote has been duly cast and recorded, provide the voter with confirmation of this;

(e) prevent any voter from voting after the close of poll.

The poll

27. Eligibility to vote

27.1 An individual who becomes a member of the corporation on or before the closing date for the receipt of nominations by candidates for the election, is eligible to vote in that election.

28. Voting by persons who require assistance

28.1 The returning officer is to put in place arrangements to enable requests for assistance to vote to be made.

28.2 Where the returning officer receives a request from a voter who requires assistance to vote, the returning officer is to make such arrangements as he or she considers necessary to enable that voter to vote.

29. Spoilt ballot papers and spoilt text message votes

29.1 If a voter has dealt with his or her ballot paper in such a manner that it cannot be

accepted as a ballot paper (referred to as a "spoilt ballot paper"), that voter may apply to the returning officer for a replacement ballot paper.

29.2 On receiving an application, the returning officer is to obtain the details of the unique identifier on the spoilt ballot paper, if he or she can obtain it.

29.3 The returning officer may not issue a replacement ballot paper for a spoilt ballot paper unless he or she:

(a) is satisfied as to the voter's identity; and

(b) has ensured that the completed ID declaration form, if required, has not been returned.

29.4 After issuing a replacement ballot paper for a spoilt ballot paper, the returning officer shall enter in a list ("the list of spoilt ballot papers"):

(a) the name of the voter, and

(b) the details of the unique identifier of the spoilt ballot paper (if that officer was able to obtain it), and

(c) the details of the unique identifier of the replacement ballot paper.

29.5 If a voter has dealt with his or her text message vote in such a manner that it cannot be accepted as a vote (referred to as a "spoilt text message vote"), that voter may apply to the returning officer for a replacement voter ID number.

29.6 On receiving an application, the returning officer is to obtain the details of the voter ID number on the spoilt text message vote, if he or she can obtain it.

29.7 The returning officer may not issue a replacement voter ID number in respect of a spoilt text message vote unless he or she is satisfied as to the voter's identity.

29.8 After issuing a replacement voter ID number in respect of a spoilt text message vote, the returning officer shall enter in a list ("the list of spoilt text message votes"):

(a) the name of the voter, and

(b) the details of the voter ID number on the spoilt text message vote (if that officer was able to obtain it), and

(d) the details of the replacement voter ID number issued to the voter.

30. Lost voting information

30.1 Where a voter has not received his or her voting information by the tenth day before the close of the poll, that voter may apply to the returning officer for replacement voting information.

30.2 The returning officer may not issue replacement voting information in respect of lost

voting information unless he or she:

(a) is satisfied as to the voter's identity,
(b) has no reason to doubt that the voter did not receive the original voting information,
(c) has ensured that no declaration of identity, if required, has been returned.

30.3 After issuing replacement voting information in respect of lost voting information, the returning officer shall enter in a list ("the list of lost ballot documents"):

(a) the name of the voter
(b) the details of the unique identifier of the replacement ballot paper, if applicable, and
(c) the voter ID number of the voter.

31. Issue of replacement voting information

31.1 If a person applies for replacement voting information under rule 29 or 30 and a declaration of identity has already been received by the returning officer in the name of that voter, the returning officer may not issue replacement voting information unless, in addition to the requirements imposed by rule 29.3 or 30.2, he or she is also satisfied that that person has not already voted in the election, notwithstanding the fact that a declaration of identity if required has already been received by the returning officer in the name of that voter.

31.2 After issuing replacement voting information under this rule, the returning officer shall enter in a list ("the list of tendered voting information"):

(a) the name of the voter,
(b) the unique identifier of any replacement ballot paper issued under this rule;
(c) the voter ID number of the voter.

32. ID declaration form for replacement ballot papers (public constituency)

32.1 In respect of an election for a public constituency an ID declaration form must be issued with each replacement ballot paper requiring the voter to make a declaration of identity.

Polling by internet, telephone or text

33. Procedure for remote voting by internet

33.1 To cast his or her vote using the internet, a voter will need to gain access to the polling website by keying in the url of the polling website provided in the voting information.

33.2 When prompted to do so, the voter will need to enter his or her voter ID number.

33.3 If the internet voting system authenticates the voter ID number, the system will give the voter access to the polling website for the election in which the voter is eligible to vote.

33.4 To cast his or her vote, the voter will need to key in a mark on the screen opposite the particulars of the candidate or candidates for whom he or she wishes to cast his or her vote.

33.5 The voter will not be able to access the internet voting system for an election once his or her vote at that election has been cast.

34. Voting procedure for remote voting by telephone

34.1 To cast his or her vote by telephone, the voter will need to gain access to the telephone voting facility by calling the designated telephone number provided in the voter information using a telephone with a touch-tone keypad.

34.2 When prompted to do so, the voter will need to enter his or her voter ID number using the keypad.

34.3 If the telephone voting facility authenticates the voter ID number, the voter will be prompted to vote in the election.

34.4 When prompted to do so the voter may then cast his or her vote by keying in the numerical voting code of the candidate or candidates, for whom he or she wishes to vote.

34.5 The voter will not be able to access the telephone voting facility for an election once his or her vote at that election has been cast.

35. Voting procedure for remote voting by text message

35.1 To cast his or her vote by text message the voter will need to gain access to the text message voting facility by sending a text message to the designated telephone number or telephone short code provided in the voter information.

35.2 The text message sent by the voter must contain his or her voter ID number and the numerical voting code for the candidate or candidates, for whom he or she wishes to vote.

35.3 The text message sent by the voter will need to be structured in accordance with the instructions on how to vote contained in the voter information, otherwise the vote will not be cast.

Procedure for receipt of envelopes, internet votes, telephone votes and text message votes

36. Receipt of voting documents

36.1 Where the returning officer receives:

(a) a covering envelope, or
(b) any other envelope containing an ID declaration form if required, a ballot paper envelope, or a ballot paper,

before the close of the poll, that officer is to open it as soon as is practicable; and rules 37 and 38 are to apply.

36.2 The returning officer may open any covering envelope or any ballot paper envelope for the purposes of rules 37 and 38, but must make arrangements to ensure that no person obtains or communicates information as to:

(a) the candidate for whom a voter has voted, or
(b) the unique identifier on a ballot paper.

36.3 The returning officer must make arrangements to ensure the safety and security of the ballot papers and other documents.

37. Validity of votes

37.1 A ballot paper shall not be taken to be duly returned unless the returning officer is satisfied that it has been received by the returning officer before the close of the poll, with an ID declaration form if required that has been correctly completed, signed and dated.

37.2 Where the returning officer is satisfied that rule 37.1 has been fulfiled, he or she is to:

(a) put the ID declaration form if required in a separate packet, and
(b) put the ballot paper aside for counting after the close of the poll.

37.3 Where the returning officer is not satisfied that rule 37.1 has been fulfiled, he or she is to:

(a) mark the ballot paper "disqualified",
(b) if there is an ID declaration form accompanying the ballot paper, mark it "disqualified" and attach it to the ballot paper,
(c) record the unique identifier on the ballot paper in a list of disqualified documents (the "list of disqualified documents"); and
(d) place the document or documents in a separate packet.

37.4 An internet, telephone or text message vote shall not be taken to be duly returned unless the returning officer is satisfied that the internet voting record, telephone voting record or text voting record (as applicable) has been received by the returning officer before the close of the poll, with a declaration of identity if required that has been correctly made.

37.5 Where the returning officer is satisfied that rule 37.4 has been fulfiled, he or she is to put the internet voting record, telephone voting record or text voting record (as applicable) aside for counting after the close of the poll.

37.6 Where the returning officer is not satisfied that rule 37.4 has been fulfiled, he or she is to:

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(a) mark the internet voting record, telephone voting record or text voting record (as applicable) "disqualified",

(b) record the voter ID number on the internet voting record, telephone voting record or text voting record (as applicable) in the list of disqualified documents; and
(c) place the document or documents in a separate packet.

38. Declaration of identity but no ballot paper (public constituency)[1]

38.1 Where the returning officer receives an ID declaration form if required but no ballot paper, the returning officer is to:

(a) mark the ID declaration form "disqualified",
(b) record the name of the voter in the list of disqualified documents, indicating that a declaration of identity was received from the voter without a ballot paper, and
(c) place the ID declaration form in a separate packet.

39. De-duplication of votes

39.1 Where different methods of polling are being used in an election, the returning officer shall examine all votes cast to ascertain if a voter ID number has been used more than once to cast a vote in the election.

39.2 If the returning officer ascertains that a voter ID number has been used more than once to cast a vote in the election he or she shall:

(a) only accept as duly returned the first vote received that was cast using the relevant voter ID number; and
(b) mark as "disqualified" all other votes that were cast using the relevant voter ID number

39.3 Where a ballot paper is disqualified under this rule the returning officer shall:

(a) mark the ballot paper "disqualified",
(b) if there is an ID declaration form accompanying the ballot paper, mark it "disqualified" and attach it to the ballot paper,
(c) record the unique identifier and the voter ID number on the ballot paper in the list of disqualified documents;
(d) place the document or documents in a separate packet; and
(e) disregard the ballot paper when counting the votes in accordance with these rules.

39.4 Where an internet voting record, telephone voting record or text voting record is disqualified under this rule the returning officer shall:

(a) mark the internet voting record, telephone voting record or text voting record (as applicable) "disqualified",
(b) record the voter ID number on the internet voting record, telephone voting record or text voting record (as applicable) in the list of disqualified documents;
(c) place the internet voting record, telephone voting record or text voting record

[1] It should not be possible, technically, to make a declaration of identity electronically without also submitting a vote.

(as applicable) in a separate packet, and

(d) disregard the internet voting record, telephone voting record or text voting record (as applicable) when counting the votes in accordance with these rules.

40. Sealing of packets

40.1 As soon as is possible after the close of the poll and after the completion of the procedure under rules 37 and 38, the returning officer is to seal the packets containing:

(a) the disqualified documents, together with the list of disqualified documents inside it,
(b) the ID declaration forms, if required,
(c) the list of spoilt ballot papers and the list of spoilt text message votes,
(d) the list of lost ballot documents,
(e) the list of eligible voters, and
(f) the list of tendered voting information

and ensure that complete electronic copies of the internet voting records, telephone voting records and text voting records created in accordance with rule 26 are held in a device suitable for the purpose of storage.

PART 6: COUNTING THE VOTES

STV41. Interpretation of Part 6

STV41.1 In Part 6 of these rules:

"*ballot document*" means a ballot paper, internet voting record, telephone voting record or text voting record.

"*continuing candidate*" means any candidate not deemed to be elected, and not excluded,

"*count*" means all the operations involved in counting of the first preferences recorded for candidates, the transfer of the surpluses of elected candidates, and the transfer of the votes of the excluded candidates,

"*deemed to be elected*" means deemed to be elected for the purposes of counting of votes but without prejudice to the declaration of the result of the poll,

"*mark*" means a figure, an identifiable written word, or a mark such as "X",

"*non-transferable vote*" means a ballot document:

(a) on which no second or subsequent preference is recorded for a continuing candidate, or

(b) which is excluded by the returning officer under rule STV49,

"*preference*" as used in the following contexts has the meaning assigned below:

(a) "first preference" means the figure "1" or any mark or word which clearly indicates a first (or only) preference,

(b) "next available preference" means a preference which is the second, or as the case may be, subsequent preference recorded in consecutive order for a continuing candidate (any candidate who is deemed to be elected or is excluded thereby being ignored); and

(c) in this context, a "second preference" is shown by the figure "2" or any mark or word which clearly indicates a second preference, and a third preference by the figure "3" or any mark or word which clearly indicates a third preference, and so on,

"*quota*" means the number calculated in accordance with rule STV46,

"*surplus*" means the number of votes by which the total number of votes for any candidate (whether first preference or transferred votes, or a combination of both) exceeds the quota; but references in these rules to the transfer of the surplus means the transfer (at a transfer value) of all transferable ballot documents from the candidate who has the surplus,

"*stage of the count*" means:

(a) the determination of the first preference vote of each candidate,
(b) the transfer of a surplus of a candidate deemed to be elected, or
(c) the exclusion of one or more candidates at any given time,

"*transferable vote*" means a ballot document on which, following a first preference, a second or subsequent preference is recorded in consecutive numerical order for a continuing candidate,

"*transferred vote*" means a vote derived from a ballot document on which a second or subsequent preference is recorded for the candidate to whom that ballot document has been transferred, and

"*transfer value*" means the value of a transferred vote calculated in accordance with rules STV47.4 or STV47.7.

42. Arrangements for counting of the votes

42.1 The returning officer is to make arrangements for counting the votes as soon as is practicable after the close of the poll.

42.2 The returning officer may make arrangements for any votes to be counted using vote counting software where:

(a) the board of directors and the ~~board of governors~~Council of Governors of the corporation have approved:
  (i) the use of such software for the purpose of counting votes in the relevant election, and

(ii) a policy governing the use of such software, and

(b) the corporation and the returning officer are satisfied that the use of such software will produce an accurate result.

43. The count

43.1 The returning officer is to:

(a) count and record the number of:
(iii) ballot papers that have been returned; and
(iv) the number of internet voting records, telephone voting records and/or text voting records that have been created, and

(b) count the votes according to the provisions in this Part of the rules and/or the provisions of any policy approved pursuant to rule 42.2(ii) where vote counting software is being used.

43.2 The returning officer, while counting and recording the number of ballot papers, internet voting records, telephone voting records and/or text voting records and counting the votes, must make arrangements to ensure that no person obtains or communicates information as to the unique identifier on a ballot paper or the voter ID number on an internet voting record, telephone voting record or text voting record.

43.3 The returning officer is to proceed continuously with counting the votes as far as is practicable.

STV44. Rejected ballot papers and rejected text voting records

STV44.1 Any ballot paper:

(a) which does not bear the features that have been incorporated into the other ballot papers to prevent them from being reproduced,
(b) on which the figure "1" standing alone is not placed so as to indicate a first preference for any candidate,
(c) on which anything is written or marked by which the voter can be identified except the unique identifier, or
(d) which is unmarked or rejected because of uncertainty,

shall be rejected and not counted, but the ballot paper shall not be rejected by reason only of carrying the words "one", "two", "three" and so on, or any other mark instead of a figure if, in the opinion of the returning officer, the word or mark clearly indicates a preference or preferences.

STV44.2 The returning officer is to endorse the word "rejected" on any ballot paper which under this rule is not to be counted.

STV44.3 Any text voting record:

(a) on which the figure "1" standing alone is not placed so as to indicate a first

preference for any candidate,

(b) on which anything is written or marked by which the voter can be identified except the unique identifier, or

(c) which is unmarked or rejected because of uncertainty,

shall be rejected and not counted, but the text voting record shall not be rejected by reason only of carrying the words "one", "two", "three" and so on, or any other mark instead of a figure if, in the opinion of the returning officer, the word or mark clearly indicates a preference or preferences.

STV44.4 The returning officer is to endorse the word "rejected" on any text voting record which under this rule is not to be counted.

STV44.5 The returning officer is to draw up a statement showing the number of ballot papers rejected by him or her under each of the subparagraphs (a) to (d) of rule STV44.1 and the number of text voting records rejected by him or her under each of the sub-paragraphs (a) to (c) of rule STV44.3.

~~**FPP44. Rejected ballot papers and rejected text voting records**~~

~~FPP44.1 Any ballot paper:~~

~~(a) which does not bear the features that have been incorporated into the other ballot papers to prevent them from being reproduced,~~

~~(b) on which votes are given for more candidates than the voter is entitled to vote,~~

~~(c) on which anything is written or marked by which the voter can be identified except the unique identifier, or~~

~~(d) which is unmarked or rejected because of uncertainty,~~

~~shall, subject to rules FPP44.2 and FPP44.3, be rejected and not counted.~~

~~FPP44.2 Where the voter is entitled to vote for more than one candidate, a ballot paper is not to be rejected because of uncertainty in respect of any vote where no uncertainty arises, and that vote is to be counted.~~

~~FPP44.3 A ballot paper on which a vote is marked:~~

~~(a) elsewhere than in the proper place,~~

~~(b) otherwise than by means of a clear mark,~~

~~(c) by more than one mark,~~

~~is not to be rejected for such reason (either wholly or in respect of that vote) if an intention that the vote shall be for one or other of the candidates clearly appears, and the way the paper is marked does not itself identify the voter and it is not shown that he or she can be identified by it.~~

~~FPP44.4 The returning officer is to:~~

~~(a) endorse the word "rejected" on any ballot paper which under this rule is not to be counted, and~~

~~(b) in the case of a ballot paper on which any vote is counted under rules FPP44.2~~

and FPP 44.3, endorse the words "rejected in part" on the ballot paper and indicate which vote or votes have been counted.

FPP44.5 The returning officer is to draw up a statement showing the number of rejected ballot papers under the following headings:

(a) does not bear proper features that have been incorporated into the ballot paper,
(b) voting for more candidates than the voter is entitled to,
(c) writing or mark by which voter could be identified, and
(d) unmarked or rejected because of uncertainty,

and, where applicable, each heading must record the number of ballot papers rejected in part.

FPP44.6 Any text voting record:

(a) on which votes are given for more candidates than the voter is entitled to vote,
(b) on which anything is written or marked by which the voter can be identified except the voter ID number, or
(c) which is unmarked or rejected because of uncertainty,

shall, subject to rules FPP44.7 and FPP44.8, be rejected and not counted.

FPP44.7 Where the voter is entitled to vote for more than one candidate, a text voting record is not to be rejected because of uncertainty in respect of any vote where no uncertainty arises, and that vote is to be counted.

FPP44.8 A text voting record on which a vote is marked:

(a) otherwise than by means of a clear mark,
(b) by more than one mark,

is not to be rejected for such reason (either wholly or in respect of that vote) if an intention that the vote shall be for one or other of the candidates clearly appears, and the way the text voting record is marked does not itself identify the voter and it is not shown that he or she can be identified by it.

FPP44.9 The returning officer is to:

(a) endorse the word "rejected" on any text voting record which under this rule is not to be counted, and
(b) in the case of a text voting record on which any vote is counted under rules FPP44.7 and FPP 44.8, endorse the words "rejected in part" on the text voting record and indicate which vote or votes have been counted.

FPP44.10 The returning officer is to draw up a statement showing the number of rejected text voting records under the following headings:

(a) voting for more candidates than the voter is entitled to,
(b) writing or mark by which voter could be identified, and

~~(c) unmarked or rejected because of uncertainty,~~

~~and, where applicable, each heading must record the number of text voting records rejected in part.~~

STV45. First stage

STV45.1 The returning officer is to sort the ballot documents into parcels according to the candidates for whom the first preference votes are given.

STV45.2 The returning officer is to then count the number of first preference votes given on ballot documents for each candidate, and is to record those numbers.

STV45.3 The returning officer is to also ascertain and record the number of valid ballot documents.

STV46. The quota

STV46.1 The returning officer is to divide the number of valid ballot documents by a number exceeding by one the number of members to be elected.

STV46.2 The result, increased by one, of the division under rule STV46.1 (any fraction being disregarded) shall be the number of votes sufficient to secure the election of a candidate (in these rules referred to as "the quota").

STV46.3 At any stage of the count a candidate whose total votes equals or exceeds the quota shall be deemed to be elected, except that any election where there is only one vacancy a candidate shall not be deemed to be elected until the procedure set out in rules STV47.1 to STV47.3 has been complied with.

STV47. Transfer of votes

STV47.1 Where the number of first preference votes for any candidate exceeds the quota, the returning officer is to sort all the ballot documents on which first preference votes are given for that candidate into sub- parcels so that they are grouped:

(a) according to next available preference given on those ballot documents for any continuing candidate, or
(b) where no such preference is given, as the sub-parcel of non-transferable votes.

STV47.2 The returning officer is to count the number of ballot documents in each parcel referred to in rule STV47.1.

STV47.3 The returning officer is, in accordance with this rule and rule STV48, to transfer each sub-parcel of ballot documents referred to in rule STV47.1(a) to the candidate for whom the next available preference is given on those ballot documents.

STV47.4 The vote on each ballot document transferred under rule STV47.3 shall be at a value ("the transfer value") which:

(a) reduces the value of each vote transferred so that the total value of all such

votes does not exceed the surplus, and

(b) is calculated by dividing the surplus of the candidate from whom the votes are being transferred by the total number of the ballot documents on which those votes are given, the calculation being made to two decimal places (ignoring the remainder if any).

STV47.5 Where at the end of any stage of the count involving the transfer of ballot documents, the number of votes for any candidate exceeds the quota, the returning officer is to sort the ballot documents in the sub-parcel of transferred votes which was last received by that candidate into separate sub-parcels so that they are grouped:

(a) according to the next available preference given on those ballot documents for any continuing candidate, or

(b) where no such preference is given, as the sub-parcel of non-transferable votes.

STV47.6 The returning officer is, in accordance with this rule and rule STV48, to transfer each sub-parcel of ballot documents referred to in rule STV47.5(a) to the candidate for whom the next available preference is given on those ballot documents.

STV47.7 The vote on each ballot document transferred under rule STV47.6 shall be at:

(a) a transfer value calculated as set out in rule STV47.4(b), or

(b) at the value at which that vote was received by the candidate from whom it is now being transferred,

whichever is the less.

STV47.8 Each transfer of a surplus constitutes a stage in the count.

STV47.9 Subject to rule STV47.10, the returning officer shall proceed to transfer transferable ballot documents until no candidate who is deemed to be elected has a surplus or all the vacancies have been filled.

STV47.10 Transferable ballot documents shall not be liable to be transferred where any surplus or surpluses which, at a particular stage of the count, have not already been transferred, are:

(a) less than the difference between the total vote then credited to the continuing candidate with the lowest recorded vote and the vote of the candidate with the next lowest recorded vote, or

(b) less than the difference between the total votes of the two or more continuing candidates, credited at that stage of the count with the lowest recorded total numbers of votes and the candidate next above such candidates.

STV47.11 This rule does not apply at an election where there is only one vacancy.

STV48. Supplementary provisions on transfer

STV48.1 If, at any stage of the count, two or more candidates have surpluses, the transferable ballot documents of the candidate with the highest surplus shall be transferred first,

and if:

(a) The surpluses determined in respect of two or more candidates are equal, the transferable ballot documents of the candidate who had the highest recorded vote at the earliest preceding stage at which they had unequal votes shall be transferred first, and
(b) the votes credited to two or more candidates were equal at all stages of the count, the returning officer shall decide between those candidates by lot, and the transferable ballot documents of the candidate on whom the lot falls shall be transferred first.

STV48.2 The returning officer shall, on each transfer of transferable ballot documents under rule STV47:

(a) record the total value of the votes transferred to each candidate,
(b) add that value to the previous total of votes recorded for each candidate and record the new total,
(c) record as non-transferable votes the difference between the surplus and the total transfer value of the transferred votes and add that difference to the previously recorded total of non-transferable votes, and
(d) compare:
    (i) the total number of votes then recorded for all of the candidates, together with the total number of non-transferable votes, with
    (ii) the recorded total of valid first preference votes.

STV48.3 All ballot documents transferred under rule STV47 or STV49 shall be clearly marked, either individually or as a sub-parcel, so as to indicate the transfer value recorded at that time to each vote on that ballot document or, as the case may be, all the ballot documents in that sub-parcel.

STV48.4 Where a ballot document is so marked that it is unclear to the returning officer at any stage of the count under rule STV47 or STV49 for which candidate the next preference is recorded, the returning officer shall treat any vote on that ballot document as a non-transferable vote; and votes on a ballot document shall be so treated where, for example, the names of two or more candidates (whether continuing candidates or not) are so marked that, in the opinion of the returning officer, the same order of preference is indicated or the numerical sequence is broken.

STV49. Exclusion of candidates

STV49.1 If:

(a) all transferable ballot documents which under the provisions of rule STV47 (including that rule as applied by rule STV49.11) and this rule are required to be transferred, have been transferred, and
(b) subject to rule STV50, one or more vacancies remain to be filled,

the returning officer shall exclude from the election at that stage the candidate with the then lowest vote (or, where rule STV49.12 applies, the candidates with the then lowest votes).

STV9.2 The returning officer shall sort all the ballot documents on which first preference votes are given for the candidate or candidates excluded under rule STV49.1 into two sub-parcels so that they are grouped as:

(a) ballot documents on which a next available preference is given, and
(b) ballot documents on which no such preference is given (thereby including ballot documents on which preferences are given only for candidates who are deemed to be elected or are excluded).

STV49.3 The returning officer shall, in accordance with this rule and rule STV48, transfer each sub-parcel of ballot documents referred to in rule STV49.2 to the candidate for whom the next available preference is given on those ballot documents.

STV49.4 The exclusion of a candidate, or of two or more candidates together, constitutes a further stage of the count.

STV49.5 If, subject to rule STV50, one or more vacancies still remain to be filled, the returning officer shall then sort the transferable ballot documents, if any, which had been transferred to any candidate excluded under rule STV49.1 into sub- parcels according to their transfer value.

STV49.6 The returning officer shall transfer those ballot documents in the sub-parcel of transferable ballot documents with the highest transfer value to the continuing candidates in accordance with the next available preferences given on those ballot documents (thereby passing over candidates who are deemed to be elected or are excluded).

STV49.7 The vote on each transferable ballot document transferred under rule STV49.6 shall be at the value at which that vote was received by the candidate excluded under rule STV49.1.

STV9.8 Any ballot documents on which no next available preferences have been expressed shall be set aside as non-transferable votes.

STV49.9 After the returning officer has completed the transfer of the ballot documents in the sub-parcel of ballot documents with the highest transfer value he or she shall proceed to transfer in the same way the sub-parcel of ballot documents with the next highest value and so on until he has dealt with each sub-parcel of a candidate excluded under rule STV49.1.

STV49.10 The returning officer shall after each stage of the count completed under this rule:

(a) record:
    (i) the total value of votes, or
    (ii) the total transfer value of votes transferred to each candidate,
(b) add that total to the previous total of votes recorded for each candidate and record the new total,
(c) record the value of non-transferable votes and add that value to the previous non-transferable votes total, and
(d) compare:

(i) the total number of votes then recorded for each candidate together with the total number of non-transferable votes, with
(ii) the recorded total of valid first preference votes.

STV49.11 If after a transfer of votes under any provision of this rule, a candidate has a surplus, that surplus shall be dealt with in accordance with rules STV47.5 to STV47.10 and rule STV48.

STV49.12 Where the total of the votes of the two or more lowest candidates, together with any surpluses not transferred, is less than the number of votes credited to the next lowest candidate, the returning officer shall in one operation exclude such two or more candidates.

STV49.13 If when a candidate has to be excluded under this rule, two or more candidates each have the same number of votes and are lowest:

(a) regard shall be had to the total number of votes credited to those candidates at the earliest stage of the count at which they had an unequal number of votes and the candidate with the lowest number of votes at that stage shall be excluded, and
(b) where the number of votes credited to those candidates was equal at all stages, the returning officer shall decide between the candidates by lot and the candidate on whom the lot falls shall be excluded.

STV50. Filling of last vacancies

STV50.1 Where the number of continuing candidates is equal to the number of vacancies remaining unfilled the continuing candidates shall thereupon be deemed to be elected.

STV50.2 Where only one vacancy remains unfilled and the votes of any one continuing candidate are equal to or greater than the total of votes credited to other continuing candidates together with any surplus not transferred, the candidate shall thereupon be deemed to be elected.

STV50.3 Where the last vacancies can be filled under this rule, no further transfer of votes shall be made.

STV51. Order of election of candidates

STV51.1 The order in which candidates whose votes equal or exceed the quota are deemed to be elected shall be the order in which their respective surpluses were transferred, or would have been transferred but for rule STV47.10.

STV51.2 A candidate credited with a number of votes equal to, and not greater than, the quota shall, for the purposes of this rule, be regarded as having had the smallest surplus at the stage of the count at which he obtained the quota.

STV51.3 Where the surpluses of two or more candidates are equal and are not required to be transferred, regard shall be had to the total number of votes credited to such candidates at the earliest stage of the count at which they had an unequal number of

votes and the surplus of the candidate who had the greatest number of votes at that stage shall be deemed to be the largest.

STV51.4 Where the number of votes credited to two or more candidates were equal at all stages of the count, the returning officer shall decide between them by lot and the candidate on whom the lot falls shall be deemed to have been elected first.

~~**FPP51. Equality of votes**~~

~~FPP51.1 Where, after the counting of votes is completed, an equality of votes is found to exist between any candidates and the addition of a vote would entitle any of those candidates to be declared elected, the returning officer is to decide between those candidates by a lot, and proceed as if the candidate on whom the lot falls had received an additional vote.~~

PART 7: FINAL PROCEEDINGS IN CONTESTED AND UNCONTESTED ELECTIONS

~~**FPP52. Declaration of result for contested elections**~~

~~FPP52.1 In a contested election, when the result of the poll has been ascertained, the returning officer is to:~~

~~(a) declare the candidate or candidates whom more votes have been given than for the other candidates, up to the number of vacancies to be filled on the board of governors~~Council of Governors ~~from the constituency, or class within a constituency, for which the election is being held to be elected,~~
~~(b) give notice of the name of each candidate who he or she has declared elected:~~
~~(i) where the election is held under a proposed constitution pursuant to powers conferred on the [insert name] NHS Trust by section 33(4) of the 2006 Act, to the chairman of the NHS Trust, or~~
~~(ii) in any other case, to the chairman of the corporation; and~~
~~(c) give public notice of the name of each candidate whom he or she has declared elected.~~

~~FPP52.2 The returning officer is to make:~~

~~(a) the total number of votes given for each candidate (whether elected or not), and~~
~~(b) the number of rejected ballot papers under each of the headings in rule FPP44.5,~~
~~(c) the number of rejected text voting records under each of the headings in rule FPP44.10,~~

~~available on request.~~

STV52. Declaration of result for contested elections

STV52.1 In a contested election, when the result of the poll has been ascertained, the returning officer is to:

(a) declare the candidates who are deemed to be elected under Part 6 of these

rules as elected,

(b) give notice of the name of each candidate who he or she has declared elected:
  (i) where the election is held under a proposed constitution pursuant to powers conferred on the [insert name] NHS Trust by section 33(4) of the 2006 Act, to the chair~~man~~ of the NHS Trust, or
  (ii) in any other case, to the chair~~man~~ of the corporation, and

(c) give public notice of the name of each candidate who he or she has declared elected.

STV52.2 The returning officer is to make:

(a) the number of first preference votes for each candidate whether elected or not,
(b) any transfer of votes,
(c) the total number of votes for each candidate at each stage of the count at which such transfer took place,
(d) the order in which the successful candidates were elected, and
(e) the number of rejected ballot papers under each of the headings in rule STV44.1,
(f) the number of rejected text voting records under each of the headings in rule STV44.3,

available on request.

53. Declaration of result for uncontested elections

53.1 In an uncontested election, the returning officer is to as soon as is practicable after final day for the delivery of notices of withdrawals by candidates from the election:

(a) declare the candidate or candidates remaining validly nominated to be elected,

(b) give notice of the name of each candidate who he or she has declared elected to the chair~~man~~ of the corporation, and

(c) give public notice of the name of each candidate who he or she has declared elected.

PART 8: DISPOSAL OF DOCUMENTS

54. Sealing up of documents relating to the poll

54.1 On completion of the counting at a contested election, the returning officer is to seal up the following documents in separate packets:

(a) the counted ballot papers, internet voting records, telephone voting records and text voting records,
(b) the ballot papers and text voting records endorsed with "rejected in part",
(c) the rejected ballot papers and text voting records, and
(d) the statement of rejected ballot papers and the statement of rejected text voting records,

and ensure that complete electronic copies of the internet voting records, telephone

voting records and text voting records created in accordance with rule 26 are held in a device suitable for the purpose of storage.

54.2 The returning officer must not open the sealed packets of:

(a) the disqualified documents, with the list of disqualified documents inside it,
(b) the list of spoilt ballot papers and the list of spoilt text message votes,
(c) the list of lost ballot documents, and
(d) the list of eligible voters,

or access the complete electronic copies of the internet voting records, telephone voting records and text voting records created in accordance with rule 26 and held in a device suitable for the purpose of storage.

54.3 The returning officer must endorse on each packet a description of:

(a) its contents,
(b) the date of the publication of notice of the election,
(c) the name of the corporation to which the election relates, and
(d) the constituency, or class within a constituency, to which the election relates.

55. Delivery of documents

55.1 Once the documents relating to the poll have been sealed up and endorsed pursuant to rule 56, the returning officer is to forward them to the chair of the corporation.

56. Forwarding of documents received after close of the poll

56.1 Where:

(a) any voting documents are received by the returning officer after the close of the poll, or
(b) any envelopes addressed to eligible voters are returned as undelivered too late to be resent, or
(c) any applications for replacement voting information are made too late to enable new voting information to be issued,

the returning officer is to put them in a separate packet, seal it up, and endorse and forward it to the chair~~man~~ of the corporation.

57. Retention and public inspection of documents

57.1 The corporation is to retain the documents relating to an election that are forwarded to the chair by the returning officer under these rules for one year, and then, unless otherwise directed by the board of directors of the corporation, cause them to be destroyed.

57.2 With the exception of the documents listed in rule 58.1, the documents relating to an election that are held by the corporation shall be available for inspection by members of the public at all reasonable times.

57.3 A person may request a copy or extract from the documents relating to an election that are held by the corporation, and the corporation is to provide it, and may impose a reasonable charge for doing so.

58. Application for inspection of certain documents relating to an election

58.1 The corporation may not allow:

(a) the inspection of, or the opening of any sealed packet containing –
  (i) any rejected ballot papers, including ballot papers rejected in part,
  (ii) any rejected text voting records, including text voting records rejected in part,
  (iii) any disqualified documents, or the list of disqualified documents,
  (iv) any counted ballot papers, internet voting records, telephone voting records or text voting records, or
  (v) the list of eligible voters, or
(b) access to or the inspection of the complete electronic copies of the internet voting records, telephone voting records and text voting records created in accordance with rule 26 and held in a device suitable for the purpose of storage,

by any person without the consent of the board of directors of the corporation.

58.2 A person may apply to the board of directors of the corporation to inspect any of the documents listed in rule 58.1, and the board of directors of the corporation may only consent to such inspection if it is satisfied that it is necessary for the purpose of questioning an election pursuant to Part 11.

58.3 The board of directors of the corporation's consent may be on any terms or conditions that it thinks necessary, including conditions as to –

(a) persons,
(b) time,
(c) place and mode of inspection,
(d) production or opening,

and the corporation must only make the documents available for inspection in accordance with those terms and conditions.

58.4 On an application to inspect any of the documents listed in rule 58.1 the board of directors of the corporation must:

(a) in giving its consent, and
(b) in making the documents available for inspection

ensure that the way in which the vote of any particular member has been given shall not be disclosed, until it has been established –

  (i) that his or her vote was given, and
  (ii) that Monitor has declared that the vote was invalid.

PART 9: DEATH OF A CANDIDATE DURING A CONTESTED ELECTION

FPP59. Countermand or abandonment of poll on death of candidate

FPP59.1 If at a contested election, proof is given to the returning officer's satisfaction before the result of the election is declared that one of the persons named or to be named as a candidate has died, then the returning officer is to:

(a) countermand notice of the poll, or, if voting information has been issued, direct that the poll be abandoned within that constituency or class, and
(b) order a new election, on a date to be appointed by him or her in consultation with the corporation, within the period of 40 days, computed in accordance with rule 3 of these rules, beginning with the day that the poll was countermanded or abandoned.

FPP59.2 Where a new election is ordered under rule FPP59.1, no fresh nomination is necessary for any candidate who was validly nominated for the election where the poll was countermanded or abandoned but further candidates shall be invited for that constituency or class.

FPP59.3 Where a poll is abandoned under rule FPP59.1(a), rules FPP59.4 to FPP59.7 are to apply.

FPP59.4 The returning officer shall not take any step or further step to open envelopes or deal with their contents in accordance with rules 38 and 39, and is to make up separate sealed packets in accordance with rule 40.

FPP59.5 The returning officer is to:

(a) count and record the number of ballot papers, internet voting records, telephone voting records and text voting records that have been received,
(b) seal up the ballot papers, internet voting records, telephone voting records and text voting records into packets, along with the records of the number of ballot papers, internet voting records, telephone voting records and text voting records and

ensure that complete electronic copies of the internet voting records telephone voting records and text voting records created in accordance with rule 26 are held in a device suitable for the purpose of storage.

FPP59.6 The returning officer is to endorse on each packet a description of:

(a) its contents,
(b) the date of the publication of notice of the election,
(c) the name of the corporation to which the election relates, and
(d) the constituency, or class within a constituency, to which the election relates.

FPP59.7 Once the documents relating to the poll have been sealed up and endorsed pursuant to rules FPP59.4 to FPP59.6, the returning officer is to deliver them to the chairman of the corporation, and rules 57 and 58 are to apply.

STV59. Countermand or abandonment of poll on death of candidate

STV59.1 If, at a contested election, proof is given to the returning officer's satisfaction before the result of the election is declared that one of the persons named or to be named as a candidate has died, then the returning officer is to:

(a) publish a notice stating that the candidate has died, and
(b) proceed with the counting of the votes as if that candidate had been excluded from the count so that –
    (i) ballot documents which only have a first preference recorded for the candidate that has died, and no preferences for any other candidates, are not to be counted, and
    (ii) ballot documents which have preferences recorded for other candidates are to be counted according to the consecutive order of those preferences, passing over preferences marked for the candidate who has died.

STV59.2 The ballot documents which have preferences recorded for the candidate who has died are to be sealed with the other counted ballot documents pursuant to rule 54.1(a).

PART 10: ELECTION EXPENSES AND PUBLICITY

Election expenses

60. Election expenses

60.1 Any expenses incurred, or payments made, for the purposes of an election which contravene this Part are an electoral irregularity, which may only be questioned in an application made to Monitor under Part 11 of these rules.

61. Expenses and payments by candidates

61.1 A candidate may not incur any expenses or make a payment (of whatever nature) for the purposes of an election, other than expenses or payments that relate to:

(a) personal expenses,
(b) travelling expenses, and expenses incurred while living away from home, and
(c) expenses for stationery, postage, telephone, internet(or any similar means of communication) and other petty expenses, to a limit of £100.

62. Election expenses incurred by other persons

62.1 No person may:

(a) incur any expenses or make a payment (of whatever nature) for the purposes of a candidate's election, whether on that candidate's behalf or otherwise, or
(b) give a candidate or his or her family any money or property (whether as a gift, donation, loan, or otherwise) to meet or contribute to expenses incurred by or on behalf of the candidate for the purposes of an election.

62.2 Nothing in this rule is to prevent the corporation from incurring such expenses, and

making such payments, as it considers necessary pursuant to rules 63 and 64.

Publicity

63. Publicity about election by the corporation

63.1 The corporation may:

(a) compile and distribute such information about the candidates, and
(b) organise and hold such meetings to enable the candidates to speak and respond to questions,

as it considers necessary.

63.2 Any information provided by the corporation about the candidates, including information compiled by the corporation under rule 64, must be:

(a) objective, balanced and fair,
(b) equivalent in size and content for all candidates,
(c) compiled and distributed in consultation with all of the candidates standing for election, and
(d) must not seek to promote or procure the election of a specific candidate or candidates, at the expense of the electoral prospects of one or more other candidates.

63.3 Where the corporation proposes to hold a meeting to enable the candidates to speak, the corporation must ensure that all of the candidates are invited to attend, and in organising and holding such a meeting, the corporation must not seek to promote or procure the election of a specific candidate or candidates at the expense of the electoral prospects of one or more other candidates.

64. Information about candidates for inclusion with voting information

64.1 The corporation must compile information about the candidates standing for election, to be distributed by the returning officer pursuant to rule 24 of these rules.

64.2 The information must consist of:

(a) a statement submitted by the candidate of no more than 250 words,
(b) if voting by telephone or text message is a method of polling for the election, the numerical voting code allocated by the returning officer to each candidate, for the purpose of recording votes using the telephone voting facility or the text message voting facility ("numerical voting code"), and
~~(c) a photograph of the candidate.~~

65. Meaning of "for the purposes of an election"

65.1 In this Part, the phrase "for the purposes of an election" means with a view to, or otherwise in connection with, promoting or procuring a candidate's election, including the prejudicing of another candidate's electoral prospects; and the phrase "for the purposes of a candidate's election" is to be construed accordingly.

65.2 The provision by any individual of his or her own services voluntarily, on his or her own time, and free of charge is not to be considered an expense for the purposes of this Part.

PART 11: QUESTIONING ELECTIONS AND THE CONSEQUENCE OF IRREGULARITIES

66. Application to question an election

66.1 An application alleging a breach of these rules, including an electoral irregularity under Part 10, may be made to Monitor for the purpose of seeking a referral to the independent election arbitration panel (IEAP).

66.2 An application may only be made once the outcome of the election has been declared by the returning officer.

66.3 An application may only be made to Monitor by:

(a) a person who voted at the election or who claimed to have had the right to vote, or
(b) a candidate, or a person claiming to have had a right to be elected at the election.

66.4 The application must:

(a) describe the alleged breach of the rules or electoral irregularity, and
(b) be in such a form as the independent panel may require.

66.5 The application must be presented in writing within 21 days of the declaration of the result of the election. Monitor will refer the application to the independent election arbitration panel appointed by Monitor.

66.6 If the independent election arbitration panel requests further information from the applicant, then that person must provide it as soon as is reasonably practicable.

66.7 Monitor shall delegate the determination of an application to a person or panel of persons to be nominated for the purpose.

66.8 The determination by the IEAP shall be binding on and shall be given effect by the corporation, the applicant and the members of the constituency (or class within a constituency) including all the candidates for the election to which the application relates.

66.9 The IEAP may prescribe rules of procedure for the determination of an application including costs.

PART 12: MISCELLANEOUS

67. Secrecy

67.1 The following persons:

(a) the returning officer,
(b) the returning officer's staff,

must maintain and aid in maintaining the secrecy of the voting and the counting of the votes, and must not, except for some purpose authorised by law, communicate to any person any information as to:

(i) the name of any member of the corporation who has or has not been given voting information or who has or has not voted,
(ii) the unique identifier on any ballot paper,
(iii) the voter ID number allocated to any voter,
(iv) the candidate(s) for whom any member has voted.

67.2 No person may obtain or attempt to obtain information as to the candidate(s) for whom a voter is about to vote or has voted, or communicate such information to any person at any time, including the unique identifier on a ballot paper given to a voter or the voter ID number allocated to a voter.

67.3 The returning officer is to make such arrangements as he or she thinks fit to ensure that the individuals who are affected by this provision are aware of the duties it imposes.

68. Prohibition of disclosure of vote

68.1 No person who has voted at an election shall, in any legal or other proceedings to question the election, be required to state for whom he or she has voted.

69. Disqualification

69.1 A person may not be appointed as a returning officer, or as staff of the returning officer pursuant to these rules, if that person is:

(a) a member of the corporation,
(b) an employee of the corporation,
(c) a director of the corporation, or
(d) employed by or on behalf of a person who has been nominated for election.

70. Delay in postal service through industrial action or unforeseen event

70.1 If industrial action, or some other unforeseen event, results in a delay in:

(a) the delivery of the documents in rule 24, or
(b) the return of the ballot papers,

the returning officer may extend the time between the publication of the notice of the poll and the close of the poll by such period as he or she considers appropriate.

ANNEX 5 – ADDITIONAL PROVISIONS – ~~BOARD OF GOVERNORS~~COUNCIL OF GOVERNORS

1. ~~Board of Governors~~Council of Governors: Terms of Office

1.1 A Governor:

1.1.1 shall be elected or appointed for a term of 3 years;

1.1.2 shall be eligible for re-election or re-appointment at the end of that term but no Governor may hold office for more than nine years. ;

1.1.3 shall cease to hold office if:

(a) he ceases to be a Member of a Trust constituency or, in the case of an Appointed Governor, if the body which appointed him withdraws its appointment at any time;

(b) his term of office is terminated in accordance with paragraph 3 below and/or he is disqualified from or is otherwise ineligible to hold office as a Governor; or

1.1.4 he resigns by notice in writing to the Trust.

1.2 Notwithstanding the provisions of paragraph 1.1.3(a) above, a Public Governor elected by a Public Constituency who ceases to be eligible to be a Member of that Public Constituency but who is eligible to be and forthwith becomes a Member of another Public Constituency shall not by virtue of paragraph 1.1.3(a) above cease to hold office but shall continue in office as Public Governor for the Constituency which elected him for the remainder of the term for which he was elected.

2. ~~Board of Governors~~Council of Governors: Removal and Disqualification

2.1 A Governor shall not be eligible to become or continue in office as a Governor if:

2.1.1 he ceases to be eligible to be a Member, save in the case of Appointed Governors;

2.1.2 in the case of an Appointed Governor, the appointing organisation withdraws its appointment of him;

2.1.3 any of the grounds contained in paragraph 14 of the Constitution apply to him;

2.1.4 he has within the preceding two years been lawfully dismissed otherwise than by reason of redundancy from any paid employment with a Health Service Body;

2.1.5 he is a person whose term of office as the chair or as a member or director of a Health Service Body has been terminated on the grounds that his continuance in office is no longer in the best interests of the health service, for non-attendance at meetings or for non-disclosure of a pecuniary interest;

2.1.6 he has had his name removed by a direction under Section 154 of the 2006 Act from any list prepared under Part 4 of that Act and has not subsequently had his name included in such a list;

2.1.7 he has failed to make, or has falsely made, any declaration as required to be made under Section 60 of the 2006 Act or has spoken or voted in a meeting on a matter in which they have direct or indirect pecuniary or non-pecuniary interest and he is judged to have acted so by a majority of not less than 75% of the ~~Board of Governors~~Council of Governors;

2.1.8 Monitor has exercised its powers to remove him as a Governor of the Trust or has suspended him from office or has disqualified him from holding office as a Governor of the Trust for a specified period or Monitor has exercised any of those powers in relation to him on any other occasion whether in relation to the Trust or some other NHS Foundation Trust;

2.1.9 he has received a written warning from the Trust for verbal and/or physical abuse towards Trust staff;

2.1.10 he has at any time been placed on the registers of Schedule 1 Offenders pursuant to the Sexual Offences Act 2003 (as amended) and/or the Children and Young Person's Act 1933 to 1969 (as amended);

2.1.11 he has within the preceding five years been convicted in the British Islands of any offence, and a sentence of imprisonment (whether suspended or not) for a period of three months or more (without the option of a fine) was imposed on him;

2.1.12 his term of office is terminated pursuant to paragraph 3 below;

2.1.13 he is a Member of a Staff Class and any professional registration relevant to his eligibility to be a Member of that Staff Class has been suspended for a continuous period of more than 6 months;

2.1.14 he is incapable by reason of mental disorder, illness or injury in managing and administering his property and/or affairs;

2.1.15 the relevant organisation which he represents ceases to exist;

2.1.16 he is a member of the UK Parliament;

2.1.17 he is a Director of the Trust or a director or a governor of another NHS Foundation Trust;

2.1.18 he is a member of a local authority overview and scrutiny committee; or

2.1.19 he has, within the preceding 2 years, been a chair~~man~~ or non-executive director of another Health Service Body.

2.2 Where a person has been elected or appointed to be a Governor and he becomes disqualified from that appointment he shall notify the Secretary in writing of such disqualification as soon as practicable and in any event within 14 days of first becoming aware of those matters which rendered him disqualified.

2.3 If it comes to the notice of the Trust that a Governor is disqualified, the Trust shall immediately declare him disqualified and shall give him notice in writing to that effect as soon as practicable.

2.4 Upon the giving of notice under paragraphs 2.2 and 2.3 above, that person's tenure of office as a Governor shall thereupon be terminated and he shall cease to be a Governor and his name shall be removed from the Register of Governors.

3. ~~Board of Governors~~Council of Governors: Termination of Tenure

3.1 A Governor's term of office shall be terminated:

3.1.1 by the Governor giving notice in writing to the Secretary of his resignation from office at any time during that term of office;

3.1.2 by the Trust if any grounds exist under paragraph 2 above;

3.1.3 by the ~~Board of Governors~~Council of Governors if he has failed to attend two consecutive meetings of the ~~Board of Governors~~Council of Governors unless within one month of the second meeting, the ~~Board of Governors~~Council of Governors is satisfied that:

(a) the absence was due to reasonable cause; and

(b) the Governor will resume attendance at meetings of the ~~Board of Governors~~Council of Governors within such period as it considers reasonable.

3.1.4 if the ~~Board of Governors~~Council of Governors resolves to terminate his term of office for reasonable cause on the grounds that in the reasonable opinion of not less than 75% of the Governors present and voting at a meeting of the ~~Board of Governors~~Council of Governors convened for that purpose that his continuing as a Governor would or would be likely to:

(a) prejudice the ability of the Trust to fulfil its principal purpose or of its purposes under this Constitution or otherwise to discharge its duties and functions; or

(b) prejudice the Trust's work with other persons or body with whom it is engaged or may be engaged in the provision of goods and services; or

(c) adversely affect public confidence in the goods and services provided by the Trust; or

(d) otherwise bring the Trust into disrepute or is detrimental to the interest of the Trust; or

(e) it would not be in the best interests of the Trust for that person to continue in office as a Governor; or

(f) the Governor is a vexatious or persistent litigant or complainant with regard to the Trust's affairs and his continuance in office would not be in the best interests of the Trust; or

(g) he has failed or refused to undertake and/or satisfactorily complete any training which the ~~Board of Governors~~Council of Governors has required him to undertake in his capacity as a Governor by a date six months from the date of his election or appointment; or

(h) he has in his conduct as a Governor failed to comply in a material way with the values and principles of the National Health Service or the Trust, and the Constitution; or

(i) he has committed a material breach of any code of conduct applicable to Governors of the Trust and/or the Governors standing orders.

3.2 Upon a Governor resigning under paragraph 3.1.1 above or upon the ~~Board of Governors~~Council of Governors resolving to terminate a Governor's tenure of office in accordance with the above provisions, that Governor shall cease to be a Governor and his name shall be forthwith removed from the Register of Governors.

3.3 The Standing Orders adopted by the ~~Board of Governors~~Council of Governors may contain provisions governing its procedure for termination under these provisions and for a Governor to appeal against the decision terminating his tenure of office.

3.4 A Governor who resigns or whose tenure of office is terminated under this paragraph 3 shall not be eligible to stand for re-election for a period of 3 years from the date of his resignation or removal from office or the date upon which any appeal against his removal from office is disposed of whichever is the later except by resolution carried by a majority of the ~~Board of Governors~~Council of Governors present and voting at a general meeting.

3.5 Where a Governor's membership of the ~~Board of Governors~~Council of Governors ceases for one of the reasons set out in paragraph 2 or paragraph 3, Elected Governors shall be replaced in accordance with paragraphs 4.1 to 4.4 below and, in the case of Appointed Governors, the Trust shall invite the relevant appointing body to appoint a new Governor to hold office for the remainder of the term of office in accordance with the processes referred to in Annex 3 within 30 days of the vacancy having arisen.

4. Vacancies – Elected Governors

4.1 In the case of an Elected Governor, where a vacancy arises within 6 months of the election then the candidate who secured the next highest number of votes for that Constituency will be appointed.

4.2 If the vacancy arises during the last 6 months of office, the office will remain vacant until it is filled at the next scheduled election.

4.3 If a vacancy arises at any other time it will be filled by holding an election, in accordance with the Election Scheme.

4.4 No defect in the election or appointment of a Governor nor any deficiency in the composition of the ~~Board of Governors~~Council of Governors shall affect the validity of any act or decision of the ~~Board of Governors~~Council of Governors.

5. ~~Board of Governors~~Council of Governors: Role

5.1 The ~~Board of Governors~~Council of Governors and each Governor shall act in the best interests of the Trust at all times and with proper regard to the provisions of the NHS Foundation Trust Code of Governance and any code of conduct for the ~~Board of Governors~~Council of Governors.

5.2 Subject to the requirement specified in paragraph 5.1 above, each Governor shall exercise his own skill and judgement in his conduct of the Trust's affairs and shall in his stewardship of the Trust's affairs bring as appropriate the perspective of the constituency or organisation by which he was elected or appointed, as the case may be.

5.3 Subject to the further provisions of this Constitution and without in any way derogating from them, the ~~Board of Governors~~Council of Governors shall;

5.3.1 assist the Board of Directors in setting the strategic direction of the Trust and targets for the Trust's performance and in monitoring the Trust's performance in terms of achieving those strategic aims and targets which have been set; and

5.3.2 monitor the activities of the Trust with the view to ensuring that they are being conducted in a manner consistent with this Constitution.

6. ~~Board of Governors~~Council of Governors: Meetings

6.1 The ~~Board of Governors~~Council of Governors shall hold not less than 4 general meetings each financial year.

6.2 All such meetings shall be open to the public unless the ~~Board of Governors~~Council of Governors resolves that the public be excluded from the meeting, whether for the whole or part of the proceedings, on the grounds that publicity would be prejudicial to the public interest or the interest of the Trust by reason of the confidential nature of the business to be transacted or for other special reasons stated in the resolution and arising from the nature of that business or the proceedings.

6.3 The ~~Board of Governors~~Council of Governors may appoint committees or sub-committees consisting of its members to advise and assist it in the discharge of its functions.

