Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

The meeting of the Board of Directors

To be held on Tuesday, 26 March 2019 at 9:15am
in the Fred and Ann Green Boardroom, Montagu Hospital

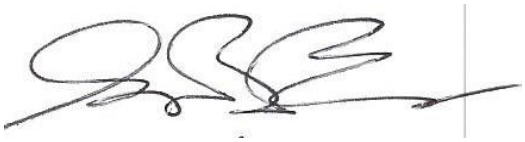
AGENDA
Part I

		Enclosures	Time
1.	Apologies for absence	(Verbal)	9:15am
2.	Declarations of Interest Members of the Board and others present are reminded that they are required to declare any pecuniary or other interests which they have in relation to any business under consideration at the meeting and to withdraw at the appropriate time. Such a declaration may be made under this item or at such time when the interest becomes known.	(Verbal)	
3.	Actions from the previous meeting	Enclosure A	
4.	NHSi QI Update and Breakthrough Objectives for 2019 / 20. Marie Purdue – Director of Strategy and Transformation	Presentation	9:20am
	Reports for Decision		
5.	Use of Trust Seal Richard Parker – Chief Executive Gareth Jones – Trust Board Secretary	Enclosure B	9:40am
6.	Standing Order, Standing Financial Instructions and Standards of Business Conduct Jon Sargeant – Director of Finance	Enclosure C	10:00am
	Reports for assurance		
7.	Finance Report as at 28 February 2019 Jon Sargeant – Director of Finance	Enclosure D	10:10am
8.	Thematic People and Organisational Development Report Karen Barnard – Director of People and Organisational Development	Enclosure E	10:25am
9.	Performance Report – 28 February 2019 Led by David Purdue – Chief Operating Officer	Enclosure F	10:40am
	BREAK		**10:55am**

10.	Staff Survey Results Karen Barnard – Director of People and Organisational Development	Enclosure G	11:05am
11.	CQC Update Sewa Singh, Medical Director	Enclosure H	11:20am
12.	New Case Assignment Definitions – Clostridium Difficile Moira Hardy – Director of Nursing, Midwifery and Allied Health Professionals	Enclosure I	11:35am
13.	Chairs Assurance Logs for Board Committee held 19 March 2019 and 22 March 2019 Kath Smart – Chair of Audit and Risk Committee Neil Rhodes – Chair of Finance and Performance Committee *(F&P report to follow)*	Enclosure J	11:45am
	Reports for information		
14.	Chair and NEDs' Report Suzy Brain England – Chair	Enclosure K	11:50am
15.	Chief Executive's Report Richard Parker –Chief Executive	Enclosure L	
16.	Minutes of Management Board, 11 February 2019 Richard Parker – Chief Executive	Enclosure M	
17.	Minutes of Audit and Risk Committee 22 November 2018 Kath Smart – Chair Audit and Risk Committee	Enclosure N	
18.	Minutes of the Charitable Funds Committee 25 January 2019 Sheena McDonnell – Chair of Charitable Funds Committee	Enclosure O	
19.	Board of Directors Agenda Calendar Gareth Jones – Trust Board Secretary	Enclosure P	12:05pm
Minutes			
20.	To approve the minutes of the previous meeting held on 29 January 2019	Enclosure Q	12:10pm
21.	**Any other business (to be agreed with the Chair prior to the meeting)**		
22.	**Governor questions regarding the business of the meeting**		12:15pm
23.	**Date and time of next meeting** Date: 30 April 2019 Time: 09:15 Venue: Boardroom, Doncaster Royal Infirmary		

24. Withdrawal of Press and Public 12:35pm

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



Suzy Brain England
Chair of the Board

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Action Notes

Meeting: Board of Directors

Date of meeting: 26 February 2019

Location: Boardroom, DRI

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

Apologies: PD

No.	Minute No	Action	Responsibility	Target Date	Update
1.	**18/11/…**	Brexit Preparations - Ensure Brexit is incorporated in to consideration of risk by Board Committees.	**Chairs QEC/F&P/ANCR**	**Future Committee meetings**	Update to be provided at meetings.
2.	**19/1/12**	Nicole Chavaudra of Bassetlaw CCG to be invited to present an update on Bassetlaw Place Plan in six months.	**GJ**	**July 2019**	On Board Calendar – no yet due.
3.	**19/1/44**	Marie Purdue to present annual plan to Board for approval on 26th March 2019.	**MP**	**March 2019**	On March Agenda

No.	Minute No	Action	Responsibility	Target Date	Update
4.	**19/1/65**	Each committee chair to refresh their TOR in terms of Health and Safety responsibilities and provide a recommendation to Board on how to proceed going forward.	**KS, LP, NR**	**May 2019**	A paper to be shared via the Trust Board Secretary and Director of Estates and Facilities at the Executive Team on behalf of the Chairs of the Sub-Committees.
5.	**19/1/66**	Environmental Issues workshop or seminar for Board on Capital Programmes and Environmental impacts to be arranged.	**KEJ / GJ**	**Date to be arranged.**	To be undertaken following Board of Directors Meeting – date TBC.
6.	**19/1/82**	Hospital cancellation rate – figures rather than percentages of cancellations to be included in the performance report.	**DP**	**March 2019**	To be included for next reporting.
7.	**19/2/9**	A deep dive of staff mandatory training requirements and compliance to be undertaken and provided to members of the Board by email.	**SM**	**March 2019**	
8.	**19/2/12**	IT issues workshop for Board on the decommissioning of faxes, reduced written letter correspondence and improved use of email.	**SM**	**Date to be arranged.**	

Doncaster and Bassetlaw Teaching Hospitals
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No.	Minute No	Action	Responsibility	Target Date	Update
9.	**19/2/42**	Scenario sample reports on EU Exit to be shared with Board.	**DP**	**March 2019**	
10.	**19/2/54**	Care Hours per day including model hospital and safe staffing data to be include in future executive summaries of the performance report.	**MH**	**March 2019**	
11.	**19/2/54**	A deep dive of the quality report detailing care hours per day to be undertaken at QEC.	**MH / LP**	**May 2019**	
12.	**19/2/55**	An update to be provided on the metrics for care of children to be provided to Board following the Clinical Governance Committee	**SS**	**March 2019**	

Date of next meeting: 26 March 2019
Action notes prepared by: G Jones
Circulation: SBE, RP, KB, MH, DP, JS, SS, MP

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Title	**Use of Trust Seal**		
Report to:	**Board of Directors**	Date:	**26 March 2019**
Author:	**Gareth Jones, Trust Board Secretary**		
For:	**For approval**		

Purpose of Paper: Executive Summary containing key messages and issues

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

Seal No.	Description	Signed	Date of sealing
105	Renewal lease be reference to an existing lease with Ramsay Health Care UK Operations LTD and DBTH, Doncaster Royal Infirmary site. (Relating to Park Hill Hospital.	Richard Parker Chief Executive	20 March 2019
		Jon Sargeant Director of Finance	

Recommendation(s)

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

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Title	**Review of Standing Financial Instructions, Standing Orders and Scheme of Delegation**		
Report to	**Board of Directors**	**Date**	**26th March 2019**
Author	**Jon Sargeant – Director of Finance**		
Purpose			Tick one as appropriate
	Decision		X
	Assurance		
	Information		

Executive summary containing key messages and issues
The Standing Financial Instructions, Standing Orders and Scheme of Delegation has been reviewed and updated in line with best practice and up to date practices in the Trust. A summary of these changes include: - Updating names for Committees and Corporate Structures (such as Divisions) - References to Prudential Borrowing Limit removed (PBL removed April 2013) - Revising budget virement limits - Making reference to CIG within business case approval process - Revising delegated authority with regards to Freedom of Information requests, Data Protection Act requirements and Health and Safety Arrangements - Making reference to GDPR within Data Protection Act requirements - Making reference to responsibilities around Intellectual Property disposals This paper was presented to Audit & Risk Committee on 19th March 2019, and it was recommended for approval by that Committee.
Key questions posed by the report
Does the Board agree to approve the updated documents?
How this report contributes to the delivery of the strategic objectives
Ensuring the Trust is appropriately governed

How this report impacts on current risks or highlights new risks
N/A
Recommendation(s) and next steps
Trust Board is asked to approve the updated documents.

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Standing Orders
Board of Directors
March 2019

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:	Jon Sargeant and Matthew Bancroft
Date written/revised:	March 2019
Approved by (Committee/Group):	Board of Directors
Date of approval:	
Date issued:	
Next review date:	March 2020
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 executive director, 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 Teaching 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 Council 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 Council 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 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 urgent circumstances be exercised by the Chief Executive after having consulted 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 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 Risk
(b) Quality and Effectiveness
(c) Nominations and Remuneration
(d) Charitable Funds
(e) Finance and Performance
(f) Working Together Partnership Committee in Common

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.

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 Trust (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 £50.00 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 Risk 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.9	CE/Finance	Jon Sargeant/Matthew Bancroft	Existing Policy	March 2019

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: March 2020

Checked by: Jon Sargeant/Matthew Bancroft **Date: March 2019**

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Standing Financial Instructions

March 2019

This procedural document supersedes: CORP/FIN 1 (B) v.6 – Standing Financial Instructions – January 2018

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:	Jon Sargeant – Director of Finance
Date written/revised:	December 2018
Approved by (Committee/Group):	Board of Directors
Date of approval:	
Date issued:	
Next review date:	March 2020
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 7	March 2019	• Updated names of structures/meetings • Updated sections relating to PBL, Data Protection, Health & Safety and budget virements.	Jon Sargeant
Version 6	30 January 2018	• Updated sections on Audit, Budgets, funded/ budgeted establishment, Banking, Payment of Directors and Employees, Non Pay Expenditure, Funds Held on Trust • Procurement and Tendering Appendix added	Winston Weir

Contents

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.

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.

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.

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 Teaching 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 Risk 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 Risk Committee to perform the role of the Audit Committee along with additional responsibilities in relation to 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 controls assurance systems, including information to governors; and

(i) reviewing 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).

2.2.3 The LCFS shall report to the Director of Finance and shall work with staff in the NHS Counter Fraud Authority.

2.2.4 The Local Counter Fraud Specialist will provide a written report to the Audit and Risk 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 Counter Fraud Authority.

2.3.5 The LSMS will provide a written report, at least annually, to the Audit and Risk 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 Risk 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 Risk 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 Risk Committee. The reporting system for internal audit shall be agreed between the Director of Finance, the Audit and 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 Council 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 Council 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

No longer required

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;

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

(b) identify potential risks; and

(c) 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, Government Accounting Manual 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 Audit and Risk Committee by delegation from the Board and to a general meeting of the Council 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 Council 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 Council 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 Procurement Director shall be sought. Wherever appropriate, the supply of goods and services shall be covered by a contract following a competitive exercise.

10.2.2 The Trust's 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 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. 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 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 Counter Fraud Authority in accordance with Secretary of State for Health's Directions.

The Director of Finance must ensure that NHS 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 Risk 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 Director of People and Organisational Development 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 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 Teaching 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 Division 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 Divisions:

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 - 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 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 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 Corporate Investment Group (CIG). 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 CIIG 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 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:

- Where the requirements are ordered under existing contracts or where in the opinion of the Finance Director:
- there is only one supplier and no reasonably satisfactory alternative product/service;
- 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 Procurement Director in confirmation of such circumstances.

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.

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:

(a) where the supply of goods (or related goods) is of a special character and does not exceed £5,000;

or where in the opinion of the Finance Director:

(b) there being only one supplier and no reasonably satisfactory alternative product/service;

(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;

(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.

In any of these circumstances the detail should be documented and the authorisation counter-signed by the Procurement Director in confirmation of such circumstances.

3.3 Officers should involve the 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 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. The advice of 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.

4.2 In all cases the 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	Procurement Director
- goods/services in excess of £100,000 and up to £500,000	Director of Finance
- goods/services in excess of £500,000 and up to £1m	Chief Executive
- goods/services in excess of £1m	Board

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 Tenders shall be advertised, issued and submitted on the Trust's e-tendering system.

4.5 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.

4.6 Tenders submitted via e-tendering will be electronically date and time stamped.

4.7 Tenders submitted via e-tendering will remain electronically locked to all Trust staff until the end time for receipt of tenders has passed.

4.8 Alterations to tenders submitted via e-tendering will be electronically marked.

4.9 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.

4.10 Technically late tenders (i.e. those uploaded in good time but delayed through no fault of the tenderer) may be regarded as having arrived in due time.

4.11 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.

4.12 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.

4.13 While decisions as to the admissibility of late, incomplete, or amended tenders are under consideration and while re-tenders are being obtained, the tenders will remain electronically unopened.

4.14 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.

4.15 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.

4.16 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.

APPENDIX 5 - 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 – November 2018 - CORP/FIN 1 (B) v.7	CE/Finance	Jon Sargeant/Matthew Bancroft	Existing Policy	March 2019

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: **March 2020**

Checked by: **Jon Sargeant/Matthew Bancroft** **Date: March 2019**

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Reservation of Powers to the Board and Delegation of Powers

March 2019

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

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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:	Jon Sargeant, Director of Finance
Date written/revised:	March 2019
Approved by (Committee/Group):	Board of Directors
Date of approval:	
Date issued:	
Next review date:	March 2020
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 8	November 2018	Renaming names of structures/meetings	Jon Sargeant
Version 7	September 2017	Various	Jon Sargeant and Matthew Kane
Version 6	September 2016	• Update to 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

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 an executive director 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 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.

All powers delegated by the Chief Executive can be re-assumed by him/her should the need arise. As Accounting 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 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 to whom powers have been delegated those powers shall be exercised by that director'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 Deputy Chief Executive after taking appropriate advice from the Director of Finance.

The Chief Executive, 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 board committees (and other committees if required).

1.3.13 Ratification of any urgent decisions taken 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 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 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 Risk 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 Risk 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 Risk 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 Risk Committee.

2. DELEGATION OF POWERS

2.1 **Delegation to Committees**

The Board may determine that certain of its powers shall be exercised by 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 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	Chief Executive – with operational responsibility delegated to the Chief Information Officer
Health and Safety Arrangements	Chief Executive – with operational responsibility delegated to the Director of Estates & Facilities

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/he should produce a scheme of authorisation for matters. In particular the scheme of 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	DOF	Decide whether any late tenders should be considered.
Annex s5	CE OR DOF	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	DIRECTORS	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 RISK COMMITTEE	Provide independent and objective view on internal control and probity.
2.2	DOF	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	COUNCIL OF GOVERNORS	Appoint external auditors.
3	CE DOF	Overall responsibility for Prudential Borrowing Limit. 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.
5	DOF	Annual accounts and reports.

SECTION 4 – SCHEME OF DELEGATION IMPLIED BY STANDING FINANCIAL INSTRUCTIONS

SCHEME OF DELEGATION IMPLIED BY STANDING FINANCIAL INSTRUCTIONS

SFI REF	DELEGATED TO	DUTIES DELEGATED
6	DoF	Banking arrangements.
7	DoF	Income systems.
8	CE	Negotiating contracts for provision of patient services.
	DoF	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.
12	CE	Capital investment programme
12.3	CE	Maintenance of asset registers.