6.4 The ~~Board of Governors~~Council of Governors' Standing Orders, as may be varied from time to time, is to provide for further details of the practice and procedure at ~~Board of Governors~~Council of Governors meetings (including general meetings).

7. ~~Board of Governors~~Council of Governors: Declarations

7.1 A Member of a Public Constituency standing for election as Governor must make a declaration for the purposes of Section 60 of the 2006 Act in the form specified below stating the particulars of his qualification to vote as a Member and that he is not prevented from being a member of the ~~Board of Governors~~Council of Governors by virtue of any provisions of this Constitution.

7.2 The specified form of declaration shall be set out on the Nomination Form referred to in the Election Scheme and shall state as follows:

"I, the above named candidate, consent to my nomination and agree to stand for election to the ~~Board of Governors~~Council of Governors in the constituency indicated in Section One of this form. I also declare that I am a member in that constituency. I, the above named candidate, hereby declare that I am not:

a. a person who has been adjudged bankrupt or whose estate has been sequestrated and (in either case) has not been discharged

b. a person who has made a composition or arrangement with, or granted a trust deed for, his creditors and has not been discharged in respect of it

c. a person who within the preceding 5 years has been convicted in the British Islands of any offence if a sentence of imprisonment (whether suspended or not) for a period of not less than 3 months (without the option of a fine) was imposed on him

d. excluded by any other provision detailed within the Trust's constitution.

I confirm that, to the best of my knowledge, the information provided on (or in connection with) this form is accurate."

8. ~~Board of Governors~~Council of Governors: Vice Chair~~man~~

8.1 No person may serve as the Vice Chair~~man~~ for more than a total of six years.

8.2 A person appointed as the Vice Chair~~man~~ shall cease to be eligible to continue serving as the Vice Chair~~man~~ if he ceases to be a Governor or Member and the Vice Chair~~man~~'s term of office may be terminated by a majority of not less than 75% of the Governors present and voting at a meeting of the ~~Board of Governors~~Council of Governors.

9. ~~Board of Governors~~Council of Governors: Appointment of Senior Independent Director

9.1 A majority of the Governors shall at a general meeting of the ~~Board of Governors~~Council of Governors appoint one of the Non-Executive Directors to be the Senior Independent Director for a term of three years. The Senior Independent Director shall be eligible for re-appointment at the end of that term but may not serve as Senior Independent Director for more than a total of six years.

9.2 The Senior Independent Director shall be available to Members and Governors if they have concerns which contact through the normal channels of the Chair~~man~~, Chief Executive or Finance Director has failed to resolve or for which such contact is inappropriate.

9.3 A person appointed as the Senior Independent Director shall cease to be eligible to continue serving as the Senior Independent Director if he ceases to be a Non-Executive Director and the Senior Independent Director's term of office may be terminated by a majority of not less than 75% of the Governors present and voting at a meeting of the ~~Board of Governors~~Council of Governors.

ANNEX 6 – FURTHER PROVISIONS

1. Eligibility for Membership

It is the responsibility of Members to ensure their eligibility and not the Trust, but if the Trust is on notice that a Member may be disqualified from Membership, the Trust shall carry out all reasonable enquiries to establish if this is the case.

2. Public Constituency

2.1 For the purposes of determining whether an individual lives in an area specified as an area for Public Constituency, an individual shall be deemed to do so if:

2.1.1 his name appears on the electoral roll at an address within the said area and the Trust has no reasonable cause to conclude that the individual is not living at that address; or

2.1.2 the Trust is otherwise satisfied that the individual lives in the said area.

2.2 An individual who is a Member of the Public Constituency shall cease to be eligible to continue as a Member if he ceases to live in the area of the Public Constituency of which he is a Member save as may otherwise be provided in this paragraph 2.

2.3 Where a Member of a Public Constituency ceases to live permanently in the area of the Public Constituency of which he is a Member he shall forthwith advise the Trust that he is no longer eligible to continue as a Member and the Trust shall forthwith remove his name from the Register of Members unless the Trust is satisfied that the individual concerned lives in some other area of a Public Constituency of the Trust. Where the Trust is satisfied that such an individual continues to live in the area of a Public Constituency of the Trust it shall, if the individual so requests, thereafter treat that individual as a Member of that other Public Constituency and amend the Register of Members accordingly provided the Trust has given that individual not less than 14 days' notice of its intention to do so.

2.4 Where a Member ceases to live temporarily in the area of the Public Constituency of which he is a Member, the Trust may permit that individual nonetheless to remain on the Register of Members for that Public Constituency if it is for good cause satisfied that the absence is of a temporary duration only and that the Member will either return to live in the area of that Public Constituency of which he is a Member or will live in some other part of the area of the Trust in which case the provisions of paragraph 2.1 shall apply as appropriate.

3. Staff Constituency

3.1 A Member of a Staff Class will cease to be eligible to be a Member of that Staff Class if they no longer meet the eligibility requirements of paragraph 7 of the Constitution and of Annex 2.

3.2 Where an individual is a Member by virtue of their eligibility to be a Member of a Staff Class and they cease to be eligible for Membership of that Staff Class but are eligible for Membership of some other Staff Class then the Trust may give notice to that Member of its intention to transfer him to that other Staff Class on the expiration of a period of time or upon a date specified in the said notice and shall

after the expiration of that notice or date amend the Register of Members accordingly.

4. Membership Termination of Tenure

4.1 A Member shall cease to be a Member if:-

4.1.1 they cease to be entitled under this Constitution to be a Member of any of the Public Constituencies or one of the classes of the Staff Constituency;

4.1.2 they resign by notice in writing to the Secretary;

4.1.3 they die;

4.1.4 they are expelled under this Constitution;

4.1.5 if it appears to the Secretary that they no longer wish to be involved in the affairs of the Trust as a Member, and after enquiries made in accordance with a process approved by the ~~Board of Governors~~Council of Governors they fail to establish that they have a continuing wish to be involved in the affairs of the Trust as a Member.

5. Board of Directors: Disqualification

5.1 In addition to the grounds of disqualification set out in paragraph 28 of the Constitution, a person may also not be or continue as a Director of the Trust if:

5.1.1 in the case of a Non-Executive Director, he no longer satisfies the relevant requirements for appointment;

5.1.2 he is a person whose tenure of office as a chair~~man~~ or as a director of a Health Service Body has been terminated on the grounds that his appointment is not in the interests of public service, or for non-disclosure of a pecuniary interest;

5.1.3 he has within the preceding two years been dismissed, otherwise than by reason of redundancy, by the coming to an end of fixed term contract or through ill health, from any paid employment with a Health Service Body;

5.1.4 information revealed by a ~~Criminal Records Bureau~~DBS check is such that it would be inappropriate for him to become or continue as a Director on the grounds that this would adversely affect public confidence in the Trust or otherwise bring the Trust into disrepute;

5.1.5 in the case of an Executive Director, he is no longer employed by the Trust;

5.1.6 he is a person who has had their name removed by a Direction under Section 154 of the 2006 Act from any list prepared under Part 4 of that Act, and have not subsequently had their name included on such a list;

~~5.1.7 he is an executive or non-executive director of another NHS Foundation Trust, or a governor, non-executive director, Chair, Chief Executive Officer or executive director or equivalent of another body whose business includes the provision or commissioning of goods and services for the purposes of the health service within the area of the Trust.~~

~~5.1.8~~5.1.7he is a member of a local authority's overview and scrutiny committee;

~~5.1.9~~5.1.8he is the subject of a disqualification order made under the Company Directors' Disqualifications Act 1986;

~~5.1.10~~5.1.9he has failed or refused to undertake any training which the Board of Directors requires all Directors to undertake;

~~5.1.11~~5.1.10he has failed to sign and deliver to the Secretary in the form required by the Board of Directors confirmation that he accepts the T~~t~~rust's Standards of Business Conduct Policy;

~~5.1.12~~5.1.11he/she is a partner or spouse of an existing Director.

6. Non-Executive Directors: Terms of Office

6.1 Subject to paragraph 6.2, a Non-Executive Director shall be appointed by the ~~Board of Governors~~Council of Governors for a term of 3 years.

6.2 The ~~Board of Governors~~Council of Governors may, prior to the expiry of the term referred to in paragraph 6.1, extend the term of office of a Non-Executive Director by a period not exceeding ~~2~~ three years if it considers such an extension is in the best interests of the Trust.

6.3 Prior to extending any term of office under paragraph 6.2, the ~~Board of Governors~~Council of Governors shall consult the Directors and may seek advice from the Appointments and Remuneration Committee.

7. Governors and Directors: Communication and Conflict

7.1 Summary

This paragraph 7 describes the processes intended to ensure a successful and constructive relationship between the ~~Board of Governors~~Council of Governors and the Board of Directors. It emphasises the importance of informal and formal communication, and confirms the formal arrangements for communication within the Trust. It suggests an approach to informal communications, and sets out the formal arrangements for resolving conflicts between the ~~Board of Governors~~Council of Governors and the Board of Directors.

7.2 Informal Communications

7.2.1 Informal and frequent communication between the Governors and the Directors is an essential feature of a positive and constructive relationship designed to benefit the Trust and the services it provides.

7.2.2 The Chair~~man~~ shall use his reasonable endeavours to encourage effective informal methods of communication including:

(a) participation of the Board of Directors in the induction, orientation and training of Governors;

(b) development of special interest relationships between Non-Executive Directors and Governors;

(c) discussions between Governors and the Chair~~man~~ and/or the Chief Executive and/or Directors through the office of the Secretary;

(d) involvement in Membership recruitment and briefing at public events organised by the Trust.

7.3 Formal Communication

7.3.1 Some aspects of formal communication are defined by the constitutional roles and responsibilities of the ~~Board of Governors~~Council of Governors and the Board of Directors respectively.

7.3.2 Formal communications initiated by the ~~Board of Governors~~Council of Governors and intended for the Board of Directors will be conducted as follows:

(a) specific requests by the ~~Board of Governors~~Council of Governors will be made through the Chair~~man~~ to the Board of Directors;

(b) any Governor has the right to raise specific issues to be put to the Board of Directors at a duly constituted meeting of the ~~Board of Governors~~Council of Governors through the Chair~~man~~. In the event of disagreement, two thirds of the Governors present must approve the request. The Chair~~man~~ will raise the matter with the Board of Directors and provide the response to the ~~Board of Governors~~Council of Governors;

(c) joint meetings will take place as and when appropriate between the ~~Board of Governors~~Council of Governors and the Board of Directors.

7.3.3 The Board of Directors may request the Chair~~man~~ to seek the views of the ~~Board of Governors~~Council of Governors on such matters as the Board of Directors may from time to time determine.

7.3.4 Communications initiated by the Board of Directors and intended for the ~~Board of Governors~~Council of Governors will be conducted as follows:

(a) request the Chairman to seek the view of the ~~Board of Governors~~Council of Governors on the Board of Directors' proposals for the Strategic Direction and the Annual Plan;

(b) presentation and approval of annual accounts, annual report and auditor's report;

(c) request the Chair~~man~~ to seek the view of the ~~Board of Governors~~Council of Governors on the Board of Directors' proposals for developments;

(d) request the Chair~~man~~ to seek the view of the ~~Board of Governors~~Council of Governors on Trust Performance;

(e) request the Chair~~man~~ to seek the view of the ~~Board of Governors~~Council of Governors for involvement in service reviews and evaluation;

(f) request the ~~Board of Governors~~Council of Governors to seek views of the Membership on proposed changes, plans and developments.

7.3.5 Formal communications will normally be conducted as follows:

(a) attendance by the Board of Directors at a meeting of the ~~Board of Governors~~Council of Governors;

(b) formal reports or presentation by Executive Directors to a meeting of the ~~Board of Governors~~Council of Governors;

(c) inclusion of minutes for information on the Agenda of a meeting of the ~~Board of Governors~~Council of Governors;

(d) reporting the views of the ~~Board of Governors~~Council of Governors to the Board of Directors through the Chair~~man~~ or Vice-Chair~~man~~;

(e) Governors attend meetings in public of the Board of Directors as observers.

7.3.6 Wherever possible and practical, written communications will be conducted by e-mail.

7.4 Resolving Conflict

7.4.1 The ~~Board of Governors~~Council of Governors and the Board of Directors must be committed to developing and maintaining a constructive and positive relationship. The aim at all times is to resolve any potential or actual differences of view quickly, through discussion and negotiation.

7.4.2 If as the first step, the informal efforts the Chairman do not achieve resolution of a disagreement or a conflict, the Chairman will follow the process described in paragraph 7.4.3 below. The aim is to resolve the matter at the first available opportunity, and only to escalate to the next step if the step taken fails to achieve resolution.

7.4.3 In the event of a conflict between the ~~Board of Governors~~Council of Governors and Board of Directors, the following action will be taken, in the sequence shown:

(a) the Chair~~man~~ will call a Resolution Meeting of the members of the ~~Board of Governors~~Council of Governors and Board of Directors, to take place as soon as possible, but no later than twenty working days following the date of the request. The meeting must comprise of two thirds of the Membership of the ~~Board of Governors~~Council of Governors and two thirds of the membership of the Board of Directors. The meeting will be held in private. The Agenda and any papers for the meeting issued in accordance with the Standing Orders of the ~~Board of Governors~~Council of Governors. The aim of the meeting will be to achieve resolution of the conflict. The Chair~~man~~ will have the right to appoint an independent facilitator to assist the process. Every effort must be made to reach agreement;

(b) if a Resolution Meeting of the members of the ~~Board of Governors~~Council of Governors and Board of Directors fails to

resolve a conflict, the Board of Directors will decide the disputed matter;

(c) if, following the formal Resolution Meeting, and the decision of the Board of Directors, the ~~Board of Governors~~Council of Governors considers that implementation of the decision will result in the Trust failing to comply with its Constitution, the ~~Board of Governors~~Council of Governors will refer the specific issue of non-compliance to Monitor.

7.4.4 The right to call a Resolution Meeting rests with the following, in the sequence of escalation shown:

(a) the Chair~~man~~;

(b) the Chief Executive;

(c) two thirds of the members of the ~~Board of Governors~~Council of Governors;

(d) two thirds of the members of the Board of Directors.

8. Indemnity

Members of the ~~Board of Governors~~Council of Governors and Board of Directors who act honestly and in good faith will not have to meet out of their personal resources any personal civil liability which is incurred in the execution or purported execution of their Board functions, save where they have acted recklessly. Any reasonable costs arising in this way will be met by the Trust and the Trust shall have the power to purchase suitable insurance or make appropriate arrangements with the National Health Service Litigation Special Health Authority to cover such costs.

9. Validity of Actions

No defect or deficiency in the appointment or composition of the ~~Board of Governors~~Council of Governors or the Board of Directors shall affect the validity of any action taken by them.

10. Registers

10.1 The Secretary shall be responsible for compiling and maintaining the Registers. Removal from any Register shall be in accordance with the provisions of this Constitution. The Secretary shall update the registers with new or amended information as soon as is practical and in any event within 14 days.

10.2 Register of Members

10.2.1 Members must complete and sign an application in the form prescribed by the Secretary; and

10.2.2 the Secretary shall maintain the Register in two parts. Part 1 shall include the name of each Member and the Constituency or class to which they belong and shall be open to inspection by the public in accordance with paragraph 34 of this Constitution. Part 2 shall contain all the information from the individual's application form and shall not be open to inspection by the public nor may copies or extracts from it be made available to any third

party. Notwithstanding this provision, the Trust shall extract such information as it needs in aggregate to satisfy itself that the actual Membership of the Trust is representative of those eligible for Membership.

10.3 Register of Members of the ~~Board of Governors~~Council of Governors

The Register shall list the names of members of the ~~Board of Governors~~Council of Governors, their category of Membership of the Board (public, staff or organisation represented) and an address through which they may be contacted which may be the Secretary.

10.4 Register of Interests of the Members of the ~~Board of Governors~~Council of Governors

Each member of the ~~Board of Governors~~Council of Governors shall complete and sign a form as prescribed by the Secretary setting out interests to be declared in accordance with the Standing Orders and the register shall contain the names of all members of the ~~Board of Governors~~Council of Governors and any interests declared including no interests.

10.5 Register of Directors

The Register shall list the names of Members of the Board of Directors, their capacity on the Board and an address through which they may be contacted which may be the Secretary.

10.6 Register of Interests of Directors

Each Member of the Board of Directors shall complete and sign a form as prescribed by the Secretary setting out any interests to be declared in accordance with the Standing Orders for the Board of Directors and the Register shall contain the names of all members of the Board of Directors and any interests declared including no interests.

11. Auditor

11.1 A person may only be appointed auditor if he (or in the case of a firm each of its members) is a member of one or more of the following bodies:

11.1.1 the bodies mentioned in section 3(7)(a) to (e) of the Audit Commission Act 1998; or

11.1.2 any other body of accountants established in the United Kingdom and approved by Monitor.

12. Accounts

12.1 The following documents will be made available to the Comptroller and Auditor General for examination at his request:

12.1.1 the accounts;

12.1.2 any records relating to them; and

12.1.3 any report of the auditor one them.

12.2 In preparing its annual accounts, the Trust is to comply with any directions given by Monitor with the approval of the Treasury as to:

12.2.1 the methods and principles according to which the accounts are to be prepared; and

12.2.2 the information to be given in the accounts.

12.3 The Trust must:

12.3.1 lay a copy of the annual accounts, and any report of the auditor on them, before Parliament; and

12.3.2 once it has done so, send copies of those documents to Monitor.

12.4 Annual reports and forward plans

12.4.1 The annual report submitted by the Trust to Monitor in accordance with paragraph 39.1 is to give:

(a) information on any steps taken by the Trust to secure that (taken as a whole) the actual Membership of its public constituencies is representative of those eligible for such Membership; and

(b) any other information Monitor requires.

12.4.2 The Trust is to comply with any decision Monitor makes as to:

12.4.3 the form of the reports;

12.4.4 when the reports are to be sent to it; and

12.4.5 the periods to which the reports are to relate.

ANNEX 7 – ANNUAL MEMBERS MEETING

1. **ANNUAL MEMBERS MEETING**

1.1 The Trust shall publicise and hold an annual meeting of its members ('Annual Members' Meeting') prior to 30 September each year

1.2 The following documents are to be presented to the members and governors of the Trust at the Annual Members Meeting by at least one member of the Board of Directors in attendance.

1.2.1 the annual accounts;

1.2.2 any report of the auditor on them; and

1.2.3 the annual report.

2. **ADMISSION OF THE PUBLIC AND PRESS**

2.1 Members, the public and representatives of the press shall be afforded facilities to attend the annual members meeting.

2.2 The Chair~~man~~ (or Deputy Chair~~man~~) shall give such directions as he thinks fit in regard to the arrangements for meetings and accommodation of members, the public and representatives of the press such as to ensure that business shall be conducted without interruption and disruption.

2.3 Members, the public or representatives of the press are not permitted to record proceedings in any manner unless with the express prior agreement of the Chair~~man~~ (or Deputy Chair~~man~~). Where permission has been granted, the Chair~~man~~ (or Deputy Chair~~man~~) retains the right to give directions to halt recording of proceedings at any point during the meeting. For the avoidance of doubt, "recording" refers to any audio or visual recording, including still photography.

3. **CHAIR~~MAN~~**

3.1 The Chair~~man~~, if present, shall preside at the annual members meeting. If the Chair~~man~~ is absent from the meeting the Deputy Chair~~man~~ shall preside.

3.2 If the Chair~~man~~ is absent from a meeting temporarily on the grounds of a declared conflict of interest the Deputy Chair~~man~~, if present, shall preside.

4. **NOTICE OF MEETING**

4.1 The Secretary shall give at least fourteen days written notice of the date and place of the annual members meeting to all Governors. Notice will also be published in communications to Trust members and on the Trust's website. The notice of the meeting will specify the business proposed to be transacted at it, and will be signed by the Chair~~man~~ or Secretary.

4.2 Lack of service of the notice on any Governor shall not affect the validity of a meeting.

4.3 Before the annual members meeting, a notice of the meeting, specifying the business proposed to be transacted at it, and signed by the Chair~~man~~ or by an officer of the Trust authorised by the Chair~~man~~ to sign on his behalf shall be placed on the Trust's website and shall be delivered to every Governor, or sent by post to the usual place of residence of such Governor, so as to be available to him at least three clear days before the meeting.

5. **PRESENTATION OF THE ANNUAL ACCOUNTS AND REPORTS**

5.1 The following documents are to be presented to the members of the Trust at the Annual Members Meeting by at least one member of the Board of Directors in attendance.

5.1.1 the annual accounts;

5.1.2 any report of the auditor on them; and

5.1.3 the annual report.

6. **AMENDMENT OF THE CONSTITUTION**

6.1 Where an amendment is made to the Constitution in relation the powers or duties of the ~~Board of Governors~~Council of Governors (or otherwise with respect to the role that the ~~Board of Governors~~Council of Governors has as part of the T~~t~~rust):

6.1.1 At least one member of the ~~Board of Governors~~Council of Governors must attend the next Annual Members' Meeting and present the amendment, and

6.1.2 The T~~t~~rust must give the members an opportunity to vote on whether they approve the amendment.

6.2 If more than half of the members present and voting approve the amendment, the amendment continues to have effect; otherwise, it ceases to have effect and the trust must take such steps as are necessary as a result.

7. **QUORUM**

7.1 20 members of the Trust~~,~~ excluding Directors and governors of the Trust.

7.2 Where the annual members meeting is combined with a ~~Board of Governors~~Council of Governors meeting for the purpose of received the annual accounts and reports, the quorum of the ~~Board of Governors~~Council of Governors shall also apply.

8. **VOTING**

8.1 Every question at a meeting will be determined by a majority of the votes of the members present and voting on the question and, in the case of an equality of votes, the person presiding shall have a second or casting vote.

8.2 As members, governors may vote at the annual members meeting except where the matter under consideration is a Constitution amendment regarding the powers or duties of the ~~Board of Governors~~Council of Governors (or otherwise

with respect to the role that the ~~Board of Governors~~Council of Governors has as part of the T~~t~~rust).

8.3 With the exception of the Chair~~man~~, Directors may not vote at the annual members meeting.

8.4 All questions put to the vote shall, at the discretion of the Chair~~man~~, be determined by oral expression or by a show of hands. A paper ballot may also be used if a majority of the members present so request.

8.5 If a majority of the members present so request, the voting (other than by paper ballot) on any question may be recorded to show how each member present voted or abstained.

8.6 If a member so requests, his vote shall be recorded by name upon any vote (other than by paper ballot).

8.7 In no circumstances may an absent member vote by proxy. Absence is defined as being absent at the time of the vote.

9. MINUTES

9.1 The names of Governors, Directors and Members present at the meeting shall be recorded.

9.2 The Minutes of the proceedings of a meeting shall be drawn up and submitted for agreement at the next ensuing meeting where they will be signed by the person presiding at it.

9.3 No discussion shall take place upon the minutes except upon their accuracy or where the Chair~~man~~ considers discussion appropriate. Any amendment to the minutes shall be agreed and recorded at the next meeting.

9.4 Minutes shall be made available to the public.

10. AGENDA

10.1 A governor or member desiring a matter to be included on an agenda shall make his request in writing to the Chair~~man~~ at least ten clear days before the meeting is notified to Governors and members. Requests made less than ten days before a meeting is notified to Governors may be included on the agenda at the discretion of the Chair~~man~~.

11. MOTIONS

11.1 A Governor or member of the Trust desiring to move or amend a motion shall send a written notice thereof at least ten clear days before the meeting is notified to Governors to the Chair~~man~~, who shall insert in the agenda for the meeting all notices so received subject to the notice being permissible under the appropriate regulations. This paragraph shall not prevent any motion being moved without notice during the meeting, on any business mentioned on the agenda.

11.2 A motion or amendment once moved and seconded may be withdrawn by the proposer with the concurrence of the seconder and the consent of the Chair~~man~~.

11.3 The mover of a motion shall have a right of reply at the close of any discussion on the motion or any amendment thereto.

11.4 When a motion is under discussion or immediately prior to discussion it shall be open to a Governor or member to move:

(i) An amendment to the motion.

(ii) The adjournment of the discussion or the meeting.

(iii) The appointment of an ad hoc committee to deal with a specific item of business.

(iv) That the meeting proceed to the next business.*

(v) That the motion be now put to a vote.*

In the case of sub-paragraphs denoted by * above, to ensure objectivity motions may only be put by a Governor who has not previously taken part in the debate.

11.5 No amendment to the motion shall be admitted if, in the opinion of the Chairman of the meeting, the amendment negates the substance of the motion.

12. CHAIR~~MAN~~'S RULING

12.1 Statements of Governors and members shall be relevant to the matter under discussion at the material time and the decision of the Chair~~man~~ of the meeting on questions of order, relevancy, regularity and any other matters shall be observed at the meeting.

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Title	**Audit and Non-Clinical Risk Committee – Chair's Log**		
Report to	**Board of Directors**	**Date**	**4 January 2018**
Author	**Philippe Serna, Chair of the ANCR Committee**		

Purpose		Tick one as appropriate
	Decision	
	Assurance	X
	Information	

Executive summary containing key messages and issues

This was the meeting deferred from November to allow for the completion of a number of audits. In line with the approach from Quality and Effectiveness Committee we opened the meeting by considering our terms of reference and have proposed some changes to those. On a similar governance related topic we also considered the current arrangements for assurance on health and safety matters.

Currently, the Health and Safety Committee feeds into ANCR and following on from our recent training I wanted to ensure we have a proper grip on this so have invited Kirsty Edmondson-Jones to come and give an assurance report every six months. There was some discussion on this and concern expressed as to whether a six-monthly report might take up a disproportionate amount of the Committee's time.

I agreed to take it away and, along with the executive director and Trust Board Secretary, decide the best way in which to move forwards. We also agreed to convene a meeting to discuss the way in which a health and safety assurance report might be structured and agreed to possibly make use of the six assurance questions developed by QEC.

Assurance area – Internal audit

We welcomed Robert Fenton to his first meeting as our new audit manager. Rob has taken over from Mark Dalton. The audit plan remains on track to be delivered within the planned number of days, with 52 out of 235 days delivered so far. We agreed to utilise an additional two days from contingency, whilst remaining in the agreed budget, to support ongoing audits many of which will report in March.

The following reports had been completed in the previous quarter and were reported on:

- Medical Equipment – Partial assurance with improvements required
- Workforce planning – Significant assurance with minor improvements
- Risk management and BAF – Significant assurance with minor improvements

The Committee was particularly pleased to see improvements in risk management and the BAF which had been flagged as amber/red in the Deloitte Well Led inspection.

Assurance area – Recommendation tracker

This item was received late but presented a good overall picture with 57 of the 73 recommendations complete and 12 in progress.

However, there remains an issue with obtaining evidence from process owners to support their assertion that a recommendation is complete. We agreed that the delay in issuing the report could have contributed to this and further agreed that KPMG should reissue the tracker at the start of February.

Assurance area – Effectiveness of internal audit

Each year the Trust is required to give a view on the relationship between it and its internal auditors and the extent to which we feel they are independent. The Director of Finance presented the report on the Trust's behalf.

It was felt that KPMG had functioned effectively in the past year. Clearly there had been a change in audit manager and we hope that our good working relationship will continue under the new arrangements. Non-audit work such as KPMG's work on the catering contract had been beneficial.

There had been challenging conversations, at times, and the relationship could not be described as 'cosy'. The Committee endorsed the DOF's verdict that the internal audit function continued to provide an effective and efficient service to the Trust and were independent.

In future we agreed that some more empirical data might be of merit to bring into the report, e.g. a survey of executives and users, as well as anecdotal information.

Assurance area - External audit management letter

The letter, compiled following the financial statement audit 2016/17, focussed on process and control issues identified during the audit. It identified recommendations which the Director of Finance is taking forward with his team.

Assurance area – Standing orders, SFIs and Scheme of delegation

We recommended the documents to Board with minor additions and areas for clarification.

Assurance area – Review of Constitution

The Committee carried out the three-yearly review of the constitution which included consideration of a number of suggested changes. There was a divergence of views presented to the Committee on some of the proposed changes. After taking due consideration of all points discussed, it was agreed to recommend the proposed changes to the Board of Directors on 30 January.

I have subsequently received further clarification on the issue of governors' terms of office which have reinforced the decision taken by the Committee with respect to recommendation to the Board.

Other Items

We reviewed and gave some independent challenge to the Trust's Overseas Visitors' Policy and considered standard agenda items on suspensions and exclusions, waiving of standing orders, losses and compensations, LCFS and BAF/corporate risk register.

Key questions posed by the report
• Is the Board assured in respect of the key areas considered in this report?
How this report contributes to the delivery of the strategic objectives
N/A
How this report impacts on current risks or highlights new risks
N/A
Recommendation(s) and next steps
That Board receives the report for assurance.

Special QEC 4 2 28 - Chair's report to Board

We held a special QEC to address the strategic assurance item deferred from our December QEC, which was slightly curtailed to accommodate a feedback session from CQC inspectors.

It was noted that all of the outputs targeted by the current R&D strategy have been delivered.

The assurance questions agreed at the October 2017 QEC were:

1. How do we ensure that research is ethically sound, with appropriate financial governance in place?
2. What assurance do we have that all research opportunities to develop capacity and capability are being explored?
3. How will we extend research beyond medical matters to include other professions?
4. How do we ensure that research is progressing Teaching Hospital status?
5. How assured are we that the Governance Tree for R&D is clear and effective?
6. How do we ensure our metrics for success in R&D sufficiently measure patient outcomes as well as activity?
7. How do we ensure we are well networked in terms of research?
8. How do we ensure that we have identified interdependencies with enabling strategies?

For each question posed, QEC considered the evidence shared and the degree to which it felt assured: this included feedback from members unable to be present at the meeting. A paper had been prepared to address the assurance questions, however it was noted that not all of the assurance questions had been addressed. It was noted that the nature of assurance is around the review of evidence and that a lack of evidence may not betoken a problem or gap, but may indicated a need for further evidence to be shared. QEC confirmed the questions and areas on which a further presentation was requested for the next QEC (23/2).

These included:

- More information on collaborative landscape, ACS/STP etc.
- More information on benefits / achievements
- Patient Outcomes – Provide patient stories / feedback on what it was like to take part in research & any other information to assure committee that metrics for success in R&D sufficiently measure patient outcomes as well as activity.
- Provide Governance Tree

- R&D to work with Karen Barnard to align timescales of teaching hospital development.
- More data and evidence to provide assurance that we are extending research beyond clinical matters to include other professions.

It was agreed that question 8 would best be addressed in the new strategy to be prepared for July 2018. QEC suggested that the paper, prepared following the Special QEC review of Strategies on what good and consistent Enabling strategies would look like, be shared with R&D. Also that the Governance /Accountability section of the Clinical Governance Strategy would constitute a good practice model to help with answering question 5. In due course, the new R&D strategy would be one of the Enabling Strategies for which QEC would be seeking assurance on implementation and delivery.

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Title	**Financial Performance – December 2017**			
Report to	**Board of Directors**	**Date**	**30 January 2018**	
Author	**Jon Sargeant - Director of Finance**			
Purpose	To update the Board on the financial position for the month of December 2017.			Tick one as appropriate
	Decision			
	Assurance			
	Information			✔

Executive summary containing key messages and issues
The Month 9 position is a deficit of £15,094k. After removal of the 16/17 STF adjustment and the variance relating to donated assets, this is restated to a deficit of £15,473k, £31k favourable to plan. During December, expenditure reduced from previous run rate levels, pay was £120k over budget in month, but £638k lower than forecast. The income is £462k better than plan (£237k better than forecast), clinical income (excluding Non PbR drugs) is £324k better than plan. The main area of under-performance in month continues to be around elective activity which is £216k behind plan in month and £1,624k behind plan YTD
Key questions posed by the report
• How will the financial plan be achieved over the next 3 months, whilst the Trust deals with its peak winter activity levels? • How will the gap in the CIP plan be achieved? (The CIP has always been back loaded and significant savings still need to come out in the next few months) • How will the Trust recover the activity shortfalls in elective activity? (The weekly produced rolling forecast on patient bookings suggests that there is considerable work to do to improve this position in January, February and March)

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

How this report contributes to the delivery of the strategic objectives
• Identify the most effective care possible • Assist in the control and reduction of the cost of healthcare • Aid focus on innovation for improvement • Assist in developing responsibly and delivering the right services with the right staff
How this report impacts on current risks or highlights new risks
• Identifies the size and scale of the gap in the financial and CIP plans for 2017/18
Recommendation(s) and next steps
The Board is asked to note the month 9 2017/18 financial position of £15.48 million deficit, £31k favourable to plan after removal of the 16/17 STF funding and any variance related to donated asset income. The Board is asked to note the risks particularly those relating to: • The stock take in the quarter 3 position • The under booked elective activity showing on the January dash board. • The back loaded CIP and significant savings that still need to come out in the next few months.

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

FINANCIAL PERFORMANCE

P9 December 2017

19th January 2018

DONCASTER AND BASSETLAW TEACHING HOSPITALS NHS FOUNDATION TRUST

P9 December 2017

1. Income and Expenditure vs. Forecast

Performance Indicator	Monthly Performance			YTD Performance		Annual	Forecast
	Actual £'000	Variance to budget £'000	Variance to Forecast	Actual £'000	Variance £'000	Plan £'000	£'000
I&E Perf Exc Impairments	(169)	(1,939) F	329	15,069	(712) F	16,489	16,070
Income	(29,616)	(462) F	199	(274,892)	(3,473) F	(361,849)	(367,541)
STF Incentive	(1,155)	0 F	0	(7,506)	0	(11,547)	(11,547)
STF Adjustment 16/17	0	0	0	(419)	(419) F	0	(419)
Donated Asset Income	0	0	0	40	(262) F		
Operating Expenditure	29,523	(1,474) F	129	288,161	3,232 A	377,048	382,646
Pay	21,106	120 A	656	194,112	3,905 A	253,402	257,974
Non Pay	8,417	(1,595) F	(526)	94,049	(673) F	123,647	124,672
I&E Perf Exc 16/17 STF and Donated Asset Income	**(169)**	**(1,939) F**	**329**	**15,448**	**(31) F**	**16,489**	**16,489**

F = Favourable A = Adverse

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

2. CIPs

Performance Indicator	Monthly Performance			YTD Performance		Annual	Forecast
	Actual £'000	Variance to budget £'000	Variance to Forecast £'000	Actual £'000	Variance £'000	Plan £'000	£'000
Employee Expenses	864	382 A	(92) A	4,102	(729) F	9265	7306
Drugs	6	(4) F	0	29	(4) F	30	39
Clinical Supplies	52	25 A	25 F	422	25 A	947	948
Non Clinical Supplies	0	25 A	0	0	25 A	100	100
Non Pay Operating Expenses	96	146 A	80 F	470	151 A	1340	1055
Income	175	(95) F	(108) A	454	(101) F	724	849
Total	**1,193**	**478 A**	**(95) F**	**5,477**	**(633) F**	**12,406**	**10,297**

3. Statement of Financial Position

All figures £m	Opening Balance 01.04.17	Current Balance 30.11.17	Movement in year
Non Current Assets	**196,907**	**192,680**	**(4,227)**
Current Assets	33,612	60,868	27,256
Current Liabilities	(31,967)	(65,578)	(33,611)
Non Current liabilities	(79,348)	(83,856)	(4,508)
Total Assets Employed	**119,204**	**104,113**	**(15,091)**
Total Tax Payers Equity	**119,204**	**104,113**	**(15,091)**

4. Other

Performance Indicator	Monthly Performance			YTD Performance		Annual	Forecast
	Plan £'000	Actual £'000		Plan £'000	Actual £'000	Plan £'000	£'000
Cash Balance	1,900	5,449	1,900 ##	1,900	5,449	1,900	1,900
Capital Expenditure	635	354	3,942 ##	3,942	2,267	6,481	8,245

5. Workforce

	Funded WTE	Actual WTE			Bank WTE	Agency WTE	Total in Post WTE	Under / (over)
Current Month	6,037	5,572			145	129	5,846	191
Previous Month	6,041	5,612			217	113	5,942	99
Movement	4	40	0		72	(16)	0 96	92

1. Context/Background

The Month 9 position is a deficit of £15,094k. After removal of the 16/17 STF adjustment and the variance relating to donated assets, this is restated to a deficit of £15,473k, £31k favourable to plan.

2. Executive Summary

Subjective Code	In Month Budget	In Month Actual	In Month Variance	In Month Forecast	In Month Variance to forecast	YTD Budget	YTD Actual	YTD Variance	Annual Budget	Forecast
1. Income	-30,309	-30,771	-462	-30,533	-238	-278,623	-282,777	-4,154	-373,396	-379,507
2. Costs	30,997	29,523	-1,474	31,009	-1,487	284,904	288,161	3,207	377,048	382,646
3.Capital Charges	1,081	1,079	-2	1,079	1	9,475	9,710	235	12,836	12,929
Total Position Before Impairments	**1,769**	**-169**	**-1,939**	**1,555**	**-1,724**	**15,756**	**15,094**	**-712**	**16,489**	**16,069**
4.Impairments	0	0	0	0	0	0	0	0	0	0
Total Position After Impairments	**1,769**	**-169**	**-1,939**	**1,555**	**-1,724**	**15,756**	**15,094**	**-712**	**16,489**	**16,069**
Remove STF relating to 16/17	0	0	0	0	0	0	419	419	0	419
Remove variance relating to Donated Asset Income						-302	-40	262		
Position to compare to control total	**1,769**	**-169**	**-1,939**	**1,555**	**-1,724**	**15,454**	**15,473**	**-31**	**16,489**	**16,488**

Commissioner	In Month Forecast	In Month Actual	In Month Variance
Barnsley CCG	-475	-428	47
Bassetlaw CCG	-5,104	-4,993	110
Doncaster CCG	-15,566	-15,002	564
NHS England	-2,222	-1,827	395
Other Associates & NCAs	-3,340	-4,218	-878
Rotherham CCG	-810	-811	-1
Total Income	**-27,516**	**-27,279**	**237**

The Trust is slightly ahead of target (£31k), and continues to forecast that it will hit its yearend control total. There are however some risks around this forecast, notably the requirement to catch up lost elective work from September to November, the challenge to sepsis income with CCG's, and the Trusts back loaded CIP programme.

The Trust's position includes the Tranche 1 winter monies, but due to the forecast lost elective activity (including the use of ring fenced elective beds not in the winter plans submitted prior to Christmas) of £1.625m for January 2018 the Trust has not improved its forecast outturn position. The Trust monitors its elective bookings on a weekly basis and the detailed specialty breakdown for this is included as appendix one.

The Trust has also applied the impact of a stock taken as a dry run for the yearend within the position. The full amount of the stock valuation movement is £1.2m, but only 55% of this has been taken into the position as an expected value as the movement still requires agreement with external audit. This will be discussed audit early February when the pre-audit work takes place. This adjustment and the adjustment on the prior year STF put the Trust close to its limit for unadjusted errors if the auditors do not agree to the treatment.

In addition the Trust has released accruals against the cost pressure reserve and utilised some of its own winter pressure reserve.

This is the first month the CIP achievement in month has exceeded £1m, with the actual achievement being £1,193k this is still c£400k under target, but however shows improvement from the recent levels of performance.

Subject to a final clinical audit the significant income risk relating to the maternity income has been resolved with the host CCG and the trust is still expecting to win the Sepsis challenge.

Over all the trust total remains at its control total although the lost elective income through September and October and any further winter pressures will put this under sever risk.

The cumulative income position at the end of Month 9 is £4,154k favourable to plan.

Income Group	Annual Budget	In Month Budget	In Month Actual	In Month Variance	YTD Budget	YTD Actual	YTD Variance
Commissioner Income	-302,465	-24,176	-24,500	-324	-226,611	-228,104	-1,493
Drugs	-22,601	-1,854	-1,625	230	-16,910	-17,955	-1,045
STF	-11,547	-1,155	-1,155	0	-7,506	-7,925	-419
Trading Income	-36,782	-3,124	-3,492	-368	-27,596	-28,793	-1,197
Grand Total	**-373,396**	**-30,309**	**-30,771**	**-462**	**-278,623**	**-282,777**	**-4,154**

The expenditure position in December was £1,474k lower than budgeted levels, after adjusting for the stock take in month.

Subjective Code	In Month Budget	In Month Actual	In Month Variance	In Month Forecast	In Month Variance to forecast	YTD Budget	YTD Actual	YTD Variance	Annual Budget	Forecast
1. Pay	20,986	21,106	120	21,744	-638	190,207	194,112	3,905	253,402	260,930
2. Non-Pay	9,444	10,204	760	10,359	-156	87,290	98,432	11,142	114,804	122,466
3. Reserves	567	-1,787	-2,354	-1,094	-693	7,432	-4,383	-11,816	8,842	-750
Total Expenditure Position	**30,997**	**29,523**	**-1,474**	**31,009**	**-1,487**	**284,929**	**288,161**	**3,232**	**377,048**	**382,646**

(Please note all future CIP savings are currently shown as non-pay reductions).

During December the Efficiency Director has reviewed in detail the CIP plan of £12.4m and re-forecasted it to a lower level of £10.3m, while still highlighting risks around Admin savings, stretch targets, discretionary and estates spend.

Detailed below is the latest breakdown of the Trust's CIP revised plan of £12.4m versus the revised forecast of £10.3m as of December 2017 by work stream and Care Group:-

		LATEST YEAR END FORECAST				
Workstream / £000's	**Revised Plan**	**In The Bag**	**Expected**	**Low Risk**	**Total**	**Forecast vs Plan**
Theatres	265	79	25	161	265	0
Medical Productivity	323	75	0	207	282	-41
Non Medical Productivity	200	82	72	0	154	-46
Mgt & Corporate	1,128	1,128	0	0	1,128	0
Clinical Pathways	1,376	694	12	183	889	-487
Procurement	1,495	1,155	340	0	1,495	0
Clincial Admin & OP	345	173	0	0	173	-172
Infrastructure	178	87	91	0	178	0
Commercial	377	305	72	0	377	0
Local	2,284	1,157	67	722	1,946	-338
G&C / Run Rate	630	208	0	0	208	-422
SUB TOTAL	**8,601**	**5,142**	**679**	**1,273**	**7,094**	**-1,507**
BDO PID Stretch - Theatres	175	0	0	175	175	0
BDO PID Stretch - Medical Productivity	143	43	0	50	93	-50
BDO PID Stretch - Mgt & Corporate	242	0	0	0	0	-242
BDO PID Stretch - Clinical Pathways - OP	400	0	0	400	400	0
BDO PID Stretch - Clinical Pathways - Beds	244	0	0	0	0	-244
BDO PID Stretch - Admin	178	0	0	0	0	-178
BDO PID Stretch - LOCAL - Stocktake	142	0	0	142	142	0
BDO PID Stretch - LOCAL - Stretch	141	0	0	28	28	-113
SUB TOTAL	**1,665**	**43**	**0**	**795**	**838**	**-827**
BDO Grip & Control	2,140	758	0	498	1,256	-884
SUB TOTAL	**12,406**	**5,943**	**679**	**2,566**	**9,188**	**-3,218**
Balance Sheet release Month 8	0	1,109	0	0	1,109	1,109
GRAND TOTAL	**12,406**	**7,052**	**679**	**2,566**	**10,297**	**-2,109**

Following CIG approval, the reallocation of funds in the capital plan have been made for the below schemes (these are reflected in the table below):

- Endoscopy Washers/Disinfectors Across Site
- Trauma Transfer Mattresses for ED

	2017/18		
Capital Scheme	Plan	Adj. to Plan	Forecast
Estates	4,416	0	4,416
Medical Equipment	1,885	0	1,885
- Endoscopy Washers Across Site	0	405	405
- Trauma Transfer Mattresses for ED	0	60	60
IT Scheme	800	0	800
- Smart ER	15	0	15
Other			
- Cross Year commitments	534	0	534
- Other Schemes & Contingency	595	-465	130
Total	**8,245**	**0**	**8,245**

Capital spend in month was £354k taking the total spend to date £2.275m. The remaining £5.97m of the plan is still to be spent in the final quarter of 2017/18, with a risk that this may not be achievable. The key area of risk lies within the estates schemes.

NHSi have asked for the Director of Finance to personally guarantee that the 2017/18 planned allocation will be spent by year end, or to revise the year end forecast.

	2017/18		
Capital Scheme	Plan	YTD Actual	To Spend
Estates	4,416	1,000	3,415
Medical Equipment	2,350	575	1,775
IT Scheme	800	135	665
Other	679	565	114
Total	**8,245**	**2,275**	**5,970**

3. Conclusion

The Trust is slightly ahead of target at the end of quarter three and continues to forecast that it will hit its yearend control total while continuing to work on the recovery programme to delivery better financial and operational grip and control. The work on the savings and governance around them has moved on at pace, and the running rate of expenditure is continuing to drop. However, there are significant risks to delivery of the forecast and the financial control total, these are

- The size of the challenge ahead of the Trust for the next 3 months, whilst the Trust deals with is peak winter activity levels. The CIP has always been back loaded and significant savings still need to come out in the next few months.
- The Trust has failed to deliver its activity targets for the past 3 months and significant changes to doctors timetables compounded by some sickness are the main reason for this. The weekly produced rolling forecast on patient bookings suggests that there is considerable work to do to improve this position in January, February and March
- Local CCG's are significantly overspent. Doncaster CCG is working with the Trust to understand what work needs to be done to deliver RTT for the next 18 months. The CCG cannot meet its control total and fund the activity the Trust needs to meet its income target. It remains to be seen how this is resolved, although the CCG are suggesting they will not pay for over performance beyond a set amount that allows them to meet. This issue is subject to CEO/DoF level discussions and whilst progress is being made there remains a gap between the parties still to be resolved.

4. Recommendations

The Board is asked to note the month 9 2017/18 financial position of £15.48 million deficit, £31k favourable to plan after removal of the 16/17 STF funding and any variance related to donated asset income.

The Board is asked to note the risks particularly those relating to:

- The stock take in the quarter 3 position
- The under booked elective activity showing on the January dash board.
- The back loaded CIP and significant savings that still need to come out in the next few months.

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Title	**Performance Report**		
Report to	**Board of Directors**	**Date**	**30th January 2018**
Author	**David Purdue, Chief Operating Officer** **Sewa Singh, Medical Director** **Moira Hardy, Acting Director of Nursing, Midwifery and Quality** **Karen Barnard, Director of People and Organisational Development**		

Purpose		Tick one as appropriate
	Decision	
	Assurance	x
	Information	

Executive summary containing key messages and issues

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

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

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

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

The Workforce report identifies sickness rates, appraisals and SET training.

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

Performance Executive Summary Board of Directors 2017

The performance report is against operational delivery in October, November and December 2017

Provide the safest, most effective care possible

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

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

Referral to Treatment

The Referral to Treatment Target, active waiters below 18 weeks set at 92%, is the target which is causing the most significant issues for the Trust.

Though performing above the National average, the Trust position remains below the target at 89.6% in December, which is deterioration of 1.3% on the November position.

The 5 specialities with the largest capacity gaps are

- Ophthalmology , currently above trajectory
- ENT, currently above trajectory
- General Surgery, currently above trajectory
- Orthopaedics, below trajectory, plans in place to recover
- Dermatology, significant risks due to staffing shortfalls in January.

Weekly PTL meetings continue to take place with Care Groups where Delivery Plans are discussed to bring performance levels back in line with commissioned activity and meeting RTT. Management of the key areas takes place through fortnightly advanced performance meetings with Ophthalmology, General Surgery, ENT and Orthopaedics.

Trajectories are set for each service with timescales to achieve 92% in line with commissioned activity.

NHSI are aware of the current capacity shortfalls and performance is planned to achieve in March 2018.

The diagnostic target was 98.49%, the key issue was a deterioration in Audiology due to staff absences over the Christmas period.

Key to performance is the need to be maintaining contracted activity and ensuring the cancelled clinics and new to follow up ratios are within the ratios set by the CCG.

Work continues to reduce both short notice hospital driven changes and cancellations and to reduce DNA rates. These pieces of work are monitored through the planned care stream of the patient pathway transformation project.

4hr Access

The target is based on the number of patients who are treated within 4hrs of arrival into the emergency department and set at 95% and reported quarterly as an average figure. This target is for all urgent care provided by the Trust for any patient who walks in. We have 2 type 1 facilities, ED at BDGH and DRI and 1 type 3 facility at MMH.

December Performance

Trust 88.6%, Including alternative pathways 89.9%

Quarter 3 90.9%, NHSI trajectory for Q2 90.3%, STF achieved

The key issues for breaches remains internal ED waits to see or be reviewed by a doctor. Potential improvements are expected after successful recruitment to the consultant tier and a review of rotas to increase the time on the shop floor of the consultants.

Measure	Dec-16	Dec-17	Difference	%Difference
4 hour performance	87%	89%	2%	
Attendance numbers	13496	13867	371	3%
Breaches	1811	1585	-226	-12%
DRI Streamed to FCMS	1227	1428	201	16%
DRI Streamed to FCMS - %	14.90%	16.40%	1.5%	10%
CDU Admissions	1146	1124	-22	-2%
95th Percentile Waiter	07:15	06:09	-01:06	-15%
4 hour bed waits	1086	812	-274	-25%
4 hour bed waits - BDGH	*206*	*187*	*-19*	*-9%*
4 hour bed waits - DRI	*880*	*625*	*-255*	*-29%*
Boarding times (hours)	7289.5	5363.9	-1925.6	-26%
Left without being seen	401	342	-59	-15%
Unplanned Re-attendance	305	208	-97	-32%

18.5% of all of DRI discharges take place at a weekend and 15.0% at BDGH

If activity levels were at the same level as Mondays then the Trust would see an extra 153 patients a week at DRI and an extra 103 patients at BDGH

A&E attendances on a Monday at DRI account for 15.4% of weekly activity rising to 15.9% at BDGH
Non Elective Admissions on a weekday that are from direct GP admissions account for is 20.3% of all Emergency Admissions on a weekday at DRI but only 9.1% at BDGH.
When we move into the weekend this drops to 11.1% at DRI and 2.5% at BDGH

Cancer Performance

November 62 day performance 88.3%, TWW performance 94%

The 62 day target was achieved by the Trust in November at 88.3%. The key issue remains in Urology, due to the number of patients requiring treatment. There were a number of delays in complex pathways within Head and Neck, Lower GI and Gynaecology but these were small numbers.

Across the Cancer Alliance the Cancer Services Managers continue to review all shared pathways at Day 38. The Trust needs to achieve and maintain a 7 day access either to diagnostics or 1st consultation and achieve discussion at Central MDT by Day 24 to allow for a smoother transition to Day 38. In November, 31.03% of patients were seen with 7 days of their referral having been made. Improvement against this measure will continue to be monitored.

Stroke Performance

<u>Performance in October</u>

Performance against the scan within 1 hour standard continues to be maintained above 48% at 52.9%.

The 4 Hour Direct Admissions standard is still not being achieved by the Trust however October saw an improved position compared with the previous months at 66.7%.

In October 6 patients were received from out of area CCGs – Rotherham, Hull, East Riding and Scotland.

David Purdue Chief Operating Officer January 2018

PERFORMANCE REPORT – December 2017

Cancer Performance

The following information relates to Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust performance in November.

Standard	Local Performance %	National Performance %
TWW	94%	95.1%
31 day	100%	97.6%
62 day	88.3 %	82.3%
31 day Sub – Surgery	100%	95.6%
31 day Sub – Drugs	100%	99.5%
31 day Sub – Other	100%	100%
62 day Screening	94.1%	91.2%
62 day Con Upgrades	88.9%	88.4%
Breast Symptomatic	95.3%	95.6%

62 day Cancer performance

62 day performance nationally has failed for the past 3 years and is not achieving for the SYB ACS. A National 8 high impact intervention plan has been shared which DBTH has responded to. Cancer performance is monitored locally through the Cancer alliance.

The 62 day target was achieved by the Trust in November at 88.3%. The key issue remains in Urology, due to the number of patients requiring treatment. There were a number of delays in complex pathways within Head and Neck, Lower GI and Gynaecology but these were small numbers.

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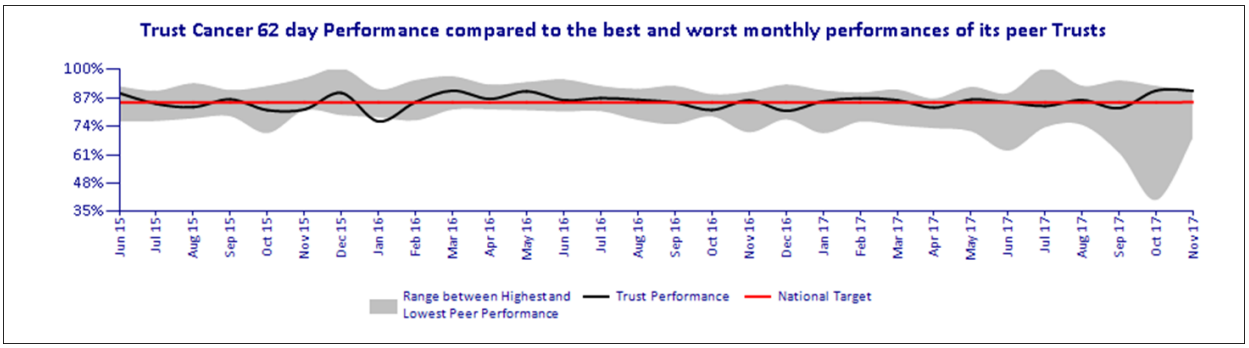
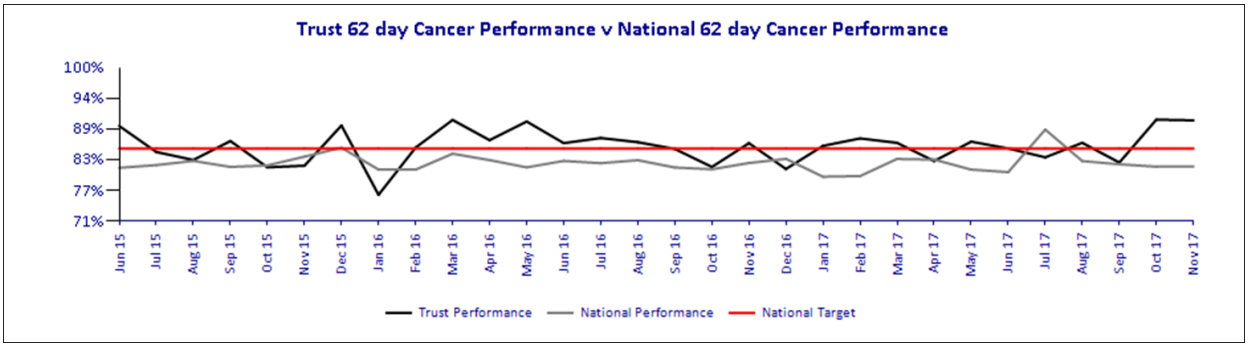
PERFORMANCE REPORT – December 2017

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





Two Week Wait Performance

The November position for two week wait was 94% which was compliant with the national target of 93%.

	2ww	Non 2ww Symptomatic Breast Referrals	31 Day - Classic	31Day Sub - Surgery	31 Day Sub - Drugs	31 Day Sub - Palliative	62 Day - Classic	62 Day Screening	62 Day Consultant Upgrades
Operational Std	93%	93%	96%	94%	98%	94%	85%	90%	TBA
Breast	98.7%	95.3%	100%	100%	100%	100%	100%	100%	100%
Gynaecology	93.3%		100%			100%	83.3%		0%
Haematology	100%		100%		100%	100%	100%	100%	100%
Head & Neck	87.3%		100%			100%	50%		
Lower GI	98.3%		100%	100%		100%	84.6%	40%	100%
Lung	95.7%		100%			100%	90%		92.9%
Other	100%		100%				100%		
Skin	90.8%		100%	100%		100%	100%		
Upper GI	80.4%		100%			100%	90%		66.7%
Urological	95.7%		100%	100%	100%	100%	77.5%		80%

The Cancer two week wait booking team has now been successfully relocated within the central booking office to allow for increased flexibility in capacity planning. As a result of the move, fewer administrative delays have been reported.

Patient choice continues to be a key reason for patients not being seen within 2 weeks. Patients who choose to be seen outside of 2 weeks are contacted by nurse specialists to ask why they do not wish to attend. The cancer management team meets regularly with the CCGs to review the information given in primary care which supports the 2 week wait position.

The table below shows the number of patients and the reasons for not meeting the required target in November.

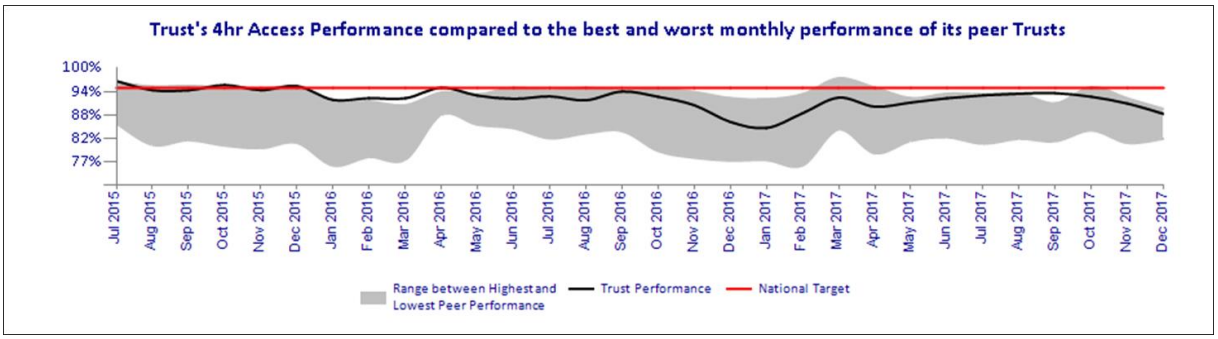
CWT Standard	Tumour Group	Performance against CWT standard	High Level View
Two Week Wait	Head & Neck	87.3%	9 breaches – 7 patient choice, 2 capacity
	Skin	90.8%	18 breaches – 11 patient choice, 3 capacity, 1 administrative delay 3 hospital cancellations
	Upper GI	80.4%	21 breaches – 11 patient choice, 6 capacity, 4 administrative delay
62 day	Gynae	83.3%	2 patients – both shared care - 1 medial delay, 1 additional investigations required at STH - IPT date not agreed between trusts.
	Head & Neck	50%	3 patients – 2 shared care, 1 local - all pathway delays
	Lower GI	84.6%	2 patients – both shared care - both complex pathways,
	Urology	77.5%	6 patients – 3 shared pathway – Pathway delays around diagnostics. 3 local pathways, 2 patient choice, 1 capacity issues
62 day Screening	Lower GI	40%	2 patient – 1 shared care and 1 local pathway – both patient choice elements to pathway
62 day Consultant Upgrade	Gynae	0%	1 patient – shared care – complex diagnostic pathway
	Upper GI	66.7%	1 patient – 1 shared care, treatment delayed for medical reasons
	Urology	80%	1 patient – 1 shared care, capacity delays and ptient choice

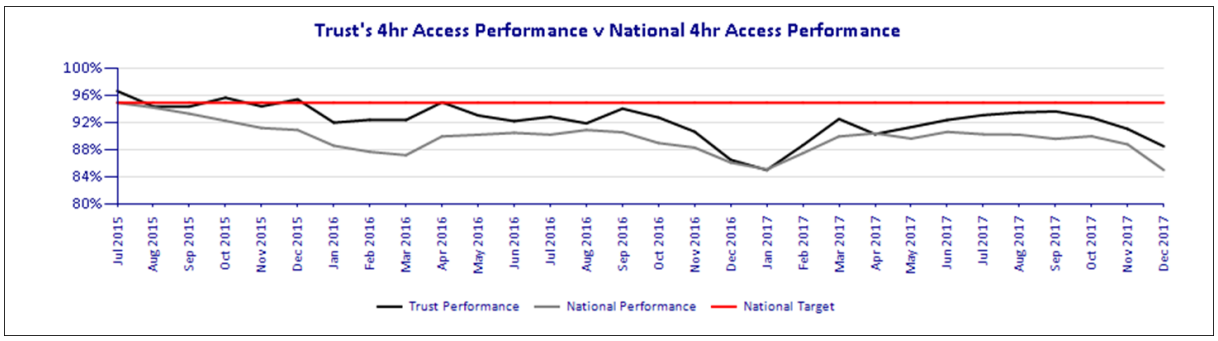
4hr Access Target

The Trust achieved 88.6% in December against the 4hr access standard of 95%. The Trust requirement for NHSi STF in Quarter 3 was achieved at 90.9% against a target of 90.1%.

National performance in December was 80.1%.

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





As part of the planning for Christmas, acute Trusts were expected to have 85% bed occupancy from the 22nd of December to the 1st of January. DBTH was at 82% bed occupancy on the 22nd and below 85% was maintained until the 27th of December following this bed capacity increased to 87% and was at 89% on the 1st of January.

Activity from the 23rd to the 31st of December saw a15.6% increase of attendances at DRI and a 3.2% increase at BDGH. Conversion rate increased to 23.4% from an average of 19.6%.

Comparison of December 2016 to 2017 is highlighted below. Key issue remained access to ED medical staff.

PERFORMANCE REPORT – December 2017

Measure	Dec-16	Dec-17	Difference	%Difference
4 hour performance	87%	89%	2%	
Attendance numbers	13496	13867	371	3%
Breaches	1811	1585	-226	-12%
DRI Streamed to FCMS	1227	1428	201	16%
DRI Streamed to FCMS - %	14.90%	16.40%	1.5%	10%
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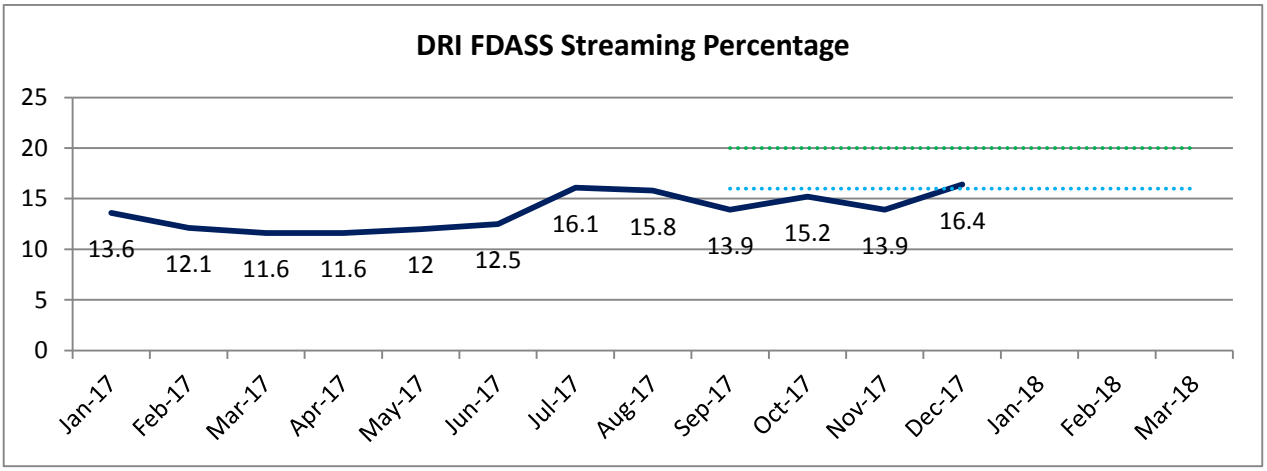
4 hour bed waits	1086	812	-274	-25%
4 hour bed waits - BDGH	*206*	*187*	*-19*	*-9%*
4 hour bed waits - DRI	*880*	*625*	*-255*	*-29%*
Boarding times (hours)	7289.5	5363.9	-1925.6	-26%
Left without being seen	401	342	-59	-15%
Unplanned Re-attendance	305	208	-97	-32%

- Performance 88.6% for December. Lowest performance since January, but 2% better than 86.6% in December 2016, with 226 fewer breaches (1585 vs 1811)
- Record number streamed to FCMS by DRI – 1428, 16.4%.
- CDU admissions slightly below average, with a 10.4% decrease at DRI and a 10.5% increase at Bassetlaw
- 4 Hour Bed Waits highest since January at 812, but significantly lower December 2016's 1086 – a 25% drop year-on-year, with 30% improvement at DRI and 10% at Bassetlaw.

Streaming

Doncaster FDASS

The number of patients streamed directly from the front door increased in December. The graph below shows the percentage of patients streamed each month.



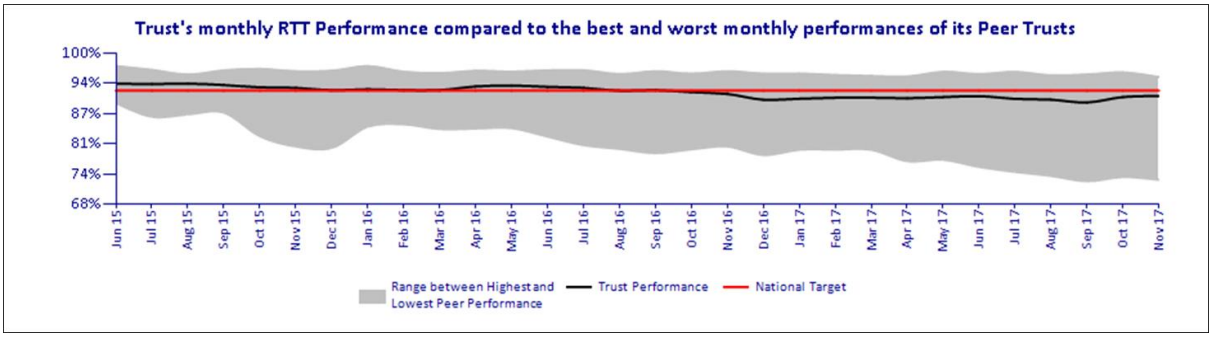
Bassetlaw

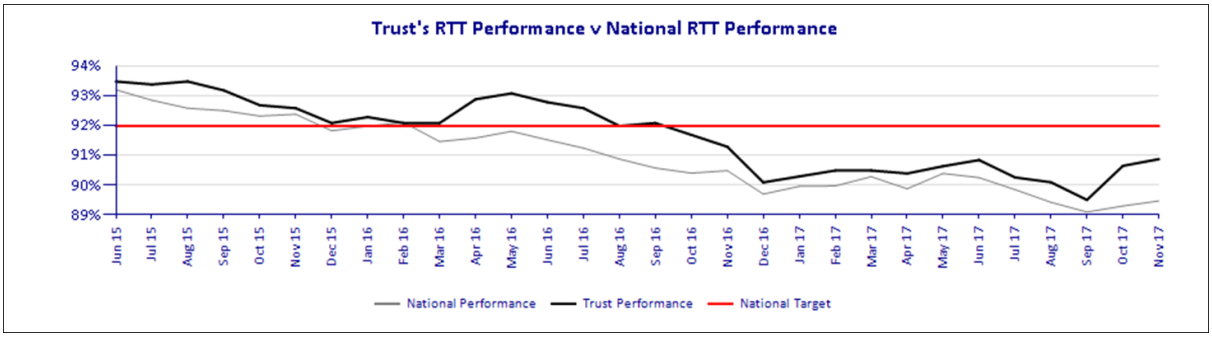
Streaming commenced at Bassetlaw on 1 October 2017. The % streamed has consistently been between 6-12%.

Referral to Treatment (RTT)

Incomplete pathways for December ended in an improved position at 89.6% against the 92% standard.

The graphs below show Doncaster and Bassetlaw's performance in relation to the National picture.





At the end of December 2017 there was one Incomplete Pathway over 52 Weeks for General Surgery.

Specialties which failed to meet 92% in December:

Specialty Group	Under 18 Weeks	18 Weeks & Over	Total	Percentage
General Surgery	2283	420	2703	84.5%
Urology	1266	117	1383	91.5%
T&O	4976	675	5651	88.1%
ENT	2535	387	2922	86.8%
Ophthalmology	2966	344	3310	89.6%

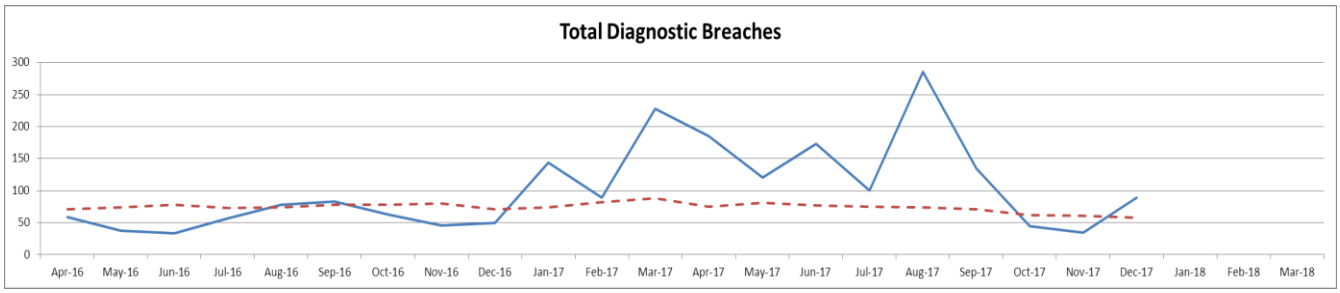
General Medicine	2402	251	2653	90.5%
Cardiology	1799	194	1993	90.3%
Dermatology	1962	232	2194	89.4%
Rheumatology	740	109	849	87.2%
Trust Total	**27749**	**3205**	**30954**	**89.6%**

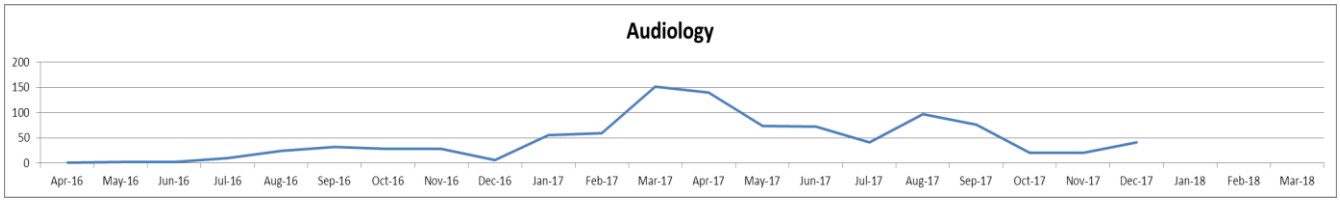
Weekly PTL meetings continue to take place with Care Groups where Delivery Plans are discussed to bring performance levels back in line with commissioned activity and meeting RTT. Management of the key areas takes place through fortnightly advanced performance meetings with Ophthalmology, General Surgery, ENT and Orthopaedics.

Trajectories are set for each service with timescales to achieve 92% in line with commissioned activity.

Diagnostics

The Trust has narrowly missed achieving the Diagnostic performance standard of 99% in December at 98.49%.





The principle reason for non-compliance with the standard was in relation to audiology capacity. Audiology diagnostic performance declined in December with 41 breaches compared with 21 breaches in November. Audiology has attributed this to annual leave and an increase in diagnostic referrals from ENT. The service predicts compliance with the standard in January.

Medical imaging is expected to continue to achieve the standard overall in January.

Stroke

Performance in October

Performance against the scan within 1 hour standard continues to be maintained above 48% at 52.9%.

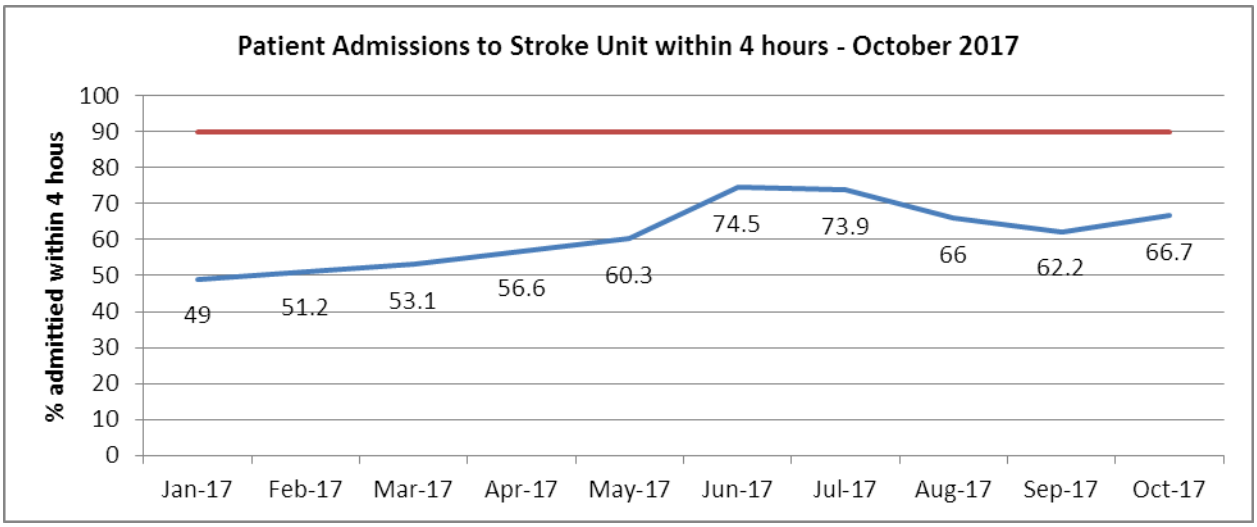
The 4 Hour Direct Admissions standard is still not being achieved by the Trust however October saw an improved position compared with the previous months at 66.7%.

In October 6 patients were received from out of area CCGs – Rotherham, Hull, East Riding and Scotland.

Direct admissions within 4hrs, target 90%

	CCG			
Direct Admission within 4 Hours	Bassetlaw	Doncaster	Other	**Total**
Yes	6	25	3	**34**
No	3	11	3	**17**
Grand Total	**9**	**36**	**6**	**51**
Performance	66.7%	69.4%	50.0%	**66.7%**

Category	Sub Category	Total
Organisational	Beds	4
	Pathway	8
	Staff Availability	
Clinical	Patient Presentation	3
	Patient Needs	2
Patient Choice	Declined	
Awaiting further validation		



Scan within 1hr, target 48%

	CCG			
Scan 1 hr	Bassetlaw	Doncaster	Other	**Total**
Yes	6	18	3	**27**
No	3	18	3	**24**
Grand Total	**9**	**36**	**6**	**51**
Performance	66.7%	50.0%	50.0%	**52.9%**

Category	Sub Category	Total
Organisational	Scanner	
	Pathway	11
	Staff Availability	1
Clinical	Criteria	
	Patient Needs	5
	Patient Presentation	7
Patient Choice	Declined	
Awaiting further validation		

Cancelled Operations

In December, 1.51% of Trust operations were cancelled. This demonstrates consistent performance with the previous month with 66 patients cancelled out of a total of 4375. 51 patients were cancelled for theatre reasons and 15 for non theatre reasons.

In should be noted that the number of operations performed in December was significantly lower than previous months - 4375 compared with an average of 5213 year to date.

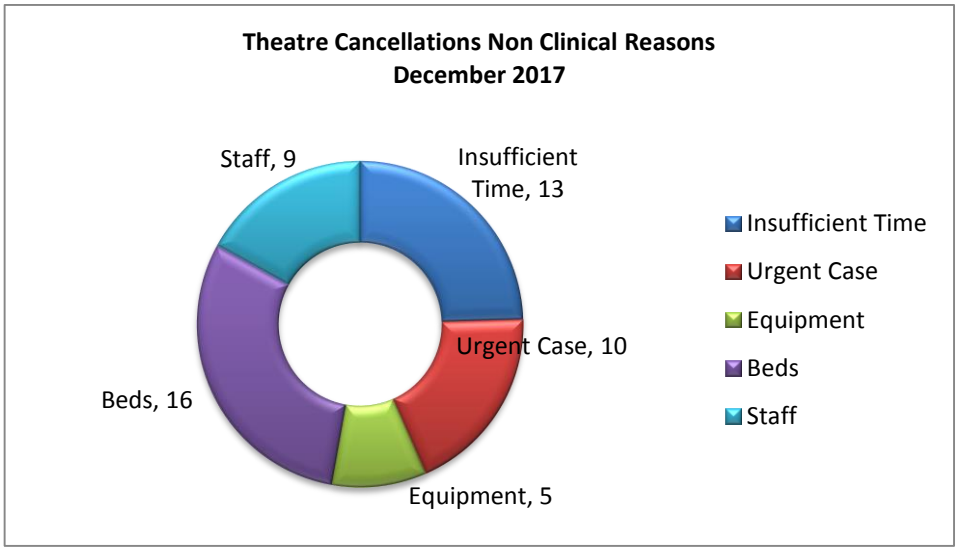
Indicator	**Standard**		**Qtr 3 2017-18**	**Oct-17**	**Nov-17**	**Dec-17**

Cancelled Operations (Total)	0.8%		1.13%	0.99%	0.95%	1.51%
Cancelled Operations (Theatre)			0.79%	0.65%	0.61%	1.17%
Cancelled Operations (Non Theatre)			0.34%	0.34%	0.34%	0.34%
Cancelled Operations-28 Day Standard	0		6	3	1	2

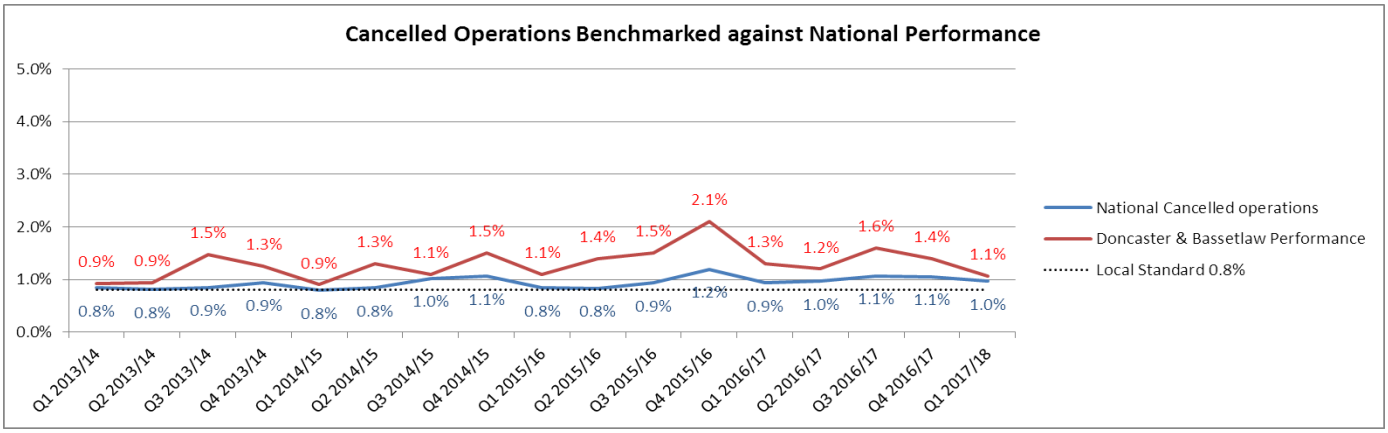
Out of these overall cancellations, 53 operations were cancelled for non-clinical reasons: 28 at Doncaster, 22 at Bassetlaw and 3 at Mexborough.

2 patients were cancelled on the day of admission and waited over the 28 day standard for their surgery to be rearranged.

The reasons for the non-clinical cancellations are displayed in the graph below:



The graph below demonstrates the Trust performance compared with the National picture.



Ambulance Handover Times within 15 minutes

The table below shows the ambulance handover times for Doncaster and Bassetlaw, and for both YAS and EMAS in September. Both Doncaster and Bassetlaw sites compare favorably with other local acute providers.

YAS AMBULANCE HANDOVER TIME - DECEMBER				
Hospital	**Handover Less than 15 mins**	**Total Arrivals At Destination**	**% Handovers in 15 minutes (Target 100%)**	**Average Handover Time**
BARNSLEY DISTRICT GENERAL	1119	2022	**60.7%**	**00:15:07**
DONCASTER ROYAL INFIRMARY	1882	2682	**79.9%**	**00:09:45**
NORTHERN GENERAL HOSPITAL	1248	3653	**43.7%**	**00:21:18**
ROTHERHAM DISTRICT GENERAL HOS	1055	2048	**59.7%**	**00:17:07**
SHEFFIELD CHILDRENS HOSPITAL	166	405	**81.0%**	**00:09:42**

DNA and CNA Rates

Indicator	Oct-17	Nov-17	Dec-17	
Outpatients: DNA Rate Total	10%	10.11%	9.73%	4032 patients
Outpatients: Hospital cancellation Rate	5.9%	5.51%	5.78%	155 clinics
Outpatients: Patient cancellation Rate	10.69%	10.35%	12.47%	5167 patients

In December, the overall DNA rate across the Trust dropped to 9.73%. This was following an increase in October and November. It is recognised that the overall Trust DNA rate is higher in some specialties than the National picture. A focused piece of work is being undertaken to improve attendance within those specialties with the highest DNA rates.
A higher percentage of

The clinic cancellation rate continues to reduce.

At a Glance -December 2017 (Month 9)

Current position

Benchmarking Position

Page		Indicator	Standard	Current Month	Month Actual	Direction of travel compared to previous Month	NHS England %	DBTHFT	Month	Peer Groups %	DBTHFT	Month
2	Monitor Compliance Framework	31 day wait for second or subsequent treatment: surgery	94.00%	November	100.00%	⇔	95.50%	See Month Actual	November	96.17%	See Month Actual	November
		31 day wait for second or subsequent treatment: anti cancer drug treatments	98.00%		100.00%		97.60%			100.00%		
		31 day wait for second or subsequent treatment: radiotherapy	94.00%		100.00%		99.60%			Not Available		
		62 day wait for first treatment from urgent GP referral to treatment	85.00%		88.30%	↗	82.50%			82.00%		
		62 day wait for first treatment from consultant screening service referral	90.00%		91.90%	↗	91.00%			88.03%		
		31 day wait for diagnosis to first treatment- all cancers	96.00%		100.00%	↗	97.60%			97.97%		
		Two week wait from referral to date first seen: all urgent cancer referrals (cancer suspected)	93.00%		94.00%	↗	95.10%			90.84%		
		Two week wait from referral to date first seen: symptomatic breast patients (cancer not initially suspected)	93.00%		94.30%	↗	95.70%			95.03%		
3		A&E: Maximum waiting time of four hours from arrival / admission / transfer / discharge (Trust)	95.00%	December	88.60%	↘	80.10%	See Month Actual	December	88.79%	92.80%	October
4		Maximum time of 18 weeks from point of referral to treatment-incomplete pathway	92.00%	December	89.60%	↘	89.47%	96.90%	November	85.42%	96.90%	November
		% of Patients waiting less than 6 weeks from referral for a diagnostics test	99.00%	December	98.49%	↘	100.00%	99.45%	November	96.90%	99.45%	November
3	Ambulance Handover Times	Ambulance Handovers Breaches -Number waited over 15 & Under 30 Minutes		September	723	↘	No Benchmarking available					
		Ambulance Handovers Breaches-Number waited over 30 & under 60 Minutes			86	↘						
		Ambulance Handovers Breaches -Number waited over 60 Minutes			6	↘						
5	Stroke	Proportion of patients scanned within 1 hour of clock start (Trust)	48.00%	October	52.90%	↘	Still looking @ data sources for obtaining this information					
		Proportion of patients directly admitted to a stroke unit within 4 hours of clock start (Trust)	90.00%		66.70%	↗						
		Percentage of eligible patients (according to the RCP guideline minimum threshold) given thrombolysis (Trust)	20.00%		11.80%	↘						
		Percentage of patients treated by a stroke skilled Early Supported Discharge team (Trust)	40.00%		71.10%	↗						
		Percentage of those patients who are discharged alive who are given a named person to contact after discharge (Trust)	95.00%		91.10%	↘						
		Implementation of Stroke Strategy - TIA Patients Assessed and Treated within 24 Hours	60.00%	December	65.90%	↓						
	Theatres & Outpatients	Cancelled Operations	0.80%	December	1.51%	↗	No Benchmarking available					
		Cancelled Operations-28 Day Standard	0		2							
		Out Patients: DNA Rate			9.73%	↗	Still looking @ data sources for obtaining this information					
		Out Patients: Hospital Cancellation Rate			5.78%		Still looking @ data sources for obtaining this information					
	Effective	Emergency Readmissions within 30 days (PbR Methodology)		October	5.96%	↘	Still looking @ data sources for obtaining this information					

Page		Indicator	Current Month	Month Actual (TRUST)	Month Actual (DRI)	Month Actual (BDGH)	Data Quality RAG Rating
9	Fractured Neck of Femur	% of patients achieving Best Practice Tariff Criteria	Dec-17	71.9%	72.0%	71.4%	
		Best Practice Criteria					
		36 hours to surgery Performance	Dec-17	71.9%	72.0%	71.4%	
		72 hours to geriatrician assessment Performance		96.9%	96.0%	100.0%	
		% of patients who underwent a falls assessment		97.0%	96.0%	100.0%	
		% of patients receiving a bone protection medication assessment		100.0%	100.0%	100.0%	
		Mortality-Deaths within 30 days of procedure		0.00%	3.70%	2.95%	

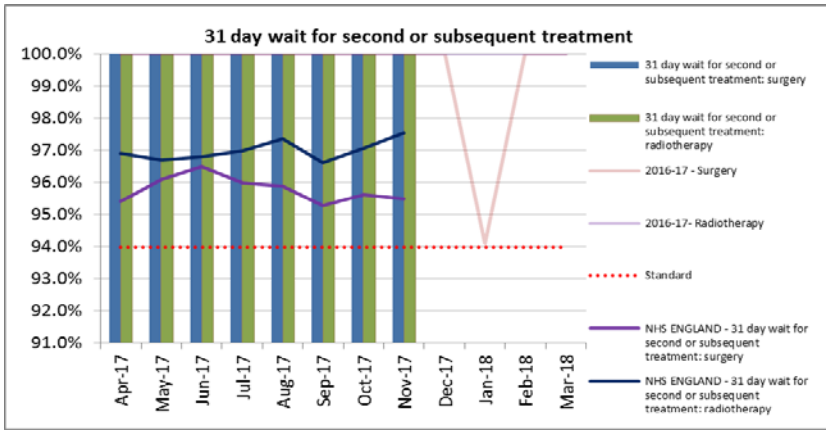
Page		Indicator	Standard (Local, National Or Monitor)		Current Month	Month Actual	Data Quality RAG Rating
11	Safe	Infection Control C.Diff	4 Per Month for Qtr 2 - 45 full year	M	Dec-17	0	
		Infection Control MRSA	0	L		1	
9		HSMR (rolling 12 Months)	100	N	Oct-17	87.1	
		Never Events	0	L	Dec-17	0	
		VTE	95.0%	N	Nov-17	95.0%	
11		Pressure Ulcers	12 Per Month 144 full Year	L	Dec-17	4	
		Falls that result in a serious Fracture	2 Per Month 23 full Year	L		1	
		Catheter UTI	Snap shot audit			1.38%	

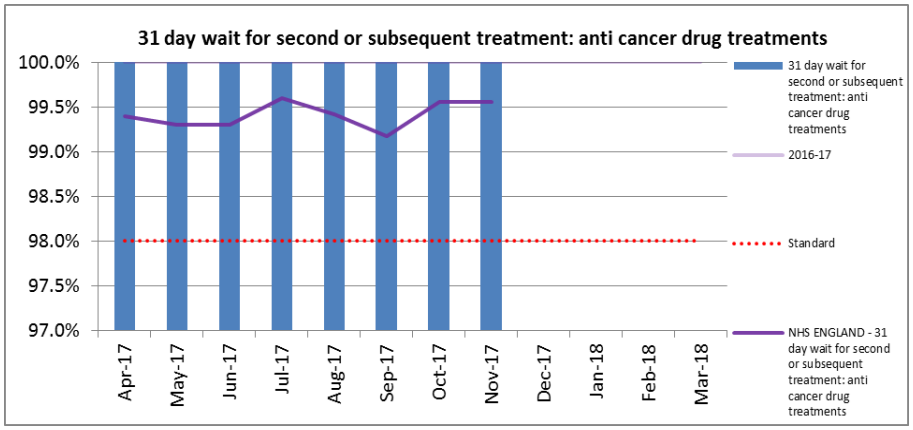
Page		Indicator	Current Month	Month Actual	Data Quality RAG Rating
12	Complaints & Claims	Complaints received (12 Month Rolling)	Dec-17	503	
		Concerns Received (12 Month Rolling)		745	
		Complaints Performance		80.4%	
		Clinical Negligence Scheme for Trusts (CNST)		27	
		Liabilities to Third Parties Scheme (LTPS)		0	
		Claims per 1000 occupied bed days		1.17	

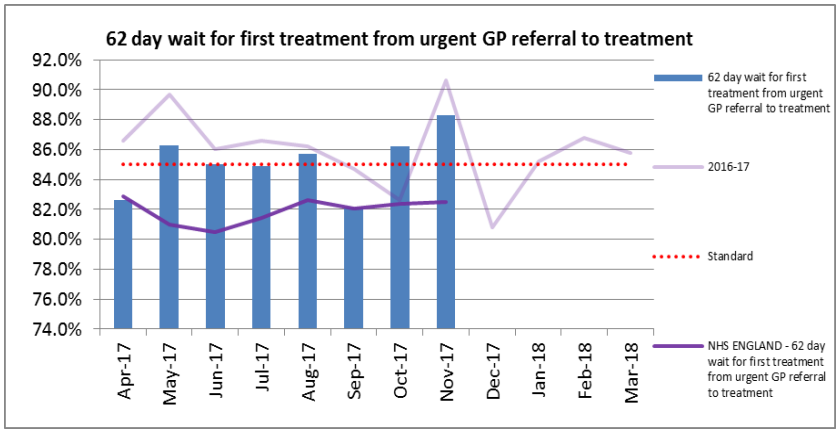
Page		Indicator	Current Month	YTD (Cumulative)	Data Quality RAG Rating
17	Workforce	Appraisals	Dec-11	62.17%	
16		SET Training		76.71%	

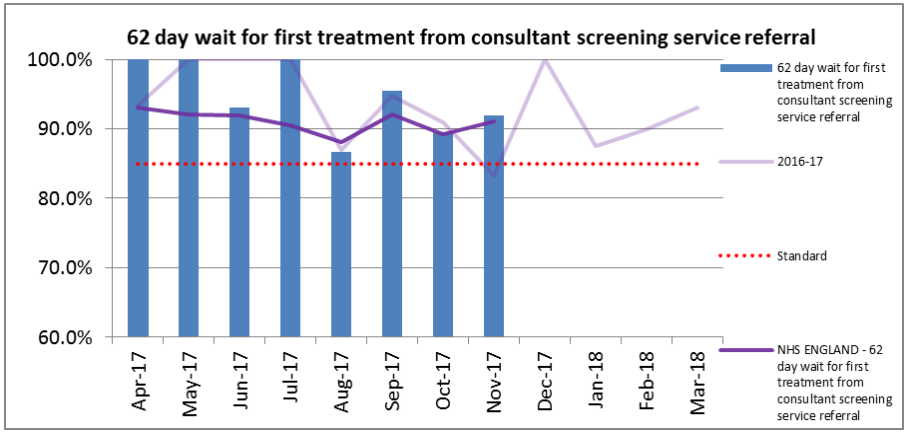
Peer Groups: Trusts Used are: Bradford Teaching Hospitals NHS Foundation Trust, Doncaster and Bassetlaw Hospitals NHS Foundation Trust, Northern Lincolnshire and Goole NHS Foundation Trust, Hull and East Yorkshire Hospitals NHS Trust, The Rotherham NHS Foundation Trust, Mid Yorkshire Hospitals NHS Trust, Calderdale and Huddersfield NHS Foundation Trust

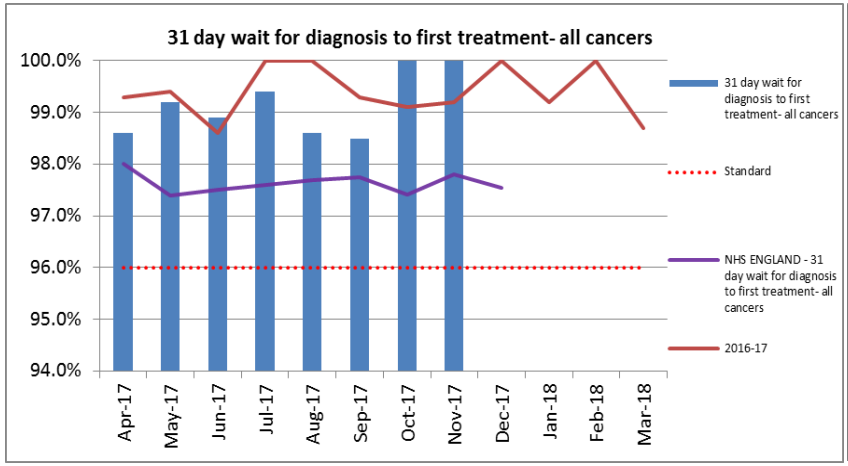
Monitor Compliance Framework: Cancer - Graphs - November 2017 (Month 8)

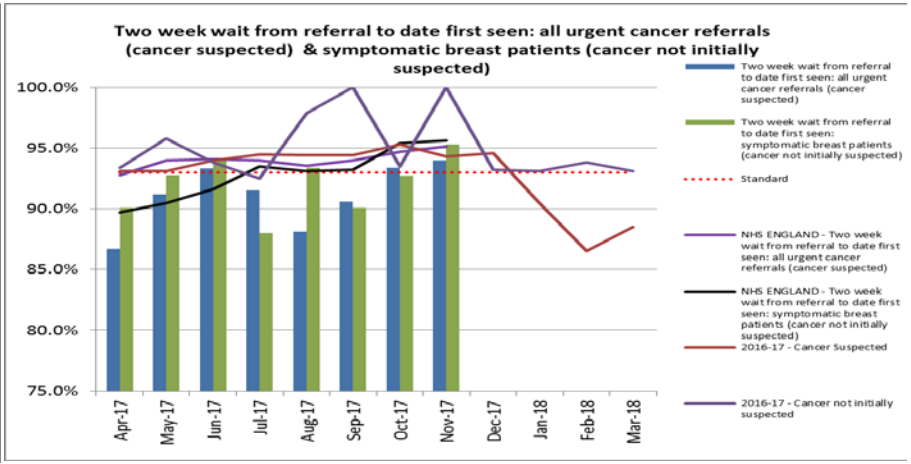




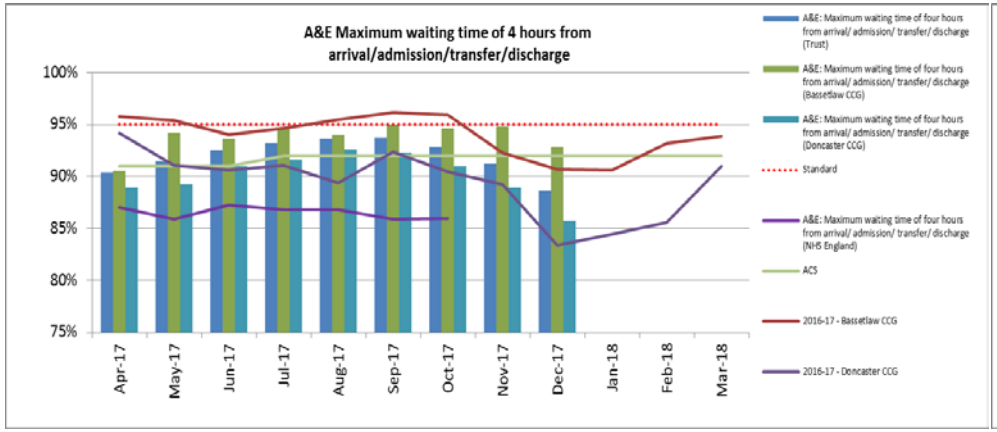


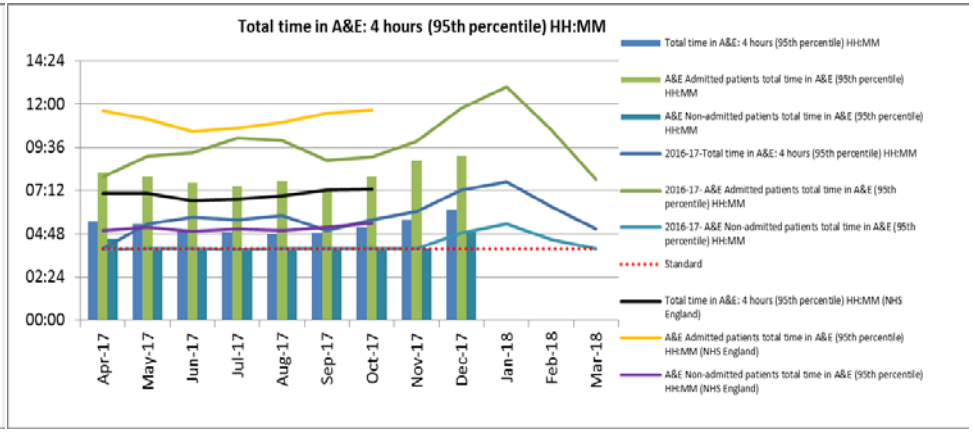


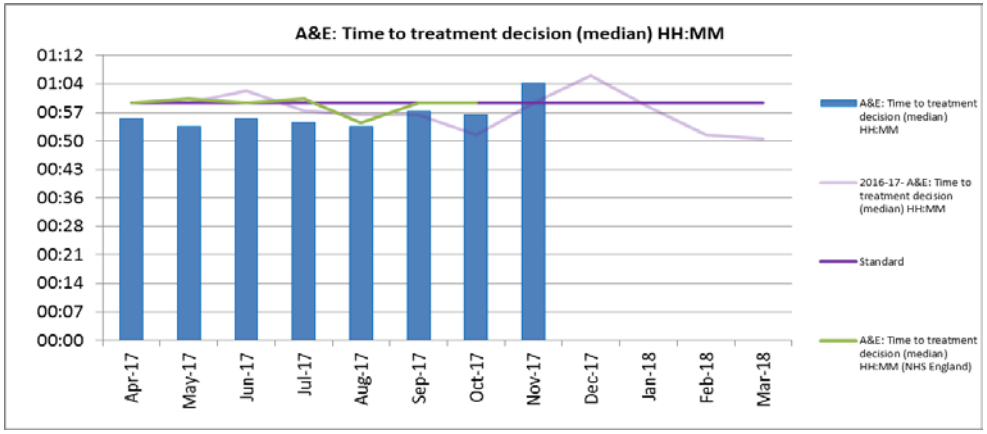


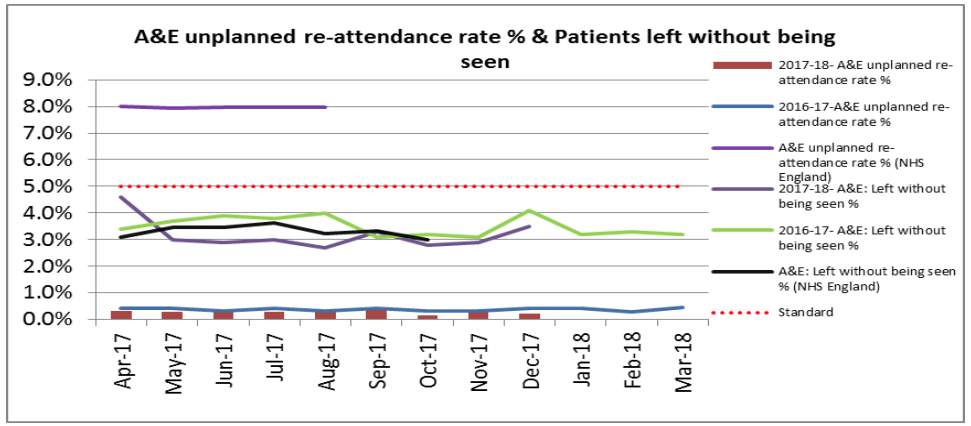


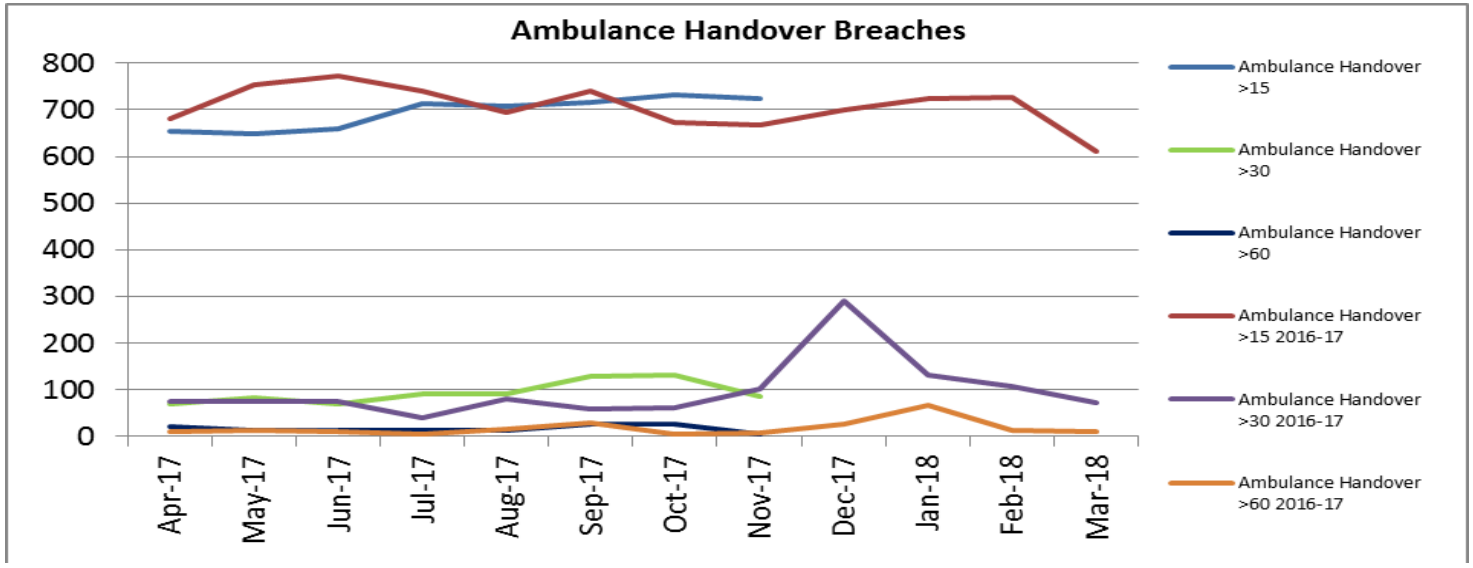
Monitor Compliance Framework: A&E - Graphs - December (Month 9)



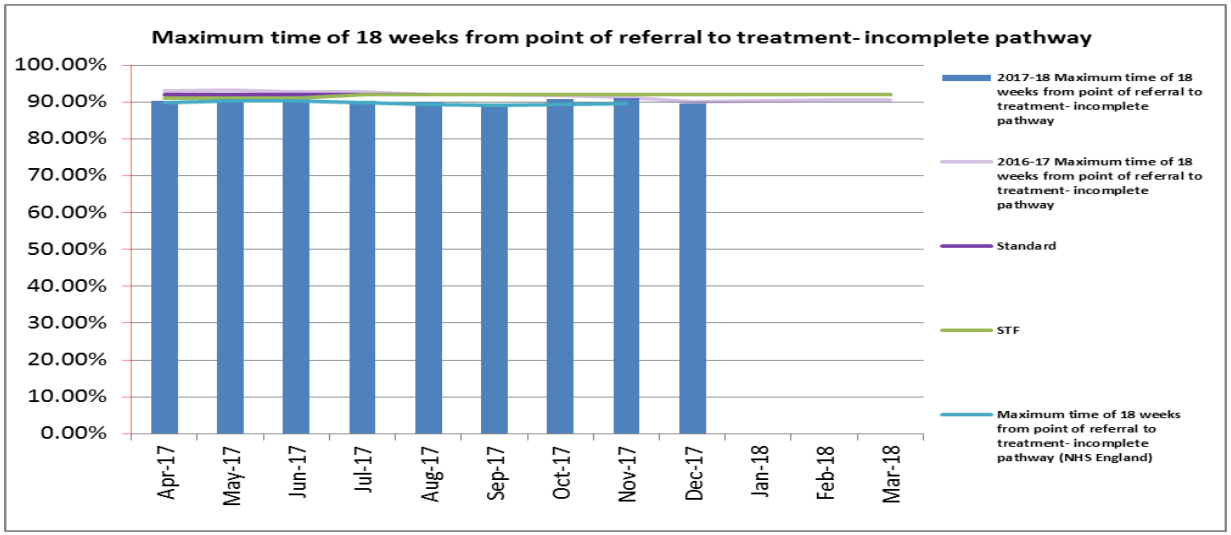


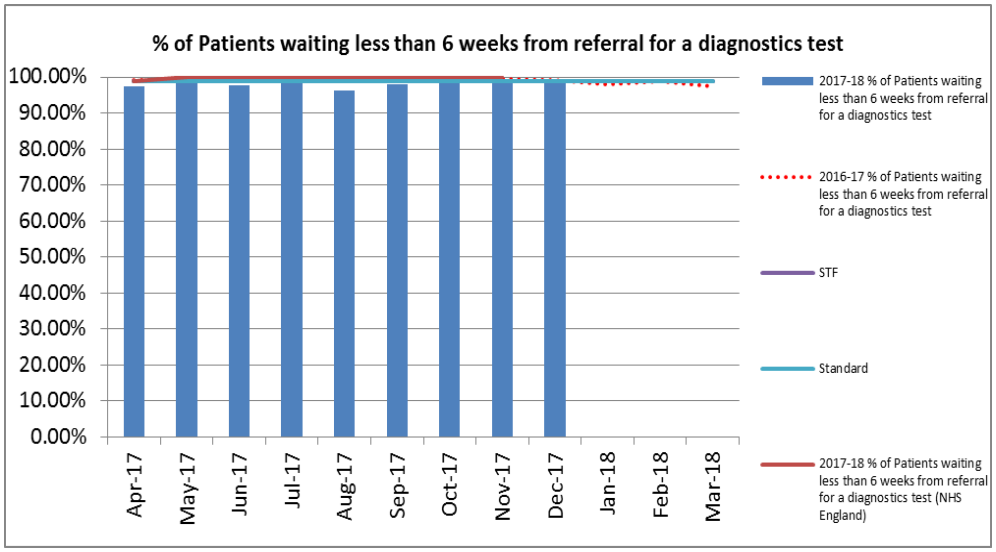


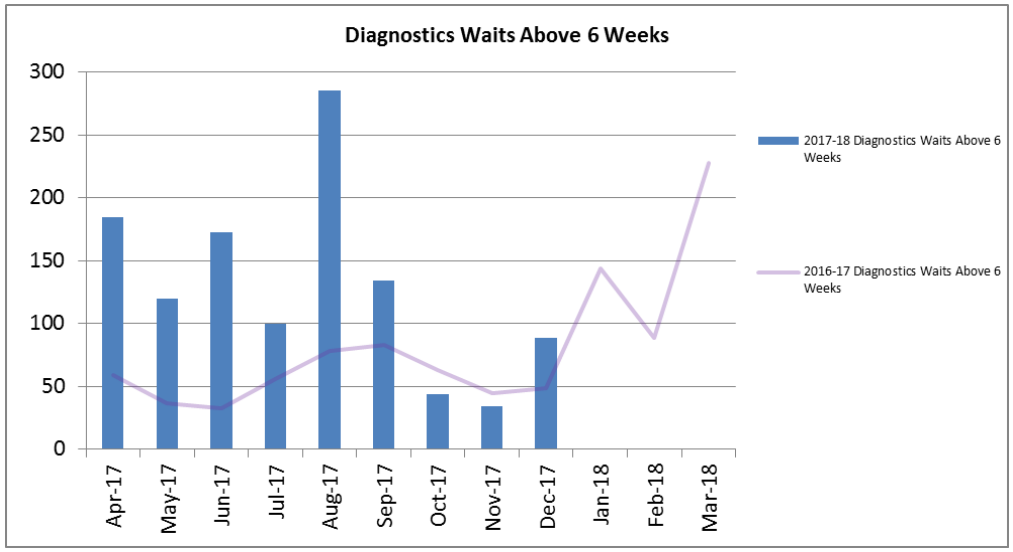




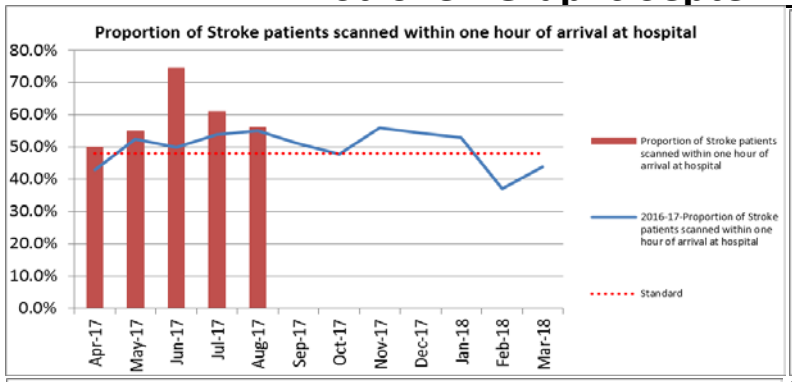
Monitor Compliance Framework: 18 Weeks & Diagnostics - December (Month 9)