SECTION 4 – SCHEME OF DELEGATION IMPLIED BY STANDING FINANCIAL INSTRUCTIONS

SCHEME OF DELEGATION IMPLIED BY STANDING FINANCIAL INSTRUCTIONS

SFI REF	DELEGATED TO	DUTIES DELEGATED
12.3.8	DoF	Calculate and pay capital charges in accordance with NHS Improvement requirements.
12.4.1	CE	Overall responsibility for fixed assets.
12.4.4	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 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

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 given. Delegation and authorisation to lower levels is only permitted with written approval of the Chief Executive who will, before authorising, 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, 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 Divisional 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	Divisional 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 £250,000 per request	Executive Director	
b) Up to £500,000 per request	DOF	
c) Over £500,000 per request	Executive Committee	
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	Capital Investment 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: a) Requisitions to £2,000 b) Requisitions to £25,000 c) Requisitions to £50,000 d) Requisitions to £100,000 e) Requisitions to £250,000 f) 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 Authorisation of call off contracts for goods and services covered by a pre-tendered Framework a) Contracts up to £250,000	 Authorised Signatory for Budget Head of Dept. General Manager or Divisional Director Executive Director Chief Operating Officer CE and DOF CE and DOF, after approval by the Board Senior Officers (Estates, Procurement, Pharmacy) DoF DoF or CE DoF or CE, after approval by the Board Senior Officers (Estates, Procurement,	SFIs Section 10 & SOs Section 11 & Annex

Delegated Matter	Authority Delegated To	Reference Document
b) Contracts over £250,000 to £1,000,000 c) Contracts over £1,000,000 to £2,000,000 d) Contracts over £2,000,000	Pharmacy) DoF DoF or CE DoF or CE, after approval by the board	
5. Capital Schemes		
Business Cases a) Production of case of need for every capital expenditure proposal	 DoF	SFIs Section 12 & 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 and part of agreed capital plan	Capital Investment Group	
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 b) Confirmation of capital funds available c) Approval of capital programme	 DoF DoF 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 ii) To 20% of original scheme budget, a maximum of £250,000 iii) Above £250,000 or 20% of original scheme budget	 DoF CE 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 Outside NHSI price caps	 Executive Director DoPOD, MD and DoF General Manager or Divisional Director General Manager General / Department Manager or Divisional /Executive Director Executive Director	SFIs Section 9
8. Expenditure on Charitable and Endowment Funds Up to £50,000 per request Over £50,000 per request	 DoF or CE 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	CE or Nominated Director and DoF	
e) Compensation payments made under legal obligation	CE or Nominated Director and DoF	
f) Extra Contractual payments to contractors		
Up to £50,000	CE or Nominated Director and DoF	
<u>Ex-Gratia Payments</u>		
g) Patients and staff for loss of personal effects		
Up to £50,000	CE or Nominated Director and DoF	
h) For clinical negligence up to £1,000,000 (negotiated settlements)		
i) Negotiate settlement up to £50,000	MD	
ii) £50,000 to £100,000	CE	
i) over £100,000	Board of Directors	
iv) Authorise payment (up to £1,000,000)	CE or Nominated Director and DoF	
i) For personal injury claims involving negligence where legal advice has been obtained and guidance applied		
i) Negotiate settlement up to £25,000	DoPOD	
ii) £25,000 to £100,000	CE	
iii) over £100,000	Board of Directors	
iv) Authorise payment (up to £1,000,000)	CE or Nominated Director and DoF	
j) Other, except cases of maladministration where there was no financial loss by claimant		
£50,000	CE or Nominated Director and DoF	
Losses, Write-Off & Compensation above delegated limits	Finance & Performance Committee	
<u>12. Reporting of Incidents to the Police</u>		SFIs Sections 2 & 14
a) Where a criminal offence is suspected (other than theft or fraud)	Director with managerial responsibility for the area	
b) Where a theft is involved	DoF or DoPOD	
c) Where a fraud is involved	DoF	
<u>13. Petty Cash Disbursements (not applicable to central Cashiers Office)</u>		SFIs Section 10
a) Expenditure up to £25 per item	Petty Cash Holder	
<u>14. Receiving Hospitality</u>		
Applies to both individual and collective items of hospitality received **or offered and declined**, in excess of £50.00.	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 Divisional 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)	Divisional 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 Divisional 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 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 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 Divisional Director COO with General Manager or Divisional Director COO with General Manager or Divisional Director COO with General Manager or Divisional Director Bed Manager with advice from COO & DoNM&AHP CE with advice from COO & 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	CE	
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, including GDPR	CE	
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. 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
47. Intellectual Property The disposal of intellectual property rights	Executive Committee	

6. ROLES AND RESPONSIBILITIES OF GOVERNORS

The Constitution states that at general meetings, the Council 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.8	CE/Finance	Jon Sargeant /Matthew Bancroft	Existing Policy	March 2019

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: March 2020

Checked by: Jon Sargeant/ Matthew Bancroft Date: March 2019

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Title	**Financial Performance – Month 11 - February 2019**		
Report to	**Trust Board**	**Date**	**22nd March 2019**
Author	**Jon Sargeant - Director of Finance**		
Purpose			Tick one as appropriate
	Decision		
	Assurance		
	Information		X

Executive summary containing key messages and issues

The Trust's deficit for month 11 (February 2019) was £224k, which is a favourable variance against plan of £855k before PSF. This is a favourable variance against forecast of £644k in month. The cumulative position to the end of month 11 is an £21.7m deficit before PSF, which is £1,455k favourable to plan (£2,334k adverse to plan including PSF) and £1,452k favourable to forecast.

The Trust now expects to deliver its control total at year end. This is a result of; the improved position against forecast and plan (especially in income), following final discussions with DCCG who are funding any undelivered CQUINs monies and delivery of the waiting list recovery plan, the funding agreed from the ICS and reduced spend on agency in February by more than forecast.

The Trust's key remaining risk is the delivery of the WL recovery plan, which attracts incentive payments of c.£2.4m, which is yet to be included in the Trust's position. The risk relating to the change in asset life's resulting from the change in RICS standards (£1.2m), as reported to the Committee in M10 has been initially agreed with our external auditors that it will not affect the current year's financial position (and therefore not assumed within the position). This is however a risk to the 2019/20 financial plan which was noted but not included in the draft 19/20 plan submission to NHSi. The YTD position does not include the prior period adjustment for depreciation, which will be accounted for in M12.

Key questions posed by the report

Is the Trust Board assured by actions taken to bring the financial position back in line with plan?

How this report contributes to the delivery of the strategic objectives
This report relates to strategic aims 2 and 4 and the following areas as identified in the Trust's BAF and CRR. • F&P 1 - Failure to achieve compliance with financial performance and achieve financial plan and subsequent cash implications • F&P 3 - Failure to deliver Cost Improvement Plans in this financial year • F&P 19 - Failure to achieve income targets arising from issues with activity • F&P 13 - Inability to meet Trust's needs for capital investment
How this report impacts on current risks or highlights new risks
Update on risk relating to delivery of 2018/19 financial plan.
Recommendation(s) and next steps
The Board is asked to note: • The Trust's deficit for month 11 (February 2019) was £224k, which is a favourable variance against plan of £855k before PSF. This is a favourable variance against forecast of £644k in month. The cumulative position to the end of month 11 is an £21.7m deficit before PSF, which is £1,455k favourable to plan (£2,334k adverse to plan including PSF) and £1,452k favourable to forecast. • The achievement with regards to the Cost Improvement Programme. • The improved financial position and that the Trust is forecasting to deliver its control total at year end subject to delivery of the WL position. • The risks set out in this paper.

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

FINANCIAL PERFORMANCE

P11 February 2019

DONCASTER AND BASSETLAW TEACHING HOSPITALS NHS FOUNDATION TRUST

P11 February 2019

1. Income and Expenditure vs. Plan

Performance Indicator	Monthly Performance			YTD Performance			Annual
	Actual £'000	Variance to budget £'000	Variance to Forecast £'000	Actual £'000	Variance to budget £'000	Variance to Forecast £'000	Plan £'000
I&E Perf Exc Impairments	247	(855) F	(644) F	21,962	(1,480) F	(1,457) F	23,138
Income	(33,172)	(2,725) F	272 A	(349,585)	(5,735) F	705 A	(375,782)
Donated Asset Income	(23)	1 A	1 A	(236)	25 A	5 A	(285)
Operating Expenditure	32,281	1,867 A	(824) F	359,163	4,350 A	(1,880) F	385,304
Pay	21,846	(8) F	(399) F	241,610	3,547 A	(906) F	259,855
Non Pay & Reserves	10,435	1,875 A	(425) F	117,554	803 A	(974) F	125,449
Financing costs	1,138	2 A	(93) F	12,385	(95) F	(283) F	
I&E Performancee excluding PSF	**224**	**(855) F**	**(644) F**	**21,727**	**(1,455) F**	**(1,452) F**	**22,853**
PSF (previously STF)	0	1,894 A	0 A	(10,555)	3,788 A	0 A	(16,238)
I&E Performance including PSF	**224**	**1,040 A**	**(644) F**	**11,171**	**2,334 A**	**(1,451) F**	**6,615**

F = Favourable A = Adverse

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

2. CIPs

Performance Indicator	Monthly Performance			YTD Performance			Annual
	Actual £'000	Variance to budget £'000	Variance to Forecast £'000	Actual £'000	Variance to budget £'000	Variance to Forecast £'000	Plan £'000
Employee Expenses	143	451 A	137 A	2,325	1,921 A	(39) F	4841
Drugs	0	58 A	58 A	591	50 A	73 A	700
Clinical Supplies	67	5 A	35 A	426	97 A	328 A	584
Non Clinical Supplies	0	0 A	0 A	0	0 A	0 A	0
Non Pay Operating Expenses	91	2,198 A	1,031 A	2,592	4,907 A	1,844 A	9787
Income	922	(699) F	(735) F	5,033	(3,350) F	(3,370) F	1913
Total	**1,222**	**2,013 A**	**527 A**	10,967	**3,625 A**	**(1,164) F**	**17,825**

3. Statement of Financial Position

All figures £m	Opening Balance	Current Balance	Movement in year
Non Current Assets	**209,108**	**205,973**	**3,135**
Current Assets	49,291	50,054	-763
Current Liabilities	-54,834	-54,705	-129
Non Current liabilities	-81,105	-87,720	6,615
Total Assets Employed	**122,460**	**113,602**	**8,858**
Total Tax Payers Equity	**-122,460**	**-113,602**	**-8,858**

4. Other

Performance Indicator	Monthly Performance		YTD Performance		Annual
	Plan £'000	Actual £'000	Plan £'000	Actual £'000	Plan £'000
Cash Balance	2,654	12,611	2,654	12,611	1,900
Capital Expenditure	1,550	1,406	12,406	5,724	13,911

5. Workforce

	Funded WTE	Actual WTE	Bank WTE	Agency WTE	Total in Post WTE
Current Month	5922.46	5564.90	220.37	107.11	5892.38
Previous Month	5909.86	5531.26	218.67	93.57	5843.50
Movement	-12.60	-33.64	-1.70	-13.54	-48.88

Key

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

**Note WTE movements in table above are currently being reviewed*

1. Executive Summary

The Trust's deficit for month 11 (February 2019) was £224k, which is a favourable variance against plan of £855k before PSF. This is a favourable variance against forecast of £644k in month. The cumulative position to the end of month 11 is an £21.7m deficit before PSF, which is £1,455k favourable to plan (£2,334k adverse to plan including PSF) and £1,452k favourable to forecast.

The Trust now expects to deliver its control total at year end. This is a result of; the improved position against forecast and plan (especially in income), following final discussions with DCCG who are funding any undelivered CQUINs monies and delivery of the waiting list recovery plan, the funding agreed from the ICS and reduced spend on agency in February by more than forecast.

The Trust's key remaining risk is the delivery of the WL recovery plan, which attracts incentive payments of c.£2.4m, which is yet to be included in the Trust's position. The risk relating to the change in asset life's resulting from the change in RICS standards (£1.2m), as reported to the Board in M10 has been initially agreed with our external auditors that it will not affect the current year's financial position (and therefore not assumed within the position). This is however a risk to the 2019/20 financial plan which was noted but not included in the draft 19/20 plan submission to NHSi. The YTD position does not include the prior period adjustment for depreciation, which will be accounted for in M12.

The YTD income position at the end of month 11 is (£5,735k) favourable to plan (excluding the impact of the PSF adjustment). The in-month income position was £2,724k favourable to plan (excluding the PSF adjustment) and £272k adverse to forecast (£705k adverse to forecast YTD). In Month 11 the income position now includes c.£3.4m of additional non-recurrent funding from Doncaster CCG, which represents 11 months of the additional £3.7m funding agreed with CCGs. Within the clinical income position a risk of c£0.5m has been provided for which relates to the high level of un-coded income at Month 11. The YTD position does not include the additional non-recurrent funding from Doncaster CCG and Bassetlaw CCG for delivery of waiting lists (£2.4m) (however this is expected to be accounted for in M12), but does include c.£1.8m of ICS funding. PSF funding has not been included for Q4 at this point as formally the Trust is still forecasting a £3.7m gap to the control total (as per previous months) in the NHSi monthly returns, as this is updated on a quarterly basis. The Trust is expecting to receive its full PSF relating to financial performance for Q4 on delivery of the control total. The at risk element is with regards to A&E performance in March (£1.7m).

Doncaster CCG has a favorable YTD variance against the Trust's plan of £707k (favorable variance against contract of £2,980k) and Bassetlaw CCG has a favorable income variance of (£2,307k) against the Trust's plan (£2,733k favorable against contract), both excluding the impact of Non PbR drugs.

Non NHS Clinical Income and Other Income is (£391k) ahead of plan in month 11 and (£3,031k) YTD, against forecast there is an in month over-performance of (£100k).

Income Group	Annual Budget	In Month Budget	In Month Actual	In Month Variance		YTD Budget	YTD Actual	YTD Variance	
Commissioner Income	-312,485	-25,245	-27,886	-2,641	F	-285,801	-291,327	-5,526	F
Drugs	-24,136	-1,936	-1,628	308	A	-22,166	-19,344	2,822	A
STF	-16,238	-1,894	0	1,894	A	-14,344	-10,555	3,788	A
Trading Income	-39,161	-3,267	-3,658	-391	F	-35,884	-38,915	-3,031	F
Grand Total	**-392,020**	**-32,342**	**-33,172**	**-830**	**F**	**-358,194**	**-360,141**	**-1,947**	**F**

Income Group	In Month Actual	In Month Forecast	In Month Variance		YTD Actual	YTD Forecast	YTD Variance	
Commissioner Income	-27,886	-28,081	195	A	-291,327	-292,221	894	A
Drugs	-1,628	-1,804	176	A	-19,344	-19,848	504	A
STF	0	0	0	F	-10,555	-10,555	0	F
Trading Income	-3,658	-3,559	-99	F	-38,915	-38,221	-694	F
Grand Total	**-33,172**	**-33,444**	**272**	**A**	**-360,141**	**-360,846**	**705**	**A**

In month the expenditure position was £823k favourable to forecast, of which pay was £399k favourable to forecast and non-pay £319k favourable to forecast. The YTD expenditure position at the end of Month 11 is £4.3m adverse to plan, £1.9m favourable to forecast (with pay £906k favourable to forecast and non-pay £895k favourable to forecast). Non-PbR drugs were significantly lower than planned levels (c.£2.7m which is offset by underperformance on income).

Subjective Code	In Month Budget	In Month Actual	In Month Variance		In Month Forecast	In Month Variance to forecast		YTD Budget	YTD Actual	YTD Variance		YTD Forecast	YTD Variance to forecast		Annual Budget	Forecast
1. Pay	21,854	21,846	-8	F	22,245	-399	F	238,062	241,610	3,547	A	242,867	-906	F	259,855	259,654
2. Non-Pay	10,000	10,267	266	A	10,585	-319	F	113,864	116,790	2,925	A	115,694	-895	F	123,825	122,157
3. Reserves	-1,441	168	1,609	A	273	-105	F	2,887	764	-2,123	F	735	-79	F	1,624	2,073
Total Expenditure Position	**30,414**	**32,281**	**1,867**	**A**	**33,104**	**-823**	**F**	**354,813**	**359,163**	**4,350**	**A**	**359,296**	**-1,880**	**F**	**385,304**	**383,884**

Capital expenditure YTD is £5,724k against the YTD plan of £12,406k, £6,682k behind plan (£3,206k behind plan excluding CT/HASU). YTD actuals against the revised plan are £6,981k behind plan (£3,505k behind plan excluding CT/HASU). The main reason for the slippage relates to estate schemes being behind plan by including; Fire Enforcement, Electrical Infrastructure, Other Minor Estates Work and Medical Equipment (including Medical Imaging). Department leads for each area have provided assurance they will deliver the capital programme in full by year end.

The cash balance at the end of February was £12.6m against a plan of £2.7m. The main movements include; the receipt of 18/19 Q4 PSF funds (£2m more than anticipated), delayed capital expenditure (£2.8m), although this is more than offset by PDC Dividend not received (£4.1m) and additional income from local CCG's. In month, the cash position has increased by £4.8m, mainly due to the additional income from local CCG's. The increased capital expenditure in February has generally not impacted cash, although this will impact the cash position in March. The full amount of available loans have been drawn down and further loan support will not be needed for the rest of 2018/19.

In January 2019, CIP savings of £1,222k (last month £3,237k) are reported, against a forecast of £1,749k, therefore an under achievement of £527k in month. The month on month decrease is mainly due to successful negotiations with Doncaster CCG regarding non-recurrent funding for block contracts last month.

2. Conclusion

The Trust now expects to deliver its control total at year end. This is a result of; the improved position against forecast and plan (especially in income), following final discussions with DCCG who are funding any undelivered CQUINs monies and delivery of the waiting list recovery plan, the funding agreed from the ICS and reduced spend on agency in February by more than plan.

The Trust's key remaining risk is the delivery of the WL recovery plan, which attracts incentive payments of c.£2.4m. The risk relating to the change in asset life's resulting from the change in RICS standards (£1.2m), as reported to the Board in M10 has been initially agreed with our external auditors that it will not affect the current year's financial

position (and therefore not assumed within the position). This is however a risk to the 2019/20 financial plan which was noted but not included in the draft submission to NHSi. The YTD position does not include the prior period adjustment depreciation, which will be accounted for in M12.

PSF funding has not been included for Q4 at this point as formally the Trust is still forecasting a £3.7m gap to the control total (as per previous months) in the NHSi monthly returns, as this is updated on a quarterly basis. The Trust is expecting to receive its full PSF relating to financial performance for Q4 on delivery of the control total. The at risk element is with regards to A&E performance in March (£1.7m).

The Board is asked to note the improved financial position and that the Trust is forecasting to deliver its control total at year end.

3. Recommendations

The Board is asked to note:

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

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Title	Terms and conditions update		
Report to	Board of Directors	**Date**	March 2019
Author	Karen Barnard, Director of People & OD		
Purpose			Tick one as appropriate
	Decision		
	Assurance		✔
	Information		✔

Executive summary containing key messages and issues

This paper provides an update to the Board on the Agenda for Change pay deal which was introduced in 2018. These changes can be categorised under the below headings;

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

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

The next increase in salaries apply from 1 April 2019; each member of staff is on a personal pay journey which is detailed within Appendix 1; due to the complexity of the arrangements briefing materials will be made available to staff and managers.

In order to progress the transition of staff from Band 1 to Band 2 current Band 1 job descriptions are being revised if there is no existing Band 2 job description for staff to move into. This is a voluntary transition for staff but it is anticipated that the majority of staff will choose to transition with support if required.