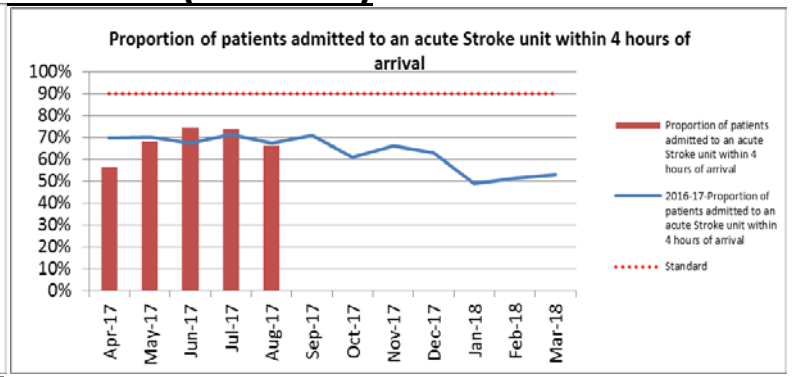


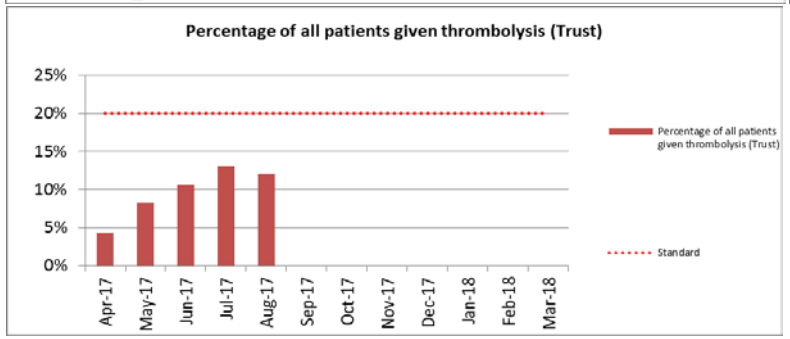


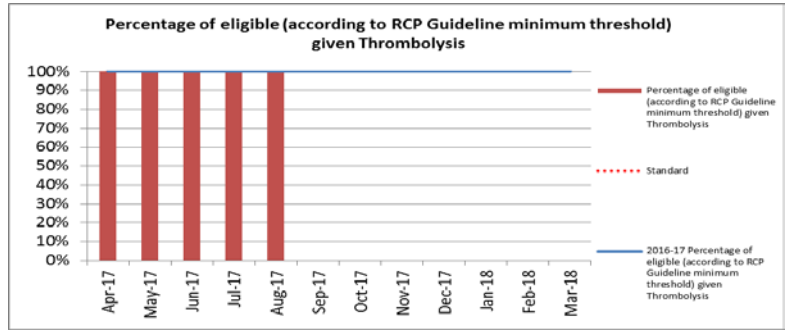


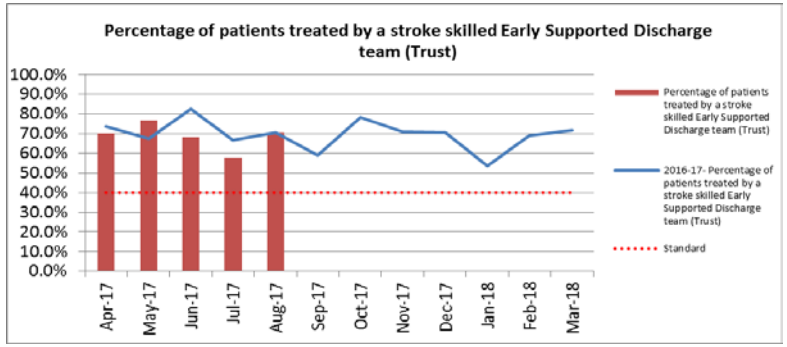
Stroke - Graphs September 2017 (Month 6)

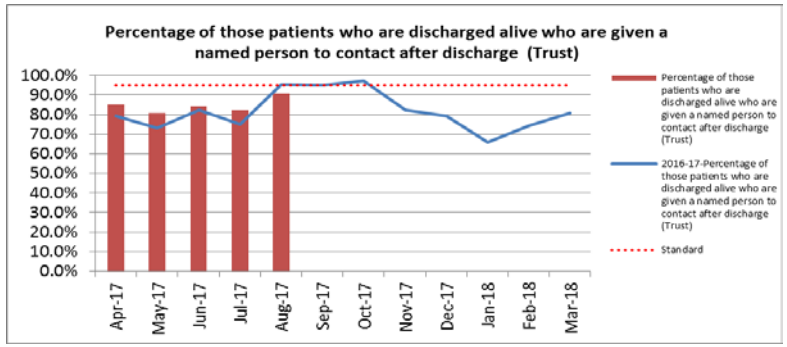


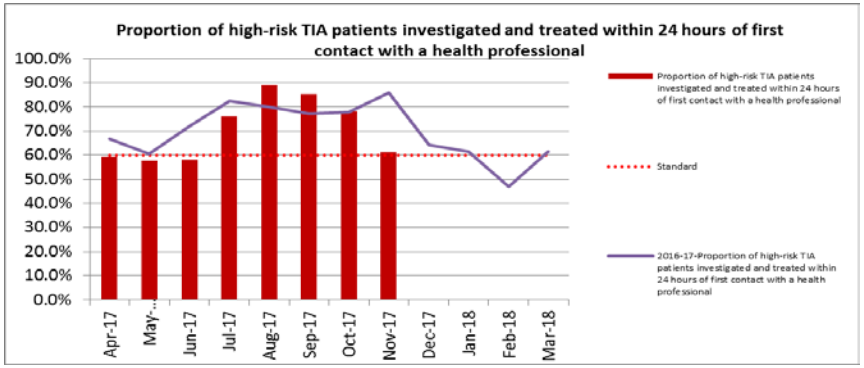




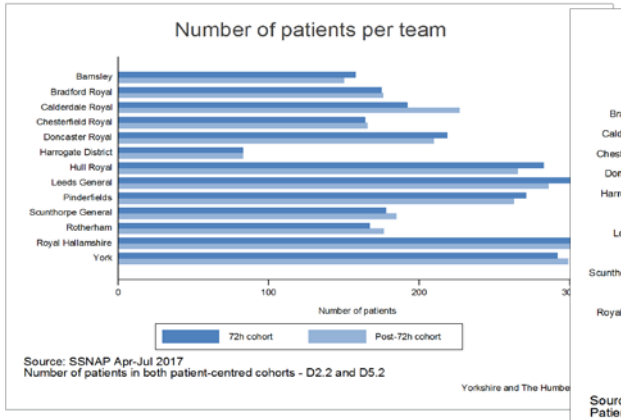


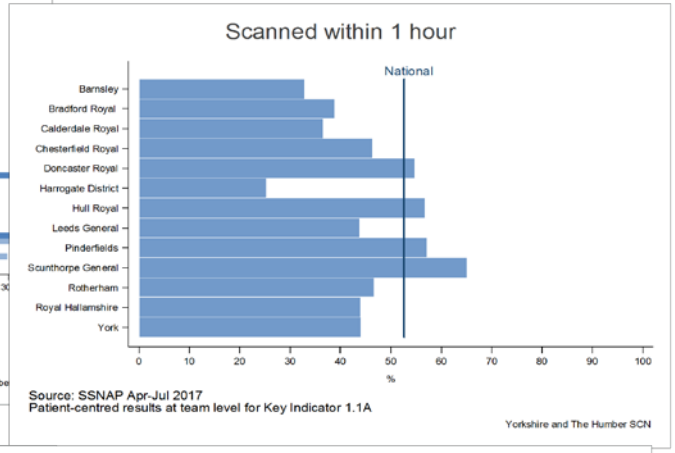


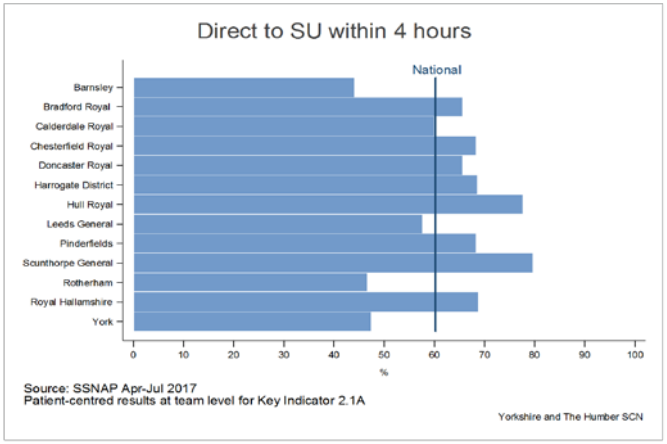


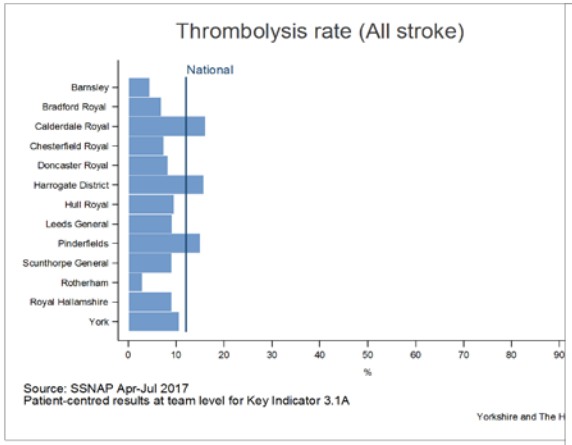


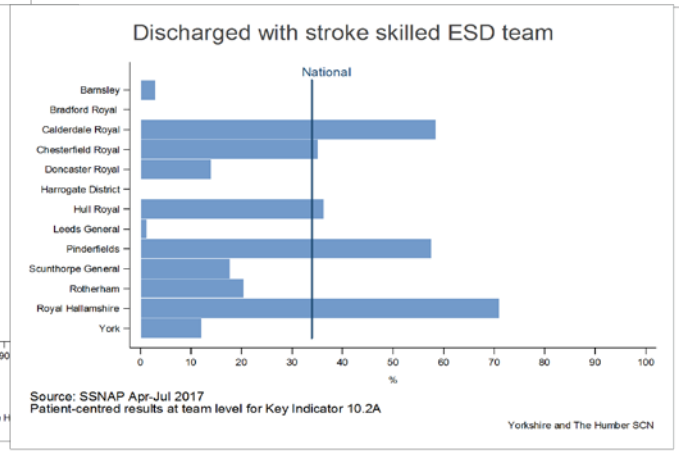
Stroke - Graphs South Yorkshire April 2017- July 2017

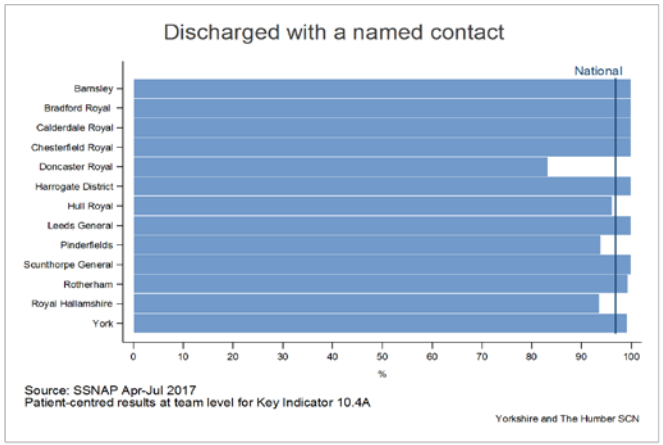












Executive Summary - Safety & Quality - December 2017 (Month 9)

HSMR: The Trust's overall rolling 12 month HSMR remains better than expected at 87.1. Crude mortality rose in December mirroring the rise we experienced last winter.

Fractured Neck of Femur: Relative mortality risk from #NOF continues to improve at both sites. At BDGH, the relative risk has dipped below 100. There has been a significant improvement in achievement of BPT which is now over 70%

Serious Incidents: The year to date reported total of SIs has exceeded that reported in the previous year. All sub-categories i.e. HAPU, serious falls and care issues have shown an increase in the last 3 months. A review iis being commenced

Executive Lead:
Mr S Singh

C-Diff The number of cases of C Diff is below the trajectory for Q3, which equals the number of cases for YTD. The DIPC is taking the lead for raising awareness of all aspects of IP&C including challenging handwashing compliance and amtimicrobial stewardship.

Fall resulting in significant harm: The number of falls remains below trajectory

Hospital Acquired Pressure Ulcers: The rate of case is above trajectory for December and Q3, but this is expected to reduce when demonstrated unavoidable through investigation

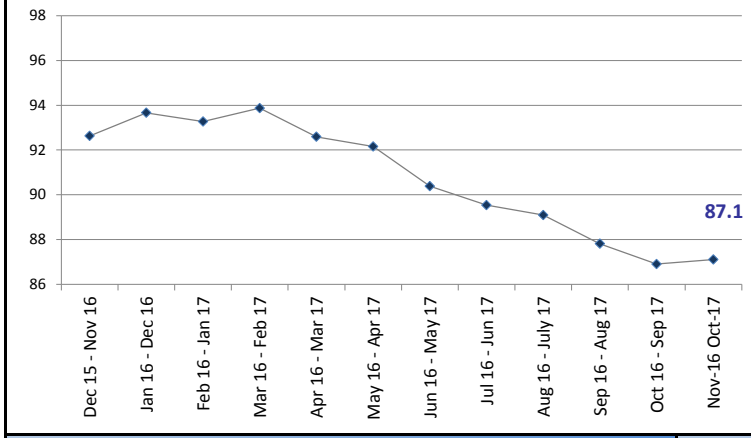
Complaints and concerns: Normal variation is seen in the rate of complaints and concerns. Performance on complaint reply times continues to improve. Weekly meetings with care groups and Director of Nursing to review complaint reply compliance are being undertaken in conjunction with quality improvement work.

Friends & Family Test: Performance for response rates in our inpatient areas dropped slightly again in December.
Performance for likely to recommend are better than the national average for both inpatient areas and ED. Response rates in ED continue to be below national average

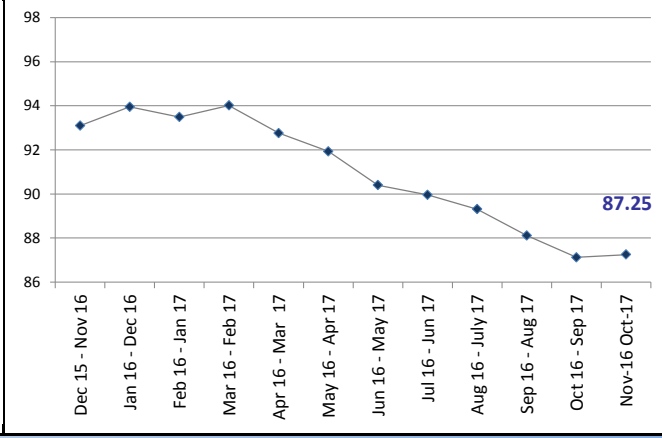
Executive Lead:
Mrs M Hardy

Hospital Standardised Mortality Ratio (HSMR) - October 2017 (Month 7)

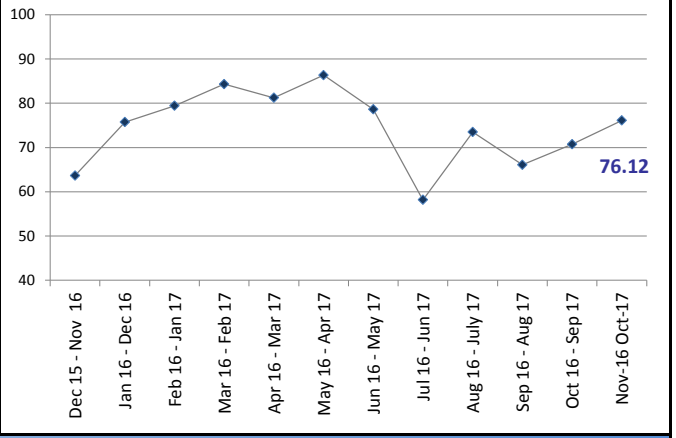
Overall HSMR (Rolling 12 months)



HSMR - Non-elective Admission (Rolling 12 months)



HSMR - Elective Admission (Rolling 12 months)

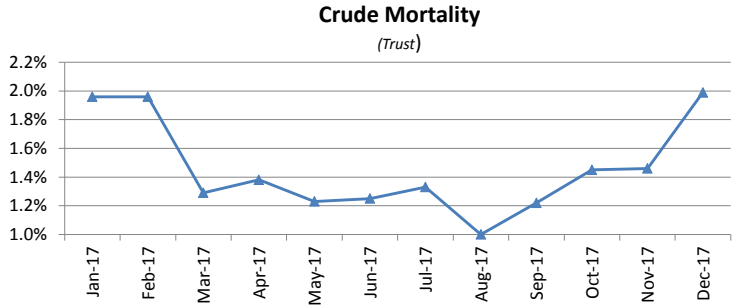


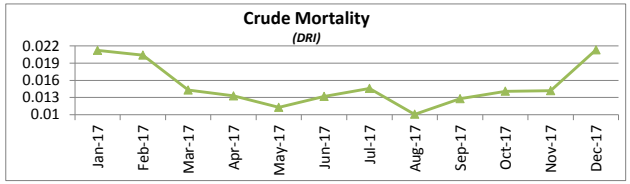
HSMR Trend (monthly)

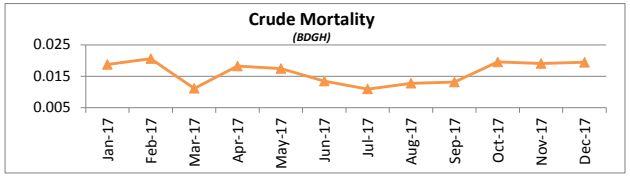
	2014	2015	2016	2017
January	115.45	116.80	99.21	94.86
February	99.11	99.94	97.73	105.44
March	102.91	90.54	97.37	82.66
April	110.49	105.91	88.50	82.27
May	90.93	101.15	96.60	78.41
June	113.74	80.27	93.67	84.08
July	109.94	92.56	97.73	91.84
August	120.18	100.27	87.52	70.43
September	110.10	90.26	95.34	83.03
October	106.58	90.29	88.66	91.41
November	106.84	88.98	82.30	
December	115.87	82.30	93.52	

Crude Mortality (monthly) - December 2017 (Month 9)

(number of deaths/number of patient discharged)



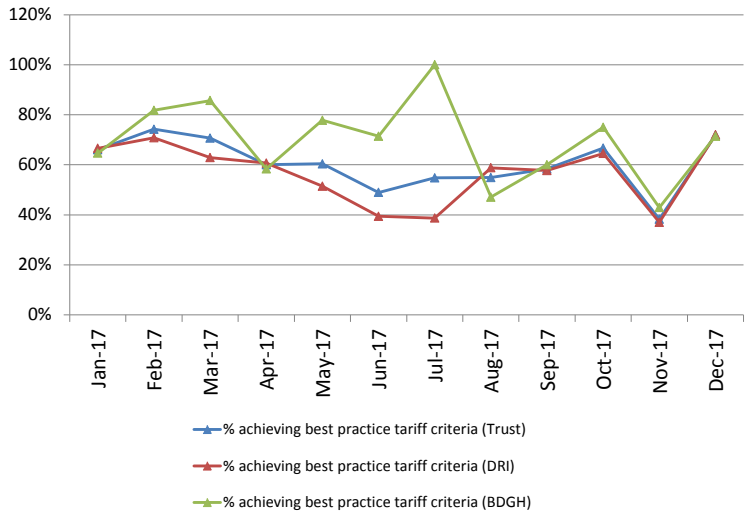




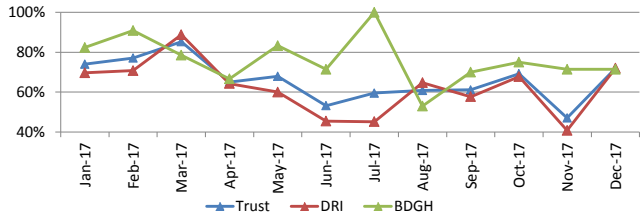
	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17
Trust	1.70%	1.96%	1.96%	1.29%	1.38%	1.22%	1.25%	1.33%	1.01%	1.22%	1.45%	1.46%
Doncaster	1.68%	2.12%	2.04%	1.43%	1.33%	1.13%	1.32%	1.46%	1.01%	1.28%	1.41%	1.42%
Bassetlaw	2.07%	1.87%	2.06%	1.11%	1.82%	1.74%	1.34%	1.09%	1.27%	1.31%	1.95%	1.90%

NHFD Best Practice Pathway Performance - December 2017 (Month 9)

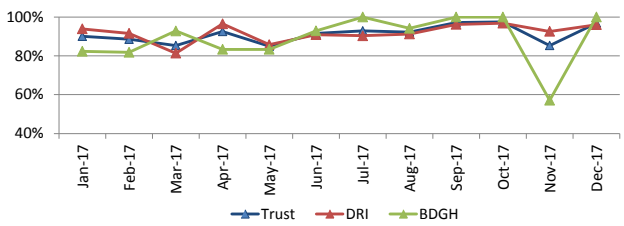
Best Practice Criteria Performance



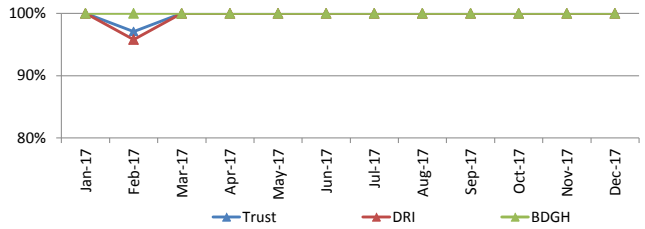
36 Hours to Surgery Performance



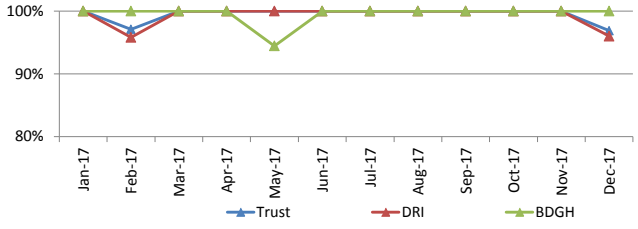
72 hours to Geriatrician Assessment Performance



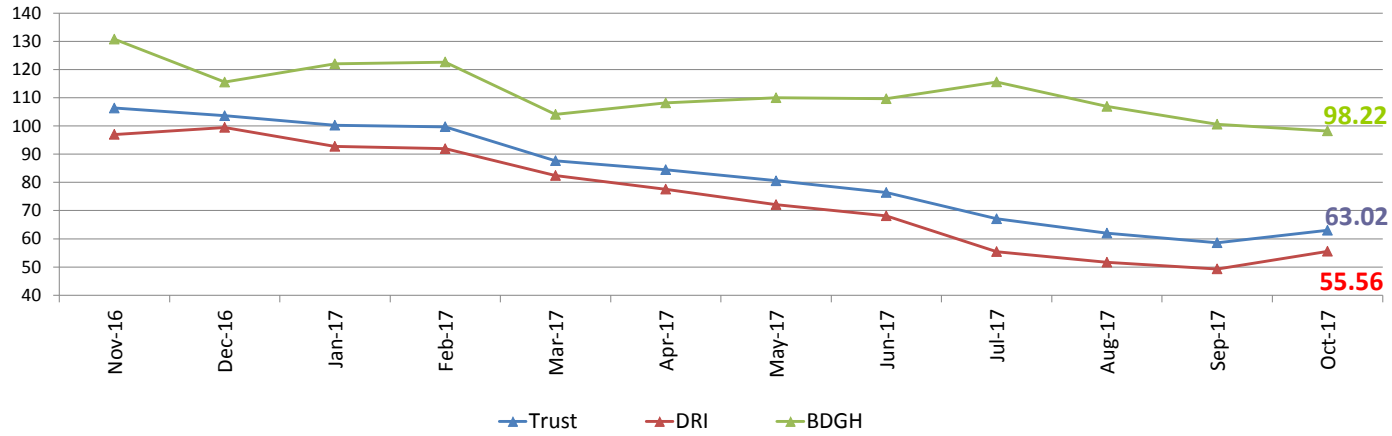
Bone Protection Medication Assessment



Falls Assessment Performance

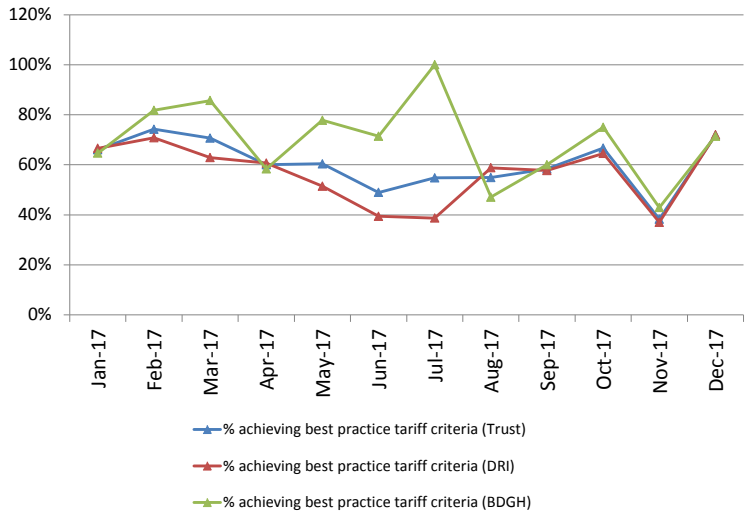


Relative Risk Mortality (HSMR) - Fractured Neck of Femur
Rolling 12 month

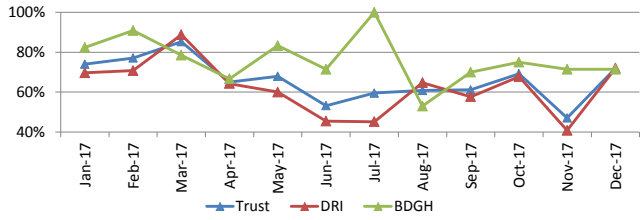


NHFD Best Practice Pathway Performance - December 2017 (Month 9)

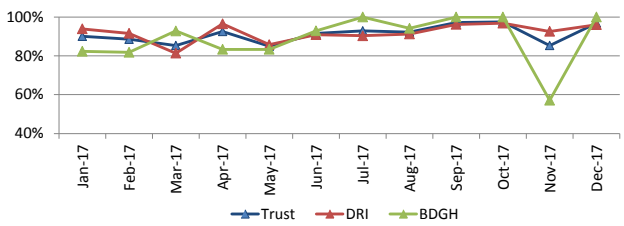
Best Practice Criteria Performance



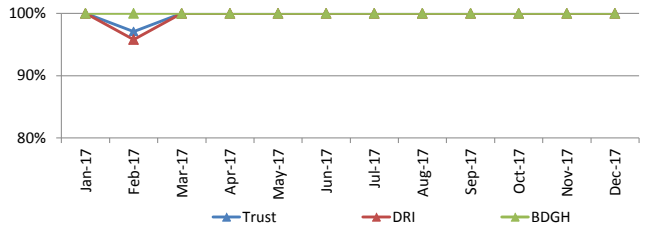
36 Hours to Surgery Performance



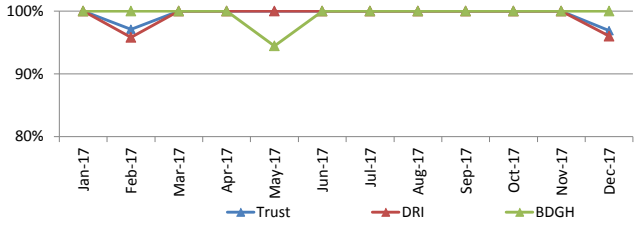
72 hours to Geriatrician Assessment Performance



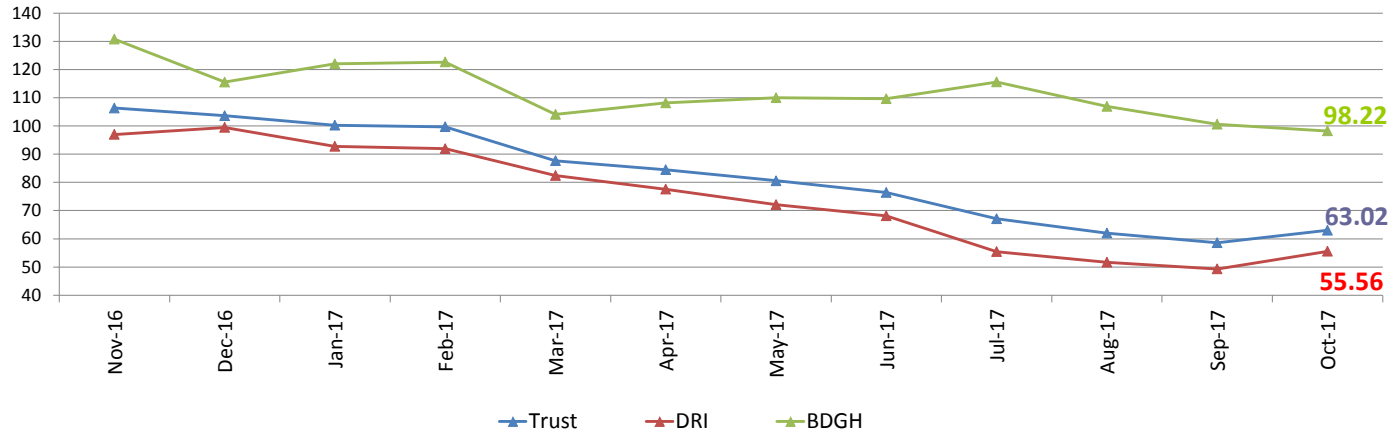
Bone Protection Medication Assessment



Falls Assessment Performance



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



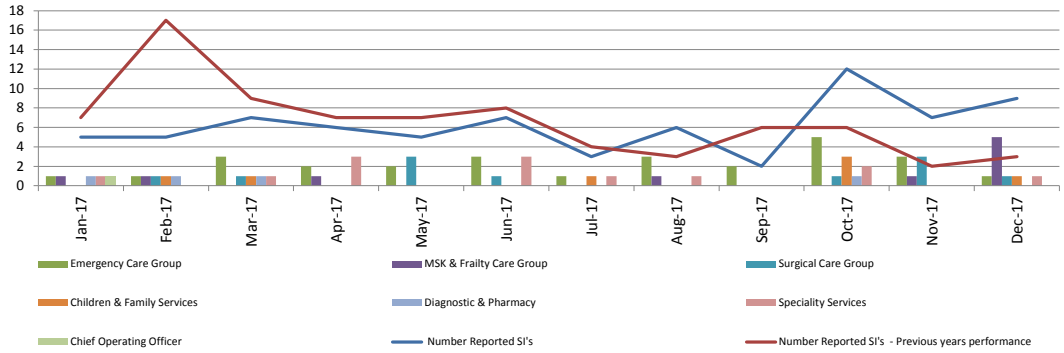
Serious Incidents - December 2017 (Month 9)

(Data accurate as at 09/01/2018)

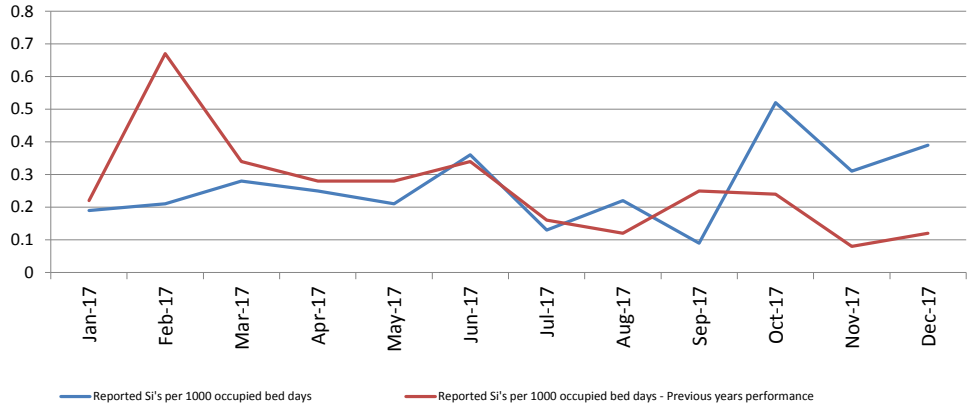
Please note: At the time of producing this report the number of serious incidents reported are prior to the RCA process being completed.

Overall Serious Incidents

Number Serious Incidents Reported
(Trust & Care Group)



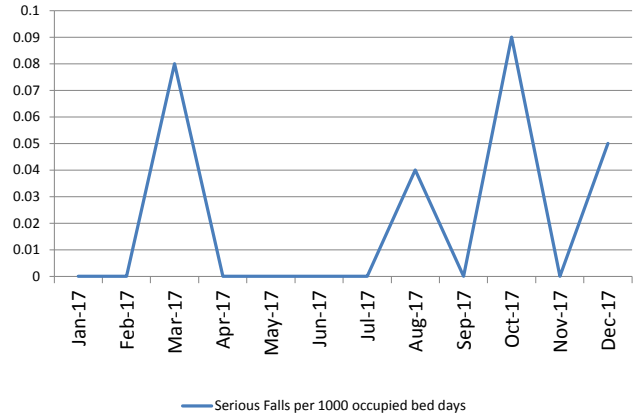
Serious Incidents per 1000 occupied bed days



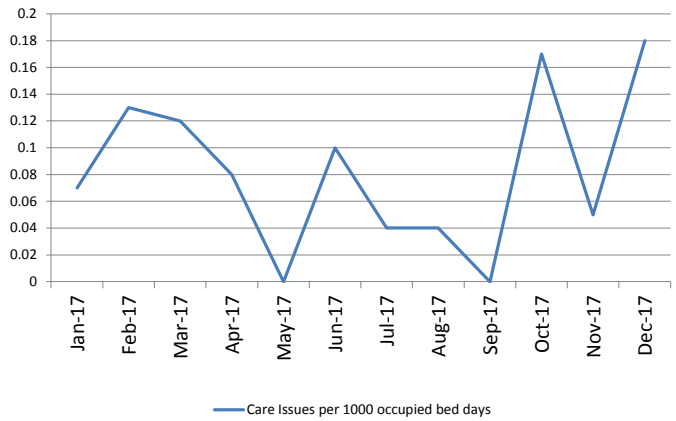
Current YTD reported SI's (Apr 17-Dec 17)	57	Number reported SI's (Apr 16-Dec 16)	46
Current YTD delogged SI's (Apr 17-Dec 17)	15	Number delogged SI's (Apr 16-Dec 16)	9

Themes

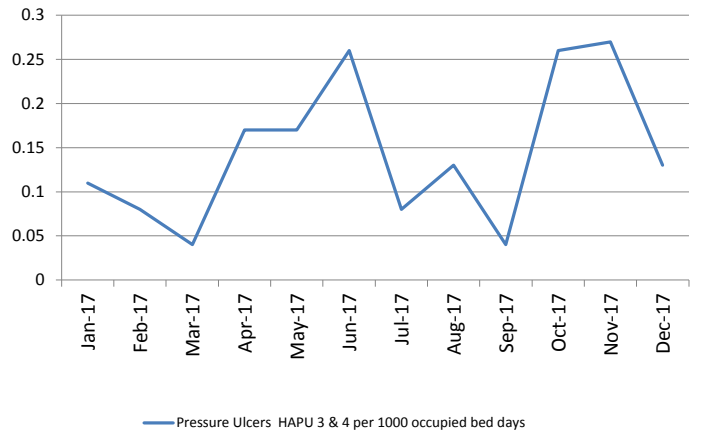
Serious Falls



Care Issues

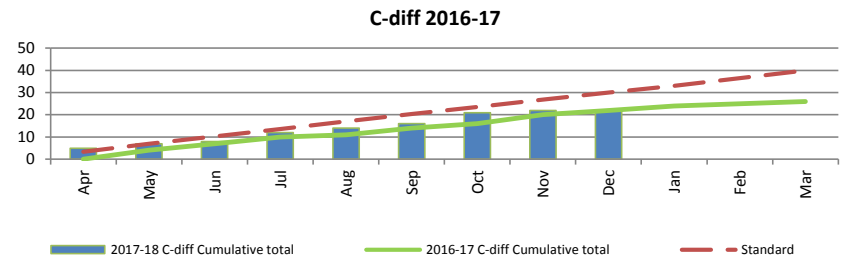


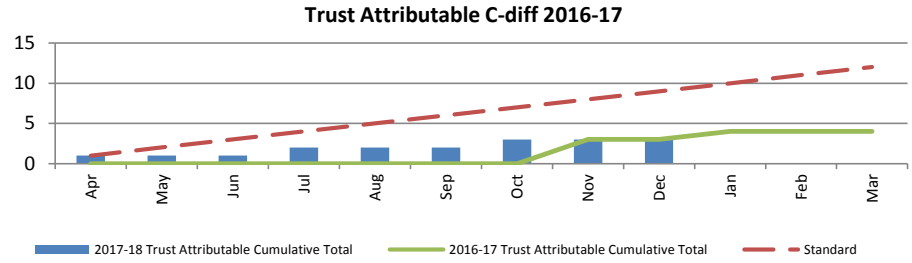
Pressure Ulcers - Category 3 & 4 (HAPU)



Monitor Compliance Framework: Infection Control C.Diff - December 2017 (Month 9)
(Data accurate as at 08/01/2018)

	Standard	Q1	Q2	Oct	Nov	Dec	Q3	YTD
2017-18 Infection Control - C-diff	40 Full Year	8	8	5	1	0	6	22
2016-17 Infection Control - C-diff	40 Full Year	7	7	2	4	2	8	22
2017-18 Trust Attributable	12	1	1	1	0	0	1	3
2016-17 Trust Attributable	12	0	0	0	3	0	3	3

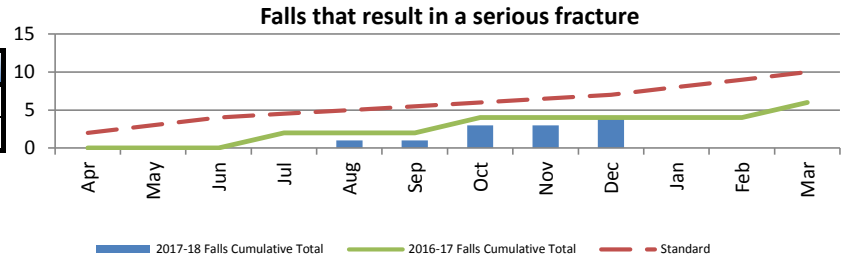




Pressure Ulcers & Falls that result in a serious fracture - December 2017 (Month 9)
(Data accurate as at 08/01/2018)

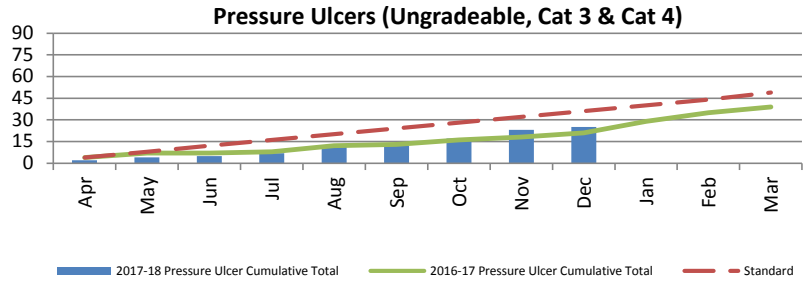
	Standard	Q1	Q2	Oct	Nov	Dec	Q3	YTD
2017-18 Serious Falls	10 Full Year	0	1	2	0	1	3	4
2016-17 Serious Falls	19 Full Year	1	2	2	0	0	2	5

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



	Standard	Q1	Q2	Oct	Nov	Dec	Q3	YTD
2017-18 Pressure Ulcers	34 Full Year	5	7	5	4	4	13	25
2016-17 Pressure Ulcers	60 Full Year	7	6	3	2	3	8	21

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

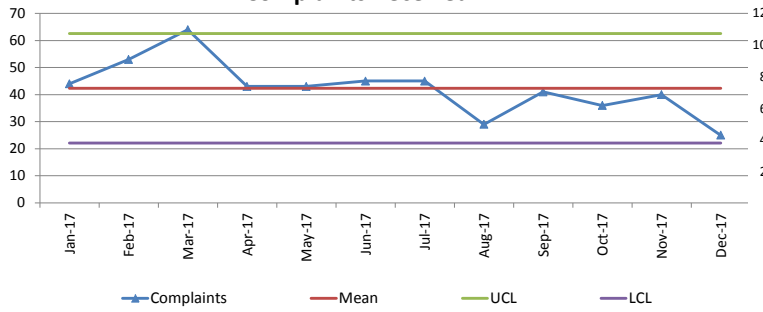


Complaints & Claims - December 2017 (Month 9)

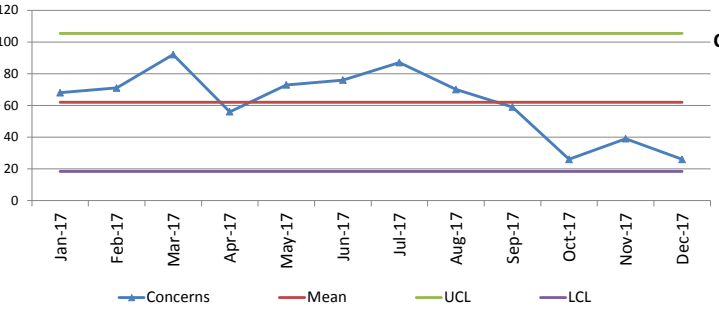
(Data accurate as at 11/01/2018)

Complaints

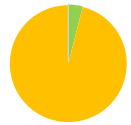
Complaints Received



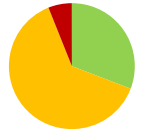
Concerns Received



December 2017 Complaints Received Risk Breakdown



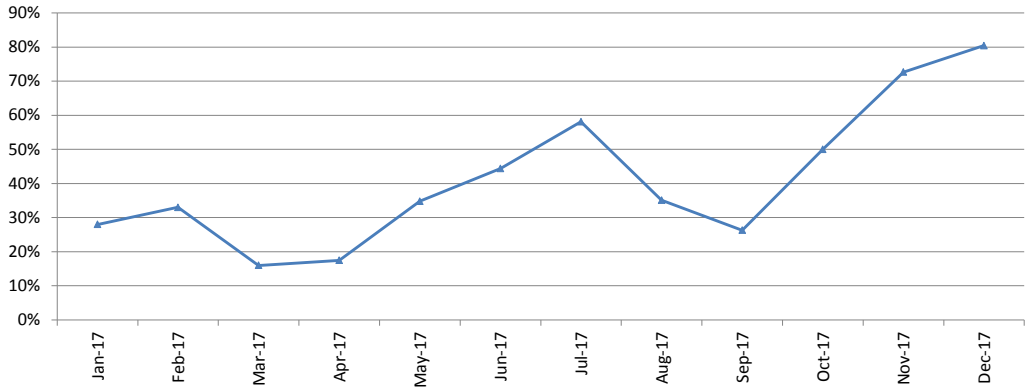
Year to Date Complaints Received Risk Breakdown



Complaints - Resolution Perfomance

(% achieved resolution within timescales)

Complaints Resolution Performance



Please note: Performance as a percentage is calculated on the cases replied and overdue, compared to the due date. Any current investigations that have not gone over deadlines are excluded data.

Parliamentary Health Service Ombusdman (PHSO)

Month	Number of cases referred for investigation	Number Currently Outstanding
Nov-17	0	5

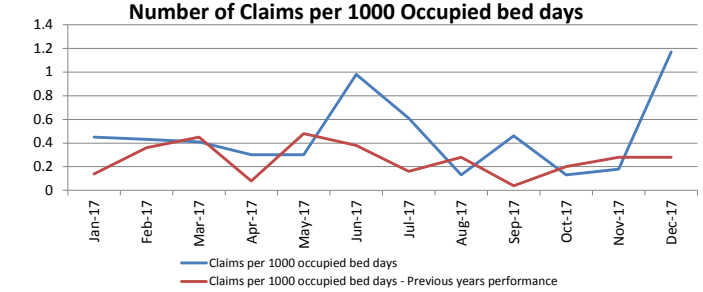
	Number referred for investigation YTD	Outcomes YTD	
2016/17	9	Fully / Partially Upheld	**2**
		Not Upheld	**7**
		No further Investigation	**0**
		Case Withdrawn	**0**
2017/18	5	Fully / Partially Upheld	2
		Not Upheld	3
		No further Investigation	0
		Case Withdrawn	0

Claims

	Current Month	Month Actual	YTD
Clinical Negligence Scheme for Trusts (CNST) Not including Disclosures	Dec-17	27	**74**
Liabilities to Third Parties Scheme (LTPS)	Dec-17	0	**9**

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

Number of Claims per 1000 Occupied bed days

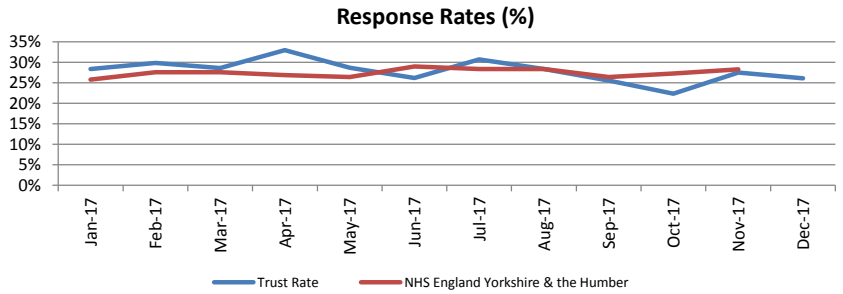


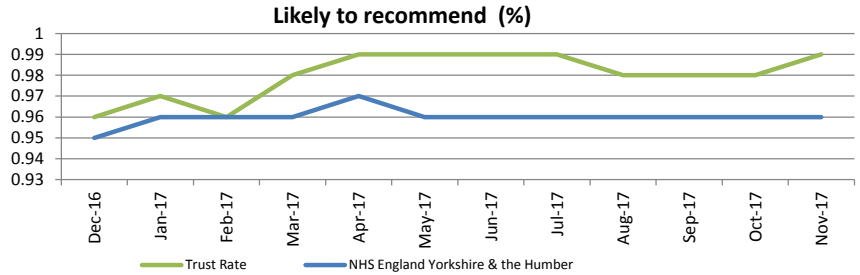
Friends & Family - December 2017 (Month 9)

(Data accurate as at 12/01/2018)

Inpatients

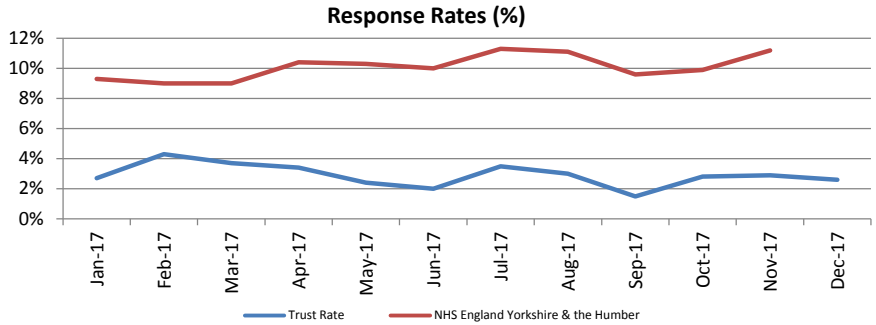
Please note: At the time of producing this report no further benchmarking data is available from NHS England.

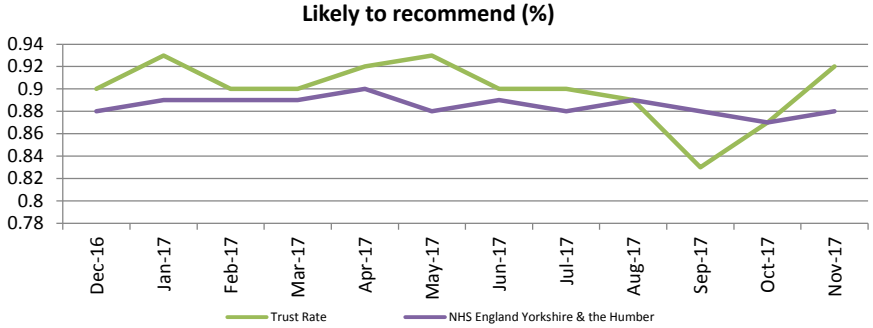




Accident & Emergency

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





Doncaster and Bassetlaw Hospitals NHS
NHS Foundation Trust

Executive summary - Workforce - December 2017 (Month 9)

Sickness absence

Due to some national difficulties with using ESR to run reports December sickness data is not yet available. November saw a small reduction in the monthly sickness levels to 4.41% in month with a slight rise in the cumulative figure to 4.29%. This figure is an improvement from the same period last year (4.82% in month and 4.5% cumulative). The increase in episodes of absence has been associated with absences of less than 28 days which is often to be expected at this time of year. The HR Business Partners continue to emphasise the need to undertake return to work interviews.

Appraisals

The Trusts appraisal completion rate as at end December 2017 has seen a further rise to 62.17% which is the second month of improvement since April 2017. However as we move to an appraisal season of April to June we are likely to see a reduction ove r the rest of the financial year as appraisals are held over until the season.

SET

We have seen a further rise in compliance with Statutory and Essential Training in December to 76.71% , with discussions at WEC focusing on the individual topics to ensure compliance is achieved.

Staff in post

Please see attached tab covering staff in post by staff group - due to the timing of the Board of Directors this month the December data is not yet available.