Any new members of staff (or staff being promoted) from 1 April 2019 will be subject to a new pay progression approach – due to the timing of pay steps in the future no member of staff will reach their pay step point until April 2020.

The pay deal also detailed a number of areas of terms and conditions which would be reviewed – details around enhancements, shared parental leave and child bereavement leave are anticipated shortly. Trust policies will be amended accordingly.

The final update is around the uplift to employers contributions to both the NHS pension scheme and NEST.

Key questions posed by the report

Does this report provide the Board with sufficient detail around the enactment of the three year pay deal.

How this report contributes to the delivery of the strategic objectives
People – As a Teaching Hospital we are committed to continuously developing the skills, innovation and leadership of our staff to provide high quality, efficient and effective care. This paper provides an update of how the NHS pay, terms and conditions have been uplifted to ensure the NHS is seen as an attractive employer.
How this report impacts on current risks or highlights new risks
Staff morale – the changes in the Agenda for Change pay and terms and conditions has sought to improve staff satisfaction with their pay. Within the NHS staff survey DBTH saw an improvement in this question.
Recommendation(s) and next steps
The Board of Directors is asked to note this report.

Terms and conditions update

Background information

The NHS Staff Council reached agreement on a refresh of the NHS Terms and Conditions of Service (Agenda for Change), and following a consultation exercise, trade union members voted to accept the proposed changes. These changes were ratified in June 2018.

These changes can be categorised under the below headings:

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

This paper provides an update on these important issues that impact on all of our employees contracted under Agenda for Change. (NB Doctors and Dentists are not contracted under Agenda for Change).

Three year pay deal

The 3 year pay deal is from 2018 to 2021. This includes reform of the pay structure which:

- increased starting salaries
- reduces the number of pay points; and
- shortens the amount of time it takes to reach the top of the pay band for most staff.

Existing pay bands were restructured and the number of pay points will be reduced to 2 points for bands 2, 3, 4, 8a, 8b, 8c, 8d and 9 and 3 points for band 5, 6 and 7. Restructuring will be completed by 1 April 2021. Consequently, the pay structure will look significantly different (see appendix).

As we transition to the new pay structure, each employee is on their own individual pay journey, for example some staff will not receive an annual increment due to a suitable pay increase in April of each year up to 2021. All staff are able to track their own pay progression from 1 April 2018 to 31 March 2021 through using the Pay Journey tool by following the below link;

https://www.nhsemployers.org/your-workforce/2018-contract-refresh/pay-journey-tool

The new pay structure will enable staff in bands 2 to 7 to access the top of the pay band more quickly than in the current system.

Band	Current system	New system
Band 1	1 year	N/A
Band 2 - 3	6 years	2 years
Band 4	6 years	3 years
Band 5	7 years	4 years
Band 6 - 7	8 years	5 years
Band 8a - 9	5 years	5 years

The value of the top points of each pay band will be increased by 6.5 per cent cumulatively over the three-year period for bands 2 - 8c. The value of the top pay points in bands 8d and 9 will be capped at the level of the increase in value at the top of band 8c. The value of the top pay points for bands 2 - 8c will increase each year as follows:

- 3 per cent in 2018/19
- 1.7 per cent in 2019/20
- 1.67 per cent in 2020/21.

In April 2019 only, a non-consolidated cash lump sum will be made available to deliver an additional 1.1 per cent to the staff employed on the top points in bands 2 – 8c (this also includes band 1 staff). For the staff employed on the top pay points in bands 2 – 8c on 31 March 2019 the total in year cash value of the award on basic pay and the additional cash sum in 2019/20 will be 2.8 per cent. For band 8d and 9 the cash lump sum will be capped at the value given to band 8c. This is not straightforward and therefore communication materials and events aimed at all Agenda for Change contracted staff will be issued to explain the changes.

Band 1 to band 2 transition

Under this pay deal the band 1 salary became the same as the minimum of band 2 with the intention that Band 1 would be removed by 2021 unless individuals wished to remain in a Band 1 role. As at 2 January 2019, DBTH employed a total of 639 band 1 staff which equates to 390.46 wte. There is a total of 18 band 1 job titles in existence across DBTH. Some of these are duplicate roles.

Band 1 closed to new starters effective 1 December 2018. Recruitment to any vacancies previously at band 1 has been taking place using draft band 2 job descriptions. All applicants have been informed that the job description may be slightly amended in the future.

All existing band 1 staff have the option to transition to a band 2 post effective 1 April 2019 – this approach has been agreed at national level to ensure that no member of staff feels disadvantaged by the timing of these changes. Work is currently ongoing to either draft band 2 job descriptions and have them matched, or identify suitable current band 2 job descriptions which are already in place within teams. Managers are engaging with staff and staff side regards this. These job descriptions will then be offered to existing band 1 staff to enable them to make their decision. DBTH is committed to upskill existing band 1 staff who accept a band 2 job description. This upskilling of staff is to be completed by 31 March 2021. Education Leads will provide support to achieve this. Individual discussions will take place with affected staff.

It is currently confirmed that the following posts will need to go through job evaluation;

- Housekeeper – Generic
- Mortuary Assistant – matching complete
- Operating Department Orderly
- Service Assistant DRI – 2 roles DRI/Montagu
- Service Assistant BDGH
- Laundry Assistant
- Post room Assistant
- Driver.

These posts will be submitted to matching panels throughout March.

A presentation has been developed in partnership with staff side colleagues and managers. The presentation is being delivered to band 1 staff during staff engagement sessions. The purpose is to explain the process, implications and enable staff to ask questions. Staff engagement sessions commenced w/c 25th February 2019 and continued until 11 March 2019. Sessions were arranged for all 3 sites, including weekends and evenings. Local arrangements are being made for any staff wanting 1-2-1 meetings with managers to discuss their personal circumstances before making their choice.

The choice exercise for staff, lasting one month, will commence once job matching is complete. A 'Choice letter' is being drafted for divisions to send out to band 1 staff. It is anticipated that DBTH will be aware of all band 1 staff decision before 30 April 2019. This will enable changes to be made on ESR during May 2019 payroll, backdated to 1 April 2019. The transition from band 1 to band 2 is not processed as a promotion and therefore is no pay increase for staff. Increment dates will change to 1 April. Staff will reach the top of band 2 in two years' time. Staff who choose to stay a band 1 will be asked during each appraisal if they would like to transition to a band 2. These staff are able to ask to transition to band 2 at any point and the effective date of the change agreed at that point. This will need to be taken into account in future budget setting. Clarification is required on protection arrangements for unsocial hour's payments and a query has been logged with NHS Employers.

Pay progression

Pay progression will no longer be automatic. It will only occur when a staff member reaches a pay step point on their pay band. A visual demonstration of this is provided in the appendix. Pay progression will be linked to performance, measured during an appraisal. The new pay progression system applies to all new starters and staff who are promoted on or after 1 April 2019. It will apply to all other staff from 1 April 2021. Staff will progress to their next pay-step point in their pay band where the following can be demonstrated:

- The appraisal process has been completed with outcomes in line with the organisation's standards and no formal capability process is in place
- There is no formal disciplinary action live on the staff member's record (this excludes sickness absence management).
- Statutory and/or mandatory training has been completed.
- For line managers only - must have completed appraisals for all their staff.
- Any local standards, as agreed through local partnership working.

Discussions will take place during 2019 with staff side to determine the local standards to be applied; it is anticipated that values based appraisals will form part of those discussions.

Staff transitioning from band 1 to band 2 will not be classed as being promoted and therefore will be unaffected until 1 April 2021. It should be noted that this is the date when all staff transitioning to band 2 effective 1 April 2019 are eligible to move to the top of band 2 and therefore a pay step point. We are seeking clarification from NHS Employers to identify if this new system will apply for these staff.

No staff member should be eligible for a pay step review appraisal until 1 April 2020. Work is being undertaken to re-write relevant policies, design new processes and systems and to communicate the changes across DBTH.

Changes to NHS Terms and Conditions

The NHS Terms and Conditions of Service handbook was republished on 1 July 2018 to reflect the changes agreed by the NHS Staff Council. Changes include;

- Enhancements – changes to percentages payable
- Enhanced shared parental leave
- Child bereavement leave
- Annual leave – buying more, selling back.

The NHS Staff Council met on 20 March 2019; therefore an update should be available at the Board of Directors meeting.

Enhancements

The table below shows the changes to enhancements which will be implemented throughout the three year deal. Band 1 staff who choose to transition to band 2 will have their unsocial hour's enhancements rates protected on a marked time basis.

Application of the new enhancements will be applied as normal through ESR.

Unsocial hours enhancement rates – 2018/19 to 2020/21

	2018/19	2019/20	2020/21
Band 1 All time on Saturday (midnight to midnight) and any week day after 8 pm and before 6 am	Time plus 49%	Time plus 48%	Time plus 47%
Band 1 All time on Sundays and Public Holidays (midnight to midnight	Time plus 97%	Time plus 95%	Time plus 94%
Band 2 All time on Saturday (midnight to midnight) and any week day after 8 pm and before 6 am	Time plus 43%	Time plus 42%	Time plus 41%
Band 2 All time on Sundays and Public Holidays (midnight to midnight	Time plus 85%	Time plus 84%	Time plus 83%
Band 3 All time on Saturday (midnight to midnight) and any week day after 8 pm and before 6 am	Time plus 36%	Time plus 35%	Time plus 35%
Band 3 All time on Sundays and Public Holidays (midnight to midnight)	Time plus 72%	Time plus 70%	Time plus 69%

Shared parental leave

Shared parental leave is currently available in the NHS but unlike maternity and adoption pay, shared parental pay is paid at statutory levels. Pending endorsement from the NHS Staff Council, from 1 April 2019 shared parental pay will be enhanced to the same levels as occupational maternity/adoption pay. Therefore, this change may encourage take-up of this entitlement. Eligibility for this enhanced level of pay will mirror current eligibility requirements for occupational maternity/adoption pay. Doctors and dentists in training have a dynamic link to section 15 of the handbook so will be eligible as well as Agenda for Change staff. The Parental Leave Policy CORP/EMP 15 will be updated once we have further details and staff will be communicated with about this change.

Child bereavement leave
It is anticipated that effective from 1 April 2019, a new provision will be available to all staff who suffer a child bereavement. The NHS will be an early implementer of the Parental Bereavement (Leave and Pay) Act 2018 but, through the NHS Staff Council, a number of the statutory elements have been enhanced. Special Leave Policy CORP/EMP 47 will be updated once we have further details.

Buying and selling annual leave, annual leave and time off in lieu (TOIL) access, and bank and agency framework
The NHS Staff Council sub group will be exploring a national framework for buying and selling annual leave. This work is expected to be complete by 31 March 2019**.** DBTH will continue with normal arrangements for Purchase of Annual Leave during 2019. We have received 95 applications, an increase from 34 applications during 2018, with an estimated saving of almost £60,000 assuming all of the staff approve the monthly deductions. The work to examine annual leave and TOIL access, and the bank and agency framework, will be undertaken once the buying and selling of annual leave work has been concluded.

Update on pension arrangements

Following a recent consultation exercise the Department of Health and Social Care (DHSC) it has been confirmed that there will be an increase to the Employers Pension Contributions from 14.38% to 20.68%. The DHSC have confirmed that only 14.3% from the employer plus the 0.08% for the administration levy will be collected via the payroll. Central payment will be made by NHS England and the Department of Health and Social Care for the respective proportions of the outstanding 6.3% for the financial year 2019/20. Further commitment was given by the government in June 2018 that the additional funding will recur annually until 31 March 2023

Other key points to note from the consultation response:

- member contributions will remain unchanged until 2021
- entitlements to survivor's pensions will be equalised for civil partners and same sex spouses
- Agenda for Change pay rises will be excluded from the final pay control regulations and there will be a wider review of the policy.

Employer contributions and administration levy
The employer contribution rate for the period 1 April 2019 to 31 March 2023 is 20.6 per cent of pensionable pay for both the 1995-2008 Scheme and the 2015 Scheme.

The employer contribution rate is set through a process known as the scheme valuation. A scheme valuation is carried out every four years and it measures the full cost of paying pension benefits (to current pensioners). The most recent 2016 scheme valuation identified the need to increase the employer contribution from 14.3 per cent to 20.6 per cent from 1 April 2019. The final valuation results will be published shortly.

Employers are required to pay a scheme administration levy in addition to the employer contribution rate, to cover the cost of the scheme administration. This levy is 0.8 per cent of pensionable pay and will be collected at the same time and in the same way as normal employer contributions. In practical terms, this means employers will pay 20.68 per cent of pensionable pay

Member contributions

Tier	Pensionable Pay (whole-time equivalent)	Contribution Rate from 2015/16 to 2021/22
1	Up to £15,431.99	5.0 per cent
2	£15,432.00 to £21,477.99	5.6 per cent
3	£21,478.00 to £26,823.99	7.1per cent
4	£26,824.00 to £47,845.99	9.3 per cent
5	£47,846.00 to £70,630.99	12.5 per cent
6	£70,631.00 to £111,376.99	13.5 per cent
7	£111,377.00 and over	14.5 per cent

Tax arrangements

NHS Pension Scheme members will receive tax relief on their pension contributions up to a certain amount. This is because contributions are taken from pay before tax is taken off, therefore contributions reduce the amount of pay subject to tax. The tax relief available for pension savings is subject to certain limits known as the annual and lifetime allowances, these are restrictions put in place by HMRC.

NEST pension scheme

From February 2018 all staff have been required to have access to a pension scheme known as auto enrolment (various staging dates were in place between 2012 and 2018). Whilst on the whole staff working for the NHS have access to the NHS Pension scheme there are some members of staff who are ineligible for that scheme and therefore an alternative has to be available – NEST is the scheme which has been made available to those staff. With effect from 1 April 2019 the minimum contributions have increased to 8% from 5% with the employer paying 3% (up from 2%). In addition DBTH is required to undertake a further auto enrolment exercise this year.

Appendices

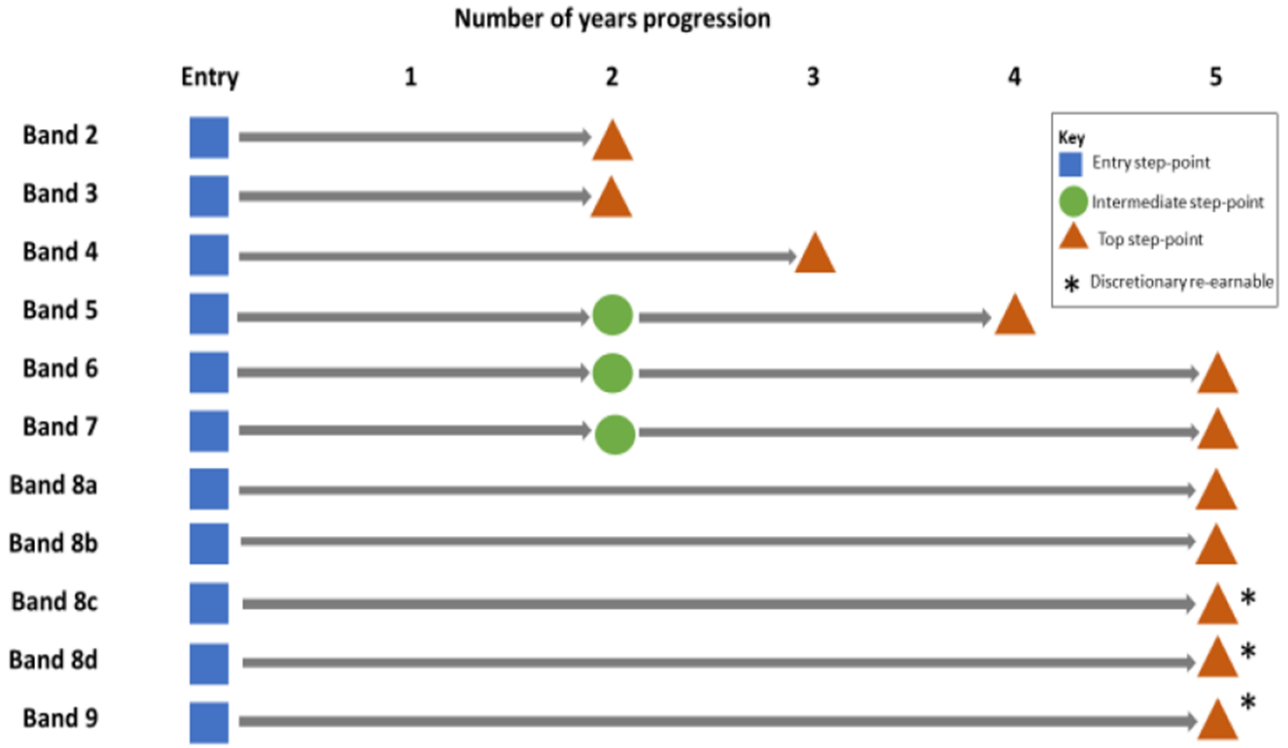
A - Pay structure 2017/18 – 2020/21
B - Pay step review points.

Appendix A – Pay structure 2017/18 – 2020/21

		Current	Year 1	Year 2	Year 3
Band	Years of experience	2017/18	2018/19	2019/20	2020/21
Band 1	1	£15,404	£17,460	£17,652	£18,005
TOP	2	£15,671	£17,460	£17,652	£18,005
Band 2	1	£15,404	£17,460	£17,652	£18,005
	2	£15,671	£17,460	£17,652	£18,005
	3	£16,104	£17,460	£17,652	£19,337
	4	£16,536	£17,460	£17,652	£19,337
	5	£16,968	£17,460	£17,652	£19,337
	6	£17,524	£17,787	£17,983	£19,337
TOP	7	£18,157	£18,702	£19,020	£19,337
Band 3	1	£16,968	£17,787	£18,813	£19,737
	2	£17,524	£17,787	£18,813	£19,737
	3	£18,157	£18,429	£18,813	£21,142
	4	£18,333	£18,608	£18,813	£21,142
	5	£18,839	£19,122	£19,332	£21,142
	6	£19,409	£19,700	£19,917	£21,142
TOP	7	£19,852	£20,448	£20,795	£21,142
Band 4	1	£19,409	£20,150	£21,089	£21,892
	2	£19,852	£20,150	£21,089	£21,892
	3	£20,551	£20,859	£21,089	£21,892
	4	£21,263	£21,582	£21,819	£24,157
	5	£21,909	£22,238	£22,482	£24,157
	6	£22,128	£22,460	£22,707	£24,157
TOP	7	£22,683	£23,363	£23,761	£24,157
Band 5	1	£22,128	£23,023	£24,214	£24,907
	2	£22,683	£23,023	£24,214	£24,907
	3	£23,597	£23,951	£24,214	£26,970
	4	£24,547	£24,915	£26,220	£26,970
	5	£25,551	£25,934	£26,220	£27,416
	6	£26,565	£26,963	£27,260	£27,416
	7	£27,635	£28,050	£28,358	£30,615
TOP	8	£28,746	£29,608	£30,112	£30,615
Band 6	1	£26,565	£28,050	£30,401	£31,365
	2	£27,635	£28,050	£30,401	£31,365
	3	£28,746	£29,177	£30,401	£33,176
	4	£29,626	£30,070	£32,525	£33,176
	5	£30,661	£31,121	£32,525	£33,176
	6	£31,696	£32,171	£32,525	£33,779
	7	£32,731	£33,222	£33,587	£33,779

	8	£33,895	£34,403	£34,782	£37,890
TOP	9	£35,577	£36,644	£37,267	£37,890
Band 7	1	£31,696	£33,222	£37,570	£38,890
	2	£32,731	£33,222	£37,570	£38,890
	3	£33,895	£34,403	£37,570	£40,894
	4	£35,577	£36,111	£37,570	£40,894
	5	£36,612	£37,161	£38,765	£40,894
	6	£37,777	£38,344	£38,765	£41,723
	7	£39,070	£39,656	£40,092	£41,723
	8	£40,428	£41,034	£41,486	£44,503
TOP	9	£41,787	£43,041	£43,772	£44,503
Band 8A	1	£40,428	£42,414	£44,606	£45,753
	2	£41,787	£42,414	£44,606	£45,753
	3	£43,469	£44,121	£44,606	£45,753
	4	£45,150	£45,827	£46,331	£45,753
	5	£47,092	£47,798	£48,324	£45,753
TOP	6	£48,514	£49,969	£50,819	£51,668
Band 8B	1	£47,092	£49,242	£52,306	£53,168
	2	£48,514	£49,242	£52,306	£53,168
	3	£50,972	£51,737	£52,306	£53,168
	4	£53,818	£54,625	£55,226	£53,168
	5	£56,665	£57,515	£58,148	£53,168
TOP	6	£58,217	£59,964	£60,983	£62,001
Band 8C	1	£56,665	£59,090	£61,777	£63,751
	2	£58,217	£59,090	£61,777	£63,751
	3	£60,202	£61,105	£61,777	£63,751
	4	£63,021	£63,966	£64,670	£63,751
	5	£67,247	£68,256	£69,007	£63,751
TOP	6	£69,168	£71,243	£72,597	£73,664
Band 8D	1	£67,247	£70,206	£73,936	£75,914
	2	£69,168	£70,206	£73,936	£75,914
	3	£72,051	£73,132	£73,936	£75,914
	4	£75,573	£76,707	£77,550	£75,914
	5	£79,415	£80,606	£81,493	£75,914
TOP	6	£83,258	£85,333	£86,687	£87,754
Band 9	1	£79,415	£84,507	£89,537	£91,004
	2	£83,258	£84,507	£89,537	£91,004
	3	£87,254	£88,563	£89,537	£91,004
	4	£91,442	£92,814	£93,835	£91,004
	5	£95,832	£97,269	£98,339	£91,004
TOP	6	£100,431	£102,506	£103,860	£104,927

Appendix B – Pay step review points



Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Title	**Business Intelligence Report**		
Report to	**Board of Directors**	**Date**	**26 March 2019**
Author	**David Purdue, Chief Operating Officer** **Sewa Singh, Medical Director** **Moira Hardy, Director of Nursing, Midwifery and AHPs** **Karen Barnard, Director of People and Organisational Development**		

Purpose		Tick one as appropriate
	Decision	
	Assurance	x
	Information	

Executive summary containing key messages and issues
This report highlights the key performance and quality targets required by the Trust to maintain NHSI compliance. The report focuses on the main performance area for NHSi compliance: Cancer 62 day classic, measured on average quarterly performance 4hr Access, measured on average quarterly performance 18 weeks measured on monthly performance against active waiters, performance measure on the worst performing month in the quarter. Diagnostics performance against key tests Infection control measures, C Diff and MRSA Bacteraemia. The report explains the proposals for changes to the 4hr standard measures and the rationale for change. DBHFT has not been identified as one of the first pilot sites. 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 CCG? Is the Trust providing a quality service for the patients? Are NEDs assured that the actions being undertaken to address underperformance and maintain current standards are robust and deliver the agreed improvements?
How this report contributes to the delivery of the strategic objectives
This report supports all elements of the strategic direction by identifying areas of good practice and areas where the Trust requires improvements to meet our expectations.
How this report impacts on current risks or highlights new risks
F&P6 - Failure to achieve compliance with performance and delivery aspects of the Single Oversight Framework, CQC and other regulatory standards F&P15 - Commissioner plans do not come to fruition and do not achieve the required levels of acute service reduction F&P5 - Failing to address the effects of the agency cap
Recommendation(s) and next steps
That the report be noted.

Executive Summary, Business Intelligence Report for Performance in December 2018, January 2019 and February 2019.

Cancer Performance

The following information relates to Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust performance in January 2019.
62 day performance is the key target for the SYB ICS, target 85%

62 day Cancer performance

January 62 day standard **85.4%**
The key issues remain problematic around complex pathways and shared breaches.
Urology; shared care issues with Sheffield impacting on timeliness of patient appointments. Additional capacity has been identified at STH, which should improve the position. Local performance was affected by issues with template biopsy equipment.

Two Week Wait Performance

January position **93.5%**

Improved position in January, predictor tool being used across all areas. 2 areas non-compliant, Head and Neck and Upper GI, affected by patient choice. Documentation being reviewed for patients at place.

4hr Access Target

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.

In **February** the Trust achieved a performance **91.01%** against the 4hr access standard of 95%.
Which was the 12th best nationally.
The trend for increasing attendances continued with an overall 6% increase
DRI saw an increase of 7.4%
BDGH saw an increase of 6.8%
1204 patients failed to be treated in 4hrs, which is 203 less than Feb 2017 with 808 more attendances
Wait to see ED doctor/ ED review accounted for 53% of the breaches.
Bed waits accounted for 22% of the breaches.
Unavoidable accounted for 16% of the breaches.

The weekly review meeting is addressing a number of issues to improve performance for factors outside of the Emergency Department. New streaming models are being piloted supported by DBTH Improvement Practice.

Additional Reporting for NHSI

18.3% of all of DRI discharges take place at a weekend and 15.4% at BDGH
If the rest of the week was at the same level as Mondays then we would see an extra 178 patients a week at DRI and an extra 108 patients at BDGH
A&E attendances on a Monday at DRI account for 15.6% of weekly activity rising to 15.9% at BDGH
Non Elective Admissions on a weekday that GP admissions account for is 20.2% of all Emergency Admissions on a weekday at DRI but only 7.7% at BDGH.
When we move into the weekend this drops to 10.9% at DRI and 2.2% at BDGH

Proposed Changes to the 4hr Access Target

Rationale for the proposed changes

- The standard does not measure total waiting times. The standard only reports performance during the first four hours and is therefore blind to the additional length of time patients spend in departments beyond this point.
- The standard does not differentiate between severity of condition. It also focuses on completion of treatment whereas, for life-threatening conditions, it is the timely commencement of treatment that is crucial.
- The current standard measures a single point in often very complex patient Pathways, this can lead to a false perception that delivery against the standard is the sole responsibility of those working within our emergency departments. Maintaining a singular focus on the four-hour target could penalise the very departments who are making the most progress towards Same Day Emergency Care
- There is strong evidence that hospital processes, rather than clinical judgement, are resulting in admissions or discharge in the immediate period before a patient breaches the standard.18% of all admissions via A&E departments occur between 3 hours 50 minutes and four hours
- The current target only directly improves the total waiting time for a minority of patients (10%), who are close to the four-hour breach time. For the remaining 90%, there is no incentive to reduce waiting times because they are already within four hours, or their wait is so long that even large reductions, i.e. from 16 hours to five, is not reflected in the target. This has led to criticism that the NHS is encouraged to 'treat the target rather than the patient'.
- Although described as simple, the standard is actually not well understood by the public.

Proposed New Measures

Measure	Clinical Rationale	Implications for Patient Care
Time to initial clinical assessment in A&E to "identify life-threatening conditions faster"	Focus on patient safety prioritisation and streaming to the most appropriate service, including liaison psychiatry and community mental health crisis services. This needs to be easily understandable for patients, and is regarded by the public as important	This will identify life-threatening conditions faster. It ensures timely clinical assessment to identify anybody who is in need of immediate treatment, and allows patients to be directed to the service and practitioner best able to meet their needs at an early stage in the patient's journey.
Time to emergency treatment for critically ill/injured patients (including heart attack, major trauma; sepsis, severe asthma and mental health presentation	Highest priority patients get high-quality care with specific time-to-treatments, with proven clinical benefit.	Complete a package of treatment in the first hour after arrival for life-threatening conditions such as: • stroke; • heart attack (MI-STEMI); • major trauma; • critically ill patients (including sepsis); • acute severe asthma; • mental health presentation
Mean waiting time for all patients and strengthened reporting of trolley waits;	Measure the mean waiting time for all patients. Strengthen rules on reporting prolonged trolley waits for admission, including reporting to the CQC.	Measures the time all patients are in A&E. Reduce risk of patient harm through long waits for admission or inappropriate admission. Reduce very long waits for those who need care.
A same-day emergency care target;	Incentivise avoidance of overnight admission and improve hospital flow.	Identifies a group of patients with urgent healthcare needs who would benefit from rapid assessment and review by a senior clinician. The aim is to complete all diagnostic tests, treatment and care that are required in a single day, in order to avoid an unnecessary overnight hospital stay. Reduction in overnight admissions and improved patient experience
Supporting Measure		
New call response standards for 111 and 999.	Assure a rapid response, and match patients (including mental health patients) to the service that best meets their needs.	Ensures that a patient's call is answered and assessed promptly when seeking help by telephone. Encourages patients to access out of hospital services, and to make use of telephone triage

Value of the Proposed Measures

Measure what's most important clinically, and to patients: the public are most concerned with time to be seen, and want to know that the sickest patients are prioritised. By measuring time to assessment, the standards will assure patients that they will be seen quickly; and much quicker than the four hours they often believe they will have to wait to be seen. Then, the standards will measure whether those with the most life-threatening conditions are beginning their treatment quickly.

Additionally, although patients themselves do not identify total time in department as a priority, there is strong clinical evidence that spending a long time in A&E has negative consequences, particularly when this leads to overcrowding. So measuring total time in department for all patients is clinically important.

Clear and straightforward to understand: people often misinterpret the current four-hour standard as the time taken to be seen. So, by actually measuring this – rather than assessing performance on the basis of time for care to be completed as we currently do – it will be clearer to patients, while assuring them that actual time to be seen is less than four hours.

Referral to Treatment (RTT)

The Referral to Treatment Target, for active waiters below 18 weeks is set at 92%. DBTH contract for 2018/19 expects the Trust to maintain the March position of 89.1% and the waiting list size to be lower than it was at the end of March 2018.

The Trust position was 87.5% in February, an improvement against last month

At the end of February, there were 42 patients less on the waiting list compared to the 31st of March.

The total number of Incomplete Pathways has increased by 411 between January and February, however the number of incomplete pathways over 18 weeks increased by 37 hence the performance has improved slightly due to the increase in the number of waiters under 18 weeks. The total number of Incomplete Pathways with a decision to admit for treatment has decreased by 14 between January and February. The number of new RTT periods in February was 986 fewer than in January but February was a short month. There were 1429 fewer Non Admitted and 116 fewer Admitted clock stops in February than in January but this February was a shorter month.

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

- Urology – increase of 47 over 18 weeks
- ENT – increase of 37 over 18 weeks
- Dermatology – increase of 34 over 18 weeks
- Cardiology – increase of 28 over 18 weeks
- Oral Surgery – increase of 18 over 18 weeks

Diagnostics

In February the Trust achieved 99.0% against the 6ww Diagnostic Performance standard of 99%.
The 99% target was missed in:

- Audiology – 97.9% - 6 breaches out of 288 waiters
- Nerve Conduction – 57.7% - 74 breaches out of 175 waiters
- Urodynamics – 81.1% - 10 breaches out of 53 waiters
- Cystoscopy – 98.8% - 2 breaches out of 162 waiters

Stroke

The Admission to SAU within 4 hours performance shows improvement at 74.0% (78.1% for NHS Doncaster patients, which is the highest since June 2018).

The number of NHS Bassetlaw patients' thrombolysed was above the 20% target for the first time since May 2018, although NHS Doncaster patients have yet to achieve 20% in any month.

The 95% target for patients leaving hospital with contact details of a named person achieved the 95% target across the board for the first time.

Scan within 1 hour was achieved at 70%

David Purdue COO, March 2019

At a Glance February 2019 (Month 11)

Doncaster & Bassetlaw Teaching Hospital NHS Foundation Trust

	Indicator	Standard	Current Month	Month Actual	Direction of travel compared to previous Month	NHS England Benchmarking: NHS England %	NHS England Benchmarking: DBTHFT	NHS England Benchmarking: Month	Peer Group Benchmarking: Peer Groups %	Peer Group Benchmarking: DBTHFT	Peer Group Benchmarking: Month
Monitor Compliance Framework	31 day wait for second or subsequent treatment: surgery	94.00%	January	100.00%	⇔	90.70%	100.00%	January	89.20%	100.00%	January
	31 day wait for second or subsequent treatment: anti cancer drug treatments	98.00%		100.00%		98.80%	100.00%		99.50%	100.00%	
	31 day wait for second or subsequent treatment: radiotherapy	94.00%		100.00%		95.60%	100.00%		Not Available	100.00%	
	62 day wait for first treatment from urgent GP referral to treatment	85.00%		85.40%	↗	76.20%	85.40%		75.20%	85.40%	
	62 day wait for first treatment from consultant screening service referral	90.00%		100.00%	↑	84.70%	100.00%		72.40%	100.00%	
	31 day wait for diagnosis to first treatment- all cancers	96.00%		98.80%	↘	95.40%	98.80%		94.40%	98.80%	
	Two week wait from referral to date first seen: all urgent cancer referrals (cancer suspected)	93.00%		93.50%	↘	91.70%	93.50%		94.00%	93.50%	
	Two week wait from referral to date first seen: symptomatic breast patients (cancer not initially suspected)	93.00%		90.20%	↘	82.80%	90.20%		82.40%	90.20%	
	A&E: Maximum waiting time of four hours from arrival / admission / transfer / discharge (Trust)	95.00%	February	91.00%	↗	84.20%	91.00%	February	81.92%	91.00%	February
	Maximum time of 18 weeks from point of referral to treatment- incomplete pathway	92.00%	February	87.50%	↗	86.70%	87.40%	January	84.18%	87.40%	January
	% of Patients waiting less than 6 weeks from referral for a diagnostics test	99.00%	February	99.01%	↘	96.40%	99.03%	January	94.10%	99.03%	January
Ambulance Handover Times	Ambulance Handovers Breaches -Number waited over 15 & Under 30 Minutes		January	836	↗	UCL: 796 & LCL: 659					
	Ambulance Handovers Breaches-Number waited over 30 & under 60 Minutes			37	↗	UCL: 122 & LCL: 56					
	Ambulance Handovers Breaches -Number waited over 60 Minutes			1	↗	UCL: 29 & LCL: 2					
Stroke	Proportion of patients scanned within 1 hour of clock start (Trust)	48.00%	December	70.00%	↗	SSNAP performance for December to March improved to A rating.					
	Proportion of patients directly admitted to a stroke unit within 4 hours of clock start (Trust)	90.00%		74.00%	↗						
	Percentage of eligible patients (according to the RCP guideline minimum threshold) given thrombolysis (Trust)	20.00%		14.00%	↑						
	Percentage of patients treated by a stroke skilled Early Supported Discharge team (Trust)	40.00%		81.00%	↗						
	Percentage of those patients who are discharged alive who are given a named person to contact after discharge (Trust)	95.00%		97.60%	↗						
	Implementation of Stroke Strategy - TIA Patients Assessed and Treated within 24 Hours	60.00%	February	54.80%	↑						
Theatres & Outpatients	Cancelled Operations	0.80%	February	1.18%	↗	No Benchmarking available					
	Cancelled Operations-28 Day Standard	0		1	↗						
	Out Patients: DNA Rate			9.04%	↗	8.20%	9.15%	October	6.89%	9.15%	October
	Out Patients: Hospital Cancellation Rate			5.99%	↘	No Benchmarking available - data not submitted to Secondary Uses Service by all Trusts					
Effective	Emergency Readmissions within 30 days (PbR Methodology)		January	6.52%	↘	7.41%	6.78%	September	8.08%	6.78%	September