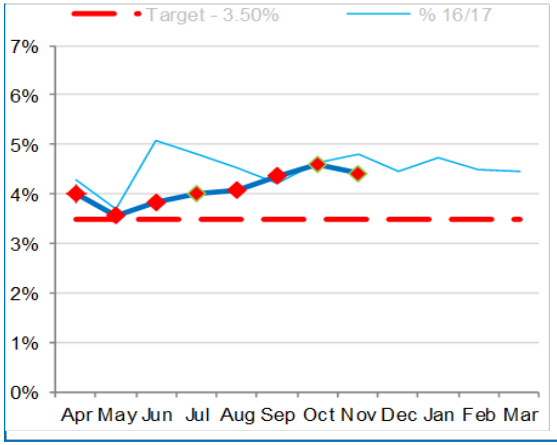
Workforce: Sickness Absence - November (Month 8)

CG & Directorate Sickness Absence - Nov 2017 (Q3)

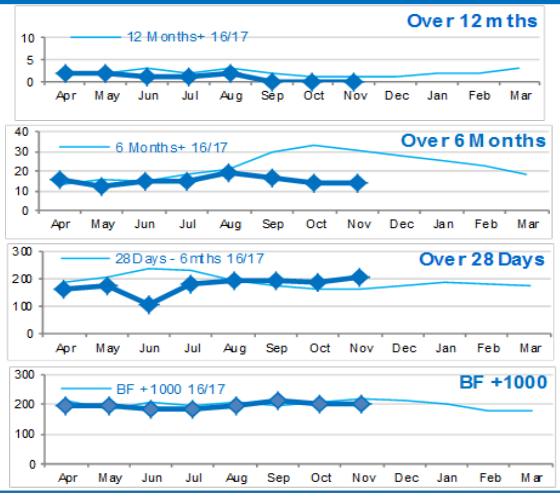
RAG: Below Trust Rate - Above Target - Above Trust Rate

Sickness

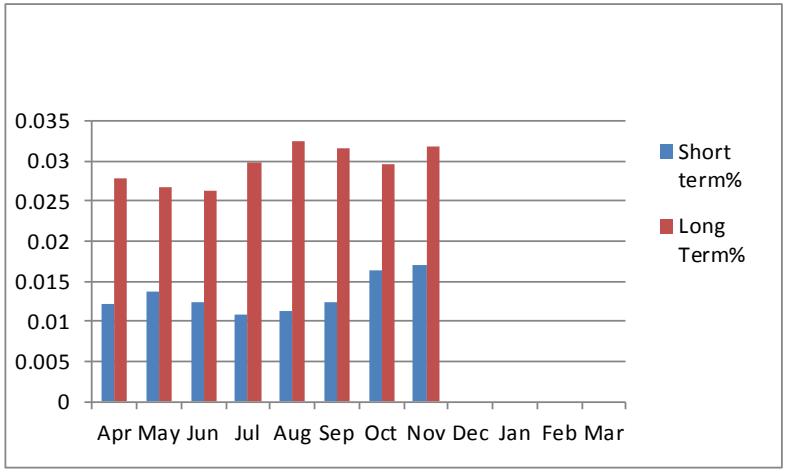
Abs Rate = 4.41% LT Abs Rate : 3.18%
Days Lost : 7,326.55



Absence Occurences

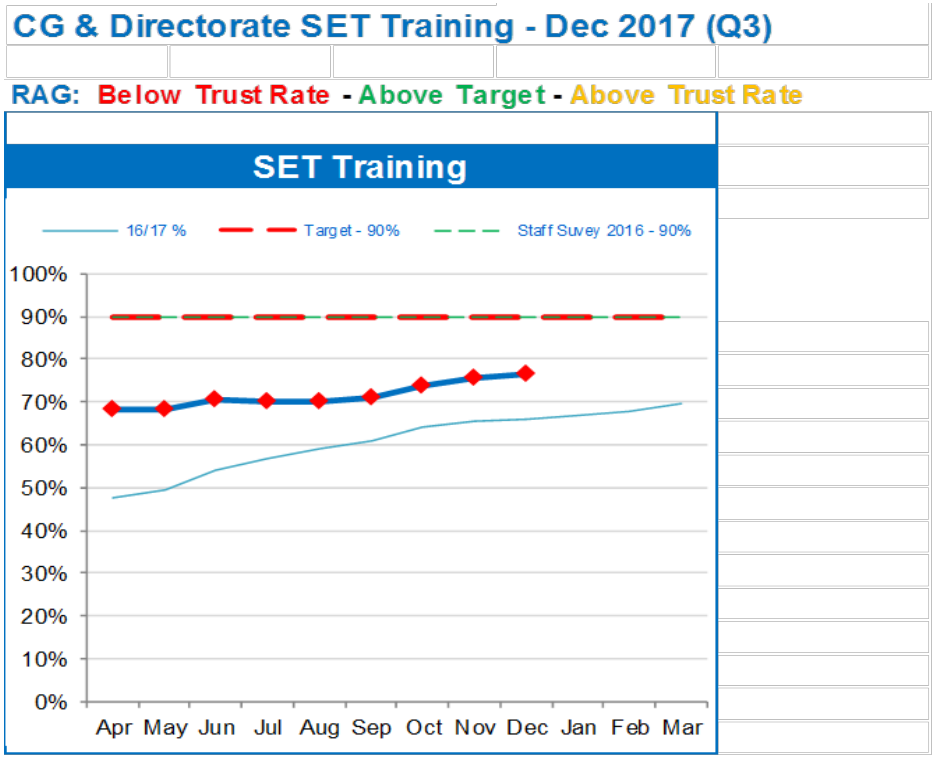


Long term / Short Term



	Apr-17		May-17		Jun-17		Jul-17		Aug-17		Sep-17		Oct-17		Nov-17		Cumulative	
	Days Lost	% Rate	Days Lost	% Rate	Days Lost	% Rate	Days Lost	% Rate	Days Lost	% Rate	Days Lost	% Rate	Days Lost	% Rate	Days Lost	% Rate	Days Lost	% Rate
Doncaster & Bassetlaw	**6616.12**	**4.01%**	**5553.89**	**3.26%**	**5770.06**	**3.50%**	**6862.34**	**4.02%**	**7025.61**	**4.12%**	**7200.57**	**4.37%**	**7903.72**	**4.60%**	**7,326.55**	**4.41%**	**57,631.53**	**4.29%**
Chief Executive Directorate	21.00	2.56%	0.00	0.00%	0.00	0.00%	0.00	0.00%	0.00	0.00%	0.69	0.08%	0.00	0.00%	0.00	0.00%	21.69	0.32%
Children & Family Care Group	837.73	4.78%	672.61	3.75%	738.05	4.28%	790.83	4.43%	746.01	4.21%	704.77	4.05%	753.22	4.03%	856.60	4.67%	6,078.69	4.26%
Diagnostic & Pharmacy Care	699.21	3.87%	507.84	2.72%	427.74	2.39%	507.66	2.73%	652.67	3.49%	748.19	4.18%	674.27	3.66%	558.20	3.13%	5,688.11	3.89%
Directorate Of Strategy &	1.00	0.23%	0.00	0.00%	1.80	0.42%	27.00	6.09%	5.00	0.99%	1.81	0.35%	12.09	2.12%	14.19	2.58%	39.08	0.98%
Emergency Care Group	1049.38	4.84%	931.75	4.19%	628.94	2.92%	739.50	3.32%	745.49	3.38%	871.92	4.08%	1157.35	5.20%	1,027.26	4.77%	7,801.82	4.47%
Estates & Facilities Directorate	1105.83	6.50%	892.26	5.09%	1014.74	6.00%	1182.10	6.76%	1277.73	7.33%	1128.03	6.71%	1136.25	6.55%	1,038.68	6.17%	8,618.73	6.29%
Recharge Medics	1.00	0.06%	0.00	0.00%	2.00	0.13%	2.00	0.12%	0.00	0.00%	19.00	1.08%	20.00	1.00%	30.00	1.69%	77.00	0.57%
Finance & Healthcare	43.60	2.00%	13.40	0.60%	93.41	4.35%	92.04	4.20%	113.84	5.05%	82.60	3.86%	78.00	3.56%	60.80	2.90%	631.60	3.61%
IT Information & Telecoms	66.97	2.05%	39.13	1.15%	51.73	1.58%	122.75	3.72%	92.27	2.84%	58.00	1.79%	132.09	3.96%	51.85	1.59%	777.30	2.96%
MSK & Frailty Care Group	722.98	3.00%	681.04	2.71%	751.38	3.06%	899.74	3.52%	795.62	3.11%	759.90	3.07%	799.37	3.10%	766.33	3.08%	6,728.94	3.36%
Medical Director Directorate	2.00	0.94%	0.00	0.00%	0.00	0.00%	3.00	1.36%	0.00	0.00%	0.00	0.00%	0.90	0.41%	0.00	0.00%	9.63	0.56%
Nursing Services Directorate	33.27	2.17%	24.80	1.51%	36.20	2.22%	52.41	3.00%	49.60	2.87%	62.93	3.75%	55.01	3.07%	70.60	4.06%	461.96	3.39%
People & Organisational	42.28	1.55%	34.00	1.18%	66.08	2.40%	102.05	3.60%	102.00	3.73%	57.75	2.13%	51.99	1.78%	35.68	1.26%	676.04	3.02%
Performance Management	120.40	1.95%	102.52	1.60%	109.79	1.76%	126.85	1.96%	163.09	2.56%	221.13	3.70%	208.00	3.49%	156.83	2.89%	1,343.40	2.75%
Speciality Services Care Group	602.71	3.42%	574.26	3.13%	693.14	3.91%	723.88	3.94%	766.62	4.19%	880.99	5.00%	935.86	5.14%	923.46	5.23%	6,665.59	4.64%
Surgical Care Group	1266.77	4.21%	1080.28	3.48%	1155.05	3.87%	1490.53	4.84%	1515.67	4.91%	1602.85	5.34%	1889.32	6.02%	1,736.07	5.70%	12,007.93	4.91%

Workforce: SET Training - December (Month 9)

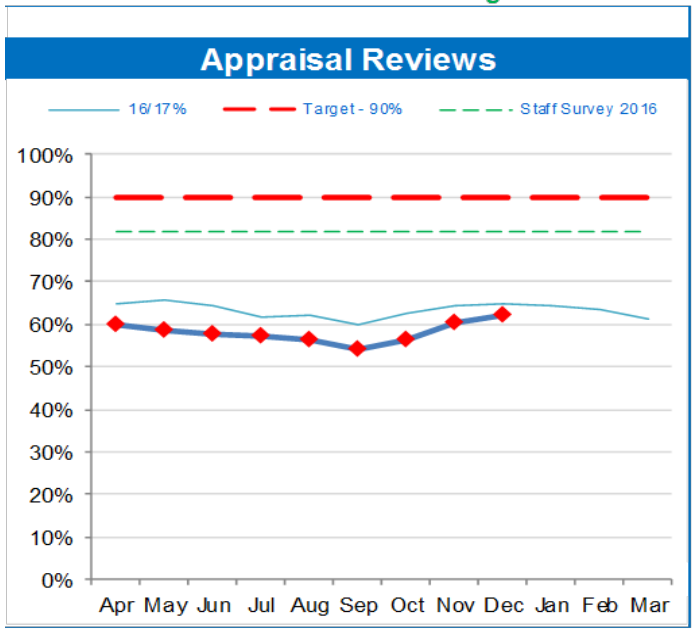


	% Compliance
Doncaster & Bassetlaw Teaching Hospitals NHS FT	**76.71%**
Chief Executive Directorate	77.96%
Children & Family Care Group	80.63%
Diagnostic & Pharmacy Care Group	87.36%
Directorate Of Strategy & Improvement	94.30%
Emergency Care Group	66.17%
Estates & Facilities	62.63%
Finance & Healthcare Contracting Directorate	96.91%
IT Information & Telecoms Directorate	93.27%
MSK & Frailty Care Group	84.38%
Medical Director Directorate	80.56%
Nursing Services Directorate	80.55%
People & Organisational Directorate	96.63%
Performance Directorate	80.69%
Speciality Services Care Group	72.93%
Surgical Care Group	75.15%

Workforce: Appraisals - December (Month 9)

CG & Directorate Appraisals - Dec 2017 (Q3)

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



Trust Total

	% Completed
Doncaster & Bassetlaw Teaching Hospitals NHS FT	**62.17**
Chief Executive Directorate	**37.04**
Children & Family Care Group	**75.94**
Diagnostic & Pharmacy Care Group	**65.87**
Directorate Of Strategy & Improvement	**90.91**
Emergency Care Group	**58.32**
Estates & Facilities	**21.11**
Finance & Healthcare Contracting Directorate	**87.10**
IT Information & Telecoms Directorate	**78.43**
MSK & Frailty Care Group	**82.66**
Medical Director Directorate	**100.00**
Nursing Services Directorate	**67.74**
People & Organisational Directorate	**88.76**
Performance Directorate	**80.43**
Speciality Services Care Group	**57.76**
Surgical Care Group	**59.72**

Workforce: Staff in post - November (Month 8)

	FTE	Headcount	FTE	Headcount	FTE	Headcount	FTE	Headcount	FTE	Headcount	FTE	Headcount	FTE	Headcount	FTE	Headcount	FTE	Headcount	FTE	Headcount	FTE	Headcount	FTE	Headcount
Staff Group	**Dec-16**		**Jan-17**		**Feb-17**		**Mar-17**		**Apr-17**		**May-17**		**Jun-17**		**Jul-17**		**Aug-17**		**Sep-17**		**Oct-17**		**Nov-17**	
Add Prof Scientific and Technic	171.53	186.00	169.53	184.00	170.00	185.00	168.76	184.00	173.34	189.00	173.68	189.00	174.74	191.00	172.45	188.00	176.46	192.00	171.70	187.00	171.90	187.00	171.47	187.00
Additional Clinical Services	1,086.57	1,318.00	1,091.93	1,324.00	1,107.45	1,341.00	1,118.22	1,355.00	1,116.66	1,356.00	1,124.68	1,365.00	1,134.49	1,376.00	1,136.40	1,378.00	1,126.65	1,366.00	1,135.30	1,373.00	1,123.63	1,361.00	1,118.74	1,357.00
Administrative and Clerical	1,063.66	1,314.00	1,074.32	1,322.00	1,087.99	1,337.00	1,086.32	1,336.00	1,089.28	1,338.00	1,097.51	1,344.00	1,091.66	1,339.00	1,090.42	1,338.00	1,086.26	1,333.00	1,084.51	1,327.00	1,085.93	1,323.00	1,067.20	1,300.00
Allied Health Professionals	324.90	373.00	323.77	372.00	322.07	371.00	319.85	368.00	317.79	369.00	316.78	367.00	320.54	372.00	325.55	378.00	331.05	384.00	336.40	389.00	333.98	385.00	334.55	386.00
Estates and Ancillary	579.63	834.00	579.34	832.00	579.62	831.00	575.10	827.00	572.83	825.00	571.80	827.00	571.28	826.00	572.38	828.00	569.27	828.00	565.03	821.00	567.59	826.00	569.05	828.00
Healthcare Scientists	127.33	141.00	126.38	139.00	128.32	141.00	128.86	142.00	129.53	143.00	129.10	142.00	127.60	141.00	127.07	140.00	124.47	137.00	122.23	136.00	125.30	139.00	124.90	139.00
Medical and Dental	493.19	593.00	493.66	601.00	497.20	613.00	491.33	610.00	498.11	523.00	497.26	522.00	501.41	616.00	500.76	617.00	497.55	636.00	499.65	633.00	505.78	637.00	504.89	628.00
Nursing and Midwifery Registered	1,594.07	1,849.00	1,579.50	1,837.00	1,585.31	1,844.00	1,592.74	1,848.00	1,593.42	1,850.00	1,593.67	1,850.00	1,585.23	1,838.00	1,584.72	1,838.00	1,581.52	1,835.00	1,568.02	1,821.00	1,580.79	1,831.00	1,577.99	1,829.00
Students	15.44	17.00	10.80	12.00	8.00	8.00	7.00	7.00	3.00	3.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	1.44	2.00	8.36	9.00	6.56	7.00
Grand Total	**5,470.33**	**6,637.00**	**5,478.88**	**6,656.00**	**5,493.82**	**6,683.00**	**5,500.38**	**6,691.00**	**5,493.97**	**6,596.00**	**5,504.48**	**6,606.00**	**5,506.95**	**6,699.00**	**5,509.75**	**6,705.00**	**5,493.23**	**6,711.00**	**5,484.28**	**6,689.00**	**5,503.26**	**6,698.00**	**5,475.34**	**6,661.00**

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Title	Nursing Workforce Information		
Report to	Board of Directors	Date	30 January 2018
Author	Moira Hardy, Director of Nursing, Midwifery & Allied Health Professionals Rick Dickinson, Acting Deputy Director of Nursing, Midwifery & Quality		
Purpose			Tick one as appropriate
	Decision		
	Assurance		✔
	Information		

Executive summary containing key messages and issues
This paper updates the Board of Directors on key issues relating to the Nursing Workforce, including the following: • Information from the UNIFY return for December 2017 planned and actual hours demonstrates the overall planned versus actual hours worked to be 96% for December 2017. • Care Hours Per Patient Day (CHPPD) is seen a slight decrease compared to recent months at 7.29 • Quality Metrics for wards, with no red flagged wards on December 2017 data. • Agency usage of 2.1%; 0.9% under the 3% agency cap • Clinical leadership time spent clinically • Information relating to staffing assessments undertaken to review nursing, midwifery and paediatric workforce establishments • Key issues and actions
Key questions posed by the report
• Are safe staffing levels being optimised with available resources? • What is the impact on quality of care with the current workforce? • How do we compare to peers for care hours provision? • Are we compliant to the agency cap target? • Can we demonstrate ongoing assessment of staffing levels with evidence based tools?
How this report contributes to the delivery of the strategic objectives
As a Teaching Hospital we are committed to continuously developing the skills, innovation and leadership of our staff to provide high quality, efficient and effective care.
How this report impacts on current risks or highlights new risks
• Risks associated to the inability to recruit to establishment and develop staff to provide harm free care, delivered with compassion and of appropriate quality. • Risk associated with not meeting regulatory and commissioner requirement. • The risks identified have been mitigated by the use of temporary staffing to provide planned versus actual hours worked at 96% in December. Despite the use of temporary staff to maintain safe staffing levels the Trust has remained within the 3% agency cap at 2.1%. The main risk in relation to staffing continues to be the recruitment to registered nurse vacancies and opportunities to recruit are actively being explored.
Recommendation(s) and next steps
The Board of Directors is asked to confirm that it is sufficiently assured taking into account the identified actions or identify areas which require further assurance.

1. INTRODUCTION

This paper provides the Board of Directors with detailed information relating to the Nursing Workforce; highlighting issues which may impact upon the Trusts ability to provide appropriate staffing levels and skill mixes. It also updates on the implementation on Care Hours per Patient Day (CHPPD), which has been a required national return since 01 May 2016 and the data submitted to UNIFY.

2. WORKFORCE INFORMATION

The workforce data submitted to UNIFY provides the actual hours worked in December 2017 by registered nurses, midwives and health care support workers compared to the planned hours. The Trusts overall planned versus actual hours worked was 96% in December 2017, a reduction from 99% in November 2017 (See appendix A). This is associated with the maternity service within the Children and Families Care Group. The reason for this is the induction period of the newly qualified midwives, where there are midwives at work, but not included in the actual staffing. The induction period has been extended to induct the midwives in all of the areas they will rotate into, and so assists subsequent rotation of staff base teams and redeployment benefits to keep safe staffing levels.

a. Actual versus planned staffing levels (based on daily data capture)

There has been a reconfiguration of the bed base at Bassetlaw Hospital during December 2017; Ward A5 closed and additional beds opened on Wards C1 and B6, with Ward B6 also remaining open across the seven days of the week instead of closing overnight on Saturday and Sunday.

The data for December 2017 demonstrates that the actual available hours compared to planned hours were:

- within 5% for 24 Wards (60%), 3 less than November
- between 5% – 10% for 11 Wards (27.5%), 6 more than November
- surpluses over 10% for 1 Wards (2.5%), 2 less than November
- deficits over 10% for 4 Wards (10%) 2 less than November

*NB: Ward A5 closed in December 2017, therefore 40 wards compared to 41 wards reporting in November 2017

The ward with a surplus in excess of 10% of the planned hours was Ward 25; Wards 25 has required additional staff to support patients requiring enhanced care.

The wards where there were deficits in excess of 10% of the planned hours are Wards M1, M2, Central Delivery Suite (CDS) and Labour Ward (Bassetlaw Hospital).

The lower than planned staffing levels was mainly due to the supernumerary newly qualified midwives being available and contributing to provision of care during their induction period in each of their rotational placements. Maternity leave and sickness also contributed to the deficit in actual hours worked.

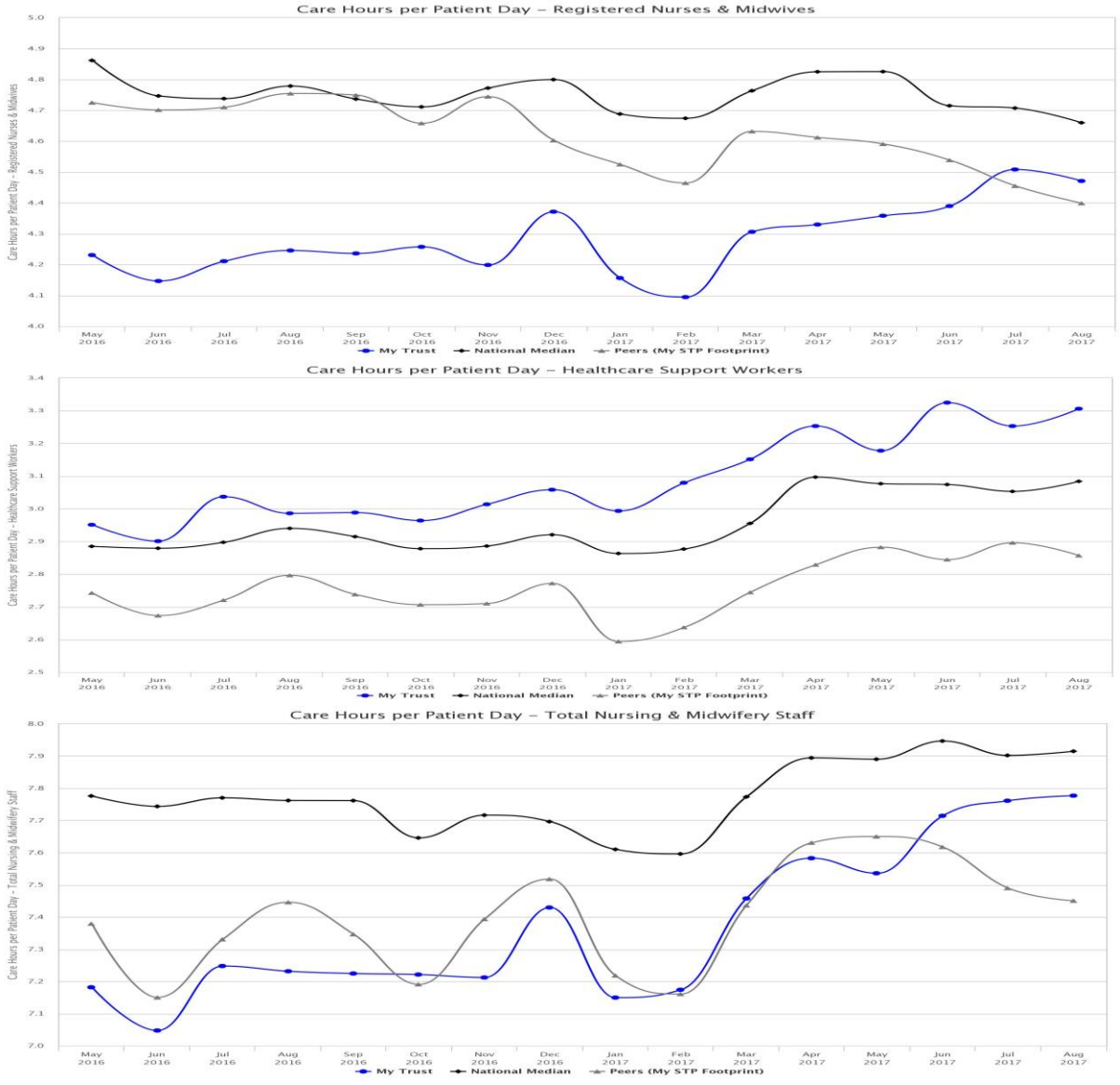
b. Care Hours Per Patient Day (CHPPD)

Utilising actual versus planned staffing data submitted to UNIFY and applying the CHPPD calculation the care hours for December 2017 are shown below, with a slight decrease in the overall and registered midwives and nurses:

Care Hours Per Patient Day (CHPPD) – December 2017			
Site Name	Registered midwives/ nurses	Care Staff	Overall
BASSETLAW HOSPITAL	4.8	3.3	8.1
DONCASTER ROYAL INFIRMARY	4.3	3.1	7.5
MONTAGU HOSPITAL	1.9	1.9	3.9
TRUST	4.24	3.05	7.29

The CHPPD care hours data from May 2016 –December 2017 remain relatively consistent, but have reduced slightly from November 2017 for the reasons described in Maternity Services, with the number of patients remaining consistent and actual hours worked being supplemented by newly qualified staff on extended induction periods.

CHPPD comparisons using national and ACS peer using Model Hospital show the following trends:



The charts illustrate that the registered nurse and midwife profile has been lower than national and peer rates, but has improved to be slightly higher than peers whilst remaining lower than the national rate. The Healthcare support worker rate has been slightly higher than peers and national rates increasing in August. The overall CHPPD rate shows an increase, lower than national rates, but higher than peers. The position is improved from previous benchmarked data and closer to national rates.

c. Safe Staffing and Efficiency

A cap of agency expenditure for registered general and specialist nursing staff, midwives and health visitors has been in place since November 2015. The annual ceiling for DBTHFT has been set at the lowest level of 3% which is a reflection of the relatively low level of bank and agency usage when compared to the national picture. The Registered Nurse rate for December is 2.1%, within the 3% cap level.

Information relating to the use of off-framework, high cost nursing agency staff continues to be reported to NHSI on a weekly basis, as does the work to eliminate the use of off framework agencies so that the Trust is compliant with the guidance.

d. Nurse Manager Clinical Time

To ensure that the Heads of Nursing, Head of Midwifery and Matrons have a visible presence in the clinical areas HoN/Ms have identified that they are aiming to work at least one clinical shift a month in one of their clinical areas, with the Matrons working two clinical shifts a month. This information is collected as part of the monthly Hard Truths returns. In addition senior sisters/charge nurses are expected to have 2 days per week as managerial/supernumerary time and this information is also being recorded monthly.

The Clinical and Supervisory Time in December 2017 was achieved for the areas shown as green with partial achievement in the areas shown as amber. Ward Supervisory time where partially taken is due to the senior sister covering shortfalls in ward staffing.

Care Group	HoN/M Clinical Time	Matrons Clinical Time	Ward Supervisory Time
Surgical			
MSK and Frailty			
Specialty Service			
Emergency			
Obstetrics and Gynae			
Children's			

e. Quality and Safety Profile

The Quality Metrics data demonstrates no wards flagged as red for quality in December 2017. A summary of the metrics can be found in Appendix A.

A Quality Summit was undertaken on Ward 17 on 23/1/2018, as this ward flagged red on November 2017 Quality Metrics, reported in December 2017. Their performance has improved in the December data. The Christmas and New Year period and winter pressures have prevented an earlier review being undertaken.

3. NURSING ACUITY DEPENDENCY TOOLS

As a result of the Board of Directors commitment to ensuring safe staffing levels, programmes of assessments have been undertaken in the following areas:

- Adult inpatient wards
- Paediatric inpatient wards
- Maternity services

The assessment for the Emergency Departments using the Baseline Accident and Emergency Staffing Tool (BEST) is scheduled to be repeated in February 2018 and will be reported subsequently.

a. AUKUH – adult inpatient areas

Using the Safer Nursing Care (SNCT *TM*)/ Association of United Kingdom University Hospitals (AUKUH *TM*) methodology, a programme of assessments has been undertaken since 2014 and a further assessment took place in July 2017. The combined result of the nine reviews undertaken is illustrated in appendix B. Overall the Trusts funded nursing workforce, using an uplift of 20.96% (based on 4% sickness absence, 15% annual leave, 1% study leave and 0.96% for other leave) is assessed as being within 2.91% (34.31wte) of the required workforce (too many). Vacancies and the contribution of the Critical Care areas remain the most significant challenges.

b. ePanda – paediatric inpatient areas

The Children's Ward at DRI continues to use ePANDA® for recording patient acuity twice daily (day and night shift). The Care Group acknowledges that due to winter pressures daily completion of this data is below expected standards, and therefore is unable to submit reliable data. This has now been addressed and closer monitoring is taking place by the senior nursing team. The Children's Ward has recently reduced its total bed establishment from 20 (including 2 designated HDU beds) to 18 (including 2 designated HDU beds). This reduction in beds has resulted in the staffing establishments (hands per shift) being more compliant with RCN recommendations for nurse staffing.

Neonatal services on both sites continue to use BADGER to record patient acuity information, which is monitored within the region. Neonatal services are guided by BaPM standards for staffing establishments, and following recruitment both DRI and BDGH neonatal services are in line with these.

c. Midwifery staffing

Following the 2015 Birthrate Plus® (BR+®) assessment of midwifery staffing the Board of Directors agreed the principle of moving the midwifery ratio to births closer to 1:28 as identified by the BR+® assessment and identified as a CQC benchmark.

The Head of Midwifery monitors the birth to midwife ratio and midwifery requirements using the principles identified in the BR+ assessment. There has been recent recruitment of newly qualified midwives, which combined with an associated reduction in birthrate has contributed to meeting the 1:28 ratio (1:28.4), which is the lowest vacancy rate in some time.

Monitoring the midwifery to birth ratio periodically between Birthrate Plus assessments is recommended and a Birthrate Plus reassessment is recommended on a 3 yearly basis. However, this review has determined that there is no urgency to undertake a Birthrate Plus assessment at this time, with consideration of the Hospital Services Review and potentially a wider accountable care system assessment in due course. For ongoing monitoring purposes, a quarterly review of birth rates and projected birth rates is taken, so that any changes in birth rate can be met with appropriate workforce plans.

4. PLANNED ACTIONS AND KEY RISKS

The major issue facing most acute hospitals nationally, and locally, continues to be the challenge of filling registered staff vacancies. The actions to mitigate the risks which have been detailed in previous

papers are continuing, along with systems and processes to meet the expectations outlined in the safe staffing and efficiency correspondence. These are:

- The continuing work of the Non-Medical workforce utilisation programme as part of DBTH Efficiency and Effectiveness programme.
- Continue to explore recruitment opportunities for nursing.
- Continue to explore opportunities for non-registered staff and their safe contribution to the nursing workforce
- Monitor the birth rate on a quarterly basis and take steps to develop appropriate workforce plans.
- Reassess AUKUH for inpatient adult wards in February, June and November 2018.
- Reassess BEST for ED in February and November 2018
- Monitor the day to day use of ePanda so that reliable data capture can enable local monitoring reviews, reporting to Board of Directors twice a year, as part of Nursing Workforce Reports.

5. RECOMMENDATION

The Board of Directors is asked to note the content of the report and support the recommendations.

Care Group	Ward	Funded Beds	Bed Numbers Open	July AUKUH Output	Total Funded Budget	Total Funded Budget HCAs (B2 & B3)	Total Funded Budget Trained (B5+)	Total Funded Budget HCAs (B2 & B3) %	Total Funded Budget Trained (B5+) %	Funded Nurse per bed	Funded establishment	Average Value AUKUH (2014 - 2017)	Average wte per bed	Variance from Budget at average value	% variance from budget - RAG rate
Surgical	B6* (Closes 16 beds Sat / Sun)	12.00	12.00	9.98	19.38	8.87	10.51	45.77%	54.23%	1.62	19.38	18.62	1.55	0.76	3.92%
Surgical	Ward 20	27.00	27.00	33.33	31.66	13.58	18.08	42.89%	57.11%	1.17	31.66	33.83	1.25	-2.17	-6.85%
Surgical	Ward 21	27.00	27.00	36.70	31.66	13.58	18.08	42.89%	57.11%	1.17	31.66	37.60	1.39	-5.94	-18.76%
Surgical	S12	20.00	20.00	21.11	21.34	7.86	13.48	36.83%	63.17%	1.07	21.34	23.99	1.20	-2.65	-12.42%
Surgical	SAW	21.00	21.00	36.38	33.60	11.81	21.79	35.15%	64.85%	1.60	33.6	30.40	1.45	3.20	9.52%
Total		**107.00**	**107.00**	**137.5**	**137.64**	**55.7**	**81.94**	**40.47%**	**59.53%**	**1.29**	**137.64**	**144.44**	**1.35**	**-6.80**	**-4.94%**
Musculoskeletal and Frailty	B5* (Reduces to X beds Sat/Sun)	30.00	30.00	33.96	43.65	19.91	23.74	45.61%	54.39%	1.46	43.65	40.63	1.35	3.02	6.92%
Musculoskeletal and Frailty	St Leger	35.00	35.00	47.70	45.15	20.79	24.36	46.05%	53.95%	1.29	45.15	49.17	1.40	-4.02	-8.90%
Musculoskeletal and Frailty	1&3	23.00	23.00	32.82	40.83	22.85	17.98	55.96%	44.04%	1.78	40.83	36.82	1.60	4.01	9.82%
Musculoskeletal and Frailty	A4	24.00	24.00	35.97	31.83	14.88	16.95	46.75%	53.25%	1.33	31.83	40.61	1.69	-8.78	-27.58%
Musculoskeletal and Frailty	Rehab 2 (was Adwick)	19.00	19.00	25.04	30.15	15.3	14.85	50.75%	49.25%	1.59	30.15	33.31	1.75	-3.16	-10.48%
Musculoskeletal and Frailty	Rehab 1 (was Wentworth)	29.00	29.00	41.39	31.56	15.92	15.64	50.44%	49.56%	1.09	31.56	40.11	1.38	-8.55	-27.09%
Musculoskeletal and Frailty	Gresley	32.00	32.00	45.76	42.08	20.79	21.29	49.41%	50.59%	1.32	42.08	45.42	1.42	-3.34	-7.94%
Musculoskeletal and Frailty	Stirling	16.00	16.00	27.70	29.26	14.88	14.38	50.85%	49.15%	1.83	29.26	29.75	1.86	-0.49	-1.67%
Musculoskeletal and Frailty	Mallard	16.00	16.00	28.71	31.18	17.01	14.17	54.55%	45.45%	1.95	31.18	32.08	2.01	-0.90	-2.89%
Total		**224.00**	**224.00**	**319.05**	**325.69**	**162.33**	**163.36**	**49.84%**	**50.16%**	**1.45**	**325.69**	**347.90**	**1.55**	**-22.21**	**-6.82%**
Specialty Services	18 ccu	12.00	12.00	18.29	22.58	7.14	15.44	31.62%	68.38%	1.88	22.58	17.58	1.47	5.00	22.14%
Specialty Services	18 haem	12.00	12.00	17.84	20.91	3.71	17.2	17.74%	82.26%	1.74	20.91	19.24	1.60	1.67	7.99%
Specialty Services	Ward 32	18.00	18.00	28.10	29.53	9.50	20.03	32.17%	67.83%	1.64	29.53	30.92	1.72	-1.39	-4.71%
Specialty Services	Ward 16	24.00	24.00	38.34	48.23	18.72	29.51	38.81%	61.19%	2.01	48.23	41.46	1.73	6.77	14.04%
Specialty Services	Ward 17	24.00	24.00	38.67	36.48	17.59	18.89	48.22%	51.78%	1.52	36.48	35.83	1.49	0.65	1.78%
Specialty Services	C2 CCU	18.00	18.00	26.20	28.69	12.81	15.88	44.65%	55.35%	1.59	28.69	27.49	1.53	1.20	4.18%
Specialty Services	S10	20.00	20.00	32.01	27.63	11.31	16.32	40.93%	59.07%	1.38	27.63	32.27	1.61	-4.64	-16.79%
Specialty Services	S11	19.00	19.00	27.55	27.19	11.31	15.88	41.60%	58.40%	1.43	27.19	27.83	1.46	-0.64	-2.35%
Total		**147.00**	**147.00**	**227.00**	**241.24**	**92.09**	**149.15**	**38.17%**	**61.83%**	**1.64**	**241.24**	**232.62**	**1.58**	**8.62**	**3.57%**
Emergency Care	A5	16.00	16.00	26.81	24.02	11.81	12.21	49.17%	50.83%	1.50	24.02	27.54	1.72	-3.52	-14.65%
Emergency Care	C1*	24.00	16.00	22.80	37.64	18.32	19.32	48.67%	51.33%	1.57	37.64	35.45	1.48	2.19	5.82%
Emergency Care	ATC	21.00	21.00	26.78	37.80	17.71	20.09	46.85%	53.15%	1.80	37.80	29.21	1.39	8.59	22.72%
Emergency Care	AMU	40.00	40.00	71.04	77.97	35.43	42.54	45.44%	54.56%	1.95	77.97	61.02	1.53	16.95	21.74%
Emergency Care	Ward 24	24.00	24.00	34.84	43.75	24.43	19.32	55.84%	44.16%	1.82	43.75	39.15	1.63	4.60	10.51%
Emergency Care	Respiratory Unit (Ward 26 & 27	56.00	56.00	89.12	73.45	34.32	39.13	46.73%	53.27%	1.31	73.45	89.68	1.60	-16.23	-22.10%
Emergency Care	Ward 25	16.00	16.00	28.79	24.02	11.81	12.21	49.17%	50.83%	1.50	24.02	33.46	2.09	-9.44	-39.30%
Total		**197.00**	**189.00**	**300.18**	**318.65**	**153.83**	**164.82**	**48.28%**	**51.72%**	**1.62**	**318.65**	**315.51**	**1.60**	**3.14**	**0.99%**
Children and Family Services	Ward G5	24.00	24.00	24.70	31.80	10.13	21.67	31.86%	68.14%	1.33	31.80	27.09	1.13	4.71	14.81%
Total		**24.00**	**24.00**	**24.70**	**31.80**	**10.13**	**21.67**	**31.86%**	**68.14%**	**1.33**	**31.80**	**27.09**	**1.13**	**4.71**	**14.81%**
Total excluding Critical care		**699.00**	**691.00**	**1008.43**	**1055.02**	**474.08**	**580.94**	**44.94%**	**55.06%**	**1.51**	**1055.02**	**1067.56**	**1.53**	**-12.54**	**-1.19%**
Surgical	Critical Care	20.00	20.00	46.10	92.84	3.52	89.32	3.79%	96.21%	4.64	92.84	56.99	2.85	35.85	38.61%
Surgical	ITU Bassetlaw	6.00	6.00	12.71	29.75	1.83	27.92	6.15%	93.85%	4.96	29.75	18.75	3.13	11	36.97%
Total		**26.00**	**26.00**	**58.81**	**122.59**	**5.35**	**117.24**	**4.36%**	**95.64%**	**4.72**	**122.59**	**75.74**	**2.91**	**46.85**	**38.22%**
Total including Critical care		**725.00**	**717.00**	**1067.24**	**1177.61**	**479.43**	**698.18**	**40.71%**	**59.29%**	**1.62**	**1177.61**	**1143.30**	**1.58**	**34.31**	**2.91%**

Budget Values for G5 only include the G5 ward budget WTE not EPAU
Budget values for AMU and ATC both exclude the Ambulatory staffing

less than 0%
between 0% and 5%
above 5%

Workforce /Quality/Safety Profiles December 2017 Data

				Planned v Actual staffing	Safe	Effective	Caring	Responsive	Well Led	Profile		WQAT annual assessment 2016/17
Care Group	**Matron**	**Ward**	**No of Funded Beds**	**Variance**	**Total score**	**Total score**	**Total score**	**Total score**	**QM total score**	**Work-force**	**Quality**	**Rating**
Surgical	NS	B6	16	96%	3.0	0.0	0.5	2.0	5.5			
	NS	20	27	96%	3.0	0.5	1.0	0.5	5.0			
	NS	21	27	101%	0.5	0.5	1.5	1.5	4.0			
	LM	S12	20	106%	1.0	2.0	0.5	2.5	6.0			
	RF	SAW	21	96%	1.0	0.0	2.0	2.0	5.0			
	LC	ITU DRI	20	98%	2.0	0.5	0.0	2.5	5.0			
	LC	ITU BDGH	6	91%	1.5	0.0	0.5	1.0	3.0			
				98%								
MSK and Frailty	SS	A4	24	104%	1.5	0.0	0.5	0.0	2.0			
	SS	B5	30.7	91%	0.0	1.0	0.0	0.5	1.5			
	AH	St Leger	35	95%	3.0	1.0	2.0	2.0	8.0			
	AH	1&3	23	99%	1.0	0.0	1.0	1.5	3.5			
	SS	Mallard	16	104%	1.0	0.5	0.0	0.0	1.5			
	SS	Gresley	32	99%	0.5	2.0	2.0	1.0	5.5			
	SS	FAU	16	97%	1.5	0.5	1.5	1.0	4.5			
	KM	Rehab 2	19	95%	2.0	2.0	0.5	1.5	6.0			
	KM	Rehab 1	29	96%	3.0	1.0	1.0	3.5	8.5			
				98%								
Specialty Service	JP	18 Haem	12	96%	1.5	0.5	0.5	0.5	3.0			
	JP	18 CCU	12	109%	0.5	0.0	0.5	1.5	2.5			
	AW	32	18	94%	1.5	0.5	0.5	1.5	4.0			
	AW	16	24	98%	2.5	0.5	0.5	1.0	4.5			
	RF	17	24	93%	3.5	0.5	0.0	1.0	5.0			
	JP	CCU/C2	18	102%	1.0	0.0	3.0	2.5	6.5			
	RF	S10	20	98%	1.5	0.0	1.0	1.5	4.0			
	RF	S11	19	105%	1.0	1.0	0.0	2.0	4.0			
				99%								
Emergency	MH	ATC	21	93%	3.0	0.5	2.5	2.0	8.0			
	SS	AMU	40	101%	2.0	0.5	1.0	2.0	5.5			
	MH	C1	16	90%	2.5	2.0	0.0	1.5	6.0			
	SC	24	24	95%	1.0	1.5	1.0	1.5	5.0			
	SC	25	16	117%	1.5	2.5	3.0	2.0	9.0			
	SC	Respiratory unit	56	92%	4.0	1.5	1.0	1.5	8.0			
				97%								
Children and Families	AB	SCBU	8	100%	0.0	0.0	0.0	0.0	0.0			
	AB	NNU	18	99%	0.5	0.0	0.0	1.0	1.5			
	AB	CHW	18	98%	0.0	0.0	0.0	0.0	0.0			
	AB	COU/CSU	21	98%	0.0	0.0	0.0	0.5	0.5			
	SS	G5	24	92%	1.0	1.0	2.0	1.0	5.0			
	SS	M1	26	80%	0.5	0.0	2.0	1.5	4.0			
	SS	M2	18	68%	0.5	2.0	0.0	0.5	3.0			
	SS	CDS	14	88%	0.0	0.0	1.0	1.0	2.0			
	SS	A2	18	95%	0.0	0.5	0.0	1.5	2.0			
	SS	A2L	6	84%	0.0	0.0	0.0	1.0	1.0			
				91%								
		Trust Position		**96%**								

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Title	**Draft National Workforce Strategy – consultation process**		
Report to	**Board of Directors**	**Date**	**January 2018**
Author	**Karen Barnard, Director of People & OD**		
Purpose			Tick one as appropriate
	Decision		
	Assurance		
	Information		

Executive summary containing key messages and issues

Health Education England (HEE) has published *Facing the facts, shaping the future,* a draft health and care workforce strategy for England to 2027 (the first to cover a 20 year period). This follows the secretary of state's commitment at the NHS Providers annual conference that for the first time health and care system would have a long-term national workforce strategy; this complements NHS Providers own report *There for us: a better future for the NHS* workforce Whilst the production of this draft strategy was led and coordinated by HEE it has content from NHSE, NHSI, PHE, CQC and the DoH. Anyone wishing to read the full document can access it at: https://consultation.hee.nhs.uk/

The draft strategy acknowledges the mixed history of NHS workforce planning and seeks to address the fragmented, variable and unanticipated responses. There is recognition that the health and social care system is facing growing care needs, changing expectations, and changing socio-economic, political, governance and technological environments. It is about putting staff at the heart of a patient centred vision. To address these changes, HEE is proposing a set of six high level principles that will underpin future workforce decisions.

1. Securing the supply of staff, with particular attention on the supply of the UK workforce in order to lessen the need to recruit staff from other countries.
2. Enabling a flexible and adaptable workforce through investment in education and training of new and current staff. While recognising that NHS professionals have distinct roles, HEE has acknowledged there is scope for blending clinical responsibilities which can be rewarding for staff.
3. Providing broad pathways for careers in the NHS, with structured career opportunities to enable staff to progress both within and between professions.
4. Widening participation in NHS jobs, so that people from all backgrounds have the opportunity to contribute and benefit and the NHS workforce of the future more closely reflects the populations it serves.

5. Ensuring the NHS and other employers in the system are inclusive modern model employers, with flexible working patterns, career structures and rewards. Part of this involves addressing the changing expectations of all the generations who work in the NHS.
6. Ensuring that service, financial and workforce planning are intertwined. Alignment across these areas is intended to foster realism alongside creativity in considering what the workforce can contribute to a new or changing service.

HEE has set out eight consultation questions. Discussion has taken place this month with the Local Workforce Action Board who are seeking feedback from employers in order that the LWAB may respond on behalf of South Yorkshire and Bassetlaw – the deadline for this response is 23 February 2018. The national consultation period is through to 23 March 2018. Initial thoughts are provided within the paper with further views to be sought via the Workforce & Education Committee, Management Board, Care Groups, Partnership Forum and staff groups during the consultation period:

1. *Do you support the six principles proposed to support better workforce planning; and In particular will the principals lead to better alignment of financial, policy, and service planning and represent best practice in the future?*
2. *What measures are needed to secure the staff the system needs for the future; and how can actions already under way be made more effective?* Areas to explore may include:
3. *How can we ensure the system more effectively trains, educates and invests in the new and current workforce?*
4. *What more can be done to ensure all staff, starting from the lowest paid, see a valid and attractive career in the NHS, with identifiable paths and multiple points of entry and choice?*
5. *How can we better ensure the health system meets the needs and aspirations of all communities in England?*
6. *What does being a modern, model employer mean to you and how can we ensure the NHS meets those ambitions?*
7. *Do you have any comments on how we can ensure that our NHS staff make the greatest possible difference to delivering excellent care for people in England?*
8. *What policy options could most effectively address the current and future challenges for the adult social care workforce?*

Whilst it is recognised that we must maximise the opportunities to bring recruits into the organisation from both within and outside of the NHS it is crucial that we maximise our retention strategy both within our Trust and within Doncaster and Bassetlaw. The Trust hosted a workforce summit involving workforce and education professionals across Doncaster health and social care commissioners and providers in order that we could consider how to both retain and attract staff within Doncaster. Key priorities are being finalized which will form a workforce workstream within the Place Plan. Our recently approved P&OD strategy is aligned to these priorities along with the ACS workforce framework.

Members of the Board are asked to provide any immediate feedback on the consultation comments or to feed them through during the consultation period.

Appendix 1 details a summary of the new and existing strategic actions
Appendix 2 details a summary from each chapter
Appendix 3 provides the headlines of our P&OD strategy implementation plan

Key questions posed by the report

Does the Board of Directors agree with the key elements of the national workforce strategy?
Is the Trust's People & OD strategy aligned to the national workforce strategy?

How this report contributes to the delivery of the strategic objectives

This report enables the Board of Directors to consider whether the recently approved P&OD strategy is aligned to the proposed national workforce strategy

How this report impacts on current risks or highlights new risks

The Trust's risk register includes:

- Recruitment and retention
- Staff morale
- Use of bank and agency staff.

Recommendation(s) and next steps

Members of the Board are asked to provide any feedback on the responses to the consultation questions.

Draft health and care workforce strategy for England to 2027

Health Education England (HEE) has published *Facing the facts, shaping the future,* a draft health and care workforce strategy for England to 2027 (the first to cover a 20 year period). This follows the secretary of state's commitment at the NHS Providers annual conference that for the first time health and care system would have a long-term national workforce strategy; this complements NHS Providers own report *There for us: a better future for the NHS* workforce Whilst the production of this draft strategy was led and coordinated by HEE it has content from NHSE, NHSI, PHE, CQC and the DoH. Anyone wishing to read the full document can access it at: https://consultation.hee.nhs.uk/

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1 Securing the supply of staff, with particular attention on the supply of the UK workforce in order to lessen the need to recruit staff from other countries.

2 Enabling a flexible and adaptable workforce through investment in education and training of new and current staff. While recognising that NHS professionals have distinct roles, HEE has acknowledged there is scope for blending clinical responsibilities which can be rewarding for staff.

3 Providing broad pathways for careers in the NHS, with structured career opportunities to enable staff to progress both within and between professions.

4 Widening participation in NHS jobs, so that people from all backgrounds have the opportunity to contribute and benefit and the NHS workforce of the future more closely reflects the populations it serves.

5 Ensuring the NHS and other employers in the system are inclusive modern model employers, with flexible working patterns, career structures and rewards. Part of this involves addressing the changing expectations of all the generations who work in the NHS.

6 Ensuring that service, financial and workforce planning are intertwined. Alignment across these areas is intended to foster realism alongside creativity in considering what the workforce can contribute to a new or changing service.

The draft strategy sets the scene by outlining changes in the NHS workforce since 2012. For example, overall there are 40,000 more clinicians substantively employed than in 2012. Nevertheless, some profession numbers have decreased. Workforce growth overall since 2012 has also been slower than anticipated with HEE pointing to worsening retention rates and the NHS becoming a relatively less attractive employment offer as part of the explanation. As a result, there are a significant number of posts unfilled. For example the

current total NHS vacancies for nurses, midwives and allied health professionals (AHPs) are almost 42,000 (9.4%). However 92% of those vacancies are filled by the temporary workforce of bank and agency staff. Within DBTH vacancy rates for qualified nurses and midwives is around 4.5% and AHPs and Scientists around 1.5%; however Board members will recall from the nurse staffing reports that ward staffing is around 98% of establishment.

Growing the workforce

HEE has identified several areas for action to address existing workforce shortages:

- *Recruitment and education.* The number of clinical staff in training has increased over the past three years. Initiatives include: encouraging more young people to consider working in healthcare through the NHS Careers service, increasing the number of clinical placements to allow greater numbers of healthcare students, expanding undergraduate medical school places, reducing student attrition rates, and developing apprenticeships and medical and nursing associate roles.
- *Retention.* HEE is to make a concerted effort to understand the growing levels of staff turnover. For example, the rate at which nurses are leaving trusts has increased from 12.3% in 2012/13 to 15.0% in 2016/17. NHSI has analysed the provider sector to develop a support plan and improve retention – this was launched in July 2017 and is already beginning to show a small reduction in nurses leaving trusts.
- *Self sufficiency.* Over time HEE intends to reduce the NHS' reliance on staff from overseas. However, it also argues for a balanced approach to enabling qualified overseas staff to train in the UK and to develop the NHS as a global learning hub. A global health strategy is to be published by HEE in spring 2018.
- *The Five Year Forward View*. The strategy details the workforce response to the Five Year Forward View. Integrated care, in the form of STPs, ACOs and ACSs, will involve staff working in new environments across traditional institutional and geographical boundaries. Local Workforce Action Boards (LWABs) are the workforce arm of the STPs and it is intended they will grow and develop as part of their health system, providing analysis, data and intelligence.
- *Social care.* The draft strategy also addresses the challenges facing the adult social care (ASC) workforce, which will require growth of between 14% and 31% before 2030. The forthcoming government green paper will build on action to address demand for social care and set out a longer term plan for addressing the challenges.

Looking to the future

The draft strategy seeks to address the longer term challenges that have been identified:

- *Requirements beyond 2021/22.* In considering future provision, HEE has focused on both affordability and patient/population demand drivers. Beyond the period of the Spending Review scenarios for demand of healthcare workforce need to consider factors such as: population growth, changes in morbidity and the trend

towards societies devoting an increasing share of their resources to health as income rises. HEEls 'do nothing more' modelling scenario suggests potential for workforce demand growth of 17% between 2021/22 and 2026/27 which would result in approximately 190,000 additional posts being required.

- *Shaping the future.* HEE outlines the requirements of the future NHS and the planning process that will help NHS staff deliver in an increasingly complex and changing world. This includes reviewing data requirements for workforce planning, developing the public health workforce, boosting productivity, focusing on digital, and introducing a system of "credentialing".
- *Developing specific workforce groups.* While believing multi-disciplinary working is a priority, HEE seeks to address the specific issues associated with seven specific workforce groups - medicine, nursing and midwifery, dentistry, allied health professionals, healthcare science, pharmacy, and the wider workforce.

The draft strategy confirms the Leadership Academy will implement the Faculty of Medical Leadership and Management review of clinical leadership. The Leadership Academy will also deliver skills training for management, Enhancing the NHS as a place where careers are forged, rather than merely a place where jobs are done.

Appendix 1 includes a summary from the draft strategy of the key new and existing strategic actions.

Appendix 2 provides headlines of each chapter of the strategy.

HEE has set out eight consultation questions. The consultation period is through to 23 March 2018. Initial thoughts on our response are provided below with further views to be sought via the Workforce & Education Committee and Management Board:

1. *Do you support the six principles proposed to support better workforce planning; and In particular will the principals lead to better alignment of financial, policy, and service planning and represent best practice in the future?* Areas to explore may include:
    - What more can be done to help staff work across organisations and sectors more easily?
    - What data do we need to ensure we can plan effectively, and how do we align across workforce, finance and service planning?
    - For what sort of measures/plans/proposals should the Workforce Impact Assessment be used?

<u>Feedback</u> - Agreement with the six principles; passporting of key credentials across organisations (eg SET training, DBS checks, health clearance as being pursued across our ACS) in order to facilitate quicker movement between organisations; introduction of established rotations (discussion at a recent Doncaster Place workforce summit identified this as an aim) so that staff can expand their portfolio without moving out of the locality (Place or ACS); system wide training and qualifications eg Care Certificate so all organisations have the same expectations; common core principles for workforce policies. In order to align workforce, finance and service planning submission timescales need to be aligned.

2. *What measures are needed to secure the staff the system needs for the future; and how can actions already under way be made more effective?* Areas to explore may include:

    - Are there fresh ideas for attracting more people to work in the NHS, either as new recruits or returners?
    - What scope is there to extend workforce flexibility using ideas such as credentialing, transferable qualifications, scope of practice and others?

Feedback - Health and care organisations must be seen as an attractive employer in order to attract new recruits. Exploration of guaranteeing a job post qualification is being explored within our ACS.

3. *How can we ensure the system more effectively trains, educates and invests in the new and current workforce?* Areas to explore may include:

    - Are there any specific areas of curricula change or new techniques such as gamification or new cross cutting subjects like leadership, public health or quality improvement science that should be taught to all clinicians?
    - How does the system ensure it spends what is needed on individual CPD and gets the most effective outcomes from it?

Feedback - Need to provide mandatory training in as effective and efficient way as possible in order that staff and funding is released to develop staff. Key skills such as quality improvement and public health techniques are vital.

4. *What more can be done to ensure all staff, starting from the lowest paid, see a valid and attractive career in the NHS, with identifiable paths and multiple points of entry and choice?* Areas to explore may include:

    - What more can be done to create careers not jobs for all staff, regardless of qualifications, entry level and current skills?
    - What reforms are required to medical education and training to deliver the doctors the system needs in the future but also supports the needs of the system now?

Introduction of recognised pathways which staff can enter and pause along the way to fit with their aspirations during their lives. Generations have differing expectations from their work/career. Explore how staff might move between roles and professions.

5. *How can we better ensure the health system meets the needs and aspirations of all communities in England?* Areas to explore may include:

    - What more can be done to attract staff from non-traditional backgrounds, including where we train and how we train?
    - How we better support carers, self carers and volunteers?

Feedback - Ensure placements are available within local communities; explore non-traditional means of delivering training.

6. *What does being a modern, model employer mean to you and how can we ensure the NHS meets those ambitions?* Areas to explore may include:

- What more would make it more attractive to work or stay in the NHS as you progress through different careers stages?
- What should the system do to ensure it is flexible and adaptable to new ways of working differing expectations of generations?

Feedback - The ability to step off a career pathway and rejoin as individual's lives suit; patterns of working hours; ensure staff can see that their views count.

7. *Do you have any comments on how we can ensure that our NHS staff make the greatest possible difference to delivering excellent care for people in England?* Areas to explore may include:
    - What opportunities are there for making a difference through skill mix changes, staff working flexibly across traditional boundaries, and enabling staff to work at the top of their professional competence?
    - What more can be done to deploy staff effectively and reduce further the use of agency staff?
    - What more should we do to help staff focus on the health and wellbeing of patients and their families?
    - What are the most productive other areas to explore around management and leadership, technology and infrastructure?

Feedback - Explore the competences required to deliver care and how roles can be developed within new frameworks. Can frameworks be developed more quickly so that different roles can be introduced quicker. Qualification frameworks need to be more fleet of foot to respond to changes in service delivery. Recognition of the contribution of the non clinical workforce to the delivery of patient care.

8. *What policy options could most effectively address the current and future challenges for the adult social care workforce?*

Feedback - Common standards across the wider social care workforce to facilitate movement between organisations.

Appendix 1 – Summary of the key new and existing strategic actions

Objectives	Action	Leads
Increase future workforce supply from education and training	Increase numbers of GP trainees to 3,250 per annum	HEE
	Expand undergraduate medical places by 25%	HEE, HEFCE, HEIs, GMC
	Expand nursing student places by a further 25%	HEE, HEIs
	Expand AHP student places	HEE, HEIs
	Campaign to maximise recruitment to clinical undergraduate courses	HEE, HEFCE, UUK
	Expand physician associates in training to over 1,000 per annum	HEE, HEIs
	Secure future supply of podiatrists and other shortage professions	HEFCE, HEE, HEIs
	Increase Nursing Associate training places to 7,500 per annum	HEE
	Increase Emergency Medicine trainees	HEE
	Train 400 clinical endoscopists and 300 reporting radiographers	HEE
	Deliver 19,000 new Mental Health staff	HEE, NHSI, NHSE
	Deliver 1,500 clinical pharmacists working in general practice	NHSE, HEE, CPPE
	Review tariff for undergraduate and postgraduate placements	DH, HEE
	Develop and roll out targeted Health Careers campaigns	HEE
Evaluate	Introducing healthcare science A-level	HEE
Increase workforce supply by recruiting experienced staff	Attract 1,000 returning nurses and 300 AHPs back into the NHS per annum	HEE
	Attract 2,000 GPs from overseas	NHSE
	Launch return to practice campaign for GPs	NHSE
Increase workforce supply through retention and help NHS become the employer of choice	National retention improvement programme	NHSI, NHS Employers, HEE
	Review reward package	DH, SPF
	Develop flexible working solutions	Trusts, NHSI, HEE
	Pearson review into health and wellbeing of NHS staff and trainees/students	HEE, GMC, NHE Employers
	Improve working lives of BAME staff; NHS Workforce Race Equality Standard (WRES)	NHSE, NHSI, HEE
	Build on “Improving Junior Doctors Lives” programme	HEE
	Improve flexible working offers for staff nearing retirement	HEE, NHS Employers, NHSI
	Improve career pathway options within and between professions	HEE

	Consider new ring-fenced workforce development funding for priority areas	DH, ALBs
	Extend use of e-rostering and effective job planning	NHS Employers, NHSI
Review and modernise education and training	Consider periodic review of number and allocation of medical school places	HEE, HEFCE, DH, DfE
	Deliver Medical Education Reform Programme – greater flexibility in training, ARCP review, review of foundation training in England	HEE, GMC, AoMRC
	Review distribution of postgraduate medical training places by specialty and geography	HEE, NHSI, NHSE
	Review Clinical Psychologists training route and psychology degree content	HEE, HEIs, Regulator
	Accelerated route to nursing pilot programme	NHSE, HEE
	Review how technology will affect roles, functions, education and training	OH, HEE
	Explore greater use of gamification in training	HEE. Royal Colleges, GMC, HEis
	Investigate areas, such as population health, that should be taught across curricula	HEE, Royal Colleges, GMC
	Expand distance, online, blended learning to a broader number of areas	HEE, HEIs
	Investigate possible changes to Point of Registration	GMC, DH, HEE
	Ensure curricula across all professional groups contain Mental Health content	HEE, Royal Colleges, Regulators, HEIs
Widen participation in the workforce	Support clinical and non-clinical apprenticeships by ensuring access to levy – review of first year use	DH, HEE
	Target non-traditional schools via Health Careers campaigns	HEE
	Improve employment opportunities for people with learning disabilities including the NHS learning disability employment programme	HEE, NHSI
Improve skill mix in workforce	Produce system wide approach to agreed investment in CPD	HEE. NHSI, Trusts
	Develop credentialing across all professions	HEE, GMC, NMC, HCPC

	Explore introduction of nationally consistent postgraduate nursing qualifications	NMC, HEE
	Development and implementation of the Advanced Clinical Practice framework	HEE, NHSI, NHSE
	Ensure Training Hubs available to all GP practices	HEE
	Ensure appropriate regulation of clinical professionals	DH, HEE
Position NHS as a centre of global excellence for health workforce, education and training	Develop, promote and facilitate innovative, ethical and mutually beneficial educational placements in the NHS and overseas	DH, HEE
	Offer ethical earn, learn, return programmes	HEE
Leadership development	Implement WRES and leadership scheme	NHSE, HEE
	Implement *Developing People, Improving Care* Framework	ALBs, DH
	Increase numbers on Leadership Academy Schemes to 20,000 per annum	HEE, NHSI
	Expand GMTS to 500 places by 2020 with an ambition to go further	HEE, NHSI
Workforce planning solutions	Review of learning disability workforce	HEE, NHSE, NHSI
	Review of community nursing qualifications	HEE, NHSI, NHSE, NMC
	Create demand modelling process for all professions post 2021	HEE, NHSI, NHSE, DH, PHE
	Explore better alignment of workforce, finance and service planning	National ALBs, DH
	Review of the workforce responsibilities of all ALBs	DH, ALBs
	Publish intelligence reports by profession and geography	HEE,
	Review data needs across system including reinstatement of vacancy data collection	NHS Digital, HEE, NHSI. NHSE, DH
Improve support for patients, carers and volunteers through education and training	Series of workstreams with Independent leadership to promote volunteering and consider training needs of individuals managing their own conditions, informal carers and volunteers	HEE PAF, DH, ALBs,

Appendix 2 – Headlines of each Chapter

Chapter 1 ***Developing a workforce strategy***

- The NHS has a mixed history of workforce planning, with fragmented approaches, numerous variables and unanticipated spikes in demand.
- Currently the NHS faces workforce challenges at various levels, and the additional need to respond to the service goals set in the Five Year Forward View.
- Action has already been taken to address many of these challenges and further plans are being put in place.
- There is a complex landscape of responsibilities for workforce at all levels but structures are in place to support joint working on delivery, both nationally and locally.
- The impact of current trends on the future workforce is uncertain, even though there are likely to be new challenges as well as opportunities to reduce demand.
- A set of principles for future workforce decisions is described - designed to better manage that uncertainty.

Chapter 2 ***Facing the facts – The NHS workforce in 2017***

- Since 2012 there has been growth of over 40,000 additional clinical staff across the NHS.
- Growth rates differ between professions and geographies.
- The NHS needs to do more to attract newly qualified staff into substantive employment and retain its current workforce.
- The rate of growth is slower than it might have been as a higher number of staff have joined professional registers from training than joined the NHS.
- Alongside growth in staff, there has been a significant growth in vacancies. The majority of vacancies are covered by bank and/or agency staff.
- We should both increase the amount of training placements available and make the NHS the employer of choice.

Chapter 3 ***Growing the workforce***

- Workforce growth comes from; new graduates; return to practice and recruitment from outside the NHS; and retention of current staff.
- Education will deliver more medical school places, increased nursing undergraduate places and other priorities.
- New roles will play a major part of growth and increasing skill mix.
- Retaining existing staff has the most immediate impact.
- A national retention programme is in place.
- As we move to self-sufficiency in staff overseas work will concentrate on England as a world-class education and training provider.

Chapter 4 ***The workforce response to the Five Year Forward View***

- Next Steps outlined priority areas for action to deliver the overall vision of the FYFV.
- The priorities are Cancer; Mental Health; Urgent and Emergency Care; Maternity; and Primary Care.
- HEE produced workforce plans designed to deliver these service priorities.
- Learning Disabilities also requires focus.
- Integrating care will be vital in delivering the FYFV effectively.

Chapter 5 ***The adult social care workforce***

- The adult social care workforce is larger than the NHS workforce but has lower average pay, fewer qualifications and more part time staff.
- Turnover is high and there are 88,000 vacancies.
- Required growth of between 14% and 31% is forecast by 2030.
- 18% of the workforce is from overseas with regional variation.
- 20,300 independent organisations provide care in England.
- The government is consulting on changing aspects of the system.

Chapter 6 ***Workforce requirements beyond 2021/22***

- Workforce planning must better align with service delivery and financial planning to be effective.
- Modelling shows that with no action, including increased productivity or service redesign, the NHS will need 190,000 additional posts by 2027.
- If supply continues at the rate of the last five years, 72,000 new staff could be expected to join the NHS by 2027.
- Trusts will need further support to address continuing productivity requirements.

Chapter 7 ***Shaping the future***

- The NHS needs better data and intelligence to improve planning.
- A greater focus on prevention will require development of the public health workforce.
- Reducing variation and delivering productivity can only be truly successful with an engaged workforce.
- Review into impact of technology on educating and training the future workforce.
- Regulation, upskilling and advanced clinical practice vital to improving skill mix.

Chapter 8 ***Developing the NHS workforce***

- Each workforce group has its own specific issues as well as those cross cutting across the service.
- Multi-disciplinary working is a priority, but focusing on individual professions is

also important.

- Advances in technology and innovation will radically change healthcare.
- A leadership strategy for the whole NHS is being implement.
- Seven workforce groups: medical; nursing and midwifery; dental; AHPs; healthcare science; Pharmacy; and the wider workforce are covered.

Chapter 9 ***Conclusion and consultation***

- Consultation will run from Wednesday 13 December 2017 to 17:00 Friday 23 March 2018.
- The consultation will revolve around eight broad questions with a number of issues addressed under each one.
- HEE will lead the consultation with the help and support of partners.

Implementation plan

Objectives	
To have outstanding leaders at all levels	To have an inclusive workforce
To have a healthy workforce	Access to training and education to support the changing workforce
Optimise the recruitment process	Teaching Hospital phase 2 incl links to research
To review the HR service model	Improved supply of people to deliver our services
Workforce plans which are fit for purpose	Motivated and engaged staff delivering better patient outcomes
Improve the use of HR systems	

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Title	**Board Assurance Framework & Corporate Risk Register**		
Report to	**Board of Directors**	**Date**	**31 January 2018**
Author	**Matthew Kane, Trust Board Secretary**		
Purpose			Tick one as appropriate
	Decision		
	Assurance		X
	Information		

Executive summary containing key messages and issues

This report provides an opportunity to review the risks on the Board Assurance Framework and Corporate Risk Register which have been evaluated by executive leads prior to this meeting.

Board Assurance Framework

The Board Assurance Framework (BAF) contains all of the risks to the Trust's five strategic objectives. Two risks have been added in the month:

Description	Escalated by	Current score	Target score
Failure to respond to patient complaints in required timescales	Director of Nursing, Midwifery and Allied Health Professionals	L5 x I2 = 10	L1 x I2 = 2
Failure to adequately treat patients due to unavailability and lack of supply of medicines	Management Board	L5 x I3 = 15	L2 x I3 = 6

In addition, there has been one changes to existing risks on the BAF:

Description	November target score	December target score
Failure to protect against cyber attack	L1 x I4 = 4	L3 x I4 = 12

Controls and assurances for all risks have been reviewed and updated.

Corporate Risk Register

The Corporate Risk Register shows those risks that are 'extreme', rated 15 and above. One addition has been made to the Corporate Risk Register in the period:

- Failure to adequately treat patients due to unavailability and lack of supply of medicines (see BAF for details)

Risk management and the Board Assurance Framework was audited in Q3 and the outcome (significant assurance with minor improvements) reported to Audit and Non-clinical Risk Committee in January 2018.

Key questions posed by the report

- Are the Board assured by the controls and assurances in place?

How this report contributes to the delivery of the strategic objectives

The BAF highlights the key risks to the strategic objectives.

How this report impacts on current risks or highlights new risks

The report sets out progress in relation to current risks and prompts Board to consider any emerging risks.

Recommendation(s) and next steps

To note the Board Assurance Framework and Corporate Risk Register in Quarter 3.

Strategic Aim 1 - We will work with patients to continue to develop accessible, high quality and responsive services.								
KEY STEPS	Ensure the delivery of the Trusts financial plan and the implementation of an agreed improvement and effectiveness plan with identified work streams and SROs. Delivering service change and savings through achieving agreed targets and milestones							
	To create a stable and motivated finance function, measured by staff turnover, implementation of restructures, staff survey							
	Implement a Patient and Carer Experience and Engagement Strategy. Implementing national and international best practice in the use of feedback to improve services.							
	Provide appropriate technology support to the Trust for the development of the Single Oversight Framework throughout 2017.							
PROGRESS	PMO moved to DoF at end June 2017. Review of governance processes being undertaken. New accountability measures instituted including refreshed effectiveness and efficiency committee. Consutlation, slotting in processes and recruitment completed for Fiannce. New staff starting during October. Patient Experience and Engagement Strategy completed and to be presented to BoD October 2017. SOF not delivered in full. Some drill downs and alerts in place. Rest to be delivered in accordance with prioritised timeframes as discussed with Director of Strategy.						Direction	
RISKS	LINK TO CRR	EXEC	CURRENT RR	CONTROLS	ASSURANCE	GAPS IN ASSURANCE	ACTION TO ADDRESS GAPS	TARGET RR
Failure to sustain a viable specialist and non-specialist range of services leading to (i) Regulatory action (ii) Impact on reputation	F&P7	Medical Director/Chief Operating Officer	L3 x I3 = 9	(i) Participation in WTP and Hospital Services Review (ii) Commissioner engagement (iii) Involvement/influence NHSE commissioning intentions (iv) R & D support for specialist services (v) Quarterly Executive discussions with STH (vi) Contribution to reconfiguration discussions	(i) Peer review programe outcome (9 June 2016) (ii) Patient outcome and service quality as published by National Registries (iii) Agreement with Sheffield over vascular services (iv) Publication of Hospital Services Review workstreams (September 2017) (v) Hospital Services Review list of priorities (vi) Particpation in review of specialist services	(i) Strategic review of specialised services in Y&H to be implemented supported by working group	N/A	L2 x I2 = 4
Failure to protect against cyber attack leading to (i) Trust becoming non-operational (ii) Inability to provide clinical services (ii) Negative impact on reputation	F&P11	Chief Information Officer	L3 x I5 = 15	(i) Penetration test of systems to identify gaps and risks; (ii) Firewalls, passwords, anti-virus equipment. (iii) Policies and reinforcement through communication to staff; (iv) Staff awareness through Certified Security Professional course and other training; (v) Trigger alerts; (vi) Care Cert system at NHS Digital (vii) All servers and systems patched to appropriate level (viii) Computers and network infrastructure get security patches automatically applied	(i) Trust unaffected by cyber attack in May 2017 (ii) Governors briefing June, 2017 (iii) Cyber maturity audit and action plan reported via ANCR to Board, Septembr 2017	Progress against Internal Audit action plan to be presented to ANCR every six months	To undertake the work from the cyber maturity audit and report through ANCR (Spring 2018)	L3 x I4 = 12
Failure to ensure adequate medical records system leading to (i) Impact on safety (ii) Impact on reputation	Q&E4	Chief Operating Officer	L3 x I3 = 9	(i) Review of bays and action plans in place (ii) RFID business case agreed (iii) Plans to make DRI a closed library (iv) RFID System operational (v) IM&T Strategy	(i) Storage bays reviewed (ii) Presentation before Board in August 2017 on RFID (iii) RFID installed, October 2017	(i) Elecrtonic Patient Rcord System (ii) Information Strategy	(i) Cosnideration of EPR in IM&T Strategy (ii) Draft Information Strategy in development (publication Spring 2018)	L2 x I2 = 4
Failure to engage with patients and staff around the quality of care and proposed service changes leading to (i) Negative patient and public reaction towards the Trust (ii) Impact on reputation (iii) Impact on staff morale (iv) Risk of long-term recruitment issues (v) Risk of delay to any service changes	Q&E5	Acting Director of Nursing, Midwifery and Quality/ Medical Drector	L3 x I3 = 9	(i) Consultations on major service changes (ii) CCC report to Board (iii) Friends and Family Test (iv) Monitoring through Patient Engagement & Expderience Committee (including CCG & Healthwatch membership) (v) Training on communication (vi) Work on learning from deaths (vii) Governor walkabouts (viii) Ward QAT (ix) Picker national surveys (x) Social media e.g. Facebook, Twitter (xi) Media & social media policy (xii) Governor/ NED briefings (xiii) MP briefings/ meetings (xiv) Governor training (xv) Meetings with local journalists (xvi) Face to face briefings with services (xvii) Staff engagement events, briefings and workshops (xviii) Communications with staff on Hospital Services Review (xviii) Internal staff surveys	(i) Consultation on HASU and children's tier 2 surgery (ii) Consultation on new strategic direction (iii) Bassetlaw Governors engagement work with the public (iv) Case law and advice taken in respect of service changes (v) F4H Strategy special, September 2017 (vi) Strategy stand at AMM (vii) Communications team is responsive on traditional and social media (viii) New, engaging website (ix) Invested in strong relationships with local journalists (x) Ensuring internal and external communications are aligned and staff engagement is considered in external comms process (xi) Communications Strategy approved by Board, October 2017 (x) Ongoing meetings with commissioners and primary care across the patch	(i) ACS sessions with NEDs and local MPs and councillors	(i) ACP communications plan is development (Spring 2018) (ii) Further ACS sessions planned for 2018 with local politicians	L2 x I2 = 4
Failure to adequately prepare for CQC inspection leading to (i) Sub-optimal performance in inspection (ii) Risk of regulatory involvement (iii) Impact on reputation	Q&E7	Acting Diretcor of Nursing, Midwifery and Quality	L2 x I3 = 6	(i) Self-assessment and mock inspection processes (ii) Engagement meetings with CQC (iii) Nottinghamshire Looked after Children and Safeguarding monitored by Trust Safeguarding People's Board	(i) CQC internal audit (ii) IRMER inspection and action plan in place (iii) Reports to Board and QEC (iv) CQC Insights (v) PIR and self-assessment completed (vi) Action plan for Child Protection - Information Sharing (vii) Positive mock inspections	(i) Positive assurance from CQC (ii) Good inspection and self-assessment outcomes	(i) Final report from CQC inspection	L2 x I2 = 6

Failure to respond to patient complaints in required timescales leading to (i) Impact on reputation (ii) Impact on patient experience	Q&E8 (New risk)	Acting Director of Nursing, Midwifery and Quality	L5 x I2 = 10	(i) PALS Team (ii) CCC report to QEC (iii) Datix reporting system (iv) Freedom to Speak Up roles (v) Risk report to CGC (vi) Regular performance meetings (vii) Performance considered at PEEC meetings (viii) Reporting arrangements with CGs	(i) Patient Experience Strategy approved	(i) Improved performance in complaints handlig	(i) Improvement plans in place and being implemented (Spring 2018)	L1 x I2 = 2
Failure to adequately treat patients due to unavailability and lack of supply of medicines leading to (i) Impact on safety of patients (ii) Impact on patient experience (iii) Potential delays to treatment (iv) Impact on trust reputation (v) Increased workload in pharmacy procurement	Q&E9 (New risk)	Chief Operating Officer	L5 x I3 = 15	(i) Support from Regional Procurement Team (ii) Arrangement of substitute drugs and medicines (iii) Databse of supply issues managed by RPT (iv) Daily updates on shortages (v) Holding to account of wholesalers for non-delivery of their contractual obligations and monitoring the performance of wholesalers in the region (vi) Local holding to account through account business managers (vii) Escalation measures to Deputy Chief Pharmacist for persistent and acute issues (viii) Logistics team communicating shortages to the ward and pharmacy team if stock not available for supply	(i) Temporary improvements to the supply chain (ii) Updates from CMU (Commercial Medicines Unit of NHSE)	(i) Longer term improvements to supply chain (ii) Awareness amongst relevant staff	Gaps to be added to database (February 2018)	L2 x I3 = 6

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

KEY STEPS	Development of a 5 year Estates Strategy, to include a Capital Development Programme linked to Condition Surveys and Corporate Risk Register.	
	Produce a clinical service model for the delivery of safe and sustainable emergency, elective, diagnostic and support services across the Trust	
	Maintain Compliance with all NHSI Access Targets and Outcomes Objectives with Sustainability and with Transformation Fund associated Targets (Four Hour Wait and RTT) as a priority.	
	Increase elective activity at BDGH and MMH to best utilise available resources and facilities	
	Produce and implement a Quality Improvement & Innovation Strategy that is based on best practice and developed with staff, containing a plan to increase QII capacity and capability within DBTH (and potentially with partners)	
	Maintain a robust and effective Programme Management Office ensuring robust systems and processes to drive, monitor and escalate effectiveness & efficiency, enabling and strategic clinical plans.	
PROGRESS	Estates Strategy now due at Finance and Performance in Oct, Board of Directors on November. Clinical Site Strategy agreed. Three key strategic steering groups set up with ToR. Work plans agreed with set timescales for service changes. STF achieved for 4hr access in Q1/2. RTT plans agreed with NHSi to be compliant by Q4. Qii Strategy to go to Board In October.	**Direction**

RISKS	LINK TO CRR	EXEC	CURRENT RR	CONTROLS	ASSURANCE	GAPS IN ASSURANCE	ACTION TO ADDRESS GAPS	TARGET RR
Failure to achieve compliance with financial performance and achieve financial plan leading to (i) Adverse impact on Trust's financial position (ii) Adverse impact on operational performance (iii) Impact on reputation (iv) Regulatory action	F&P1	Director of Finance	L3 x I5 = 15	(i) Business and budget planning processes. (ii) Financial governance policies and procedures. (iii) Monthly monitoring of financial performance. (iv) Data analysis of trends and action to address deterioration. (v) Continued liaison with budget holders to identify risks to delivery. (vi) Demand and capacity planning proccesses. (vii) Detailed monitoring by Finance and Performance Committee. (viii) Budgets set on recurrent outturn resulting in a more robust financial plan. (ix) Budgets signed off by care groups and corporate departments. (x) Monthly monitoring at Board and directorate level. (xi) Uncommitted general contingency reserve. (xii) Regular finance meetings with budget holders. (xiii) Performance review meetings with NHSI. (xiv) All directorates signed up to control total. (xv) Support from BDO. (xvi) Appointment of suitably quaified Efficiency Director.	(i) Exceeded control total in 2016/17 (ii) Production of 2017/18 budget (iii) Unqualified opinion on 2016/17 accounts (vi) Accounts submitted to NHSI by deadline (v) Financial plans submitted to NHSI (vi) Board approval of budgets (vii) Budget setting approved by Finance and Performance Committee (viii) Minutes of accountability and NHSI meetings (ix) External Audit review of financial performance (within Annual Accounts work) (x) First round of accountability meetings taken place (xi) BDO governance review (xii) Regular finance reports to F&P	(i) Consistent reporting of achievement against plan (ii) 2017/18 external audit (iii) Completion of BDO action plan	(i) Work relating to BDO action plan - Spring 2018	L2 x I5 = 10
Failure to deliver accurate financial reporting underpinned by effective financial governance leading to (i) Regulatory action (ii) Impact on reputation	F&P2	Director of Finance	L3 x I4 = 12	(i) Checklist of control accounts reviewed by the Finance Director (ii) Board report reconciled to general ledger on a monthly basis (iii) All CIPs reported as actioned have been through budget retraction (iv) Governance structure for SBS system	(i) Unualified opinion on 2016/17 accounts (ii) Consistency of reporting over sustained period (iii) Internal audit reports show significant assurance with only minor improvements in respect of financial reporting	(i) Continued positive audits on financial reporting (ii) M9 accounting position for 2017/18	N/A	L1 x I4 = 4
Failure to deliver Cost Improvement Plans in this financial year leading to (i) Negative impact on Turnaround (ii) Negative impact on Trust's financial positon (iii) Loss of STF funding	F&P3	Director of Finance	L4 x I4 = 16	(i) Full Quality Risk Assessment and operational deliverability assessment of plans. (ii) Regular consideration of schemes by Management Board and Executive Team. (iii) Collaboration with other providers, to identify joint opportunities. (iv) CIP tracker developed to provide visibility of progress agianst plan. (v) Engagement in working together programme. (vi) PMO led by new Effeiciecy Director, with associated management processes, key deliverables, risk logs and reporting to Finance and Performance Committee. (vii) Implementation of innovation from external reviews. (viii) Regular meetings with NHSI to track progress. (ix) Regenerated E&E Committee. (x) CIP reovery meetings (fortnightly) with each group.	(i) Performance against CIP for 16/17 of £11.9m. (ii) Monthly CIP reports to Finance and Performance and Board. (iii) Assurance provided to NHSI at quarterly meetings. (iv) New PMO governance processes agreed and implemented. (v) BDO governance review.	(i) Outstanding recurrent CIP target to be found (ii) BDO governance review actions implemented	(i) BDO action plan being implemented and will reported to E&E Committee and F&P (ongoing).	L1 x I5 = 5

Failure to ensure that estates infrastructure is adequately maintained and upgraded in line with current legislation, standards and guidance. **Note:** A number of different distinct risks are contained within this overarching entry. For further details please consult the E&F risk register. leading to (i) Breaches of regulatory compliance and enforcement (ii) Claims brought against the Trust (iii) Inability to provide safe services (iv) Negative impact on reputation (v) Reduced levels of business resilience (vi) Inefficient energy use (increased cost) (vii) Increased breakdowns leading to operational disruption (viii) Restriction to site development	F&P4	Director of Estates and Facilities	L4 x I5 = 20	(i) Annual business plan supports identification of issues by Care Groups / Directorates (ii) Risk-based capital investment plans (iii) Maintenance and support service contracts (iv) Independent Authorising Engineers appointed for key services, providing annual audits and technical guidance (v) Revised business planning process for all capital investments (vi) Estate condition and backlog maintenance assessment undertaken via 6-7 facet survey (vi) Progress and monitoring of actions undertaken through compliance committees e.g. health and safety committee (vii) Board level health and safety training undertaken, October 2017 (viii) Completion of in-depth high voltage scheme (June 2017)	(i) Presentations to Finance and Performance and Governors Briefings (ii) Catering contract agreed May 2017 (iii) New service assistants in post April 2017 (iv) Completed 6/7 facet survey (v) Asbetos and window surveys complete (vi) Asbestos management plan up to date (vii) Window risk assessments complete (viii) Water management protocols complete and progress commenced (ix) Electrical infrastructure surveys complete (xii) Waste contract completed and delivered (xiii) New catering contract signed (xiv) New gas main (xv) Continuously premise assurance model (xvi) Estates Strategy approved by Board and capital plan	(i) Outcomes of NHSI/Loughborough University estates work. (ii) Additional 6/7 facet work.	(i) MP developing capital schemes for ACS funding (Autumn 2017) (iii) New electrical supplier to site	L2 x I5 = 10
Failing to address the effects of the medical agency cap leading to (i) Negative patient and public reaction towards the Trust (ii) Impact on reputation	F&P5	Director of People and OD/ Chief Operating Officer/Medical Director	L4 x I4 = 16	(i) Teaching hospital status communicated through recruitment. (ii) Care Group to escalate recruitment difficulties to MD/COO. (iii) Use of Trust staff in first instance to address gaps wherever possible. (iv) Signed memo of understanding between all Trusts in the WTP to abide by a standard set of principles. (v) P&OD / Workforce reports to BoD. (vi) Workforce and Education Committee. (vii) Agency spend and breaches going to Exec Team and Finance and Performance. (viii) Better system around rate-to-fill and fill rates. (ix) Use of social media to attract new candidates. (x) Relationships with universities. (xi) GMC Survey. (xii) Medical agency locum panel. (xiii) BDO Grip & Control work. (xiv) Use of alternative workforce.	(i) Recruitment report to Board May 2017. (ii) Workforce and Education Committee assurance reports to QEC & F&P. (iii) Agency spend and breaches going to Exec Team and F&P. (iv) Improved rate-to-fill and fill rates. (v) Latest GMC Survey, in upper quartiles for a number of specialties. (vi) F&P monitoring agency spend and reporting to Board. (vi) Agency spend to F&P	(i) Develop new service model to mitigate medical staff shortage, working acrss the Trust. (ii) Develop and progress workforce from using alternative workforce for service delivery. (iii) Agree with Trusts in WTP to minimise cap breaches. (iv) Decrease local agency spend. (v) Scrutiny of qualified nursing process to be put in place. (vi) Flexible use of staff across ACS system. (vii) Acute hospital review (March 2018). (viii) Flash report on agency spend. (ix) Collaborative bank pilot.	(i) MH to put in place process for scrutinising qualified nurses (November 2017) (ii) Discussions around using flexible staff taking place (October/November 2017). (iii) Hospital@ work (March 2018) (iv) Three steering groups picking in gaps in assurance (March 2018). (v) Working group set up to explore staffing configuration (November 2018)	L3 x I2 = 6
Failure to achieve compliance with performance and delivery aspects of the Single Oversight Framework, CQC and other regulatory standards leading to (i) Regulatory action (ii) Impact on reputation	F&P6	Chief Operating Officer	L4 x I4 = 16	(i) Performance Management and Accountability Framework. (ii) Business planning processes (iii) Relevant policies and procedures. (iv) Daily, weekly & monthly monitoring of targets. (v) Regular monitoring of compliance. (vi) Data analysis of trends and action to address shortfalls. (vii) Continued liaison with leads to identify risks to delivery. (viii) CQC Compliance Governance and Assurance Process. (ix) External reviews policy. (x) Monitoring at monthly Care Group accountability meetings. (xi) A&E QAT process. (xii) Demand and capacity planning proccesses. (xiii) Weekly review of A&E Action plan in accountability meeting chaired by COO. (xiv) Licence to Operate linked to SOF	(i) Full and unconditional registration with CQC (ii) Business Intelligence and Performance Reports (iii) Annual Report & Quality Account (iv) CE quarterly objectives report (BoD - quarterly) (v) Internal audit of CQC readiness (vi) CQC Intelligent Monitoring reports & risk ratings (viii) (vii) In Group 2 on four hour waits (viii) A&E Improvement Progarmme North - showcasing best practice (ix) System Perfect	(i) CQC self-assessments and mock inspections (ii) Well-led review of effectiveness 2017	(i) New accountability framework linked to SOF being put in place for care groups and corporate depts (Spring 2018)	L3 x I3 = 9

Failure to ensure that estates infrastructure is adequately maintained and upgraded in accordance with the Regulatory Reform (Fire Safety) Order 2005 and other current legislation standards and guidance. **Note:** a number of different distinct risks are conatained within this overarching entry. For further details please consult the EF risk register. leading to (i) Breaches of regulatory compliance could result in Enforcement or Prohibition notices issued by the Fire and Rescue Services (ii) Claims brought against the Trust (iii) Inability to provide safe services (iv) Negative impact on reputation	F&P12	Director of Estates and Facilities	L4 x I5 = 20	(i) Regular external inspections from SYRS and Notts Fire Service (ii) Improved fire safety risk assessments and evacuation strategies (iii) Improved Fire Safety Training (iv) Programme upgrade of fire detection systems (v) Programme upgrade of structural fire precautions (compartments) (vi) External Audit Fire Authorised Engineer (vii) Fire safety training Trust Board and Exec Team (viii) Further Development of Fire Safety Response Team structure (ix) Risk based Capital Investment plans identified by estate condition and backlog maintenance assessments via 6 - 7 facet surveys (x) Progress and monitoring of actions undertaken through compliance committees eg health and safety committee	(i) Physical works to DRI and MMH (ii) Fire safety action plan (iii) Report to Board in June 2017 (iv) Fire safety training scheduled July 2017 (v) Staff trained in fire safety - June 2017 (vi) Compartmentalisation, fire stopping, fire doors, fire dampers to the East Ward Block (DRI) basement, ground floor and level seven and other areas across the site (vii) Upgrade of existing, and provision of additional, fire alarm and detection systems at DRI and Montagu Hospital. (viii) Approval of evacuation strategies for W&Cs and East Block. (ix) HSE inspections of Women's Block (x) Montagu evactuation strategy approved, December 2017	(i) Full compliance with requirements of Fire Service (ii) Training on evacuation strategies	(i) Training to be rolled out across 2017/18.	L2 x I5 = 10
Inability to meet Trust's needs for capital investment leading to (i) Inability to sustain improveemnts in Trust's estate. (ii) Negative impact on patient safety. (iii) Negative impact on reputation.	F&P13	Director of Finance	L4 x I4 = 16	(i) Finance reports to Board and Finance and Performance Committee. (ii) Capital governance structure - Corporate Investment Group and Capital Monitoring Group. (iii) Guidance and templates for investment and disinvestment. (iv) Proactive prioritiation of schemes.	(i) DBTH part of bidding process for ACS funds	(i) Knowledge of possible funding remaining for ACS capital schemes.	(i) MP developing capital schemes for ACS funding (Autumn 2017)	L1 x I4 = 4
Lack of adequate CT scanning capacity at DRI leading to (i) Negative impact on patient safety. (ii) Inability to safely manage the emergency and inpatient activity.	Q&E2	Chief Operating Officer	L3 x I3 = 9	(i) Allocation within 2017/18 capital programme. (ii) Engagement with care group directors.	(i) Business case cleared at CIG	(i) Business case development and approval	(i) Business case to go to CIG, F&P and Board, January 2018 (ii) Submission to NHSI	L2 x I2 = 4
Risk of fraud leading to (i) Impact on Trust's finance (ii) Negative impact on reputation	ANCR1	Director of Finance	L2 x I4 = 8	(i) Local Counter Fraud Specialist work plan and investigations (ii) Fraud awareness training. (iii) DH Counter-Fraud regime and oversight (iv) Liaison with DOF and Chair of ANCR	(i) Quarterly and annual LCFS reports (ii) Achievement of satisfactory NHS Protect Quality Assessment outcome (iii) Full completion of 2016/17 operational fraud plan and 2017/18 plan in place (iv) Completion of fraud staff survey (vii) 79% completed fraud awareness training in 2017/18 (viii) NHS Protect assurance report to Board, October and November 2017	N/A	N/A	L1 x I4 = 4

Strategic Aim 3 - We will increase partnership working to benefit people and communities.

KEY STEPS	Work with STP and Place based partners to ensure that the Trust maintains a sustainable future to deliver the needs of the local populations and the legal responsibilities required by NHSI and the CQC	
	Ensure the completion of the Trusts Strategic Vision to reflect the aims and objectives for the Trust within the STP, Place and legal and regulatory requirements of NHSI and the CQC	
	Work with external partners to review service delivery across the wider STP footprint to ensure services which support place based ambitions and the delivery of high quality and sustainable services	
	Develop a specific programme of work to ensure that the future structure of the Medical Directors office reflects the future needs of the Trust, STP and Place and the composition of the medical workforce	
	Evaluate the potential for Public/Private Partnerships, linked to the Trust strategic direction.	

PROGRESS	Evidence of active particpation in Doncaster Place Plan implementation. Strategic Direction includes input on both place plans, involved partner governors and has been presented at DCCG and Bassetlaw ACP. Strategic Direction 2017-2022 agreed and submitted to NHSI. Acute Hospitals Review has DBTHFT clinicians and managers on five key workstreams. Review of roles and reponsibilities within the MD's office has been completed. Options for Capital funding through JV/WOS models disucssed at commercial board	Direction

RISKS	LINK TO CRR	EXEC	CURRENT RR	CONTROLS	ASSURANCE	GAPS IN ASSURANCE	ACTION TO ADDRESS GAPS	TARGET RR
Breakdown of relationship with key partners and stakeholders leading to (i) Negative impact on strategic objectives (ii) Negative impact on reputation	F&P9	Chief Executive	L3 xI4 = 12	(i) Partnership working processes - Working Together, STP, Accountable Care Systems, HWB (ii) Engagement with commissioners & other local trusts (iii) Attendance at CCG governing body meetings (iv) CE meetings with NHS England (v) Regular briefings to Members of Parliament (vi) Partner Governor seats on the Board of Governors (vii) Regular item on Exec Team for feeding back	(i) CE Reports (ii) Updates on HWB activity (iii) Updates regarding Working Together and STP programme via CE report (BoD) (ii) (iv) Committees in common and STP MoUs (v) Support from commissioners (vi) Bassetlaw and Doncaster Place Plans endorsed. (vii) Well Led Governance Review reinforces the Trust's partnership arrangements. (viii) ACS Conference for Governors taken place, October 2017 (ix) CiC meetings underway	(i) Approval of Provider MoU	(i) Final MoU to be brought to Board of Directors, Spring 2018	L2 x I4 = 8
Failure to ensure business continuity / respond appropriately to major incidents leading to (i) Negative impact on reputation (ii) Regulatory enforcement (iii) Negative impact on performance	F&P10	Chief Operating Officer	L2 x I4 = 8	(i) Business continuity plans (ii) Business Continuity Policy (iii) Statement of Compliance against National Core Standards for EPRR (iv) BRSG which monitors BC planning progress (v) Business Continuity Group linked to operational structures (vi) Major Incident Plan (vii) Training of A&E staff on CBRN incidents (viii) Emergency response plans in place (annually reviewed) - Evacuation of a hospital site - Mass Casualty Plan - Pandemic Influenza Plan - Severe Eeather Plan - Prison Plan - CBRNE plan (ix) Incident Control Rooms in line with EPRR Command and Control guidelines (x) Communications exercises undertaken twice yearly as required by statute (xi) Command & control training for BoD & senior managers on-call (xii) Revision of plans following test exercises. (xiii) On-call senior mangement trained - Leading in a crisis and public enquiry simulation	(i) Power outage testing Summer 2017 (ii) Annual confirmation of compliance against National Core Standards for Emergency Preparedness, Resilience and Response (BoD, Nov 2016) (iii) Test exercises: Sickness, fuel (2016) (iv) Internal Audit follow-up review of business continuity arrangements (v) Risk assessment of major incident and business continuity plans with NHS England (2015) (vi)Y&H peer review of major incident plans 2016. (vii) External review of HAZMAT - compliant (September 2015) (viii) Hazardous Substances policy agreed by Board 29.11.2016 (ix) Tabletop exercises undertaken, SY risk assessment completed and two power cuts (x) Working with Care Groups to develop relevant desktop exercises. (xi) Trust unaffected by system-wide cyber attack, May 2017 (xii) Winter planning agreed by Board in July 2017 (xiii) Compliance with Annual Statement of Compliance against the NHS Core Standards for Emergency Preparedness, Resilience and Response (2017/18) (xiv) Presentation to Board on Emergency Planning, November 2017 (xv) Business continuity exercise (mostly completed), December 2017	(i) Business continuity plans reviewed (ii) Further testing of plans	(i) Emergency plans in process of review (Spring 2018)	L2 x I3 = 6

Strategic Aim 4 - We will support the development of enhanced community based services, prevention and self-care.								
KEY STEPS	Work with partners to reduce demand on the acute services to ensure that demand equates to available resources							
PROGRESS	CCGs quip monitored monthly. PLCV agreed with both CCGs. Referrals being monitored against overall referral patterns, evaluated at the joint Planned care Board. Care groups being monitored against contracted activity.						Direction	
RISKS	LINK TO CRR	EXEC	CURRENT RR	CONTROLS	ASSURANCE	GAPS IN ASSURANCE	ACTION TO ADDRESS GAPS	TARGET RR
Inability to sustain the Paediatrics service at Bassetlaw leading to (i) Withdrawal of overnight service (ii) Negative impact on local community	Q&E3	Chief Operating Officer	L2 x I2 = 4	(i) Consultant led paediatric assessment unit in place. (ii) Arrangements for transferring overnight stays to DRI. (iii) Communication with CCG and HOSC. (iv) Arrangements with Sheffield Children's Hospital. (v) Ongoing paediatric nurse recruitment.	(i) Reports on transferrals (ii) Positive response to recruitment (iii) Discussions with Notts Health O&S Committee in July 2017 (iv) Report to Board, August 2017 regarding future of overnight paediatric service (v) CEO's presentation to Governors, September 2017 (vi) Decision taken by Bassetlaw CCG, October 2017	(i) Recruitment of medical and nursing staff	(i) Regular recruitment exercises	L2 x I2 = 4
Reduction in hospital activity and subsequent income due to increase in community provision leading to (i) Increased pressure on acute services (ii) Negative impact on financial plan	F&P14	Director of Finance	L4 x I3 = 12	(i) Measures to ensure ward base matches with cost base (ii) Contract negotiation (III) Nursing workforce report (iv) Agency bank report (v) Corporate Investment Group processes (vi) Business change processes for associated service changes (vii) Contract changes to go to F&P	(i) DBTH input into Place Plan (ii) Assessment received for MoU	(i) Understanding of impact of Place Plan	(i) Meetings taking place with Council and other partners to assess impact (ongoing)	L4 x I2 = 8
Commissioner plans do not come to fruition and do not achieve the required levels of acute service reduction leading to (i) Increased pressure on acute services (ii) Negative impact on strategic direction (iii) Negative impact on financial plan	F&P15	Chief Operating Offcer	L3 x I3 = 9	(i) Potential to dual run services (ii) Contractual negotiations (iii) External advice on contractual changes (iv) Cosnideration of changes through ACPs	(i) Active monitoring of position (ii) Place Plans in place (iii) Clinical services strategy in place	(i) Finance Strategy	Strategies being presented to F&P and Board - Spring 2017	L2 x I3 = 6

Strategic Aim 5 - As a Teaching Hospital we are committed to continuously developing the skills, innovation and leadership of our staff to provide high quality, efficient and effective care.								
KEY STEPS	Co-ordinate the development of an innovative and sustainable workforce plan across the Trust. Developing and implementing plans to improve leadership, recruitment and retention initiatives							
	Co-ordinate, develop and ensure the implementation, delivery and monitoring of the staff engagement action plan to ensure the delivery of the Trusts values and an improvement in the national staff survey results for 2017/ 18							
	Co-ordinate the production and delivery of Board and Executive Team Development Programmes							
	To create a stable and motivated finance function, measured by staff turnover, implementation of restructures, staff survey							
PROGRESS	Support from HEE identified to deliver refresher training to Calderdale facilitators and to develop an internal trainer. Work underway to map trainee ACPs to future workforce models. Workforce models being developed in support of the 3 steering groups. Recruitment site on website refreshed with associated material. Trust wide staff experience group established, 2 meetings held. Flu CQUIN target achieved. Staff survey in progress. Active communications to demonstrate progess this year and to deliver improved response rate. Action plans in place within Care Groups and directorates. Board development programme being shaped - various sessions held.						**Direction**	

RISKS	LINK TO CRR	EXEC	CURRENT RR	CONTROLS	ASSURANCE	GAPS IN ASSURANCE	ACTION TO ADDRESS GAPS	TARGET RR
Inability to recruit right staff and have staff with right skills leading to (i) Increase in temporary expenditure (ii) Inability to meet FYFV and Trust strategy (iii) Inability to provide viable services	F&P8	Director of People & OD	L4 x I4 = 16	(i) HR policies and procedures. (ii) Monitoring of use of agency staff through robust processes to stay within cap. (iii) Medical staff recruitment action plans. (iv) Care Group Business Plans – workforce plans. (v) E-Rostering processes. (vi) VCF processes. (vii) Consultant appointment approval processes. (viii) NHS Professionals processes & management information. (ix) Pilot of Assistant Practitioner role. (x) Links with universities, increasing local placements. (xi) Developing bands 1-4 nursing roles.	(i) Increased fill-rate (ii) Recruitment report to Board, May 2017 (iii) Regular NHSI reporting which is reported to Exec Team, increased to bank as well as agency (iv) Benchmarking work (v) WTP work (vi) New style agency report reported monthly to Exec Team (vii) Work with ACS Local Workforce Action Board (viii) Accountability arrangements embedded (ix) Regular reports to F&P (x) Review of cohort recruitment (xi) Work on apprenticeships (x) We care for junior doctors work	(i) Workforce tracker	N/A	L2 x I4 = 8
Failure to engage and communicate with staff and representatives in relation to immediate challenges and strategic development leading to (i) Deterioration in management-staff relationships (ii) Negative impact on performance (iii) Negative impact on reputation	Q&E1	Director of People & OD	L3 x I4 = 12	(i) Staff survey action plan. (ii) Process to engage with LNC. (iii) Process to engage with Partnership Forum. (iv) HR policies and procedures. (v) Staff engagement project strands. (vi) Staff experience group. (vii) Listening events by CEO. (vii) E&E Committee communications plan. (viii) One-page strategy summaries.	(i) Suspensions/exclusions reports to ANCR (ii) P&OD reports to Board (iii) Briefings regarding staff engagement during restructures (iv) Records of ongoing engagement via Partnership Forum (v) Staff Survey results (vi) Grievance and employment tribunal rates (vii) Outcomes of negotiation & work with staff side. (ix) Delivery of engagement plan KPIs. (x) Listening events (xi) Buzz and social media interaction (xi) Meetings with staff regarding Hospital Services Review.	(i) Staff survey action plans (corporate & local). (ii) National staff survey (in train) (iii) Obs and Gynae staff survey (January 2018)	(i) Care group action plans being developed and implemented (various) (ii) Publication of national staff survey reuslts (April 2018) (iii) Obs and Gynae results (January)	L2 x I4 = 8
Failure to improve staff morale leading to (i) Recruitment and retention issues (ii) Impact on reputation (iii) Increased staff sickness levels ***Further details of risk given in risk deep dive, QEC, 14/12/17***	Q&E6	Director of People and OD	L3 x I4 = 12	(i) Monitoring by staff experience group (ii) Revised appraisal process (iii) Chief Executive's listening exercises and 'you said, we did' (iv) Staff involved in strategy engagement (v) Management passport qualification developed (vi) Localised action plans (vii) Staff survey action plan monitored by Board and QEC (viii) Revamped staff brief (xi) 'Bugbears and bright ideas' approach (x) Agreed approach to staffside - management meetings (xi) Achievment of teaching hospital status	(i) Feedbcak from Friends and Family Q1 (ii) Feedback from CEO's listening events (iii) Bugbears and bright ideas outcomes (iv) Report to QEC and Board, June 2017, on staff survey action plan (v) Place to work indicator in staff F&F up 11% in Q1 (vi) WEC assurance report to QEC (vii) People and OD Strategy approved by Board in October 2017	(i) Consistent positive scores for staff Friends and Family Test (ii) Refreshed P&OD Strategy action plan (various)	(i) Additional listening exercises (ii) P&OD action plans (Various)	L2 x I4 = 8

Doncaster & Bassetlaw Teaching Hospitals Corporate Risk Register																
No.	Description of Risk		Exec owner	Relevant committee	Original Risk Score 1:Low…5:Extreme		Overall Original Risk Score	Controls	Current Risk Score 1:Low 5:Extreme		Overall Current Risk Score	Direction of travel	Target Risk Score 1:Low 5:Extreme		New and developing controls	Owner and target date
	Source (Lack of….Failure to ….)	Consequences (Results in ….Leads to ….)			Like-lihood	Impact			Like-lihood	Impact			Like-lihood	Impact		
F&P1	Failure to achieve compliance with financial performance and achieve financial plan	(i) Adverse impact on Trust's financial position (ii) Adverse impact on operational performance (iii) Impact on reputation (iv) Regulatory action	Director of Finance	Finance & Performance	4	5	20	(i) Business and budget planning processes. (ii) Financial governance policies and procedures. (iii) Monthly monitoring of financial performance. (iv) Data analysis of trends and action to address deterioration. (v) Continued liaison with budget holders to identify risks to delivery. (vi) Demand and capacity planning proccesses. (vii) Detailed monitoring by Finance and Performance Committee. (viii) Budgets set on recurrent outturn resulting in a more robust financial plan. (ix) Budgets signed off by care groups and corporate departments. (x) Monthly monitoring at Board and directorate level. (xi) Uncommitted general contingency reserve. (xii) Regular finance meetings with budget holders. (xiii) Performance review meetings with NHSI. (xiv) All directorates signed up to control total. (xv) Support from BDO. (xvi) Appointment of suitably quaified Efficiency Director.	3	5	15	⟺	2	5	Additional grip and conrol mechnaisms as proposed through BDO	ET - March 2018
F&P3	Failure to deliver Cost Improvement Plans in this financial year	(i) Negative impact on Turnaround (ii) Negative impact on Trust's financial positon (iii) Loss of STF funding	Director of Finance	Finance & Performance	4	5	20	(i) Full Quality Risk Assessment and operational deliverability assessment of plans. (ii) Regular consideration of schemes by Management Board and Executive Team. (iii) Collaboration with other providers, to identify joint opportunities. (iv) CIP tracker developed to provide visibility of progress agianst plan. (v) Engagement in working together programme. (vi) PMO led by new Effeiciecy Director, with associated management processes, key deliverables, risk logs and reporting to Finance and Performance Committee. (vii) Implementation of innovation from external reviews. (viii) Regular meetings with NHSI to track progress. (ix) Regenerated E&E Committee. (x) CIP reovery meetings (fortnightly) with each group.	4	4	16	⟺	1	5	Additional grip and conrol mechnaisms as proposed through BDO	ET - March 2018
F&P4	Failure to ensure that estates infrastructure is adequately maintained and upgraded in line with current legislation, standards and guidance. **Note:** A number of different distinct risks are contained within this overarching entry. For further details please consult the E&F risk register.	(i) Breaches of regulatory compliance and enforcement (ii) Claims brought against the Trust (iii) Inability to provide safe services (iv) Negative impact on reputation (v) Reduced levels of business resilience (vi) Inefficient energy use (increased cost) (vii) Increased breakdowns leading to operational disruption (viii) Restriction to site development	Director of Estates and Facilities	Finance & Performance	5	5	25	(i) Annual business plan supports identification of issues by Care Groups / Directorates (ii) Risk-based capital investment plans (iii) Maintenance and support service contracts (iv) Independent Authorising Engineers appointed for key services, providing annual audits and technical guidance (v) Revised business planning process for all capital investments (vi) Estate condition and backlog maintenance assessment undertaken via 6-7 facet survey (vi) Progress and monitoring of actions undertaken through compliance committees e.g. health and safety committee (vii) Board level health and safety training undertaken, October 2017 (viii) Completion of in-depth high voltage scheme (June 2017)	4	5	20	⟺	2	5	(i) Review and develop buisness continuity and disaster recovery plans (ii) Comprehensive review of Estates and facilities risk register and risk escalation process (iii) Seek additional funding to rectify condition and backlog maintenanace issues	DP - Spring 2018 KEJ - Spring 2018 TBC
F&P5	Failing to address the effects of the medical agency cap	(i) Negative patient and public reaction towards the Trust (ii) Impact on reputation	Director of People and OD/ Chief Operating Officer/Medical Director	Finance & Performance	N/A	N/A	N/A	(i) Teaching hospital status communicated through recruitment. (ii) Care Group to escalate recruitment difficulties to MD/COO. (iii) Use of Trust staff in first instance to address gaps wherever possible. (iv) Signed memo of understanding between all Trusts in the WTP to abide by a standard set of principles. (v) P&OD / Workforce reports to BoD. (vi) Workforce and Education Committee. (vii) Agency spend and breaches going to Exec Team and Finance and Performance. (viii) Better system around rate-to-fill and fill rates. (ix) Use of social media to attract new candidates. (x) Relationships with universities. (xi) GMC Survey. (xii) Medical agency locum panel. (xiii) BDO Grip & Control work. (xiv) Use of alternative workforce.	4	4	16	⟺	3	2	(i) Develop new service model to mitigate medical staff shortage. (ii) Develop and progress workforce from using alternative workforce for service delivery.	KB/SS/DP - ongoing As above
F&P6	Failure to achieve compliance with performance and delivery aspects of the Single Oversight Framework, CQC and other regulatory standards	(i) Regulatory action (ii) Impact on reputation	Chief Operating Officer	Finance & Performance (impact on performance) Quality & Effectiveness (impact on quality)	5	4	20	(i) Performance Management and Accountability Framework. (ii) Business planning processes (iii) Relevant policies and procedures. (iv) Daily, weekly & monthly monitoring of targets. (v) Regular monitoring of compliance. (vi) Data analysis of trends and action to address shortfalls. (vii) Continued liaison with leads to identify risks to delivery. (viii) CQC Compliance Governance and Assurance Process. (ix) External reviews policy. (x) Monitoring at monthly Care Group accountability meetings. (xi) A&E QAT process. (xii) Demand and capacity planning proccesses. (xiii) Weekly review of A&E Action plan in accountability meeting chaired by COO. (xiv) Licence to Operate linked to SOF	4	4	16	⟺	3	3	New accountability framework to go live	DP - Spring 2018

F&P8	Inability to recruit right staff and have staff with right skills	(i) Increase in temporary expenditure (ii) Inability to meet FYFV and Trust strategy (iii) Inability to provide viable services	Diretcor of People & OD	Finance & Performance	5	4	20	(i) HR policies and procedures. (ii) Monitoring of use of agency staff through robust processes to stay within cap. (iii) Medical staff recruitment action plans. (iv) Care Group Business Plans – workforce plans. (v) E-Rostering processes. (vi) VCF processes. (vii) Consultant appointment approval processes. (viii) NHS Professionals processes & management information. (ix) Pilot of Assistant Practitioner role. (x) Links with universities, increasing local placements. (xi) Developing bands 1-4 nursing roles.	4	4	16	⟺	2	4	(i) Exploring recruitment with other partners and through other methods. (ii) Agency report development	MH - Nov 2017 KB - Sep-Nov 2017
F&P11	Failure to protect against cyber attack	(i) Trust becoming non-operational (ii) Inability to provide clinical services (ii) Negative impact on reputation	Chief Information Officer	Finance & Performance	5	5	25	(i) Penetration test of systems to identify gaps and risks; (ii) Firewalls, passwords, anti-virus equipment. (iii) Policies and reinforcement through communication to staff; (iv) Staff awareness through Certified Security Professional course and other training; (v) Trigger alerts; (vi) Care Cert system at NHS Digital (vii) All servers and systems patched to appropriate level (viii) Computers and network infrastructure get security patches automatically applied	3	5	15	⟺	1	4	Controls proposed by recent cyber security audit	SM - January 2018
F&P12	Failure to ensure that estates infrastructure is adequately maintained and upgraded in accordance with the Regulatory Reform (Fire Safety) Order 2005 and other current legislation standards and guidance. **Note:** a number of different distinct risks are conatained within this overarching entry. For further details please consult the EF risk register.	(i) Breaches of regulatory compliance could result in Enforcement or Prohibition notices issued by the Fire and Rescue Services (ii) Claims brought against the Trust (iii) Inability to provide safe services (iv) Negative impact on reputation	Director of Estates and Facilities	Finance & Performance	5	5	25	(i) Regular external inspections from SYRS and Notts Fire Service (ii) Improved fire safety risk assessments and evacuation strategies (iii) Improved Fire Safety Training (iv) Programme upgrade of fire detection systems (v) Programme upgrade of structural fire precautions (compartments) (vi) External Audit Fire Authorised Engineer (vii) Fire safety training Trust Board and Exec Team (viii) Further Development of Fire Safety Response Team structure (ix) Risk based Capital Investment plans identified by estate condition and backlog maintenance assessments via 6 - 7 facet surveys (x) Progress and monitoring of actions undertaken through compliance committees eg health and safety committee	3	5	15	⟺	2	5	(i) Further review of Risk Based capital investment plans (ii) Comprehensive review of Estates and Facilities risk regster and risk escalation process (iii) Seek additional funding to rectify condition and backlog maintenance issues	JS - Spring 2018 KEJ - Spring 2018 TBC
F&P13	Inability to meet Trust's needs for capital investment	(i) Inability to sustain improveemnts in Trust's estate. (ii) Negative impact on patient safety. (iii) Negative impact on reputation.	Director of Finance	Finance & Performance	5	4	20	(i) Finance reports to Board and Finance and Performance Committee. (ii) Capital governance structure - Corporate Investment Group and Capital Monitoring Group. (iii) Guidance and templates for investment and disinvestment. (iv) Proactive prioritiation of schemes.	4	4	16	⟺	1	4	Clarity around process over STP capital projects.	TBC
Q&E9	Failure to adequately treat patients due to invailability and lack of supply of medicines	(i) Impact on safety of patients (ii) Impact on patient experience (iii) Potential delays to treatment (iv) Impact on trust reputation (v) Increased workload in pharmacy procurement	Chief Operating Officer	Quality & Effectiveness	5	3	15	(i) Support from Regional Procurement Team (ii) Arrangement of substitute drugs and medicines (iii) Databse of supply issues managed by RPT (iv) Daily updates on shortages (v) Holding to account of wholesalers for non-delivery of their contractual obligations and monitoring the performance of wholesalers in the region (vi) Local holding to account through account business managers (vii) Escalation measures to Deputy Chief Pharmacist for persistent and acute issues (viii) Logistics team communicating shortages to the ward and pharmacy team if stock not available for supply	5	3	15	NEW	2	3	TBC	TBC

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

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

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Title	**Chair's and NEDs' Report**		
Report to	**Board of Directors**	**Date**	**30 January 2018**
Author	**Suzy Brain England, Chair**		
Purpose			Tick one as appropriate
	Decision		
	Assurance		
	Information		x

Executive summary containing key messages and issues
The report covers the Chair and NEDs' work in December 2017 and January 2018 and includes updates on a number of activities: • Changes to Board of Governors • Governor update • Non-executive Director recruitment • NHS Providers Board • Auditors
Key questions posed by the report
N/A
How this report contributes to the delivery of the strategic objectives
The report relates to all of the strategic objectives.
How this report impacts on current risks or highlights new risks

N/A
Recommendation(s) and next steps
That the report be noted.