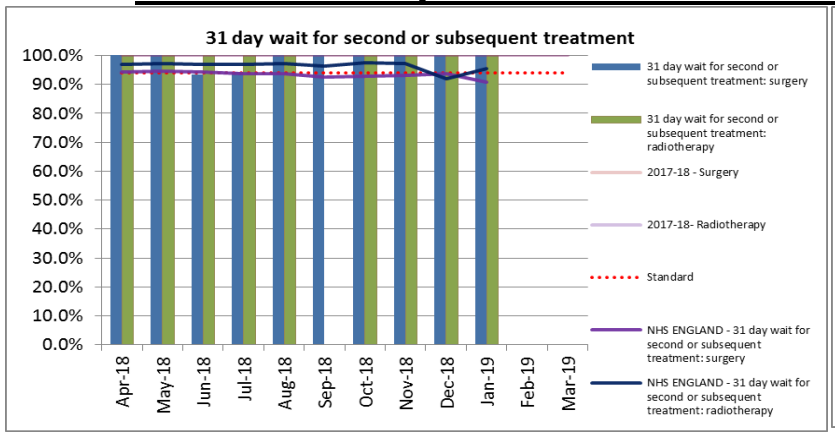
	Indicator	Current Month	Month Actual (TRUST)	Month Actual (DRI)	Month Actual (BDGH)	Data Quality RAG Rating
Fractured Neck of Femur	% of patients achieving Best Practice Tariff Criteria	Feb-19	47.50%	45.45%	57.14%	
	Best Practice Criteria					
	36 hours to surgery Performance	Feb-19	52.50%	51.52%	57.14%	
	72 hours to geriatrician assessment Performance		90.00%	87.88%	100.00%	
	% of patients who underwent a falls assessment		92.50%	90.91%	100.00%	
	% of patients receiving a bone protection medication assessment		92.50%	90.91%	100.00%	
	Mortality-Deaths within 30 days of procedure		7.50%	6.10%	12.50%	

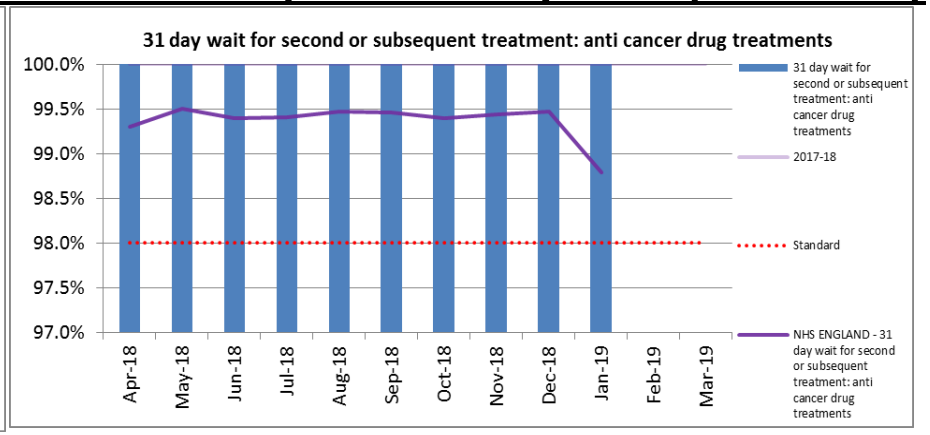
	Indicator	Standard (Local, National Or Monitor)		Current Month	Month Actual	Data Quality RAG Rating
Safe	Infection Control C.Diff	4 Per Month - 45 full year	M	Feb-19	0	
	Infection Control MRSA	0	L		0	
	HSMR (rolling 12 Months)	100	N	Dec-18	91.94	
	Never Events	0	L	Feb-19	0	
	VTE	95.0%	N	Dec-18	95.0%	
	Avoidable Pressure Ulcers Cat 3&4	21 Full Year	L	Feb-19	2	
	Falls that result in a serious Fracture	2 Per Month 23 full Year	L	Feb-19	0	
	Catheter UTI	Snap shot audit			0.48%	

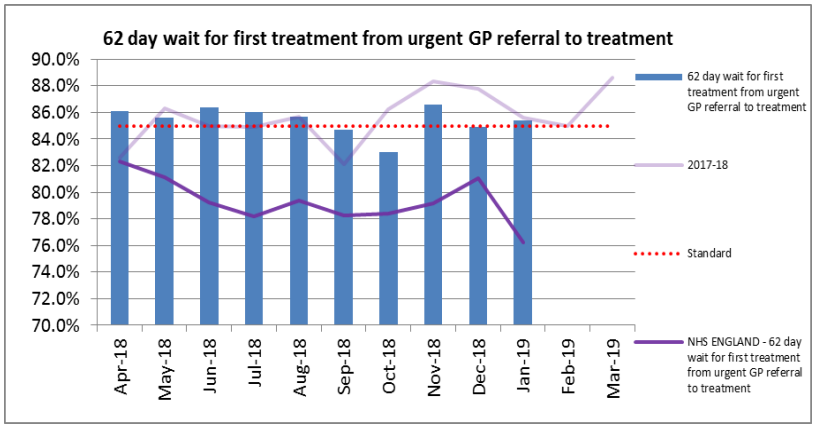
	Indicator	Current Month	Month Actual	Data Quality RAG Rating
Complaints & Claims	Complaints received (12 Month Rolling)	Feb-19	410	
	Concerns Received (12 Month Rolling)		737	
	Complaints Performance		88.5%	
	Clinical Negligence Scheme for Trusts (CNST)		4	
	Liabilities to Third Parties Scheme (LTPS)		8	
	Claims per 1000 occupied bed days		0.18	

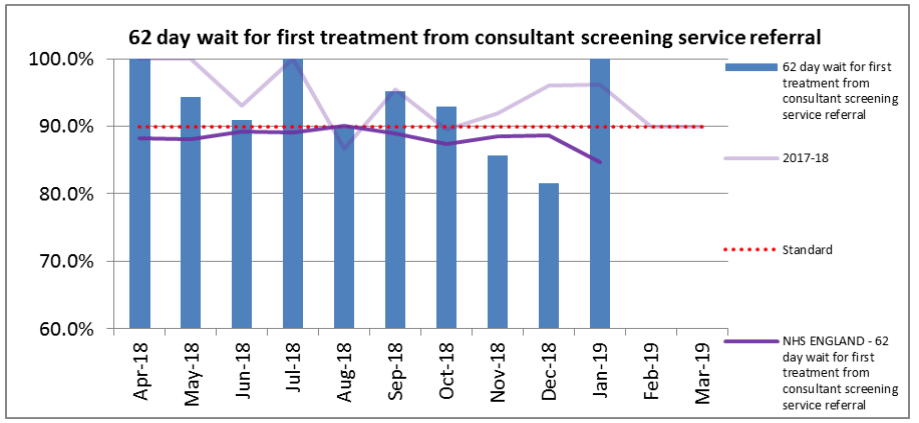
	Indicator	Current Month	YTD (Cumulative)	Data Quality RAG Rating
Workforce	Appraisals	Feb-19	78.85%	
	SET Training		81.31%	

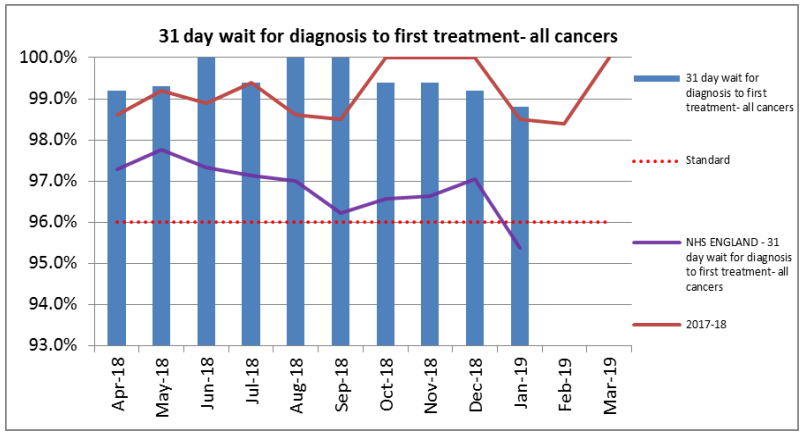
Monitor Compliance Framework: Cancer - Graphs - January 2019 (Month 10)

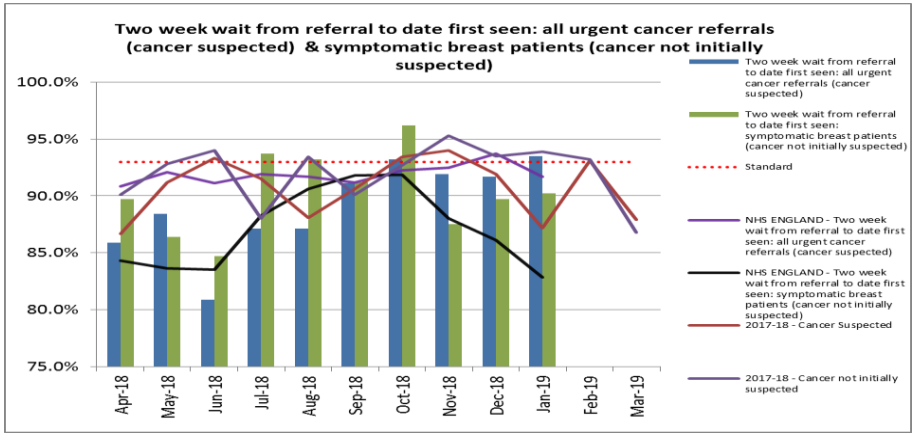




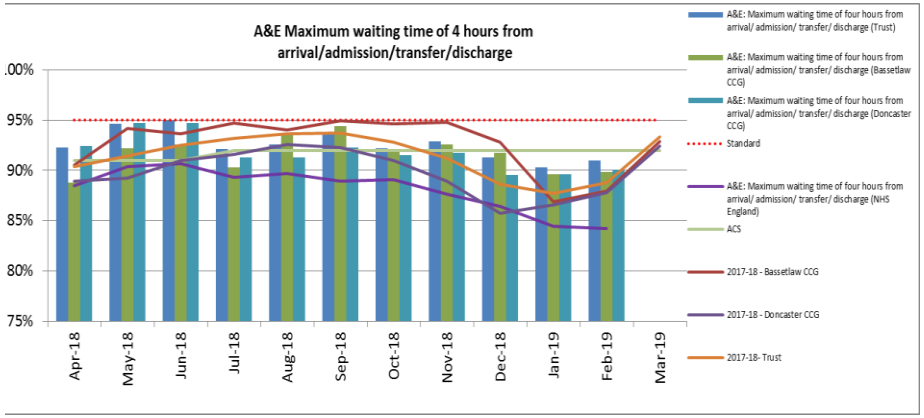


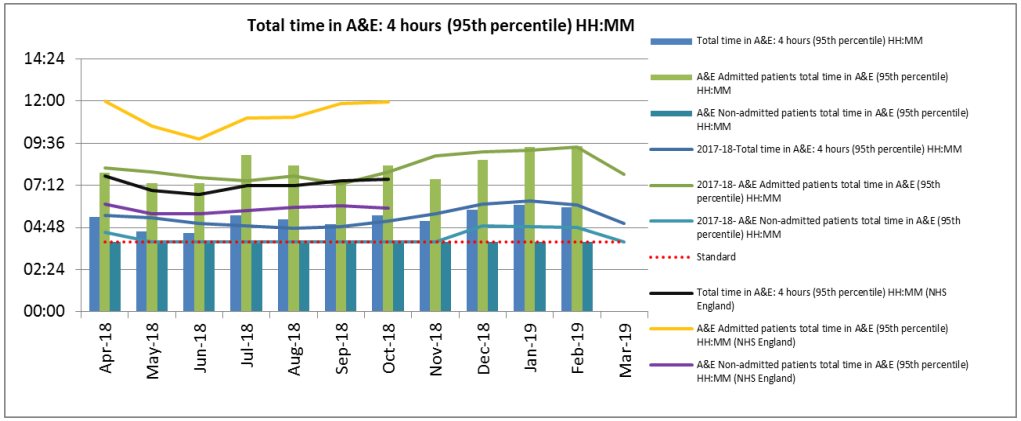


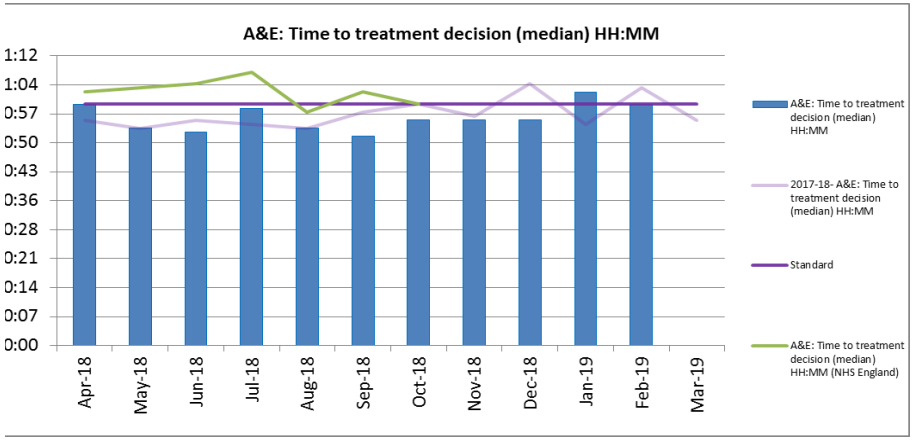


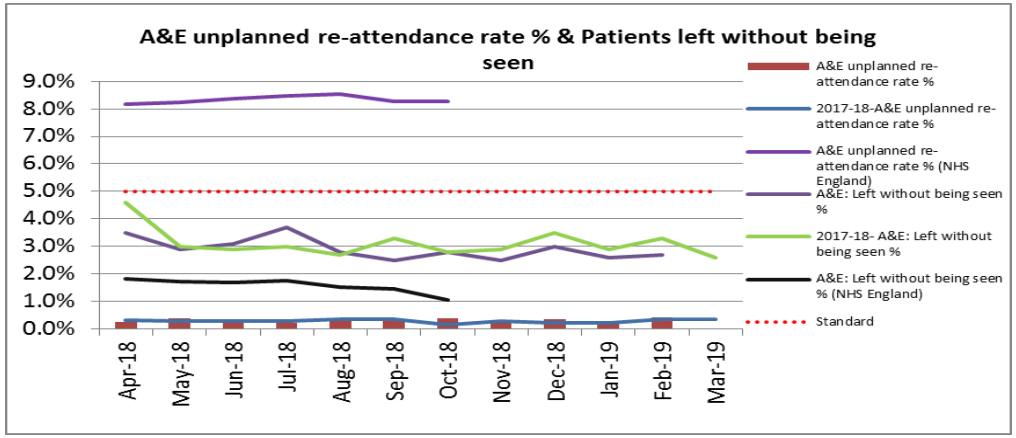


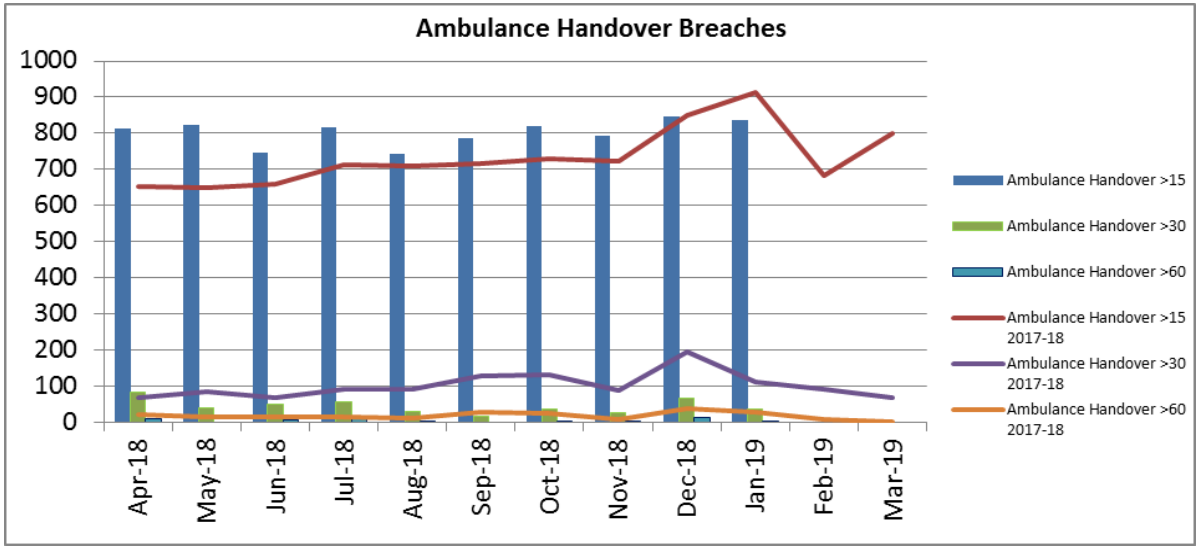
Monitor Compliance Framework: A&E - Graphs - February (Month 11)