Chair's Report – January 2018

To all our Board, staff, governors and patients, I wish you a happy new year.

Changes to Board of Governors

The Agenda Planning Group for the Board of Governors met on 18 December and agreed some changes to the way in which Board of Governors meetings are conducted. Governors agree that we want to keep the meetings in the Education Centre to keep costs down but that we need to overcome the issues we have been having with space, time and acoustics.

The changes include:

- Starting the meeting half-an-hour earlier, at 5.30pm, with a view to finishing at 7.30pm to avoid finishing too late. We are all mindful that many staff and external speakers who attend Governors have already been at work from 8am. We are part of the health service and should be encouraging staff to have a healthy work/life balance.

- Moving the meetings into Rooms 1 and 2 of the Education Centre and adopting the 'carousel' format of round tables with one executive and one non-executive director sat on each table. Additional microphones have been procured to support this new way of working.

- A revised agenda format with external speakers and items that engage governors front-loaded on the agenda when the Board of Governors is at its most energised and items for noting, minutes and action lists at the end. Clear time limits will be given for each of these items (15 minutes including questions) to keep everyone focused. In order to maximise engagement in the Finance and Performance items, and the Chair and CEO's reports, it is proposed that these reports be illustrated through graphical, large-text presentations as well as the paper reports.

- Inviting the chairs of the relevant governor committees to produce a chair's log setting out the key issues arising from their committee's work that quarter.

- Reducing the amount of paper printed for items 'to note' by placing electronic links to Board of Directors and Board of Governors' committee minutes on the agenda. Hard copies will be made available on request.

We will be piloting the changes at January's meeting.

Governor update

Governors held a successful Timeout session on 18 December where the issues covered included the Bassetlaw patient surgery, the Butterfly Volunteers, Overseas Visitors and the Patient Advisory and Liaison Service. My thanks to everyone who attended or led tables.

This was followed by the first Governor Forum session on 11 January and a very well attended Governor Briefing session on the CQC Well Led process prior to the inspection focus group which 12 governors took part in.

A number of governors also attended core skills induction with NHS Providers on 18 January at Bassetlaw Hospital and we will look to cover this session again, in house, perhaps at the Timeout in March. I joined the training - in between my CQC interview and being a patient – which was both engaging and had good levels of participation.

In my role as a member of the NHS Providers' Board I have agreed to be part of the Governor advisory committee, upon which Roy Underwood has represented the Trust for a number of years. With Roy deciding to stand down at the end of his term this year, Peter Abell has put himself forward for the committee which will go forward to a vote in March. I am sure everyone will support Peter in his bid to take on this national role.

Finally, before Christmas, I received the resignation of Andrina Hardcastle, Bassetlaw Public Governor. Andrina had been a governor for six months. I have written to her wishing her well for the future. The remaining portion of her role will be up for election later this year.

Non-executive Recruitment

We received almost 40 applications for the two non-executive roles and interviewed 12 over 19 and 22 January. My thanks to the governors and directors who gave up the two days to carry out this very important task.

Pat Drake (clinical) and xxx are being recommended to Governors on 31 January, subject to the necessary checks. Pat will commence in role on 1 February and xxx on 1 April.

My thanks also go to Ruth Allarton who has very ably stepped up to the role of associate non-executive and made some very important contributions within committee and at Board. It has been very heartening to know we have governors who are able to make the step up and cover these important roles.

NHS Providers Board

I attended the NHS Providers away day dinner and Board meeting on 9 and 10 January which included a strategic discussion and consideration of business planning for 2018. We discussed whether we should approach the Secretary of State to say that what was billed as Winter Pressure was now being experienced all year around and that it was now time to rethink the funding of the NHS which achieved significant media coverage. We kicked back at what appeared to be regulatory permission to breach targets; collectively we wanted to defend single sex accommodation which had been hard won and to defend targets such as RTT and 4-hour A&E.

CQC

I want to send my thanks to NEDs, Governors, Executive directors and other members of staff who made the regulatory team welcome and answered questions willingly. A couple of forums for engagement with the CQC attracted no or low attendance. This has given us an opportunity to think again about our engagement with junior doctors and other clinicians.

Auditors

I met with KPMG and the new audit team, led by Rob Fenton, earlier in the month. We reflected on what had been achieved in the past year and plans for 2018. The team also shared with me their reflections on how Audit Committee was working.

NED Reports

Alan Armstrong

On 16 January, Alan visited the SCBU and Children's Ambulatory Care Unit at Bassetlaw.

He found that both departments had high standards of housekeeping, welcoming entrances and well laid out notice boards. A small improvement point on the PAWS notice board in ambulatory care is that information was November data and the Head of Nursing is going to address this.

Highlights for Alan were:

- Competency framework for nurse in charge
- Pragmatic solution of paediatric assessment form and respiratory nurse specialist role

All the staff he spoke to were welcoming, professional in their approach and answered his questions in a complete manner.

Philippe Serna

Philippe deputised for me at the first committee in common meeting on 4 December 2017. A summary of that meeting is given elsewhere on the agenda.

Linn Phipps

On 19 January, Linn attended our first Patient Experience Day. This was brilliant, and all the team are to be warmly congratulated.

Moira introduced the day with emphasis on how we can be as caring and compassionate as possible. A memorable quote drawn from the "Be with the patient" programme:

"I don't want to be called a customer, being a patient is different. I've never felt vulnerable, frightened or insignificant when I've been buying a pair of shoes".

There was discussion around what compassionate care means – things like seeing patients as people not a disease, communicating, listening, asking what I can do to help, "remembering how vulnerable they feel". Among so many powerful quotes, this one:

"People will forget what you said, forget what you did, but they'll never forget how you made them feel."

Patient testimonies provided the greatest emotion and causes for reflection on the day. As well as Carol's Story, which the Board have seen, there was a video around "The last 1000 days", with the memorable quote, "These days are yours".

But of all the day, the deepest impact for me came from a video ("Clip one") around our value of "Everybody counts", emphasising the need to walk in someone else's shoes. This was probably the best I've ever seen and to be honest, it moved me to tears. This ended with the question to staff, about patients, if you could "hear what they hear, feel what they feel, would you treat them differently?" It would be fantastic if everyone could see this.

At the back of the room there was a display of thank you cards. The themes I noticed being mentioned were: care, kindness, dedication, help, support.

There was also an excellent array of stalls, including one on R&D and "The 10 things you can do to promote health research".

10 things you can do to promote health research...

NHS
National Institute for Health Research

A Patient Research Ambassador is someone who promotes health research from their point of view. They could be a patient, service user, carer or lay person who is enthusiastic about health research. They should be willing to communicate that to other patients, carers, members of the public and healthcare professionals.

These are just some of the activities a Patient Research Ambassador could be involved in.

1. **Help to raise awareness** of research to patients, carers and the public (for example, via events and health awareness days)
2. **Be involved locally** to support national initiatives such as the NIHR 'I Am Research' campaign
3. **Assist with training** of research staff to promote quality research
4. **Work with research staff** to improve how a study might work for participants in hospital or at an organisation
5. **Advise on** and help to collate surveys to assess the quality of patient research experience
6. **Be part of** an interview panel when employing research staff
7. **Review studies** with research staff to view their progress
8. **Lay membership** of your local research and development (R&D) group or committee
9. **Speak to** local special interest groups about research
10. **Be a resource for** patients, carers and the public thinking about taking part in research

w: http://bit.ly/researchambassador

t: @NIHR_PRAI

Delivering research to make patients, and the NHS, better

Chief Executive's Report
30 January 2018

Winter Pressures

Like all chief executives I received correspondence in the first week of January from NHS England and NHSI in respect of managing winter pressures.

The letter, which made the national press, recommended the rescheduling of all non-urgent inpatient elective care to free up capacity for our sickest patients with cancer operations and time-critical procedures needed to prevent rapid deterioration in a patient's condition going ahead as planned.

The letter also proposed highlighted freeing up human resource capacity by considering day-case procedures and routine follow-up outpatient appointments and confirmed the suspension of sanctions for mixed sex accommodation breaches.

Ahead of the guidance DBTH had already decided to reduce elective activity to clinically urgent, with all other cases considered on a case by case basis. We recommenced elective work on 18 January.

Clearly this is always a difficult time of the year for the NHS and staff work incredibly hard to maintain services. I passed on our thanks on behalf of the Board of Directors.

CQC Well Led Inspection

We have now completed our announced 'Well Led' CQC inspection, which was the follow-on from the unannounced inspection which took place between 12 to 14 December 2017.

I would like to thank all directors, governors and staff who were involved, for the time and effort they took to help the inspectors to conduct their visit.

The direction of the revised strategy, and development of the governance structures were recognised, with acknowledgement of the work in progress across the Trust. The CQC feedback for Well Led was also positive in respect of the improvements we have made in developing and providing our services.

We expect to have a draft report for 'factual accuracy' review in mid-March 2018, with the final report publication and ratings a few weeks after that.

Improvements coming to Bassetlaw

Substantial investment has been made to revise the way that patients book into the service, creating a number of new rooms and enhancing the current 'patient-streaming' system.

When people attend the Emergency Department, they are currently seen by a trained clinician who performs a short examination to understand what treatment and care the patient needs.

At present, this is done within the reception waiting area. As part of this investment, the Emergency Department will also see the creation of three further rooms, one for consultants and another for Health Care Assistants to carry out observation checks. The other will be fitted for flexible use, meaning it can be repurposed as needed when the service becomes busy.

The work started week commencing 8 January and is expected to be completed by the end of March. Patient care will remain unaffected.

Patient wi-fi launched

Launched in two formats, 'Public' and 'Ward', wireless Internet is now available to visitors of the Trust waiting for appointments, allowing them to browse sites such as Facebook and BBC News.

In addition, a more substantial service is open to those receiving day case and inpatient treatment allowing them to stream films as well as make video calls in order to speak to relatives and friends.

For security and to support appropriate use of the facility there are some restrictions on what can be viewed, but the vast majority of popular sites will be available free of charge, with users asked to agree to an acceptable use policy.

This service has been designed and installed by the Trust's in-house IT team, which has provided it at minimal cost, using existing links and technology, while making sure it remains totally separate from the Trust's internal network to ensure it remains secure.

Panto came to DRI

The Trust beamed Cast's Christmas pantomime Beauty and the Beast live into Doncaster Royal Infirmary at Christmas, providing entertainment for patients staying at the hospital.

Over 200 people at DRI watched as the show was streamed via the Internet onto televisions and for one special screening for off-duty staff and their children in the hospital's Lecture Theatre.

With such fantastic feedback, the Trust and the theatre are planning for a repeat performance in 2018.

Catering Contract Goes Live

The Trust's new multi-million pound catering contract went live on 12 January and is now operational. To assist with the transition, the new operators, Sodexo, have sent more than 70 staff to work on the project.

As with any multi-million pound contract, there are going to be some teething issues and we are taking a keen interest in the initial feedback from staff and patients and the Director of Estates and Facilities will ensure that the Executive Team and the Board of Directors are updated on the implementation.

Meeting with NHS Improvement

The Trust's Executive Team met with NHS Improvement after Board on 19 December. It was a positive meeting with much emphasis on the Trust's efforts to achieve its financial control total.

The Director of Finance continues to keep in contact with NHSI and to ensure the Chief Executive, Chair and Executive Team are fully briefed on progress.

Changes at Barnburgh Surgery

The CCG has informed the Trust that Dr Karen Wagstaff, the sole GP at Barnburgh Surgery, has notified of her intention to terminate her contract with the NHS on 8 May 2018.

The CCG are responsible for ensuring that the 2,900 patients currently registered at Barnburgh Surgery have ongoing access to a GP and therefore they have begun exploring options. A procurement exercise was launched on Friday 12 January 2018 to try and find a GP to take over the contract for this practice.

Ministerial changes

Following the Cabinet reshuffle at the start of 2018, Rt. Hon. Jeremy Hunt MP continues as Secretary of State for Health and adds Social Care to his brief. The new ministerial team is as follows:

Minister	Rank	Portfolio
The Rt Hon. Jeremy Hunt MP	Secretary of State	Overall responsibility
Caroline Dinenage MP	Minister of State for Health and Social Care	All aspects of hospital care, NHS performance and operations, the workforce, patient safety and maternity care
Stephen Barclay MP		
Steve Brine MP	Parliamentary Under Secretary of State (Public Health and Primary Care)	NHS transformation, including out-of-hospital care, primary care, public health and sexual health
Jackie Doyle-Price MP	Parliamentary Under Secretary of State (Care and Mental Health)	Mental health, adult social care, carers, community services, cancer, dementia, learning disabilities and all elements of primary care – including dentistry and pharmacy
Lord O'Shaughnessy of Maidenhead	Parliamentary Under Secretary of State for Health	All aspects of health and department business in the House of Lords; as well as leaving the EU, medicines & industry, life sciences industry, data and technology, and specialised commissioning

Change at CQC

Sir David Behan will step down as Chief Executive of the CQC in the summer.

Moira becomes Director of Nursing

The Nominations and Remuneration Committee has appointed Moira Hardy as its new Director of Nursing, Midwifery and Allied Health Professionals. The new role provides clear leadership to clinical staff, overseeing the development and delivery of outstanding patient care, while driving the organisation's strategies for Quality, Patient Experience and Infection Control and Prevention.

Lynda becomes a professor

Lynda Wyld, Honorary Consultant Breast Surgeon at DBTH, has been made Professor of Surgical Oncology by the University of Sheffield.

As an Acute *Teaching* Hospitals Trust, and a leading *partner* in health and social care across South Yorkshire and Bassetlaw, we will work with our *patients, partners and the public* improve the delivery of high *quality* integrated care.

We always put the patient first
Everyone counts – we treat each other with courtesy, honesty, respect and dignity
Committed to quality and continuously improving patient experience
Always caring and compassionate
Responsible and accountable for our actions – taking pride in our work
Encouraging and valuing our diverse staff and rewarding ability and innovation.

Objective	Lead	Supporting Actions	Expected Outcome	Impact on Risks	Expected Outcome at 31/ 03/ 2018	Measurable Milestones	Update on delivery at September 2017	Rating	Update on delivery at December 2017	Rating	Update on Delivery at March 2018	Rating	Actions to be taken forward to 2018/ 2019
Ensure the delivery of the Trusts financial plan and the implementation of an agreed improvement and effectiveness plan with identified work streams and SROs. Delivering service change and savings through achieving agreed targets and milestones	CEO	**Director of Finance** Maintain and develop the programme management office, ensuring robust systems and processes to drive, monitor and escalate effectiveness & efficiency, enabling and strategic clinical plans.	PMO processes reviewed to meet needs of revised Board sub-committees (Finance and Performance) Milestones and resources required clearly identified for sign off by SRO Up to date position on EEP available monthly Escalations made appropriately to the Transformation Board and F & P Committee	Reduces likelihood of failure to deliver financial plan and Cost Improvement Plans in this financial year	**DOF** - EEP delivery is in line with forecasts and expectations Progress with delivery of strategic and enabling work streams is documented accurately and all escalations have been appropriately managed	**DOF** - Review for F&P by July 2017 Up to date accurate information - ongoing	PMO moved to DoF at end June 2017. Review of governance processes being undertaken. New accountability measures instituted including refreshed effectiveness and efficiency committee.	Amber	As September	Amber			
		Directors Lead agreed improvement work streams as SRO, delivering service change and savings through achieving agreed targets and milestones			Programmes managed to deliver agreed programme outcomes and within agreed timeframes.	Delivery to agreed programme plans	Strategic workplans developed to contribute to CIP	Amber	Strategic delivery groups developed and functioning well. Milestone plans developed for implementation.	Green			
Work with STP and Place based partners to ensure that the Trust maintains a sustainable future to deliver the needs of the local populations and the legal responsibilities required by NHSI and the CQC	CEO	**Directors** Ensure that the Trust maintains strong and effective partnerships at Place and STP level	**DS&I** - Place plans reflected in Strategic Direction Ongoing involvement in ACP development	Reduces likelihood of failure to sustain a viable specialist and non-specialist range of services through inability to recruit right staff and have staff with right skills	**DS&I** - Place plans reflected in Strategic Direction Ongoing involvement in ACP development	**DS&I** - Evidenced by joint projects - t.b.c.	Evidence of active participation in Doncaster Place Plan implementation. Strategic Direction includes input on both place plans, involved partner governors and has been presented at DCCG and Bassetlaw ACP. Joint projects and contractual arrangements in development	Green	Involved in place Plan Doncaster. COO and CEO more involved at Bassetlaw Working with DMBC colleagues to promote closer working with project teams	Green			
Ensure the completion of the Trusts Strategic Vision to reflect the aims and objectives for the Trust within the STP, Place and legal and regulatory requirements of NHSI and the CQC	CEO	**Director of Strategy and Improvement** Produce a final DBTH Strategic Vision document to the NHSI timescales that is approved by the Board, with input from all appropriate stakeholders	**DS&I** - Completed Strategic Vision document approved by Board Strategic plan with milestones and responsibilities identified Robust evidence of communication and engagement plan being implemented with stakeholders. Launch in line with Communications Plan	Reduces the likelihood of failing to achieve compliance with performance and delivery aspects of the Single Oversight Framework, CQC and other regulatory standards	**DS&I** - Progress on strategic milestones as per plan with any escalations being appropriately managed Robust process for escalation where plans are not on track Evidence of functioning governance structure	**DS&I** - Strategic Vision to NHSI by end July 2017 Launch in line with Communications Plan August 2017	Strategic Direction 2017-2022 agreed and submitted to NHSI. Communications plan developed with Comunications team and implemented.	Green	Milstones requested from Directors for development of summary and animation - work ongoing on this - working to align to place plans	Green			
		Executive Directors Lead the refresh of the strategies related to areas of responsibility to ensure the delivery of the Trust's revised Strategic Direction	**DS&I** - Completed Qii Strategy and implementation plan agreed by Board		**DS&I** - Completed Qii Strategy agreed by Board and implementation in line with plan	**DS&I** - Completed Qii Strategy agreed by Board and implementation in line with plan	QIi Strategy developed reviewed by QEC and minor amends implemented - Board sign off due in October 2017	Amber	QIi Strategy ratified and being implemented in line with action plan	Green			
Produce a clinical service model for the delivery of safe and sustainable emergency, elective, diagnostic and support services across the Trust	**COO** **Medical Director** **Director of Nursing Midwifery and Quality**	**Directors** Work with the Lead Directors to ensure the delivery of the clinical service model	Publication of a clinically engaged site strategy to deliver improvements in site efficiency and effectiveness	Reduces likelihood of failing to sustain a viable specialist and non-specialist range of services through inability to recruit right staff and have staff with right skills	Increased elective capacity on BDGH and MMH. Improved emergency/trauma pathways at DRI	Published strategy July 2017 Service site reorganisations Q2-3	Clinical Site Strategy agreed. 3 key strategic steering groups set up with ToR. Work plans agreed with set timescales for service changes. Changes being mapped against the Acute Services Review	Amber/Green	3 Steering Boards well established. Plans in place to improve utilisation of facilities on each of the 3 main sites.	Green/Amber			
Maintain Compliance with all NHSI Access Targets and Outcomes Objectives with Sustainability and with Transformation Fund associated Targets (Four Hour Wait and RTT) as a priority.	**COO**	**Directors** Support the COO to deliver national access and outcome standards in line with the trajectories set by contract or NHSI	Meet/exceed NHSI agreed trajectories	Reduces the likelihood of failing to achieve compliance with performance and delivery aspects of the Single Oversight Framework, CQC and other regulatory standards	DBTHFT is green for governance	Quarterly updates via single oversight framework	STF achieved for 4hr access in Q1/2. RTT plans agreed with NHSi to be compliant by Q4. Discussions on going with CCG to develop confirm sustainable RTT trajectories.	Amber/Green	STF achieved for Quarter 3. Cancer 62 days currently on track. Diagnostics achieved in quarter. RTT being modelled with the CCGs to agree trajectories for the end of March.	Green/Amber			
Work with partners to reduce demand on the acute services to ensure that demand equates to available resources		**Directors** Support the COO to deliver a capacity and demand plan to deliver activity plans in line with trajectories set by contract of NHSI	Support CCGs to deliver Quipp and manage demand within existing resources	Reduces the likelihood of failing to sustain a viable specialist and non-specialist range of services through inability to recruit right staff and have staff with right skills	Contractual levels of activity are met for patient needs	Quarterly updates via single oversight framework	CCGs quip monitored monthly. PLCV agreed with both CCGs. Referrals being monitored against overall referral patterns, evaluated at the joint Planned care Board. Care groups being monitored against contracted activity	Green	Joint Planned Care Board meets monthly reviewing impact of PLCV and assessing activity against contract	Green			
Increase elective activity at BDGH and MMH to best utilise available resources and facilities		**Directors** Take the actions necessary to support the COO with transfer of appropriate elective and diagnostic activity to BDGH and MMH	COO - Meet service demands within existing resources DS&I - Contribution by S&I to review of elective activity by site and plan for future outsourcing requirement		**COO** - Service reorganisations are in place to maximise elective capacity **DS&I** - Contribution by S&I to review of elective activity by site and plan for future outsourcing requirement	**COO** - Site strategy milestones identified **DS&I** - Milestones will be contained within the plan	Work plans agreed as part of the Planned Care Workstream with set milestones for service transfer	Green	Work plans in place via the planned care board to ensure the appropriate movement of services	Green			
Work with external partners to review service delivery across the wider STP footprint to ensure services which support place based ambitions and the delivery of high quality and sustainable services		**Directors** Take an active role across the area of responsibility within the STP and Place to ensure services are safe and sustainable and meet the needs of the local populations	DBTHFT role in the place and ACS is maximised to deliver sustainable high quality services		DBTHFT place plan clearly identifies the Trust as a key stakeholder in the ACS	Active involvement in ACS work streams to represent DBTH	Acute Hospitals Review has DBTHFT clinicians and managers on 5 key workstreams	Green	DBTH actively involved in the hospital services review and in the key workstreams for ACS	Green			
Co-ordinate the development of an innovative and sustainable workforce plan across the Trust. Developing and implementing plans to improve leadership, recruitment and retention initiatives	**Director of People and Organisational Development**	**Executive Directors** Take appropriate actions within areas of responsibility to develop and deliver a sustainable workforce plan using Calderdale framework and alternative profesions.	Workforce plan in place which will enable/facilitate the delivery of the Trust's service plans. Commissions in place with HEI/FEs in order to deliver the workforce models. Reduced vacancy levels and reduced spend on bank and agency staff.	Reduces the likelihood of failing to engage and communicate with staff and representatives in relation to immediate challenges and strategic development	Workforce plan developed with clear description of workforce models to be adopted. Clarity as to required commissions through HEE/HEI/FEs. Recruitment plan in place for each staff group.	Capacity developed for use of Calderdale framework across the trust. Recruitment strategy for hard to recruit to staff groups developed. Recruitment section of website refreshed.	Support from HEE identified to deliver refresher training to Calderdale facilitators and to develop an internal trainer. Work underway to map trainee ACPs to future workforce models. Workforce models being developed in support of the 3 steering groups. Recruitment site on website refreshed with associated material.	Amber	Bassetlaw @ project group established to review the workforce model. Workforce planning planned as part of the business planning process. Confirm and challenge processes in place to review rostering and use of bank and agency staff. Successful recruitment to key vacancies, eg midwives, ED and Paediatric Consultants. DBTH key partner in the ACS workforce workstreams	Amber			
		Executive Directors Develop the leadership skills within own teams and Care Groups. Identifying and developing talent at all levels to ensure effective succession planning	Leadership teams equipped to deliver the Trust's strategy and supporting strategies. Future talent pool identified together with agreed approach to harness that talent.		Leadership teams are equipped to deliver the Trust's strategic direction and operational plans effectively.	Identification of leadership development requirements. Offering developed ensuring best use of external resource that is available. Approach to identifying future talent in place. Talent pool identified with associated development plan.	QIi workshop delivered to senior leaders. Roles and responsibilities workshop for senior leaders in support of strategy delivery delivered. Insights development programme scheduled for November. Leadership development has explicit reference in P&QD strategy	Amber	Insights development workshop held for all senior managers (GM,HoN, Deputy Directors). Action plan developed following that day. Insights development planned for Executive Team and Care Group Directors and Assistant Directors. Development of behaviour charter in progress. Head of Leadership and Organisational Development role being established.	Amber			
Co-ordinate, develop and ensure the implementation, delivery and monitoring of the staff engagement action plan to ensure the delivery of the Trusts values and an improvement in the national staff survey results for 2017/ 18		**Directors** Review the staff survey results relating to areas of responsibility and contribute to the development and delivery of the corporate action plan and the necessary improvements.	Improved staff survey results. Achievement of CQUIN target for health and wellbeing. Well functioning staff experience group.		Improved staff survey results. Improvements in health and wellbeing scores in order to achieve the CQUIN target. Improved involvement of staff in service change.	Staff experience group established. All Care Groups/Directorates to have agreed action plans to improve their survey results. Action plan in place to achieve health and wellbeing CQUIN. Progress against the Trust wide staff survey action plan.	Trust wide staff experience group established, 2 meetings held. Flu CQUIN target achieved. Staff survey in progress. Active communications to demonstrate progess this year and to deliver improved response rate. Action plans in place within Care Groups and directorates.	Amber	Staff experience group developed leadership behaviour expectations which is incorporated in leadership role job descriptions and included in delivery of management skills passport. Improvement in staff survey response rate to 49.9%. Survey monkey underway within maternity services to review progress following the RCOG review.	Amber			
Co-ordinate the production and delivery of Board and Executive Team Development Programmes		**Directors** Take an active role in the delivery of effective Board and Executive Team development days	The Trust will have a Board and Executive Team which works effectively and which is driving forward the Trust's vision, values and strategic direction		Executive Team and Board development plans in place with regular development sessions scheduled. Positive assessment against CQC/NHSI's well led domain. Positive feedback through staff survey results.	Identification of development requirements. Programme developed together with identification of delivery partner. Programme in place.	Board development programme being shaped - various sessions held. Ongoing programme in development.	Amber	Following the recruitment to the full complement of the Executive Team an Insights development workship is being planned. Appraisal will include 360 degree feedback utilising the Healthcare Leadership model. Board development programme being finalised	Amber			
To create a stable and motivated finance function, Measured by staff turnover, implementation of restructures, staff survey	**Director of Finance**	**Directors** Ensure the finance team are integrated into Corporate and Care Group Teams		Reduces likelihood of failing to achieve compliance with financial performance, delivering accurate financial reporting underpinned by effective financial governance and delivering financial plan			Consultation, slotting in processes and recruitment completed. New staff starting during October. Work extended to add in PMO to process with a review of the PMO to take place in q3 2017/18.	Amber	All changes implemented, and appointed too with substantive staff. Now on an bedding in period. Deputy Director of Finance substantively appointed with an estimated started date of March 5 2018. One resignation for the Head of Financial Accounts, but otherwise now fully established in Finance. PMO re-organisation underway and interim appointed for 6 months.	Green			
To stabilise and embed systems within the organisation and finance function to deliver a strong financial control environment. Measured by delivery of strong financial information, audit reports, understanding of financial performance.		**Directors** Ensure the delivery of the agreed financial plans within the areas of responsibility					Trust behind plan, work with BDO is intended to bring the plan back in line. Additional governance for CIP and additional senior leadership resource being put in place,; Action plans and stronger controls being identified in line with external assurance report on grip and control	Amber	Grip and Control work bedding in, clear reductions in run rate sine work started, however more traditional Trust Schemes still struggling. Significant culture changes needed, as transparancey of systems becomes more obvious some 'non corporate' behaviours are being exposed. Work for next year needs to start in earnest and it is very close to call whether this years financial target overall will be hit.	Amber			
Maintain a robust and effective Programme Management Office ensuring robust systems and processes to drive, monitor and escalate effectiveness & efficiency, enabling and strategic clinical plans.		**Directors** Within the areas of responsibility ensure the identification, delivery and monitoring of efficiency and effectiveness programmes	Ensure current and developing efficiency and effectiveness programmes have robust and measurable programme management arrangement in place.		All programmes have measurable programme management arrangements in place	Arrangements and metrics in place in Quarter 1	Transferred to DoF for E&E - currently agreeing support of Steering Group projects	Amber	As above	Amber			
Ensure a robust clinical governance system is maintained and developed across the Trust to deliver the national quality, performance and professional standards applicable to the Trusts services. Taking proactive actions to identify and address any areas of weakness.	**Medical Director**	**Directors** Ensure that systems and process are in place within the areas f responsibility to support good governance	Sustain and improve care quality and patient safety	Reduces the likelihood of failing to sustain a viable specialist and non-specialist range of services through inability to recruit right staff and have staff with right skills	Sustain performance and improve across a range of quality metrics	Maintain care quality metrics within planned trajectory	Quality metrics defined in accordance with CQC Insights and incorporated within a Quality dashboard. These metrics have been employed to set Care Group quality and effectiveness objectives. The dashboard will be monitored at CQC and QEC. At present, overall Trust care quality is on trajectory to deliver end of year objectives.	Green	Quality dashboard has been collated and is available on a shared Trust drive. Access has ben provided to all Clinical Governance teams. We are working on placing the dashboard on the web so that access to stakeholders is improved. Incorporated within the dashboard are metrics relating to workforce and patient experience. We have seen a rise in Sis reported over the last quarter. These are being investigated. Apart from SI numbers, we remain on trajectory to achiew end of year targets.	Green			
Complete the delivery of the action plan following the Royal College Review.		**Directors** Support the delivery of the RCOG action plan.	Deliver all actions to address the Clinical Governance recommendations in the RCOG report		Improved obstetric patient safety, care quality and patient feedback	Delivery of action plan within defined timeline	Action plan in reponse to RCOG review has been developed by the Care Group and it is expected that all actions will be complete by April 2018. Weekly meetings are held to monitor progress and we remain on track to deliver the vast majority of the actions in line with the defined timeline. Embedding an improved culture focussed on quality may take longer.	Amber	There has been considerable progress in completing actions in reponse to the RCOG report. We have updated the RCOG and they are satisfied with the progress to date. There remain a few actions relating to service redesign where progress has been slow and we intend to increase focus in order to complete these actions.	Amber			
Develop a specific programme of work to ensure that the future structure of the Medical Directors office reflects the future needs of the Trust, STP and Place and the composition of the medical workforce		**Directors** Support the development of clinical leadership to maintain the Trusts influence at Place and within the STP	Enhance capacity and capability of the Medical Director's office to meet Trust requirements		Delivery of all Medical Director, Responsible Officer and Caldecott Guardian functions	Progress to delivery of Medical Director objectives	Review of roles and reponsibilities within the MD's office has been completed. There will be considerable overlap between HR and the MD's office in many areas. These have been agreed and progress is being made towards implementation	Amber	Head of Medical staffing has now commenced and will support improved delivery of recruitment, casework and productivity. Following a review of MD functions and staff, plans have been developed to enable changes to occur over the next two quarters.	Amber			
Implement a Patient and Carer Experience and Engagement Strategy. Implementing national and international best practice in the use of feedback to improve services.	**DNMQ**	**Directors** Increase experience and engagement in the delivery of services to ensure high quality patient centred services, with tangible measurements, improvement targets and KPI reports to the PEC.	1.Patient experience and engagement strategy completed. 2.Tools and techniques to engage with patients agreed. 3. Increased participation of patients to service improvement work. 4. Metrics for measuring patient experience agreed. 5.Monitoring of patient experience metrics monitored and reported to PEEC monthly. 6.Positive patient experience reported in addition to complaints data.	Reduces likelihood of breakdown of relationship with key partners and stakeholders	Tools and techniques to engage with patients used routinely in clinical areas. Data demonstrates improved patient experience	Timescale for; 1. July 2017. 2. September 2017 3. December 2017 4. September 2017 5. September 2017 6. September 2017	Patient Experience and Engagement Strategy completed and to be presented to BoD October 2017. Strategy Outlines tools and techniques to engage with patients and involve them in Qii work. Metrics for measuring patient experience in development and to be presented to QEC October 2017. Metrics will be monitored at PEEC once tool agreed (OCt 17). Template to capture all feedbcak developed and to be launched October 17 PEEC	Green	Patient Experience and Engagement Strategy approved at BoD. Action plan to deliver the stanetgy to be presented to January Patient Experience & Engagement Committee. Template fo capture feedbcak in use across Care Groups and have been used at PEEC since November 2017	Green			
Review the quality assurance tool and quality metrics in line with national quality guidance and launch in May 2017.		**Directors** Ensure that reliable metrics are in plan in all areas to demonstrate the quality of services	1. Review and agree Quality Metrics. 2. Monitor Quality Metrics via QEC / Board 3. Implement Perfect Ward App Trust wide		Metrics demonstrate improved and sustained quality for patients.	Timescale for delivery; 1. May 2017 2. May 2017 3. September 2017	Quality Metrics reviewed and agreed in Q1. Metrics monitored at QEC in June / August / Oct 2017. Outline proposal for Perfect Ward app to be developed - October 2017	Green	QM's monitored via QEC. All QAT's to be completed by 31March 2018 Briefing paper in relation to Perfect Ward App to be presented to ET by March 2018	Green			
Oversee the development of a 3 year plan with appropriate milestones to support the implementation of the DBTH Strategic Vision	**Director of Strategy and Improvement**	**Directors** Ensure that the Director of Strategy and Service Improvements is aware of developments within clinical and support services at local, Place and STP levels	S&I Director is made aware of developments and engaged in discussions about implementation and support required	Reduces the likelihood of failing to achieve compliance with performance and delivery aspects of the Single	All service developments are made in line with strategy objectives and can evidence S&I discussion	Ongoing - as new developments come online	Ongoing - stakeholders still not always using this route of communication into DBTH	Amber	Ongoing - stakeholders still not always using this route of communication into DBTH	Amber			

Produce and implement a Quality Improvement & Innovation Strategy that is based on best practice and developed with staff, containing a plan to increase QI capacity and capability within DBTH (and potentially with partners)		**Directors** Within the areas of responsibility support the development of capacity and capability in the identification and delivery of quality, efficiency and effectiveness programmes and projects	All capacity and capability issues identified to the PMO and Director of S&I by the SROs of all programmes	Oversight Framework, CQC and other regulatory standards	All project implementation plans are signed off by SRO and QI training implemented as planned in the QI strategy	Work stream sign off by July 2017 QI plan milestone sin line with strategy - currently being agreed	QI training plan rolled out as planned - not all PMO PMs attended yet. Projects identified for supporting workstreams and strategic workplans including pre-operative assessment, stroke repatriation and LOS (DRI/BDGH), transport and enhanced recovery.	Amber	QI action plan being implemented all milestones met to date	Green			
Prepare for and implement the GDPR legislation within the Trust by the end of March 2018	**Chief Information Officer**	**Directors** Take actions necessary to support the delivery of the GDPR	GDPR readiness by April 2018. financial impacts completed for budgeting purposes. SET training updated. DPO appointed	N/A	GDPR ready to implement for May 18	Plan available by October 17	Plan is on track for presentation by end of October.	Green	Tha IG Group is the GDPR control group, and it is currently working methodically through the GDPR Action plan. Privacy Impact Assessments and Privacy Notices are currently being progressed. A key issue for all Data Controllers is the GDPR defined zero cost and reduced timeframe implications for Subject Access Requests (SARs). Optional: The Data Protection Bill – which is due to receive Royal Assent by Easter 2018 - will define what SAR costs will actually be chargeable in the UK.	Green			
Deliver, with available resource, the prioritised IT work plan and associated projects in support of the care group initiatives, the transformation agenda and the CIP activities		**Directors** Take actions necessary to identify the IT needs within the areas of responsibility	Develop portfolio approach to projects. Establish governance group. Deliver regular updates to care groups. Deliver planned work	Reduces the likelihood of failing to deliver Cost Improvement Plans in this financial year	Portfolio governance and communication plan agreed and rolled out. 80% of project delivered - depending on resource and finance at capital level	Governance mechanism agreed October 17	Portfolio of projects established and monitored. IT and Information governance group TOR to be signed off October, reporting to MB and FPC. First meeting likely to be Nowember 17. Communications regularly with care group GM community. Capital has been constrained in H1 with expectation that funds will be available in H2. Focus on current environment	Green	The establishment of the portfolio management approch for IT projects and developments continues at pace. Standardised templates and operating procedures have been introduced for all new projects. Projects and developments are being monitored on a weekly basis for issues, risks and progress. Financial planning for 2018/19 is well underway. Regular meetings have been held with the Exec Team and GM's on a 1:1 basis to confirm requirements and manage expectations.	Green			
Deliver the appropriate integration and interoperability technology in support of the Doncaster Place based Intermediate Care Record and if appropriate the STP		**Directors** Take actions necessary to support the delivery of the Intermediate Care Record	Develop the internal DBTH architecture to deliver first stage data to the ICR. Develop technology that supports the internal and external portal. Deliver the clinical viewer for external use	Reduces likelihood of breakdown of relationship with key partners and stakeholders	Architecture agreed. Contributions to ICDR at Doncaster CCG level. Pilot of clinical viewer complete. Engagement with care groups and consultant community	Architecture draft agreed October 17. Initial pilot presented to clinicians December 17	Significant work in providing data to ICDR within project timelines. Clinical viewer is on track to deliver Alpha version by end of financial year. Demo's of progress regularly made to exec and clinical community. Enabling works necessary to ensure technical issues remain very low during pilot	Green	Good progress continues. DBTH are currently testing the functionality of the system and completing data verification checks on the data. The overall project is still on target to achieved the agreed go-live date.	Green			
Provide appropriate technology support to the Trust for the development of the Single Oversight Framework throughout 2017.		**Directors** Take actions necessary to support the development and delivery of the Single Oversight Framework	Deliver the first stage of the BI framework and 80% of the Single Oversight Framework	Reduces likelihood of failing to achieve compliance with performance and delivery aspects of the Single Oversight Framework, CQC and other regulatory standards	BI framework designed and implemented. Initial build of BI dashboards in ED and one other identified care group. SOF implemented for systems used today - explore options for getting information from non Trust environments e.g. ERS	BI Framework to pilot by Nov 17. SOF first iteration by Aug 17 including alerts and drill down	SOF not delivered in full. Some drill downs and alerts in place. Rest to be delivered in accordance with prioritised timeframes as discussed with Director of Strategy. BI pilot framework output is on track to deliver late November 17. ED dashboard in development	Amber	A significant amount of data has been collated from DBTH systems we can access routinely (i.e. CaMIS, Symphony, RIS etc.). Currently pursuing access to other data sources. The information team are currently evaluating the requirements for vthe BI tool with the aim of providing timely management information. Initial prototype components for the BI dashboard have been developed.	Amber			
Development of a 5 year Estates Strategy, to include a Capital Development Programme linked to Condition Surveys and Corporate Risk Register.	**Director of Estates & Facilities**	**Directors** Take actions necessary to identify the needs of the areas services within the areas of responsibility	The publication of a new 5 year EFM Strategy, linked to a revised Clinical Site Development Strategy	Reduces likelihood of failing to ensure that appropriate estates infrastructure is in place	The availability of an EFM Strategy Document	Draft document available for comment by July 17, ratified by Aug 17	Draft doc delayed until other supporting strategies were available, now due at Finance and Performance in Oct, Board of Directors on Nowember.	Amber	Strategy agreed at Board of Directors in December. Action plan tracikgn progress aginst implementation, KPMG audit of strategy and capital process Jan 10th.	Green			
Evaluate the potential for Public/Private Partnerships, linked to the Trust strategic direction.		**Directors** Contribute to the evaluation of all options for developing the Trusts infrastructure and estate	**DE&F** - The development of capital funding options to support the Trust Strategic Direction		**DE&F** - Opportunities identified and agreed by Board of Directors. **DS&I** - Support business case development with Finance Team Evaluation of DBTH benefits realisation methodology	**DE&F** - Options developed through new Commercial Board monthly meetings **DS&I** - Project implementation reviews to include lessons learned from business case development	Options for Capital funding through JV/WOS models disucssed at commercial board. Letter received 6th Oct from NHSI regarding NHS Trusts exoiding tax - which will impact on desirability of progressing WOS schemes. Capital bids will be submitted as calls for funding become available as with successfull bid for CT/HASU - ED DRI outstanding. EFM Strategy will contain 5-7 year backlog investment programme.	Amber	Gateshead NHS Trust commissioned to undertake a review of opportunity for WOS, report due 12tlh Jan to Direcot of Finance. CT/HASU business case costs provided by Y21+ partner IHP by 11th Jan, full BC due at Board in Jan for submission to NHSi in February.	Amber/Green			

DONCASTER & BASSETLAW TEACHING HOSPITALS NHS FOUNDATION TRUST

Minutes of the Finance & Performance Committee
held at 9:15am on Thursday 14 December 2017
in the Boardroom, DRI

PRESENT	:	Neil Rhodes, Non-executive Director (Chair) Philippe Serna, Non-executive Director Jon Sargeant, Director of Finance David Purdue, Chief Operating Officer Simon Marsh, Chief Information Officer
ALSO IN ATTENDANCE:		Ruth Allarton, Associate Non-executive Director Anna Moulding, Acting Deputy Director of Finance Ruth Bruce, Head of Performance *(from 12:15pm)* Matthew Kane, Trust Board Secretary Anthony Jones, Deputy Director of P&OD Julia Docherty, BDO Kate Sullivan, Corporate Governance Officer Marie Purdue, Director of Strategy & Transformation Laura Fawcett, Surgical Care Group Business Manager
OBSERVERS	:	Bev Marshall, Governor Observer
APOLOGIES	:	Karen Barnard, Director of People & Organisational Development

Action

Apologies for Absence

17/12/1 Apologies were noted from Karen Barnard and Kirsty Edmondson-Jones.

Action Notes from Previous Meeting

17/12/2 The action log was reviewed and updated.

17/8/17 & 34 – It had been agreed to consult with Executives to establish future deep dive topics, considering the Committee's areas of responsibility and assigned risks. Ideas had come in from Execs and the Trust Board Secretary would build deep dives in to work plan.

General Surgery Update

17/12/3 An update on the performance of the General Surgery department had been scheduled however, due to the unannounced CQC inspection visit, there had been insufficient capacity to prepare a report in time for the meeting and the Chief Operating Officer apologised to the Committee for this. Laura Fawcett, Business Manager for the Surgical Care Group gave a brief verbal update on RTT performance and work being done to increase theatre capacity. The Chair commented that for the committee to be able to prepare questions and understand the issues it must have a written report in advance of the meeting.

17/12/4 The General Surgery presentation was deferred to January 2018. **DP**

Financial Performance Highlights

17/12/5 The Director of Finance presented to the Committee summarising performance in Month 8 (November). The Chair reminded the Committee that it had previously been understood that the full finance information would not be available in time for the meeting which had been scheduled earlier than usual due to the Christmas holiday period.

17/12/6 The Director of Finance provided an overview of the financial position. A YTD deficit of £15,675k was noted, £1,932k behind plan. The in-month position was £252k worse than the forecast deficit. The clinical income position had improved from that seen in months 6 and 7, and run rate expenditure had been broadly in line with forecast levels.

17/12/7 Pay - The Clinical Admin Review was behind plan and a meeting to discuss mitigation plans had been set up. Overall there had been a reduction in spend of 250k; although substantive pay costs were up but there had been a significant reduction in agency spend. Work was underway to identify whether the reduction had been due to CIP or G&C. In response to a query from the Chair it was reported that there had been a reduction in the average agency spend in all areas apart from nursing.

17/12/8 Risks - At the previous meeting the Committee had received a detailed update on key risks to financial performance; some of the issues related to the CCG challenging some coding and charges; the DoF was pleased to report that the issues relating to maternity and sepsis coding had been resolved and the CCG had agreed to pay.

17/12/9 An update on the cash and capital positions was provided.

17/12/10 The Committee considered the report and discussed trends and risks to STF funding. Bev Marshall asked whether the Committee felt comfortable with the forecast position remaining the same as the previous month given that the Trust was 8 months in to the year and was reporting an underperformance against forecast, this was discussed. The DoF reminded the Committee that significant work had been undertaken to restate the forecast several months prior; since that time new risks had been identified and some income had been lost. He concurred that currently the position was very tight however some of the risks identified had gone in the favour of the Trust. December would be a key month as the Trust moved in to winter and the Trust may need to take the decision to restate the forecast for 2017/18 at the time of reporting on the December position.

17/12/11 Philippe Serna welcomed the reported increase in income in-month and he asked for the reasons behind this. The Director of Finance gave details of factors that had improved the income position, the previous month there had been a drop in ED income but this had recovered in November and the Trust

was now looking prospectively at bookings as opposed to backwards and this work would be covered in the BDO presentation in more detail. In response to a further query about orthopaedic income it was reported that this was not yet back on track; until the position with the CCG was clear the Trust was not operating on patients under 12 weeks unless urgent.

17/12/12 The Committee NOTED:

(a) NOTED the month 8 2017/18 financial position of £15.7 million deficit, £1,932k adverse to plan after removal of the 16/17 STF funding and any variance related to donated asset income.

(b) NOTED the risks particularly those relating to Doncaster CCG.

(c) NOTED that the DoF may be required to adjust the forecast position of the Trust and if so that he would seek delegated powers from the Board in order to do this.

BDO

17/12/13 The Committee received a detailed presentation from Julia Docherty, BDO, on progress with the following:

- Grip & Control
- Cost run rate improvement
- Stretch CIP
- Booked Vs planned activity
- Nursing temporary staff
- Medical temporary staff
- Risks and Issues.

The presentation was circulated to the Committee electronically during the meeting.

17/12/14 Grip & Control - Support and challenge meetings were going well using the emerging dashboards to stimulate discussion and actions to improve performance with escalation. The PMO was now shadowing the meetings to take forward as business as usual in the new year. A new VCP would go live the following day subject to final approval from the Director of F and Director of People and Organisational Development.