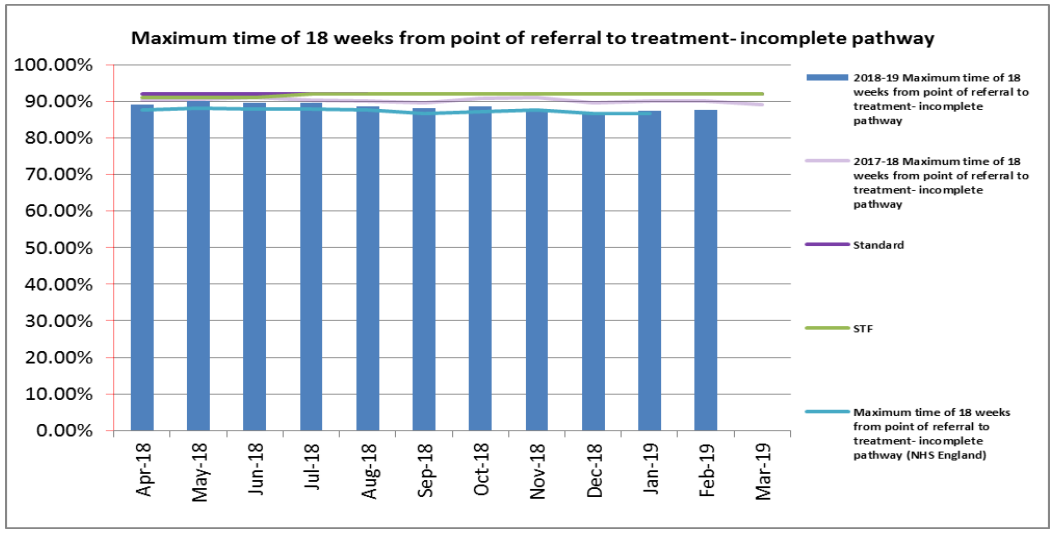


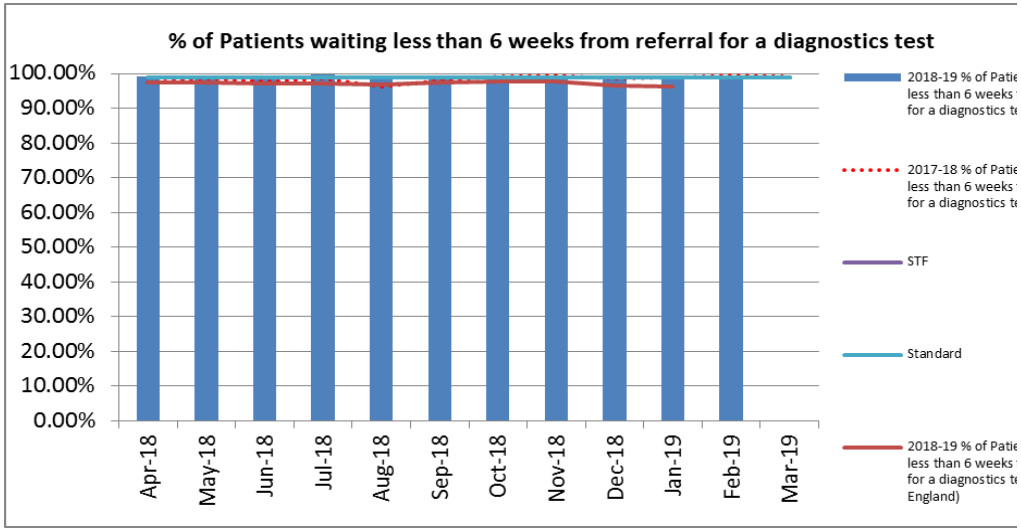


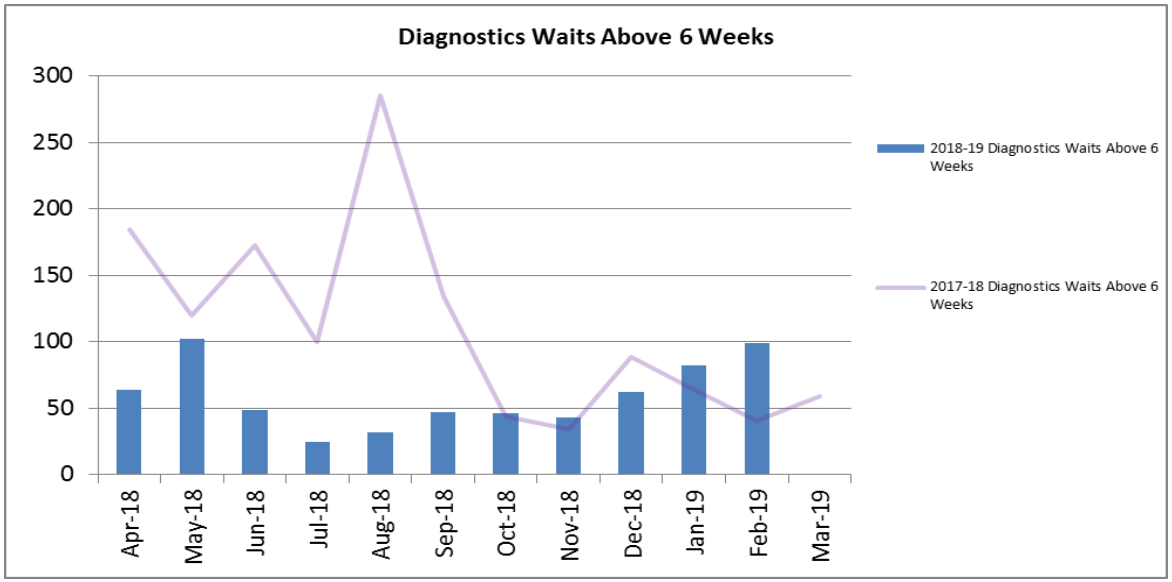




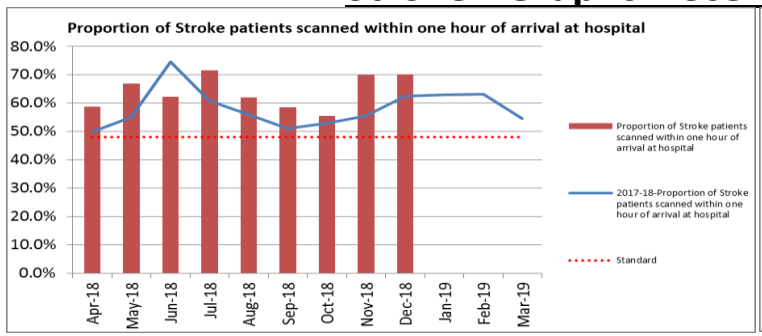
Monitor Compliance Framework: 18 Weeks & Diagnostics February 2019 (Month 11)

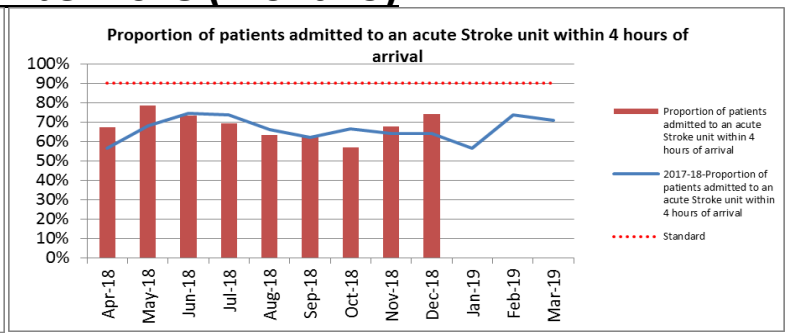


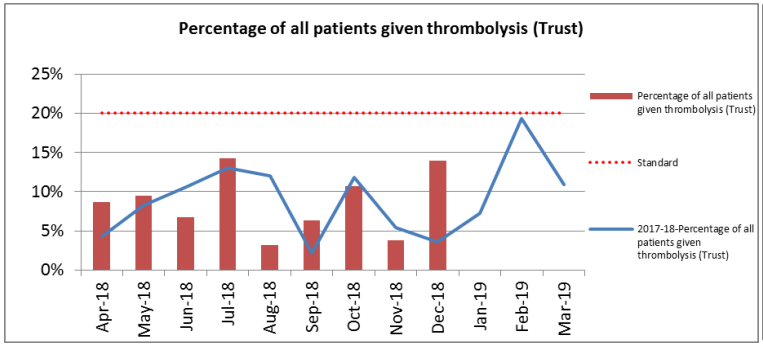


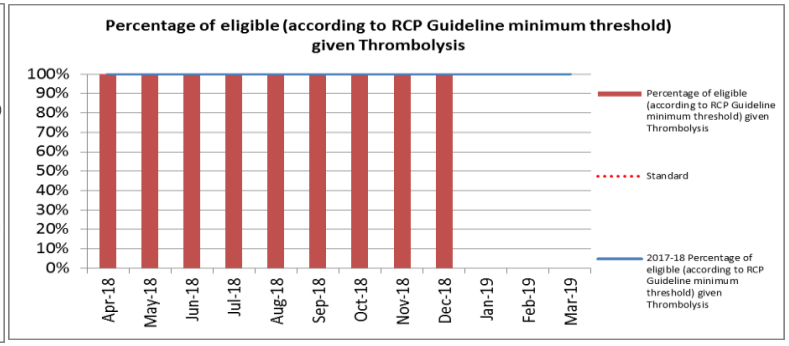


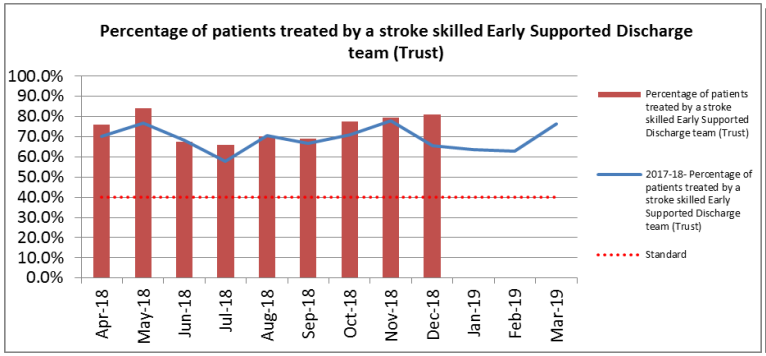
Stroke - Graphs December 2018 (Month 9)

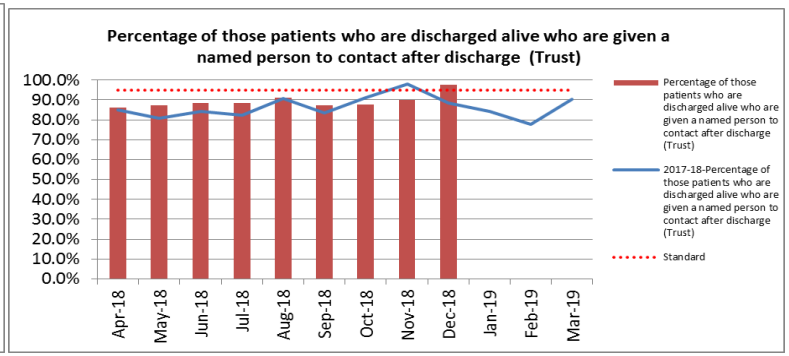


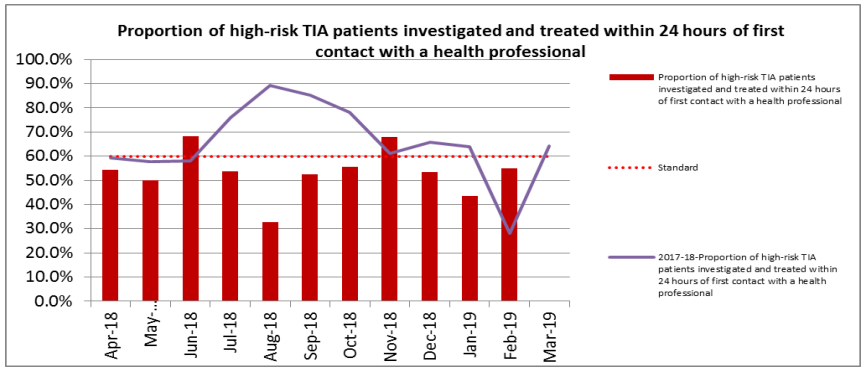












Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Executive Summary - Safety & Quality - February 2019 (Month 11)

HSMR:	The Trust's rolling 12 month HSMR for the 2018 calendar year remains better than expected at 92.0. However, crude mortality for January 2019 was high at nearly 2.0%
Fractured Neck of Femur:	Relative risk mortality remains better than expected and BPT was acheieved in about 50% of patients. The main cause remains access to theatres in 36 hours.
Serious Incidents:	There were 4 SIs reported in February 2019. 1 HAPU and 3 where there were issues with clinical care. It is expected that the trust will see a small rise in SIs due to Care Issues and HAPU this financial year.
Children & Young People	There have been no SIs reported in paediatrics during this calendar year and complaint levels have been low.

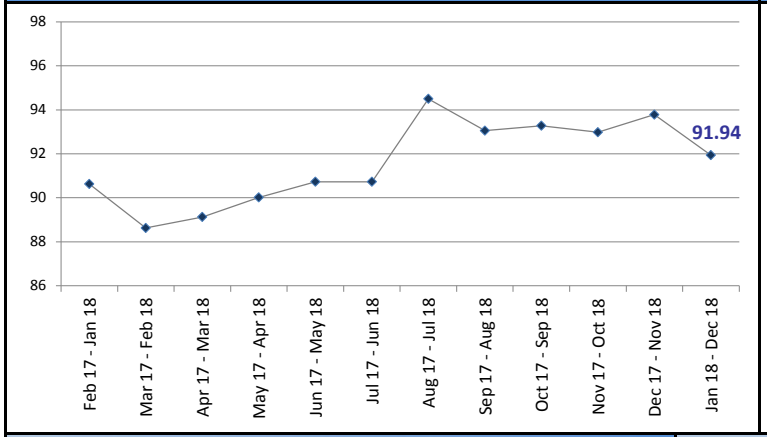
Executive Lead:
Mr S Singh

C-Diff	The rate is below that of the same period last year, the year to date position and national trajectory
Fall resulting in significan harm:	The rate is less than the same period in February 2018 and remains higher than the YTD position
Hospital Acquired Pressure Ulcers:	The rate is less than the same period in February 2018 and the same as the YTD position
Complaints and Concerns	The rate of complaints and concerns remains within normal variation. Complaint resolution against agreed timescales has improved in February as anticipated. Following the Internal Audit of complaints reporting arrangements is being reviewed.
Friends & Family Test:	Response rates for both ED and inpatient areas have seen an increase in February. Positivity of responses remained above regional performance.

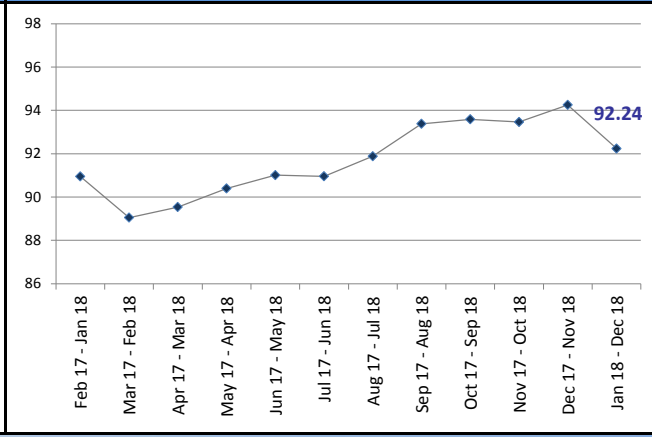
Executive Lead:
Mrs M Hardy

Hospital Standardised Mortality Ratio (HSMR) - Dec 2018 (Month 9)

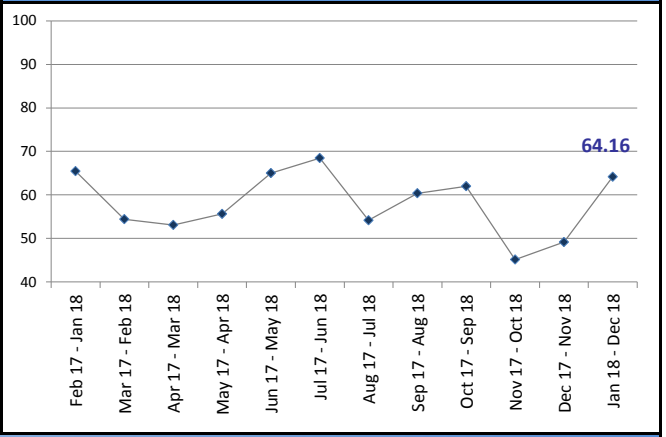
Overall HSMR (Rolling 12 months)



HSMR - Non-elective Admission (Rolling 12 months)



HSMR - Elective Admission (Rolling 12 months)

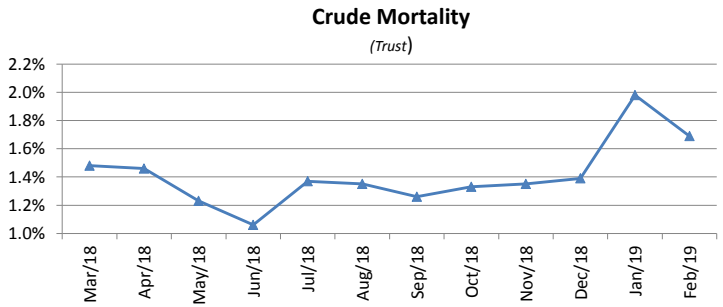


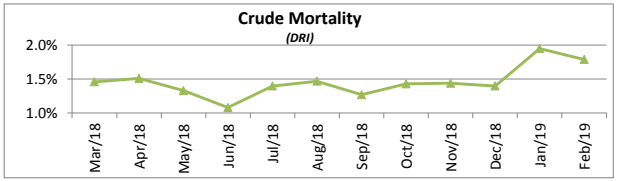
HSMR Trend (monthly)

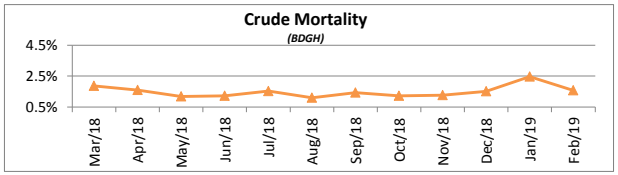
	2015	2016	2017	2018
January	116.80	99.21	94.86	93.45
February	99.94	97.73	105.44	83.61
March	90.54	97.37	82.66	88.42
April	105.91	88.50	85.36	96.62
May	101.15	96.60	82.88	91.33
June	80.27	93.67	89.99	89.67
July	92.56	97.73	96.09	107.41
August	100.27	87.52	73.78	94.47
September	90.26	95.34	87.30	89.65
October	90.29	88.66	98.57	94.91
November	88.98	82.30	88.02	97.70
December	82.30	93.52	99.02	79.59

Crude Mortality (monthly) - Feb 2019 (Month 11)

(number of deaths/number of patient discharged)



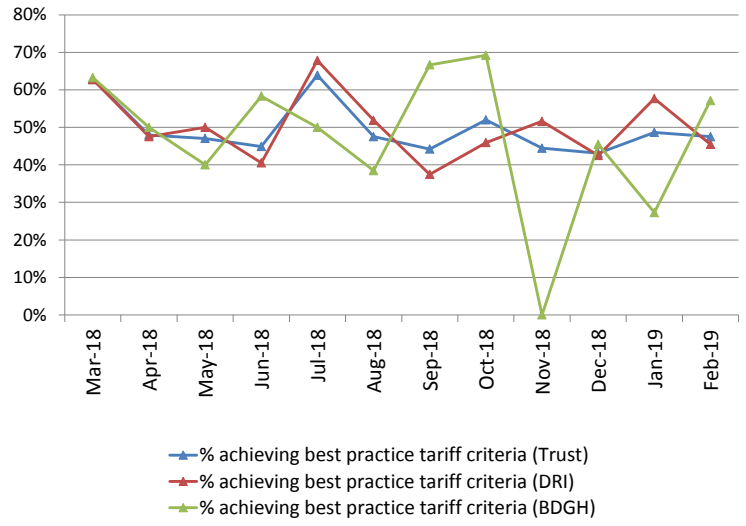




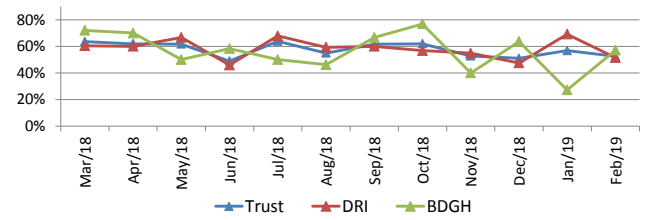
	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19
Trust	1.48%	1.46%	1.23%	1.06%	1.37%	1.35%	1.26%	1.33%	1.35%	1.36%	1.98%	1.69%
Donc	1.46%	1.51%	1.33%	1.08%	1.40%	1.47%	1.27%	1.43%	1.44%	1.45%	1.95%	1.79%
Bass	1.87%	1.60%	1.19%	1.23%	1.53%	1.10%	1.43%	1.23%	1.27%	1.26%	2.47%	1.58%

NHFD Best Practice Pathway Performance -February 2019 (Month 11)

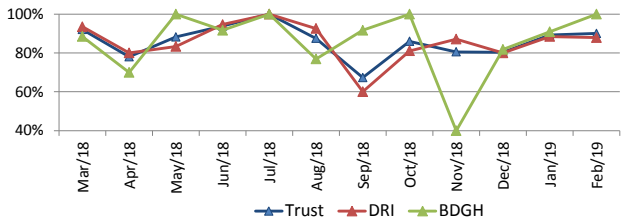
Best Practice Criteria Performance



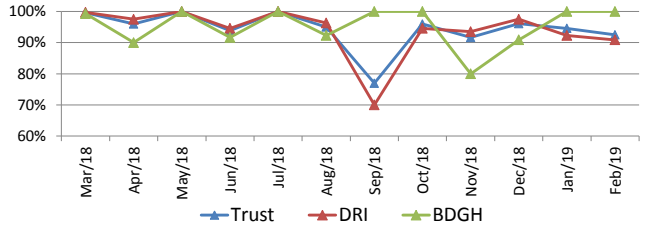
36 Hours to Surgery Performance



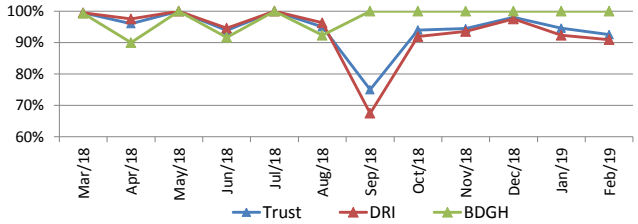
72 hours to Geriatrician Assessment Performance



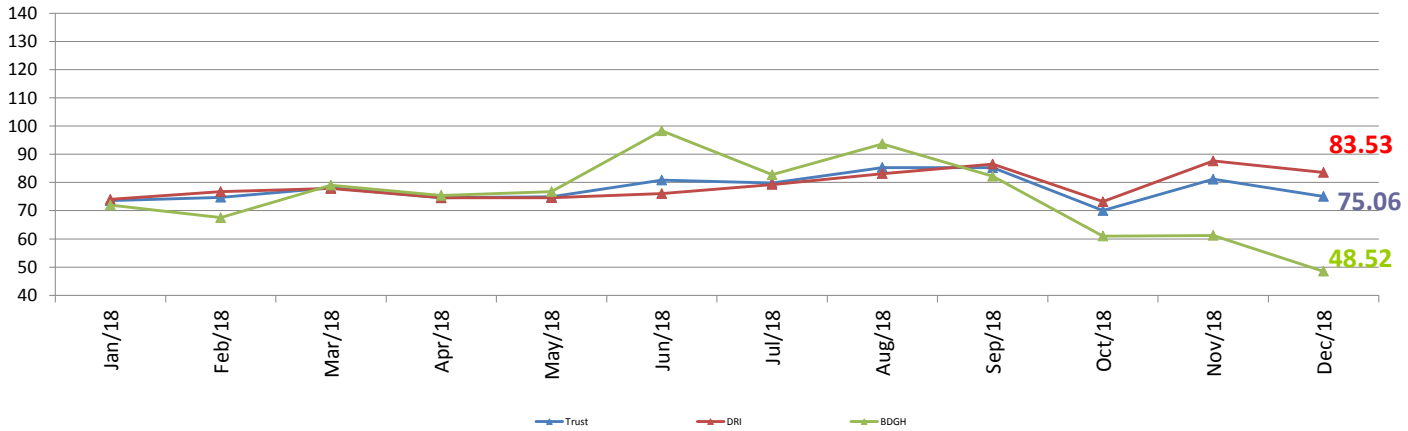
Bone Protection Medication Assessment



Falls Assessment Performance



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



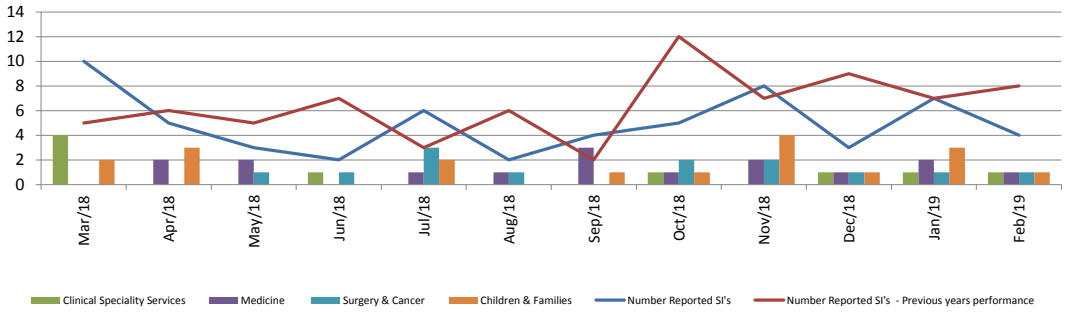
Serious Incidents - Feb 2019 (Month 11)

(Data accurate as at 15/03/2019)

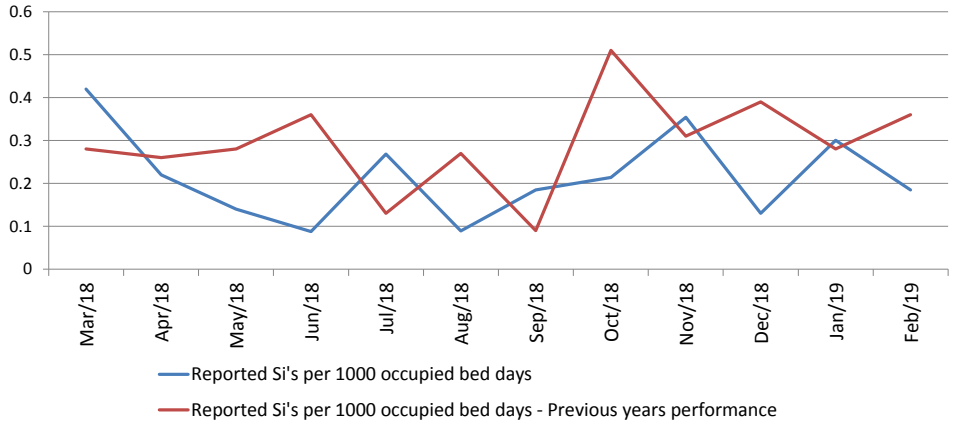
Please note: At the time of producing this report the number of serious incidents reported are prior to the RCA process being completed.

Overall Serious Incidents

Number Serious Incidents Reported
(Trust & Care Group)



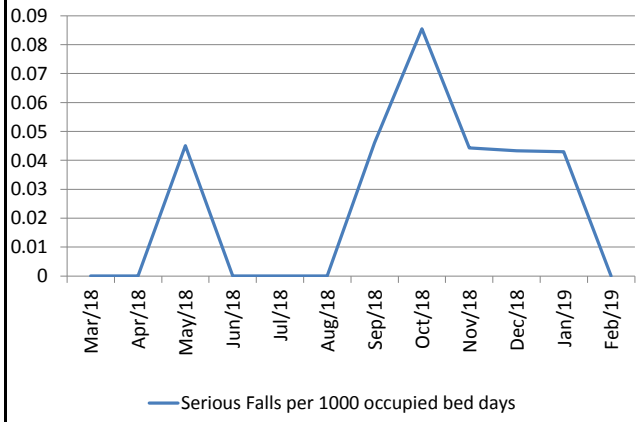
Serious Incidents per 1000 occupied bed days



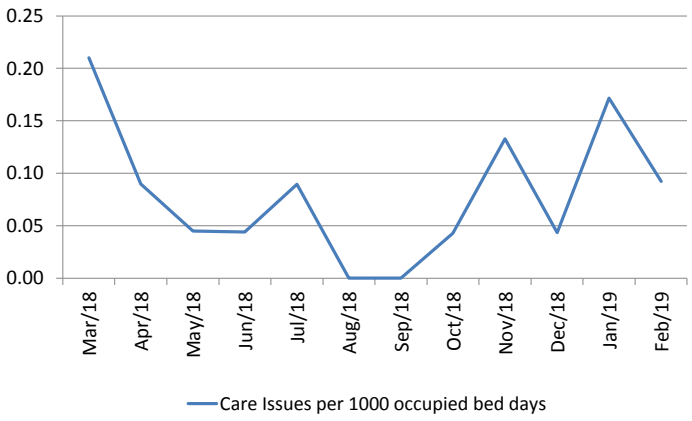
Current YTD reported SI's (April-Feb 19)	49	Number reported SI's (Apr-Feb 18)	72
Current YTD delogged SI's (April-Feb 19)	4	Number delogged SI's (Apr-Feb 18)	36

Themes

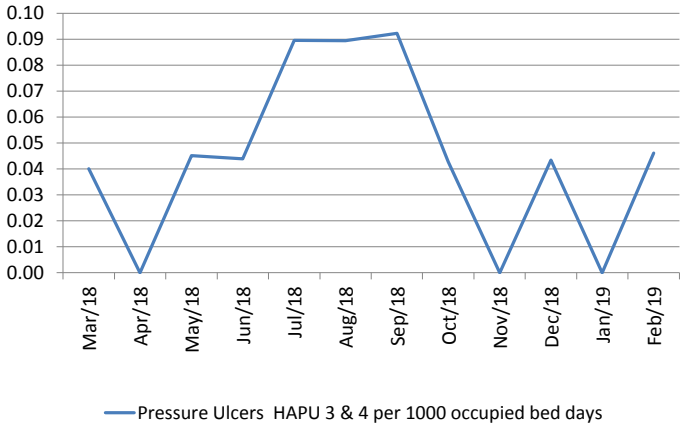
Serious Falls



Care Issues

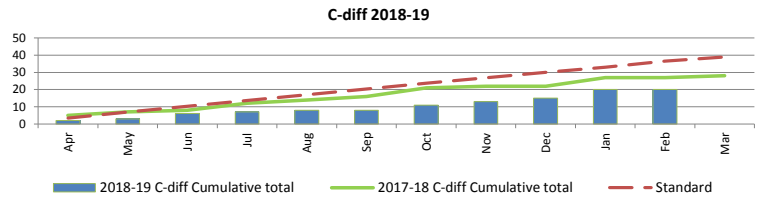


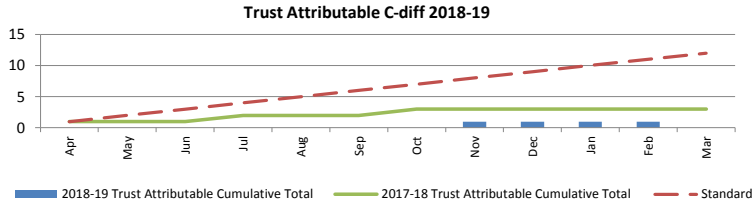
Pressure Ulcers - Category 3 & 4 (HAPU)



Infection Control C.Diff - Feb 2019 (Month 11)
(Data accurate as at 15/03/2019)

	Standard	Q1	Q2	Q3	Jan	Feb	YTD
2018-19 Infection Control - C-diff	39 Full Year	6	2	7	5	0	20
2017-18 Infection Control - C-diff	40 Full Year	8	8	6	5	0	27
2018-19 Trust Attributable	12	0	0	1	0	0	1
2017-18 Trust Attributable	12	1	1	1	0	0	3

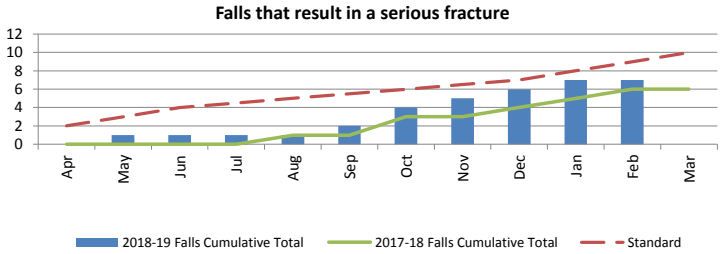




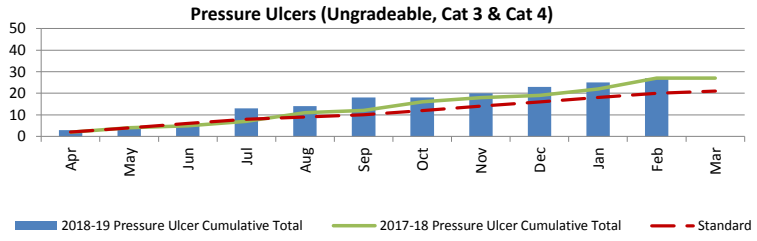
Pressure Ulcers & Falls that result in a serious fracture - Feb 2019 (Month 11)
(Data accurate as at 15/03/2019)

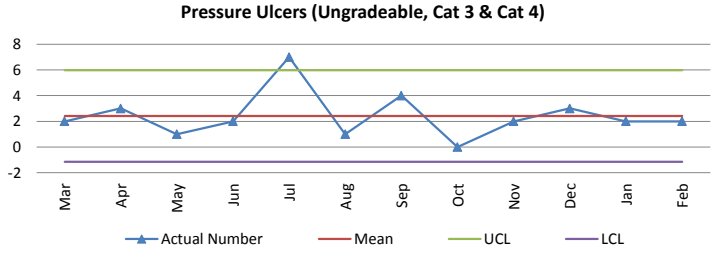
	Standard	Q1	Q2	Q3	Jan	Feb	YTD
2018-19 Serious Falls	10 Full Year	1	1	4	1	0	7
2017-18 Serious Falls	6 Full Year	0	1	3	1	1	6