17/12/15 An update on G&C work in 'core' and 'additional' staffing areas along with cost run rate improvement was provided. Handover of Nursing, AHPs and Estates to the PMO had been completed. Handover of additional areas was expected by mid-January. This was discussed and it was clarified that once BDO handed over to the PMO the PMO would ensure the smooth running and, over time, hand over to the care groups. The Director of Finance commented that he was assured that the processes were appropriate and sustainable and acknowledged that significant work had been undertaken. However, there was some disappointment that more financial improvements were not yet

coming out of the work done so far and there was more work to do to embed the changes.

17/12/16 Ruth Allarton commented that some organisations were filling gaps with AHPs and getting excellent patient outcomes, she recognised that some of this Transformation work was happening but she asked when the Trust was going to take this forward enough to challenge medical spend. This was discussed in detail; transformation work was still ongoing and the Director of Finance agreed that this was something the Trust needed to look at as part of its longer term plans but he pointed out that in the past similar plans had not necessarily resulted in benefits.

17/12/17 Stretch CIP - An overview of work in initial focus areas was provided, these included Theatres, beds and outpatients. An explanation of the weekly flash reports was provided and an example was emailed to the chair during the meeting.

17/12/18 Booked Versus Planned Activity - A graph illustrating the trend in weekly booked vs planned income across all PODs and Care Groups was provided, there had been an improvement of £1.8m over the last five weeks. It was important to share learning from those areas that had achieved the best improvements.

17/12/19 Nursing – Temporary Staff - BDO now had confidence in the e-rostering data and could identify the areas that were getting the rotas approved on time as well as the five worst areas. Ruth Allarton asked how the Trust identified where staffing increases had been due to additional beds or seasonal pressures; work was underway to change some of the headings in the reports to identify this and show better analysis.

17/12/20 Medical - Temporary Staff - The majority of temporary staffing costs were agency with some bank staff costs. Attention was drawn to slide 20 which showed spend on temporary staffing by care group. It was believed that around 80% of spend was to cover vacancies. The information provided in the report would be the focus of the weekly meetings. The Trust needed to consider how it could fast-track recruitment and how well it was using international agencies.

17/12/21 Key risks and issues - Key risks were discussed; these included speed of adoption and 'pull' and Philippe Serna expressed surprise that this had been identified as a key risk. He expected there to still be significant support from BDO at this stage and this was discussed. There were 3 additional senior BDO staff on site to provide support to the Trust but the Trust did need to do more to adopt the work.

17/12/22 Positives:

- Engagement getting better at all levels
- Growing recognition of financial problem (clinical leads and medical temp run rate)

- Some indication of financial improvement (income trend, total nursing and midwifery temp spend fallen two weeks running)
- Positive reaction in general to new processes and controls (although some mixed messages)
- Opportunity to capture lessons learned to sustain progress

17/12/23 David Purdue left the meeting to attend to business relating to the CQC Inspection.

17/12/24 The BDO update and presentation was NOTED.

2018 Committee Priorities Discussion

17/12/25 The Committee had previously agreed to consider what assurance it wanted to receive over the next year and executives had been asked to identify the key areas within their directorates that the Committee should focus on.

17/12/26 Finance - The Committee considered what financial assurance it should receive; the Director of Finance felt that broadly the Committee already covered the areas that it should and the matter was discussed. The Committee needed:

- Sight of Financial performance against plan
- To understand the underlying position
- To look forward to estimate risks and opportunities
- To focus on savings and transformational programmes and whether these were adding value and benefits
- To periodically be updated on the finance strategy, for example staff in post and progress with projects.
- There needed to be more commercial information and the Committee should consider looking at efficiency and effectiveness plans.
- To seek assurance in terms of governance of large capital schemes.
- To seek assurance in terms of relationships with the ACS and CCGs and other local providers such as RDaSH and STH. This was also a wider issue for the Board and it was agreed that the Trust Board Secretary would work with the DoF to consider this.

17/12/27 Performance - It was noted that the Chief Operating Officer had left the meeting. The Committee discussed what assurance it should receive in terms of performance and agreed the following priorities;

- 62 day targets for cancer in the context of the ACS
- National RTT & 4hr access
- In 2018/19 CGs should have milestones within that to deliver and there needed to be an early warning systems to bring underperformance to the attention of the finance department and the Committee.
- In terms of escalation processes the Committee needed to agree under what circumstances it was appropriate for CGs to present to the Committee; it was agreed that that the committee needed to be

assured about the performance monitoring framework not operational issues and there needed to be a purpose to presentations.

- The Committee should move to exception reporting
- It was felt that in general the Committee dived a lot deeper in to financial issues than performance issues and this needed into change and equal consideration should be given to value, quality & efficiency.

17/12/28 IM&T - The Chief Information Officer had circulated a list of priorities outside of the meeting, these included:

- Cyber Security
- Business Intelligence
- The IT Project Portfolio (i.e. EUC, JAC, ICE, H@N, Bed Management, CAMIS Upgrade, Telephony Upgrade
- Clinical Portal / EPR
- GDPR

The Committee discussed how these crossed over with other enabling strategies and also with the work of other committees.

17/12/29 People & Organisational Development - The Committee agreed that it should seek assurance in terms of:

- Reviewing and continuing work with rostering and the roll out to other staff groups.
- Workforce planning and profiling
- Bank and agency spend
- Recruitment strategy and processes
- Continuation of development of teaching hospital status – to retain and recruit quality staff.
- The ACS and how we link to partners to deliver pathways
- Organisational change process
- Leadership work - Culture and behaviour
- Benchmarking with ACS

17/12/30 The Director of Estates and Facilities had submitted a report outside of the meeting. The Trust Board Secretary would work with Executives to formalise what had been agreed.

17/12/31 The 2018 Committee Priorities were discussed and NOTED and would form the basis if the Committee Work Plan for the forthcoming year. **MK**

Corporate Risk Register & BAF

17/12/32 Due to time constraints the committee agreed to review the report outside of the meeting; Any questions or concerns would be feedback to the Trust Board Secretary via email.

CT / HASU Update

17/12/33 The Director of Finance provided an update on work to progress the business case. The case, which needed to be submitted to NHSI by the end of January, had been delayed. A key issue had been delays getting building cost estimates which when received had been significantly higher than anticipated. A meeting was in place with the P21 partner to understand this and all executives involved in the project were working hard to progress matters. It was agreed to bring CT/HASU business case to the January meeting for recommendation on to Board. **DP/JS**

17/12/34 The CT/HSU Update was NOTED.

Finance Strategy

17/12/35 The Committee received the 5 Year Financial Planning update and the DoF provided an overview of key points. Since the last meeting the first iteration had been reviewed in detail, the long term financial model was complete and service developments had been costed on a bottom up basis and this was reflected in the plan. Further work was needed in terms of CIP and also in terms of the commercial side of the strategy. It was noted that assumptions were set out in the report. The Committee discussed the plan in the context of the ACS.

17/12/36 In terms of CIP and the ongoing work with BDO the Chair asked where ownership of the work would sit once the organisation moved to business as usual and this was discussed. Marie Purdue gave overview of how the transition would work though projects and steering groups. It was expected that more work would be needed in terms of change management systems.

17/12/37 The Finance Strategy would come back to February's Committee for recommendation to February's Board. Prior to this the Strategy would be reviewed with the Executive Team; the Chair would be cited on the outcome of discussions. **JS**

17/12/38 The 5 Year Finance Strategy Update was NOTED.

Workforce Highlights

17/12/39 Anthony Jones presented the report which provided data for month 7 (October) and included vacancy levels, agency spend and usage, sickness rates, appraisals, SET training, turnover and retention rates.

17/12/40 The Chair welcomed the inclusion of numbers as well as percentages. Overall the report had improved significantly and was progressing very well and in line with requests from the Committee. Anthony Jones would feed this back to the team.

17/12/41 Vacancy Levels – New data was presented which showed vacancy levels by staff group; the Chair noted that the vacancy rate for medical and dental staff stood at 15%. The Committee felt it would be helpful to understand exactly

where those vacancies were and this was discussed. The new data had come out of the work with BDO and work was underway to look at the data more closely and understand the drivers. Anthony Jones undertook to look in to whether more detailed information could be provided in future reports. **AJ**

17/12/42 The Workforce Highlights report was NOTED.

Performance Highlights

17/12/43 The Committee received the report which focussed on the three main performance areas for NHSI compliance; Cancer, 4hr Access and 18 weeks RTT. The report also highlighted the ongoing work with Care Groups and external partners to improve patient outcomes. Further to feedback at previous meetings more detail had been included in the report; the increased in depth narrative and clear illustration of direction of trends was welcomed by the Chair who asked whether the Board report was to presented the information in the same way; Ruth Bruce undertook to check this.

17/12/44 An overview of in-month 4hr access, RTT and cancer performance was provided.

17/12/45 The Performance Report was NOTED.

17/12/46 The Director of Finance was required to leave the meeting at this point.

With the meeting no longer quorate due to there being no executive in attendance the meeting concluded at 1.15pm.

Time and date of next meeting:

Date: 29th January 2018
Time: 9:15am
Venue: Boardroom, DRI

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

UNAPPROVED

Minutes of the Meeting of the Management Board
of
Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust
on
Monday 11 December 2017 at 2pm
in the Boardroom, DRI

Present:

David Purdue	Chief Operating Officer
Andrew Barker	Care Group Director - Diagnostics & Pharmacy
Karen Barnard	Director of People & Organisational Development
Kirsty Edmondson-Jones	Director of Estates & Facilities
Eki Emovon	Care Group Director - Children and Families
Moira Hardy	Acting Director of Nursing, Midwifery and Quality
Thrinath Kumar	Care Group Director - MSK & Frailty
Simon Marsh	Chief Information Officer
Tim Noble	Associate Medical Director
Richard Parker	Chief Executive (Chair)
Gillian Payne	Care Group Director - Speciality Services
Marie Purdue	Acting Director of Strategy & Improvement
Jon Sargeant	Director of Finance
Jochen Seidel	Care Group Director - Surgical
Sewa Singh	Medical Director

In attendance:

Matthew Kane	Trust Board Secretary
Mandy Espey	General Manager – Emergency
Dr Naushad Khan	Emergency consultant (part)
Dr Prakash Subedi	Emergency consultant (part)
Alasdair Strachan	Director of Education (part)

Apologies:

Willy Pillay	Assistant Medical Director

Action

Apologies for absence

MB/12/17/1 Apologies for absence were given on behalf of Willy Pillay and Nick Mallaband.

Minutes of the previous meeting

MB/12/17/2 The minutes of Management Board on 13 November 2017 were

approved as an accurate record of the meeting.

Matters arising and action notes

MB/12/17/3 The action notes were reviewed and updated:

- In relation to action point 1, David Purdue undertook to discuss with relevant staff.
- In relation to point 7, it was clarified that care group directors and general managers should be made aware of any offers.
- In relation to point 10, the report had not yet been completed.

STRATEGY

ACS/ACP Update

MB/12/17/4 Richard Parker provided an update on the Hospital Services Review.

MB/12/17/5 Engagement work had been undertaken with clinicians and the public which would provide a set of recommendations that the ACS would consider. Key issues for each of the workstreams were set out.

MB/12/17/6 Meetings were being held with the CEOs of the trusts, to gauge the level of support for some of the recommendations and proposals before they moved to the next stage.

MB/12/17/7 There would also be discussions around the management structure of the ACS which posed some opportunities for the Trust and governance with one option being to pursue special purpose vehicles. By the end of next year, there would be a single control total for the system and an integrated performance matrix.

MB/12/17/8 Priorities for 2018 included establishing the single financial control total for the area and delivering the 92% RTT standard by April 2019, although the latter was subject to discussions over whether the funding was routed direct to providers through NHSI or through NHS England to the CCGs. Other priorities included investment in IT and capital.

MB/12/17/9 In response to a question from Jochen Seidel as to whether Bassetlaw would be identified as a single maternity led unit, Richard Parker stated that discussions were ongoing as to what each site could offer. Richard Parker had also fed back some concerns regarding the Trust being required to handle echo cardiology referrals from Sheffield which was having a negative impact on the Trust's own diagnostic waits.

MB/12/17/10 In response to a question from Eki Emovon, Richard Parker explained that recommendations in relation to the work-streams would come forward in February for consultation with the providers before further refinement and then wider public consultation. Richard Parker referred to the recent national workforce strategy which set out where workforce pressures would be the most acute over the next 10 years. Obstetrics was one of the areas covered although, notably, Emergency was not.

MB/12/17/11 Nursing continued to be a pressure point with 36,000 nursing vacancies expected by 2022. More money would go into supporting the apprenticeship levy. Such was the demand that other trusts were offering jobs at the end of students' second year of qualification training. It was understood that, in future, associate nurses would be able to enter a nursing programme on completion of their training.

The update was NOTED.

MB/12/17/12

Becoming a Veteran Friendly Hospital

MB/12/17/13 Management Board considered a report of the General Manager for MSK and Frailty which updated the work being undertaken to make the Trust a veteran friendly hospital.

MB/12/17/14 During the GIRFT visit from Professor Tim Briggs, the Trust was asked whether it was prepared to become part of the Veteran Friendly Hospital Alliance network. Currently 20 hospitals were signed up. The initiative had strong support from service charities, NHS bodies, the Department of Health and the Ministry of Defence.

MB/12/17/15 As part of the scheme, the Trust would require a clinical champion (identified as Mr Andrew Bruce) and a management champion (Mandy Espey). The national manifesto set out expectations of participating hospitals and what was expected for accreditation to be Veteran Friendly:

- Make information, including a leaflet and posters, available to veterans and their families explaining what to expect.
- Train staff to be aware of veterans' needs, that they should not face disadvantage and that special consideration is appropriate in some cases.
- Inform staff if a veteran or their GP has told the hospital they have served in the Armed Forces.

- Ensure veterans and their partners who have moved as a result of Armed Forces service do not lose their place on any waiting list

- Signpost to extra services that might be provided to the Armed Forces community by a charity or service organisation in the hospital.

- Look into what services are available in their locality and which patients would benefit from being referred to these services.

MB/12/17/16 Management Board were supportive of the initiative and RECOMMENDED to the Board of Directors' the Trust's participation.

PERFORMANCE

Finance Report

MB/12/17/17 Management Board received the Finance Report for November 2017.

MB/12/17/18 The monthly position was £1.213m deficit, £1.425m worse than plan.

MB/12/17/19 The main reasons for the Trust being behind plan were:

- Negative impact of not doing as much elective work in September and October as originally planned.

- Additional costs for temporary staff particularly medical agency.

- Higher than expected costs for building maintenance.

MB/12/17/20 The main risk was that if the Trust failed to meet financial targets it would not receive up to £6m of STF funding from the Department of Health. Finances would also come under scrutiny from NHS Improvement and some freedoms to act may be restricted. This was already being felt in other trusts. In order to support delivery, and to strengthen grip and control over finance, the Trust was currently working to ensure the delivery of all efficiency programmes and care groups could help by ensuring the effective use of all resources.

MB/12/17/21 Richard Parker reflected on the challenges and the recent meeting with senior Trust leaders to set out the financial position and the need to continue making efficiency gains. Discussions with the CCG over contract delivery were also shared.

MB/12/17/22 The Finance Report was NOTED.

GOVERNANCE

Corporate Risk Register

MB/12/17/23 Management Board considered a report of the Trust Board Secretary which set out for consideration the Board Assurance Framework and Corporate Risk Register.

MB/12/17/24 During the last meeting of Management Board, an extreme risk around cross cover working at BDGH by GP VTS was considered. It was agreed that the Chief Operating Officer, Care Group Director and Trust Board Secretary would meet to understand the risk scoring process. That meeting took place and when the frequency and impact were triangulated against the existing Trust guidance this resulted in a new score of L2 x I5 = 10 (high risk).

MB/12/17/25 One risk – relating to the Availability and Supply of Medicines - was escalated from Datix for consideration for inclusion on the Corporate Risk Register and Andrew Barker provided some context for its escalation.

MB/12/17/26 Following a brief discussion, which tested the soundness of the rating, it was agreed that the corporate risk relating to Availability and Supply of Medicines be added to the Corporate Risk Register. The report was NOTED.

Forthcoming Assessments, Inspections and Reviews

MB/12/17/27 Management Board considered a report of the Trust Board Secretary which set out forthcoming assessments, inspections and reviews.

MB/12/17/28 The CQC Well Led inspection on 16-18 January was noted. Richard Parker also advised that an unannounced inspection could happen at any point.

MB/12/17/29 The report was NOTED.

KEY ISSUES FOR CARE GROUPS

QiMET Project

MB/12/17/30 Management Board received a presentation from Dr Naushad Khan and Dr Prakash Subedi, Emergency Department consultants, on the Quality

Improvement Medical Educational Training project whose aim was to generate more trained emergency doctors.

MB/12/17/31 The programme had begun in October 2015 and currently had 23 trainees. The programme aimed to tackle the shortage of emergency medicine doctors and consultants with a blended approach involving them spending time in one the Trust's hospitals. The programme was not about 'draining' talent from other countries as they would return home after completing the programme.

MB/12/17/32 Dr Subedi had already visited Sri Lanka who had indicated a willingness to be involved and was looking for the Trust to further develop the work. This had been supported by the Royal College of Nursing.

MB/12/17/33 Alasdair Strachan supported further development of the progress made so far and felt that engaging the University in the work would be an important first step. Sewa Singh endorsed the programme subject to further work to ensure its financial soundness.

MB/12/17/34 Richard Parker congratulated Drs Subedi and Khan on the work undertaken and requested that further work be done in conjunction with NHS England to ensure work was not duplicated. **SS**

MB/12/17/35 The presentation was NOTED.

Extra sessions rates of pay and overnight on call rates of pay

MB/12/17/36 Management Board considered an issue raised by the Cardiology MS Consultant which had identified some discrepancies between rates of pay for additional sessions amongst doctors in different specialties.

MB/12/17/37 The item had previously been scheduled for discussion at a care group director meeting but due to scheduling was not discussed.

MB/12/17/38 Richard Parker stated that the rates of pay should be known amongst Management Board and standardisation was desirable but that it was accepted that there may be exceptions to the rule and, where this was the case, these should be brought to care group directors' attention and Management Board for discussion.

MB/12/17/39 Details of rates of pay had been circulated but were not accepted as fully accurate and further work was required to address this.

MB/12/17/40 It was AGREED that the Assistant Medical Director, Director of Finance and People and OD would review the levels of payment and bring the **WP/KF**

accurate position to LNC for discussion with a view to standardising rates acknowledging that there may be variation dependent on the case and where this was the case it would be brought to care group directors and Management Board for discussion.

Update on admin cost cutting scheme

MB/12/17/41 Management Board considered a report of the Chief Operating Officer which set out progress on clinical admin redesign.

MB/12/17/42 The aim of the project was to undertake a review of clinical administration to ensure a reliable, efficient and fit for purpose infrastructure to support service delivery and future demands.

MB/12/17/43 The review was now coming to a conclusion, based on a number of principles including:

- Central referral gateway (mainly central, process refinement)
- Central outpatient booking (mainly central, pockets devolved)
- Devolved Waiting List Management to Care Groups for greater control and management (currently mixed) and central waiting list teams within care groups
- Skill Mixing/Equity
  - removing typing from B3 medical secretaries
  - creating Team Leader posts (centralised supervisory/1st line management, performance oversight)
  - equitable banding/roles across clinical admin function
  - equitable allocation across care groups/specialties
- Pathway co-ordinator teams – patient centred approach

MB/12/17/44 The project included all ESR admin and clerical posts, clinical admin and patient facing roles and generic functions across the groups. It excluded corporate administration, unique roles and management. Work would be phased and take place in five tranches. Details of the approach and work to date were set out.

MB/12/17/45 Next steps would include a series of care group "confirm & challenge" meetings to apply professional judgement to resource allocation proposal, banding of job descriptions and follow-up analysis, development of single operating procedures and then a proposal to move to the new model followed by deployment plans.

MB/12/17/46 In response to a question from Gillian Payne regarding job matching, David Purdue explained that the model for job matching had been agreed. He also acknowledged that the final outcome may be

contentious but the project needed to be brought to a conclusion with people in permanent roles.

MB/12/17/47 Tim Noble advised that one of the issues with banding of administration roles was that while typing was classed as a Band 2 role this did not take into account the quality dimension i.e. that a Band 4s typing was usually more accurate. Allocating all typing to a Band 2 often meant that the quality control aspect in the chain was transferred to a consultant who was the most expensive resource. David Purdue advised that this aspect would be monitored through a KPI and addressed in the new version of Medisec.

MB/12/17/48 David Purdue clarified that typing pools would remain within care groups and specialty fields and savings target would still be met.

MB/12/17/49 Richard Parker advised that the framework had been set, and model and job descriptions being agreed and general managers had implemented the proposals. The situation would be kept under a watching brief and brought to Management Board on a regular basis to address any issues that were arising.

The presentation was NOTED.

MB/12/17/50

Agency Locums paid breaks

MB/12/17/51 Management Board considered a report of the Director of People and Organisational Development which proposed to introduce a 'no paid break' rule for agency locums which was currently costing the Trust an extra £89k per year. It was confirmed that the Trust would continue to pay breaks for internal bank staff.

MB/12/17/52 The Director of People and Organisational Development had canvassed a number of neighbouring trusts who had all stated that they did not pay breaks for agency locums. Two local Trusts (SCH and NLAG) had tried to impose a "no paid break" policy for internal bank medics and had reversed the decision following negative employee relations.

MB/12/17/53 Tim Noble challenged that breaks were actually possible in many instances and therefore locums may try and recoup the costs in other ways i.e. by staying later.

MB/12/17/54 Management Board AGREED that:

1. From 1st January 2018 a "no paid break" rule be introduced for agency locums, reducing an estimated agency cost for 2017/18 by approximately

£22 (and £89k per year recurrently).

2. There would be increased governance and control for substantive trust staff completing additional shifts and medical staff on a bank contract.

3. Current practices, procedures and processes be reviewed across all Care Groups to ensure appropriate authority levels were put in place and certify that break overrules were only allowed when necessary.

Clinical Excellence Awards

MB/12/17/55 An update was given from Richard Parker on the 2015-16 offer for the Clinical Excellence Awards programme.

MB/12/17/56 The following had been offered:

- Full points' back-pay from 1 November 2015.
- From thenceforth full points would be applied, backdated to 1 April.

MB/12/17/57 The offer would go to the next LNC. All offers would be made on the basis of clear examples of excellence which must meet the criteria as laid out.

MB/12/17/58 The update was NOTED.

Information Items to Note

MB/12/17/59 The following information items were NOTED:

- Business Intelligence Report as at 31 October 2017
- Chief Executives Report
- Minutes of the Corporate Investment Group meeting held on 30 October 2017
- Minutes of the Planned Care Programme Board meeting held on 19 October 2017
- Minutes of the Children's & Family Board meetings held on 13th October and 10th November 2017
- Minutes of the Elective Care Steering Group meetings held on 2nd October and 6th November 2017
- Minutes of the Urgent & Emergency Care Steering Group meetings held on 2nd October and 6th November 2017

Any other business

MB/12/17/60 Intensive Care Consultants – Jochen Seidel advised that due to maternity leave the number of consultants in Intensive Care would shrink to six. It was suggested that existing locums and colleagues in other trusts be utilised to maintain the rota. There was also the possibility of attracting qualifying trainees to the role. It was AGREED that the matter be taken to Executive Team for agreement on 13 December 2017.

ED consultants rates

MB/12/17/61 The Trust would be holding the line in a consistent manner in terms of what it paid over Christmas although there was evidence that some locums were cancelling. David Purdue would discuss with Andrew Morgan. The Trust would seek to pay reasonably, recognising its constraints and taking advice from regulators.

Items for escalation to the Board of Directors

MB/12/17/62 None.

Items for escalation from sub-committees

MB/12/17/63 None.

Date and time of next meeting

MB/12/17/64 The next meeting of Management Board would take place 15 January 2018 at 2pm in the Boardroom.

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Title	**Report from the Guardian for Safe Working**		
Report to	**Board of Directors**	**Date**	**January 2018**
Author	**Dr Jayant Dugar, Guardian for Safe Working**		
Purpose			Tick one as appropriate
	Decision		
	Assurance		√
	Information		

Executive summary containing key messages and issues
The 2016 national contract for junior doctors encourages stronger safeguards to prevent doctors working excessive hours, during negotiations on the junior doctor contract agreement was reached on the introduction of a 'guardian of safe working hours' in organisations that employ or host NHS trainee doctors to oversee the process of ensuring safe working hours for junior doctors. The Guardian role was introduced with the responsibility of ensuring doctors are properly paid for all their work and by making sure doctors aren't working unsafe hours. The 2016 contract continues to be implemented with 112 junior doctors employed by this Trust on the 2016 contract as at December 2017. This contract changes how safe working is delivered compared to previous contract. This relies on exception reporting by junior doctors and proactive changes by the Trust to avoid unsafe working. This is done through an electronic system called DRS4 provided by Skills for Health. The previous contract relied on a monitoring process. The Guardian is required to provide the Board of Directors with quarterly reports. No gross safety issues have been raised with the Guardian by any trainee. There have been 89 exceptions raised by junior doctors - 14 of which were education related re missed education meetings which have been taken note of by the educational supervisors. There were 5 reports from general surgery where a trainee was asked to cover nights instead of days -this was discussed with the college tutor in surgery and agreed that this practice was detrimental to training and will be avoided in the future. There were 13 exception reports from a trainee in Stroke medicine relating to excessive workload, hours and missed training in October- November. This was progressed to a work schedule review – the detail of which is included in the report. No fines have been levied during this 6 month period. The Guardian for

Safe Working advises that that the trainees have safe working practice as designed by the 2016 contract.
Key questions posed by the report
Is the Board assured that the Trust has safe working in place for doctors in training?
How this report contributes to the delivery of the strategic objectives
• **As a Teaching Hospital we are committed to continuously develop the skills, innovation and leadership of our staff to provide high quality, efficient and effective care** Junior doctors will have improved support and education through the implementation of the new junior doctor's contract which is designed to ensure doctors are working safely and receiving the appropriate training. By having appropriately trained doctors patients will receive a good experience whilst receiving care.
How this report impacts on current risks or highlights new risks
• **Workforce.** By having a safe workforce we remain an attractive employer to current trainees and to help future recruitment.
Recommendation(s) and next steps
The Board of Directors are asked to note this update for the 2 quarters and be assured that trainee doctors have a safe working practice as envisaged by the 2016 contract.

QUARTERLY REPORTS ON SAFE WORKING HOURS July 2017 – Sept 2017 and October- Dec 2017: DOCTORS AND DENTISTS IN TRAINING

Introduction

This report sets outs the information from the Guardian of Safe Working as part of the 2016 Terms and Conditions for Junior Doctors to assure the board of safe working for junior doctors. This report is for the period July 2017 – Sept 2017 and October –Dec 2017

The Board should receive a quarterly report from the Guardian as per 2016 contract, which will include:

- Aggregated data on exception reports (including outcomes), broken down by categories such as specialty, department and grade.
- Details of fines levied against departments with safety issues.
- Data on rota gaps / staff vacancies/locum usage
- A qualitative narrative highlighting areas of good practice and / or persistent concern.

This is a combined report as they background information which is collated by medical staffing was delayed due to posts being vacant in medical staffing.

High level data

Total number of training posts in DBTH	290
Number of posts contracted by DBTH	161
Number of posts contracted by other Organisations	129
Number of doctors / dentists in training on 2016 TCS	112
Amount of time available in job plan for guardian to do the role:	2 PAs
Admin support provided to the guardian (if any):	yes*
Amount of job-planned time for educational supervisors:	0.25 PAs per trainee

*Embedded within medical staffing

The picture is changing as all new contracts to junior doctors are on 2016 terms. The number of junior doctors on 2016 contract has gone up from 38 to 112 from August.

a) Exception reports (with regard to working hours)

Exception reports by Care Group 01/07/17-30/09/17				
Care Group	No. exceptions carried over from last report	No. exceptions raised	No. exceptions closed	No. exceptions outstanding
General Medicine		15	15	0
General Surgery		9	9	0
ENT		4*	4	0
Emergency Medicine		1	1	0
Psychiatry		2	2	0
Total		31	31	0
Exception reports by Care Group 01/10/17-current date				
Care Group	No. exceptions carried over from last report	No. exceptions raised	No. exceptions closed	No. exceptions outstanding
Emergency Medicine	0	5	0	5
General Medicine	0	37	26	11
General Surgery	0	10	10	0
ENT	0	5*	5	0
Renal Medicine	0	1	0	1
Total	0	58	41	17

*These relate to an incorrect workplan being issued- this has been resolved

For these quarters, exception reports have only been submitted by individuals across Emergency, Surgical and Medicine Care Groups. A total of 89 exception reports have been raised within these 2 quarters of which 14 have been related to Education all of which are related to missed attending meetings which have been taken note of by the educational supervisors.

There were 5 reports from general surgery where a trainee was asked to covers nights instead of day-this was discussed with the college tutor in surgery and agreed that this practice was detrimental to training and will be avoided in the future.

There were 13 exception reports from a trainee in Stroke medicine relating to excessive workload, hours and missed training in October- November. This was progressed to a work schedule review (see below).

There are delays in supervisors signing off the exception reports as some supervisors were having technical issues.

With regards to doctors still on the 2002 contracts there is no hours monitoring information available at present. The 2002 terms and conditions of service stipulate monitoring must be done twice a year (or once by agreement) so this should be taken in to account. The Trust has established a small medical staffing team. Hours monitoring and exception reporting will now be actioned

b) Work schedule reviews

There was a workload safety concern in stroke medicine. This was actioned into a work plan review to review arrangements when other members of team are on leave or on call. This is a small team and there is acceptance of high workload when there is only 1 trainee doctor rostered.

Some measures have been put in place and partial cover with locums will help partially. Other solutions like Physicians associates, nurse practitioners, or extra registrar are all being explored. This will be kept under close monitoring by myself.

c) Locum and bank usage

The information provided is complex to analyse as it includes long term locums and data for non-training grade staff to cover rota gaps. This information needs to be refined further as this has an impact on safety and training within the organization. These tables show a significant reliance on locum and bank hours to fill gaps. These numbers should be viewed cumulatively to look for areas with workforce problems. These will be the departments where workforce reviews will be helpful to find solutions.

July to September 2017		
	Internal Bank Hours	Agency Hours
Acute	401.25	295.33
Anaesthetics	318.00	270.75
Cardiology		37.50
Care of the Elderly	209.00	236.00
Emergency Med	1101.92	783.75
Endocrinology	35.50	193.25
ENT	36.00	446.50
General Medicine	22.50	0.00
General Surgery	20.00	844.00
Obstetrics & Gynaecology	97.00	696.50
Paediatrics & Neonatal	254.50	858.00
Respiratory		148.50
Renal	155.50	26.50
Stoke medicine	53.50	365.58
Trauma & Orthopaedics	180.50	2169.84
Urology	47.50	333.50
Grand Total	**2932.67**	**7705.50**

October to 19 December 2017		
	Internal Bank Hours	Agency Hours
Acute	1113.75	265.25
Anaesthetics	621.00	421.17
Cardiology		314.50
Care of the Elderly	204.00	1085.92
Emergency Med	919.50	1432.58
Endocrinology		485.00
ENT	4.50	382.00
Gastroenterology		80.75
General Surgery	108.25	1014.75
Obstetrics & Gynaecology	473.50	828.50
Paediatrics & Neonatal	591.75	1186.17
Renal		426.00
Respiratory		541.00
Stoke medicine	7.50	1133.91
Trauma & Orthopaedics	116.00	5475.08
Urology		701.50
Grand Total	**4159.75**	**15774.08**

Vacancies

VACANCIES	August - December
Acute Medicine	1
Anaesthetics	2
Emergency medicine	3
Obstetrics & Gynaecology	8
Paediatrics	1
Renal	1
Surgery	1
Trauma & Orthopaedics	1
Urology	2
Total	**20**

This vacancy information is provided by medical recruitment team, but includes substantive vacancies, some of which are filled by long term locums. This information is useful, if it shows vacant posts by rota and department which need to be filled by other people on the rota or short term locums as this would show if any departments are under significant pressure. I am advised that this data collection is being refined.

d) Fines

No fines have been levied in this quarter.

Qualitative information

It is reassuring that no instance of immediate safety concern has been brought to my notice by junior doctors on 2002 or the 2016 contract.

14 instances of missing educational meeting due to busy ward have been reported and noted by educational supervisors. This level of missed training opportunities seems to be low and may indicate under reporting. Two of these cases had a pattern and one has been resolved (surgery) and second one is being looked to work schedule review as above.

I have been assured by medical recruitment department that all doctors are rostered on a rota which is compliant with 2002 and 2016 contracts as applicable.

Engagement

I have attended the Regional guardian forum in Leeds. This Trust has low number of exception reports possibly explained by low number of trainees on 2016 contract and compliant rotas and working practices.

The second meeting of junior doctors forum has happened on 24th July with good engagement from the Junior doctors.I have also attended 3 trainee forum meetings to engage with the junior doctors,these were in addition to the inductions meetings.

Software System

No change from previous report. Trust should consider moving to e-rostering solution linked to exception reporting to ensure full compliance with new contract

Issues arising & Actions

1. *Whilst there has been no recent hours monitoring for doctors on 2002 contract I am advised that this will happen this year.*
2. *Workload issue in Stroke medicine- workplan reviewed –some solutions being progressed –will be monitored closely*

Recommendation

The Board of Directors can be assured that the trainee doctors have a safe working practice as envisaged in the 2016 contract.

Working Together Partnership Vanguard
Committees in Common Briefing for Trust Boards
Monday 15th January 2018

This is a new monthly briefing for Trust Board members to hear in their public board meetings about the work of the Working Together Partnership Vanguard (WTPV). The Working Together Partnership is comprised of seven Acute Trusts who, by collaborating on a number of common issues, aim to strengthen each organisation's ability to delivery safe, sustainable, local services. http://workingtogethernhs.co.uk/

Committees in Common update

The first Committees in Common meeting took place on the 4th December. Whilst the Committees in Common meeting remains a private meeting, it has been agreed, wherever possible, that a briefing from the meeting will be reported in public. This is the first of those briefings.

General Programme Update

Key highlights from the Working Together Programme Team this month (which can be found in more detail in the stakeholder newsletter **here**) include:

- Updates on pathology, the hospital services review and committees in common (as found in this briefing)
- An invite to a radiology event on 25th January

Pathology

In September 2017 NHS Improvement (NHSI) published requirements around the development of 29 pathology networks across the NHS. They have looked into pathology services across the UK and believe that implementing the 29 networks will provide high quality, rapid and comprehensive diagnostic services for patients, which are delivered in the most efficient manner; and that this will facilitate the introduction of, and widest access to, new investigations and diagnostic systems, and improve future training and career development for scientific and technical staff.

All hospitals have been asked to look at the way services are delivered with this in mind to ensure they are safe and sustainable. Reference Groups for blood sciences, microbiology and cellular pathology have been established to explore how best a South Yorkshire and Bassetlaw network would work in a hub and spoke model
Once the validation of the data, and reference group conversations are complete the options will be considered by each Trust to ensure that the recommendations are supported by all of the partner organisations.

There is already a strong partnership across South Yorkshire and Bassetlaw Trusts, and the Pathology Steering Group, which is attended by Clinical Directors and Service Managers, has been in place for some time. The Group is Chaired by Richard Parker (CEO - Doncaster and Bassetlaw Teaching Hospitals FT) with Medical Director Sponsorship from David Throssell (Medical Director – Sheffield Teaching Hospitals FT).

Hospital Services Review

During the last few months of 2017, the Hospital Services Review has conducted 15 Clinical Working Groups (which are made up of clinicians from each service within each of the hospitals), five public engagement events (in addition to an online survey, work with seldom heard groups and staff drop-in sessions in Trusts) and work is now underway to review the insight and identify themes that have started to emerge from the engagement activity.

Public and staff engagement activity continues to take place in January and will continue to be incorporated into the work of the review team.

The team will be developing proposed options in January, modelling them in February and running them against the evaluation criteria (to which the public have previously contributed) in early March. Equality Impact Assessments will be developed alongside each proposed model. A number of further events will take place in early March to look at all the proposed options and gather public opinion on these before the final preferred proposed options are put forward in the final review report in April.

National Life Sciences Industrial Strategy

On 5th December the national Life Sciences Industrial Strategy was published with up to £3.5bn allocated by the government. Work is taking place to look into the opportunity for the ACS to support this agenda in relation to advanced manufacturing, digital, and health and care technologies.

Board of Directors Agenda Calendar

STANDING ITEMS			OTHER / AD HOC ITEMS
MONTHLY	**QUARTERLY**	**BIANNUAL / ANNUAL**	
FEBRUARY 2018			
CE Report	QEC Minutes	Budget Setting / Business Planning / Annual Plan	Finance Strategy
Business Intelligence Report	Board Assurance Framework & corporate risk register Q3		
MB Minutes			
HWB Decision Summary			
Finance & Performance Minutes			
Finance Report			
Chairs' Assurance Logs			
MARCH 2018			
CE Report		Budget Setting / Business Planning / Draft Annual Plan	
Business Intelligence Report		Staff Survey	
MB Minutes			
HWB Decision Summary			
Finance & Performance Minutes			
Finance Report			
Chairs' Assurance Logs			
APRIL 2018			
CE Report	ANCR minutes	Draft Annual Report	Mandatory training update
Business Intelligence Report	Chief Executive's Objectives	Draft Quality Account	
MB Minutes	Complaints, Compliments, Concerns and Comments Report	Budget Setting / Business Planning / Final Annual Plan	
HWB Decision Summary			
Finance & Performance Minutes			

As at 15 December 2017

Finance Report			
Chairs' Assurance Logs			
MAY 2018			
CE Report	Board Assurance Framework & corporate risk register Q4 (inc. annual assurance summary)	Annual Report	
Business Intelligence Report	QEC Minutes	Quality Account	
MB Minutes		Annual accounts	
HWB Decision Summary		ISA260 and quality account assurance	
Finance & Performance Minutes		Charitable Funds minutes	
Finance Report		Mixed Sex Accommodation	
Chairs' Assurance Logs			
JUNE 2018			
CE Report	Board Assurance Framework	MB Annual Report	
Business Intelligence Report	Report from the Chair of the ANCR committee (Verbal)	SOs, SFI, Scheme of Delegation	
Bed Plan		ANCR Annual Report	
MB Minutes			
Finance & Performance Minutes			
Finance Report			
Chairs' Assurance Logs			
JULY 2018			
CE Report	Chief Executive's Objectives		Reference Costs
Business Intelligence Report	ANCR Minutes		Diversity and Inclusion
MB Minutes			
Finance & Performance Minutes			
Finance Report			
Chairs' Assurance Logs			

AUGUST 2018			
CE Report	QEC minutes	Proposed AMM arrangements	Health and Wellbeing
Business Intelligence Report	ANCR Minutes	Annual Security Report	
Nursing Workforce		Infection Control Annual Report	
MB Minutes		Risk Policy	
Finance & Performance Minutes			
Finance Report			
Chairs' Assurance Logs			
SEPTEMBER 2018			
CE Report			Catering Report
Business Intelligence Report			Teaching Hospital
Nursing Workforce			
MB Minutes			
Finance & Performance Minutes			
Finance Report			
Chairs' Assurance Logs			
OCTOBER 2018			
CE Report	ANCR minutes	Charitable Funds minutes	
Business Intelligence Report	Chief Executive's Objectives	Fred & Ann Green Legacy minutes	
MB Minutes	Complaints, Compliments, Concerns and Comments Report		
Finance & Performance Minutes			
Finance Report			
Chairs' Assurance Logs			
NOVEMBER 2018			
CE Report	QEC minutes	Annual Compliance against the National Core Standards for Emergency Preparedness, Resilience and Response (EPRR)	
Business Intelligence Report	Board Assurance Framework & corporate		

	risk register Q2		
Nursing Workforce			
MB Minutes			
Finance & Performance Minutes			
Finance Report			
Chairs' Assurance Logs			
DECEMBER 2018			
CE Report	Report from the Chair of the ANCR committee (Verbal)		
Business Intelligence Report			
MB Minutes			
Finance & Performance Minutes			
Finance Report			
Chairs' Assurance Logs			
JANUARY 2019			
CE Report	ANCR minutes (16.12.16)	Budget Setting / Business Planning / Annual Plan	Constitution
Business Intelligence Report	Chief Executive's Objectives	SOs, SFI, Scheme of Delegation	CT/HASU (part 2)
MB Minutes	Complaints, Compliments, Concerns and Comments Report		Joint working
Finance & Performance Minutes			External reviews policy
Finance Report			
Chairs' Assurance Logs			

Minutes of the meeting of the Board of Directors
Held on Tuesday 19 December 2017
In the Boardroom, Montagu Hospital

Present:	Suzy Brain England OBE	Chair of the Board
	Alan Armstrong	Non-executive Director
	Karen Barnard	Director of People and Organisational Development
	Moira Hardy	Acting Director of Nursing, Midwifery and Quality
	John Parker	Non-executive Director
	Richard Parker	Chief Executive
	Linn Phipps	Non-executive Director
	David Purdue	Chief Operating Officer
	Neil Rhodes	Non-executive Director
	Jon Sargeant	Director of Finance
	Philippe Serna	Non-executive Director
	Sewa Singh	Medical Director
In attendance:	Ruth Allarton	Associate Non-executive Director
	Kirsty Edmondson-Jones	Director of Estates and Facilities
	Matthew Kane	Trust Board Secretary
	Simon Marsh	Chief Information Officer
	Marie Purdue	Director of Strategy and Transformation
	Emma Shaheen	Head of Communications and Engagement

ACTION

Welcome and apologies for absence

17/12/1 There were no apologies submitted for the meeting.

Declarations of Interest

17/12/2 Board was reminded of the need to keep their registers of interests up-to-date.

17/12/3 Linn Phipps declared a non-material interest in item 4 on the agenda owing to her involvement in the NHS England Active Programme.

17/12/4 Ruth Allarton declared a non-material interest in item 6 on the agenda relating to her involvement in the veterans' service.

Actions from the previous minutes

17/12/5 The list of actions from previous meetings was noted and updated.

17/12/6 In relation to action 17/06/34, it was agreed that an informal meeting with care group directors be arranged in due course.

Orthotics

17/12/7 The Board considered a presentation from the Trust's clinical lead for orthotics, Graham Moore, on the orthotics service.

17/12/8 Orthotics was defined as: "a medical device applied to an external part of the body aimed at providing support, re-alignment and/or the prevention of a deformity." Orthotists are part of the Allied Health Professions (AHP) who are autonomous registered practitioners providing assessment and solutions to patients with problems of the neuro, muscular and skeletal systems.

17/12/9 Orthotists provided solutions for the entire body and recent examples were provided. Key challenges within the service included the difficulty in recruiting orthotists, long wait times, inpatient delays and being a final service solution.

17/12/10 A number of changes had been made to the service to improve these challenges including full staff meetings, workforce review and redesign, links with universities (Salford and Strathclyde), staff engagement to find solutions to problems, cost review with the Procurement Team, education of MDT to offer primary service and decommissioning of orthotic manufacturing unit.

17/12/11 The clinical team consisted of seven orthotists and one orthotic therapy assistant. Outpatient clinics and inpatients were run at all three Trust sites. The service also provided work for RDaSH and they attended two special schools in addition to their clinical work across the Trust and partnership work with NHS England and the CCG.

17/12/12 Future plans included working with manufacturers on delivery times and procurement to further reduce costs, research and clinical trials, joint projects with universities and more self-care and primary care pathways.

17/12/13 The Board commended the work, particularly on staff engagement and research work. In response to a question from Linn Phipps, Graham Moore explained some of the difficulties in terms of inspiring a new generation of orthotists. Work had taken place on making Doncaster Royal Infirmary a good place to learn and this had yielded results.

17/12/14 The team had also been actively involved in quality, innovation and improvement work around appointments and 'did not waits'. In response to a question from Philippe Serna, it was explained that it had been necessary to close the in-house manufacturing unit as it did not provide value for money. All manufacturing rights of prosthetics remained with the manufacturer.

17/12/15 The presentation on Orthotics was NOTED.

Strategy & Transformation Update

17/12/16 The Board considered a report of the Director of Strategy and Transformation that presented for approval the enabling strategy for Information Management and Technology.

17/12/17 There was a brief consideration of how progress against strategies would be reported, which was still under consideration, and would be determined amongst executives once the Finance Strategy had been approved by Board in February.

17/12/18 The Board commended the Information Management and Technology Strategy as easy to read. In response to a question from Ruth Allarton, the Chief Information Officer reflected on the work taking place at Accountable Care System level which was complex due to the number of systems in place across the different trusts. Another area of work that was developing across the patch was around tele-health.

17/12/19 Neil Rhodes commented that the Finance and Performance Committee had considered the document at length and felt that it was both affordable and now dynamic. Linn Phipps also praised the document although requested further work around risk and explaining what consumer enablement and interoperability meant. Alan Armstrong emphasised the need for training which was a challenge and should be audited.

17/12/20 Commenting briefly on the Finance Strategy, Jon Sargeant advised that this document was taking shape although further work was required on capital requirements. Capital was also a live issue in relation to the Information Management and technology Strategy with much of the national capital monies channelled into the bottom line even though essential equipment such as laptops were eight years old.

17/12/21 Linn Phipps identified further work on the risks section of the document and non-executives requested assurance that risks were being managed appropriately. **SM**

17/12/22 The enabling strategies for Information Management and Technology Strategy were APPROVED, subject to amendments above.

Becoming a Veteran Friendly Hospital

17/12/23 The Board considered a report of the Chief Executive which sought approval for the Trust to become a veteran friendly hospital.

17/12/24 During the GIRFT visit from Professor Tim Briggs, the Trust was asked whether it was prepared to become part of the Veteran Friendly Hospital Alliance network. Currently 20 hospitals were signed up. The initiative

had support from charities, NHS bodies and the Ministry of Defence.

17/12/25 As part of the scheme, the Trust would require a clinical champion (identified as Mr Andrew Bruce) and a management champion (Mandy Espey). The national manifesto set out expectations of participating hospitals and what was expected for accreditation to be Veteran Friendly:

- Make information, including a leaflet and posters, available to veterans and their families explaining what to expect.
- Train staff to be aware of veterans' needs, that they should not face disadvantage and that special consideration is appropriate in some cases.
- Inform staff if a veteran or their GP has told the hospital they have served in the Armed Forces.
- Ensure veterans and their partners who have moved as a result of Armed Forces service do not lose their place on any waiting list
- Signpost to extra services that might be provided to the Armed Forces community by a charity or service organisation in the hospital.
- Look into what services are available in their locality and which patients would benefit from being referred to these services.

17/12/26 The Board AGREED:

(1) To agree to become part of the Veterans Covenant Hospital Alliance.

(2) To sign the Armed Service Covenant.

(3) To work with partners to deliver key expectations laid out in the manifesto in order to gain accreditation.

(4) To report back on progress in 12 months' time. **RP**

Chair's Assurance Log for Board Committee held 14 December 2017

17/12/27 The Board considered the assurance reports of the Chair of Finance and Performance Committee and Quality and Effectiveness Committee following their meetings on 14 December 2017.

17/12/28 Board was advised that the Finance and Performance Committee included a light-touch finance report – due to limited information being available – and an hour with BDO, with whom the Trust was working on its CIP pipeline and delivery. Performance remained within reasonable tolerances and all

efforts were going into ensuring that the Trust's finance plan was achieved.

17/12/29 It was felt that when the meeting with care group directors was arranged the BDO representative should also attend. The Medical Director reflected on the differing levels of capability on financial matters from amongst the care group directors.

17/12/30 The Quality and Effectiveness Committee received the embryonic version of the new quality dashboard that would be brought to Board once the qualitative data had been added. A similar dashboard could be developed for finance, it was suggested. The Director of Finance would discuss this with the Chief Executive.

17/12/31 Board RECEIVED the Chairs' Logs for assurance.

Finance Report – November 2017

17/12/32 The Board considered a report of the Director of Finance that set out the Trust's financial position at month 8, 2017/18.

17/12/33 The month eight position was £1.044m deficit, £252k worse than plan. The Trust's year-to-date position was £15.675m deficit, which was £1.932m behind forecast. Despite being behind plan, the clinical income variance was improving, while run-rate expenditure also continued to reduce.

17/12/34 The Director of Finance reported on the key issues including:

- The backdated repayment (400-450k) with a key partnership organisation who utilises the Trust's site facilities.
- Arrangements with the CCG to cover the cost of maternity sessions that were subject to clinical audit.
- Tranche one of the winter monies for ED would be received if the Trust hit 92.35% by Q4.
- Tranche two monies were more of a challenge as the Trust was required to hit more ambitious targets.
- The cash position had dipped slightly due to later than anticipated receipt of STF monies.

17/12/35 There was a substantial discussion on the likelihood of the Trust hitting its control total by year-end. The Director of Finance reported that he would be in a better position to report on this at the Board meeting in January 2018. Subject to discussions with NHS Improvement, the Director of Finance advised that he may be required to adjust the forecast position of the Trust and sought delegated powers in order to do this.

17/12/36 The Chief Executive reiterated to Board that if the Trust made its best endeavours to hit its plan and work in partnership with neighbouring providers then it would ensure it had the trust of the regulator, which was important for the long-term sustainability of the Trust.

17/12/37 The Board NOTED:

(a) NOTED the month 8 2017/18 financial position of £15.7 million deficit, £1,932k adverse to plan after removal of the 16/17 STF funding and any variance related to donated asset income.

(b) NOTED the progress made with the implementation of the recovery plan agreed at the last meeting.

(c) NOTED the risks particularly those relating to Doncaster CCG.

(d) DELEGATED to the Director of Finance powers to adjust the forecasted financial position at the end of 2017/18.

Performance Report as at 30 November 2017

17/12/38 The Board considered a report of the Chief Operating Officer, Medical Director, Acting Director of Nursing, Midwifery and Quality and Director of People and Organisational Development that set out clinical and workforce performance in month 8, 2017/18.

17/12/39 Performance against key metrics included:

4 hour access - In November the Trust achieved 91.2% against the 95% standard (including GP access). In total, over 13,000 patients were seen.

RTT – In October, the Trust performed below the standard of 92% achieving 90.8%, an improvement over the previous month. Five specialities remained with a high number of patients above 18 weeks, due to a shortfall in capacity, these being: Ophthalmology, ENT, General Surgery, Dermatology and Orthopaedics.

Cancer targets – In October the 62 day performance achieved the 85% standard, coming in at 86.2%. 62 day pathways remained a national priority and the key performance target for the Accountable Care System.

HSMR – The Trust's rolling 12 month HSMR remained better than expected at 86.42, an improvement from last month.

C.Diff – The number reported were below trajectory for November but still above for year-to-date.

Nursing Workforce - The Trust’s overall planned versus actual hours worked

in November was 99%.

Appraisal rate – The Trust's appraisal completion rate saw a further rise to 60.39%.

SET training - There had been an increase in compliance with Statutory and Essential Training (SET) and at the end of November 2017 the rate was 75.6%.

17/12/40 The Board reflected on the recent challenges including winter pressures and the CQC inspection. In response to a question from Alan Armstrong, the Medical Director and Chief Executive gave an update on the current position with regard to stroke recruitment. The importance of plans to make Montagu Hospital into a centre of excellence for rehabilitation were emphasised.

17/12/41 The Director of People and Organisational Development briefly advised of plans to bring appraisals into a three-month window, April to June and would be bringing details of the National Workforce Strategy to the Board.

17/12/42 The Medical Director relayed details of the actions being taken to improve performance in respect of fractured neck of femur and trauma and orthopaedics. It was noted that some of the serious incidents reported by the Trust were originally acquired within the community. Board were advised that NHS England had attributed the Trust its third MRSA bacteraemia in a year. However, the Respiratory Ward was no longer flagging as a cause for concern.

17/12/43 The Board NOTED the Performance Report.

Reports for Information

17/12/44 The following items were NOTED:

- Chair and NEDS' report
- Chief Executive's report
- Quality and Effectiveness Committee, 24 October 2017
- Minutes of Charitable Funds Committee, 26 September 2017
- Minutes of Management Board, 13 November 2017
- Board of Directors' Calendar

17/12/45 Board were advised of a recent emergency planning exercise undertaken by the Trust. The exercise concerned a mass casualty event in the region to which the Hospital was required to respond. Although the day was cut short following the announcement of the CQC inspection, Neil Rhodes placed on record his commendation for Jeannette Reay and Neil Colton for a well-planned event.

17/12/46 Philippe Serna fed back on the recent ACS Audit Committee chairs meeting.

Items escalated from Sub-Committees

17/12/47 None.

Minutes

17/12/48 The minutes of the meeting of the Board of Directors on 28 November 2017 were APPROVED as a correct record.

Any other business

None.

Governors questions regarding business of the meeting

17/12/49 There were no governors present.

Date and time of next meeting

17/12/50 9.00am on Tuesday 31 January 2018 in the Boardroom, Doncaster Royal Infirmary.

Exclusion of Press and Public

17/12/51 It was AGREED that representatives of the press and other members of the public be excluded from the remainder of the meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest.

Suzy Brain England **Date**
Chair of the Board