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	Q3	Jan	Feb	YTD
2018-19 Pressure Ulcers	21 Full Year	6	12	5	2	2	27
2017-18 Pressure Ulcers	27 Full Year	5	7	7	3	5	27





Hard Truths - Feb 2019 (Month 11)

(Data accurate as at 15/03/2019)

				Planned v Actual		Safe	Effective	Caring	Responsive	Well Led	Profile	
Division	Matron	Ward	No of Funded Beds	CHPPD	Variance	Total score	Total score	Total score	Total score	QM total score	Work-force	Quality
Surgery & Cancer		B5	30.7	5.7	101%	0.0	0.5	0.5	1.0	2.0		
		B6	16	6.5	98%	3.5	0.0	1.0	1.5	6.0		
	AH	St Leger	35	6.3	95%	1.0	0.5	1.0	2.0	4.5		
	AH	1&3	23	7.2	94%	1.0	0.0	0.0	2.0	3.0		
		20	27	4.9	107%	2.0	0.5	2.0	1.0	5.5		
		21	27	4.7	105%	2.5	0.5	1.0	2.0	6.0		
		S10	20	4.8	99%	3.5	0.0	1.0	2.0	6.5		
		S11	19	5.0	100%	1.5	0.0	0.0	2.0	3.5		
		S12	20	4.6	102%	2.5	0.0	2.0	2.5	7.0		
		SAW	21	7.4	100%	3.0	0.0	1.0	1.5	5.5		
					97%							
Medicine	JC	A4	24	5.7	108%	0.0	0.5	1.0	1.5	3.0		
	JC	C1	16	5.2	102%	0.0	0.5	2.5	2.5	5.5		
	JC	CCU/C2	18	5.7	107%	2.0	1.5	2.0	1.5	7.0		
	JC	ATC	21	7.3	100%	1.5	0.5	2.0	1.5	5.5		
	SS	AMU	40	7.2	104%	3.0	2.5	1.0	1.5	8.0		
	MT	FAU	16	7.1	94%	1.0	4.0	1.0	2.0	8.0		
	AW	16	24	7.1	116%	2.5	1.0	1.5	1.0	6.0		
	AW	17	24	5.2	100%	2.5	2.5	0.0	2.5	7.5		
		18 Haem	12	6.4	99%	4.0	0.0	0.0	1.0	5.0		
		18 CCU	12	6.5	97%	2.0	1.0	2.0	2.5	7.5		
		24	24	5.3	105%	2.5	1.0	2.0	1.5	7.0		
		25	16	6.4	101%	2.0	0.5	1.0	1.0	4.5		
		Respiratory unit	56	6.0	108%	2.0	1.0	2.0	1.0	6.0		
		32	18	5.5	100%	1.5	0.5	1.5	3.0	6.5		
	MT	Mallard	16	7.7	103%	3.0	1.0	1.0	2.5	7.5		
	MT	Gresley	32	5.5	104%	0.0	3.0	1.0	1.0	5.0		
	MT	Rehab 2	19	4.0	111%	2.5	1.5	2.0	2.0	8.0		
	MT	Rehab 1	29	6.7	119%	1.5	1.5	2.0	1.5	6.5		
					105%							
Clinical Speciality Services		ITU DRI	20	23.4	94%	3.0	3.0	0.0	1.5	7.5		
		ITU BDGH	6	19.3	95%	0.0	3.0	2.0	0.5	5.5		
					94%							
Children and Families	AB	SCBU	8	16.6	95%	0.0	0.0	0.0	0.5	0.5		
	AB	NNU	18	12.5	98%	0.0	0.0	0.0	0.5	0.5		
	AB	CHW	18	9.6	98%	1.0	0.0	0.0	0.5	1.5		
	AB	COU	12	13.5	98%	0.0	0.0	0.0	0.5	0.5		
	TB	G5	24	5.9	101%	2.5	3.0	2.0	2.0	9.5		
	JH	M1	26	10.1	84%	1.0	3.0	2.0	1.0	7.0		
	JH	M2	18	7.6	85%	1.0	3.0	2.0	1.0	7.0		
	SR	CDS	14	23.2	88%	1.0	1.0	0.5	1.0	3.5		
	JH	A2	18	7.8	76%	2.0	3.0	0.0	0.5	5.5		
	KC	A2L	6	23.5	87%	1.0	1.0	1.0	1.0	4.0		
					89%							

The workforce data submitted to UNIFY provides the actual hours worked in February 2019 by registered nurses or midwives, and health care support workers compared to the planned hours. The Trusts overall planned versus actual hours worked was 100% in February 2019, the same as in January 2019. There are no wards flagging as red on quality.

The data for February 2019 demonstrates that the actual available hours compared to planned hours were:

23 wards (57.5%) within 5% of the planned staffing level, 1 less than last month

9 wards (22.5%) between 5-10% of planned staffing levels, the same as last month.

3 wards (7.5%) <10% higher than planned staffing level, the same as last month.

5 wards (12.5%) >10% lower than planned staffing level, 1 more than last month.

The wards where there were deficits in excess of 10% of the planned hours are; CDS, M1, M2, A2 and A2L. Maternity are carrying vacancy and have redeployed staff to areas of increased activity. Triage and M2 have merged overnight on occasions to improve skill mix. The maternity ward rosters also requiring revision of the roster plan to optimise the use of staff resources.

The wards with greater than 10% of actual staffing over planned staffing are the Stroke Unit and Rehab 1 and 2 all due to enhanced care needs.

Care Hours Per Patient Day (CHPPD) - Feb 2019 (Month 11)

(Data accurate as at 15/03/2019)

Utilising actual versus planned staffing data submitted to UNIFY and applying the CHPPD calculation the care hours for February 2019 are shown below

Site Name	Registered midwives/ nurses	Care Staff	Overall
BASSETLAW HOSPITAL	4.09	2.96	7.04
DONCASTER ROYAL INFIRMARY	4.12	3.06	7.19
MONTAGU HOSPITAL	1.94	3.33	5.27
TRUST	3.98	3.06	7.04

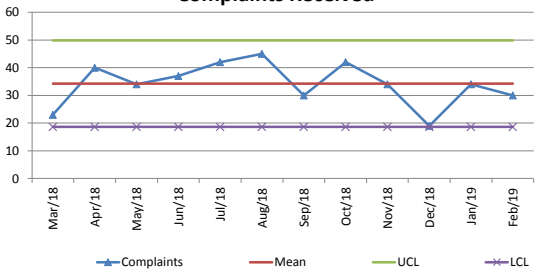
The data for February 2019 shows slight reduction in hours across all sites in February 2019. Closed and escalation beds were open on both Bassetlaw and DRI sites, which may account in some way for the reduction. The registered nurse and midwife profile continues to be lower than national and peer rates, with the Healthcare support worker rate slightly higher than peers and national rates. The overall CHPPD rate shows a fluctuating rate, lower than peer and national rates.

Complaints & Claims - February 2019 (Month 11)

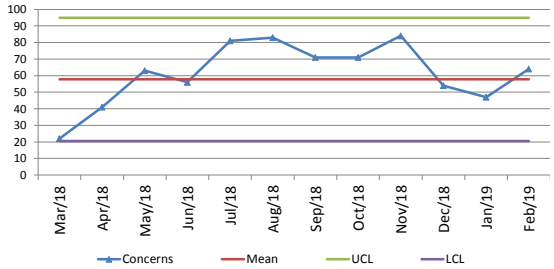
(Data accurate as at 15/03/2019

Complaints

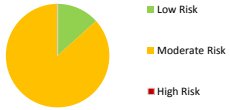
Complaints Received



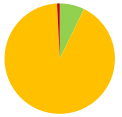
Concerns Received



Feb 2019 Complaints Received Risk Breakdown



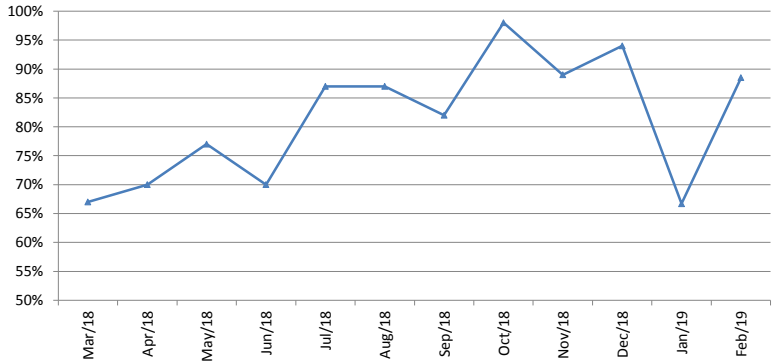
Year to Date Complaints Received Risk Breakdown



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
Feb-19	0	7

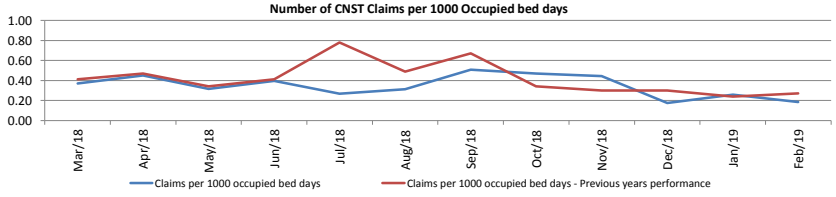
	Number referred for investigation YTD	Outcomes YTD	
2016/17	8	Outstanding	0
2017/18	7	Fully / Partially Upheld	2
		Not Upheld	1
		No further Investigation	0
		Case Withdrawn	0
		Not Investigated	3
		Outstanding	1
2018/19	8	Fully / Partially Upheld	3
		Not Upheld	0
		No further Investigation	0
		Case Withdrawn	0
		Outstanding	6

Claims

		Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	YTD
Clinical Negligence Scheme for Trusts (CNST) Not including Disclosures	2018/19	10	7	9	6	7	11	11	4	10	6	4		85
	2017/18	8	12	10	18	11	17	9	9	9	6	6	9	116
Liabilities to Third Parties Scheme (LTPS)	2018/19	2	6	1	1	7	0	2	0	2	3	8		32
	2017/18	2	3	1	1	2	1	1	4	1	2	4	2	20

Please note: At the time of producing this report the number of claims reported are provisional and prior to validation

Number of CNST Claims per 1000 Occupied bed days

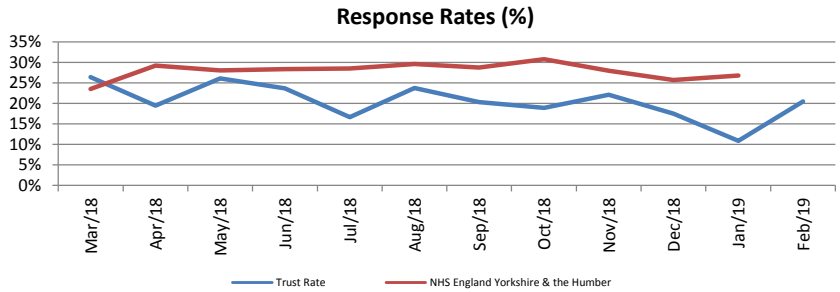


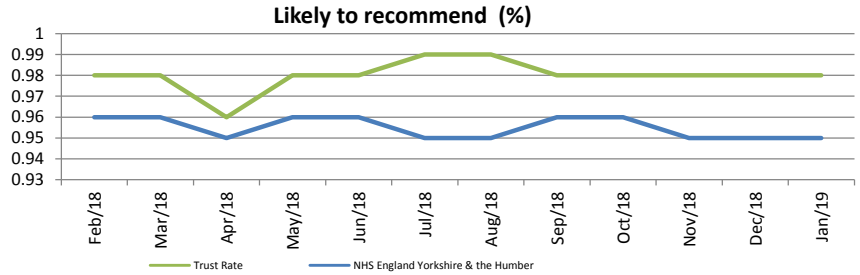
Friends & Family - February 2019 (Month 11)

(Data accurate as at 13/03/2019)

Inpatients

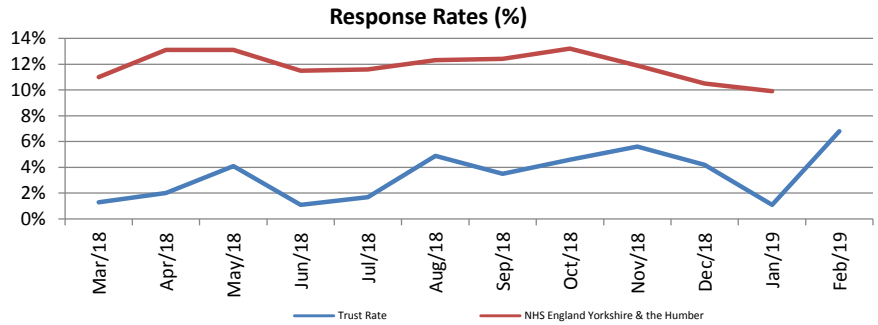
Please note: At the time of producing this report no further benchmarking data is available from NHS England.

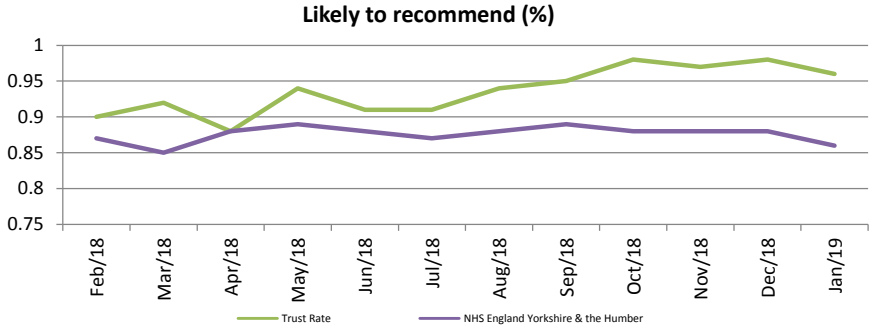




Accident & Emergency

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

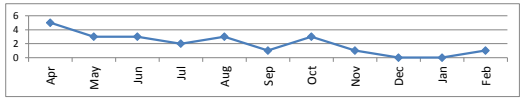




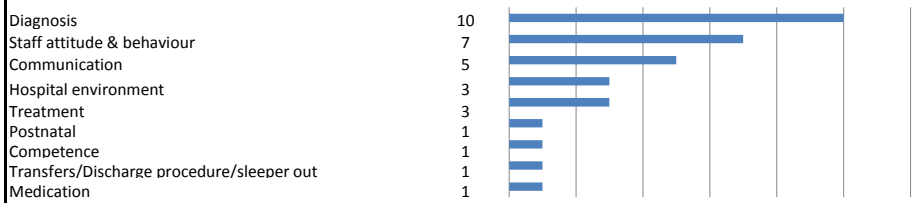
Childrens & Young People - Quality Metrics
February 2019 (Month 11)
(Data accurate as at 5/03/2019

Complaints

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	YTD
Number of complaints received	5	3	3	2	3	1	3	1	0	0	1		22



Thematic breakdown (Apr 19 - Feb19)



Please note that a direct correlation between the number of complaints received and the subjects within thematic breakdown can not been made as most of the complaints have more than one subject noted.

Of the complaints received during 2018-19 the most frequent cause for complaint has been around diagnosis (10), this comprises of subjects relating to Time taken to make a diagnosis (6), Allegations of Missed diagnosis (3) and an Allegation of lack of diagnosis (1). Complaints relating to Staff Attitude and Behaviour (7) also feature as a main cause for complaint with subjects ranging from being Insensitive to patient needs/unhelpful (2), patients finding staff dismissive (2), Conduct/Staff disposition (2) and a complaint regarding Inappropriate comments/Staff calling by an inappropriate name (1). Complaints relating to Communication also features (5) with this being due to Lack of information to relatives/NOK (3) and Inconsistent information between staff (2).

Datix Incidents & Serious Incidents

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	YTD
Number of Datix Incidents Reported	25	31	42	34	27	27	25	52	34	26	32		355

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	YTD
Number of Serious Incidents Reported *(including de-logged)*	0	0	0	0	0	0	0	0	0	0	0		0

Duty Of Candour (Doc)

There have been **0** incidents within Children and Young Persons which have triggered Duty of Candour to be completed.

Please note: An incident which has caused moderate, severe or patient death requires DoC to be completed

Executive summary - Workforce - February 2019 (Month 11)

Sickness absence

February has seen a reduction in sickness absence with rates for being 4.52% (the lowest rate since October 2018) and the cumulative position being 4.43%. Long term absences (and the rate) have reduced across the board with there being no absences in excess of 12 months for the second time only this year; short term absence has also reduced from 2.59% to 1.97% reducing back to December 2018 rates .

Appraisals

The Trusts appraisal completion rate on the attached has maintained at 78.85% as at the end of February 2019 following the end of the appraisal season. The Trust is currently planning for this year's appraisal season which has included soundbites in respect of conducting a quality appraisal, candid conversations and values and behaviours. Appraisal sessions will continue during the appraisal season.

SET

Disappointingly SET compliance continues to hover around 81% with rates being at 81.31% as at the end of February. Specific focus continues on topics where compliance rates are lower and with the Divisions where compliance rates are low and is included in the CQC action plans. Attention is also being given to ensuring staff have the correct requirement in relation to topics such as resuscitation and safeguarding.

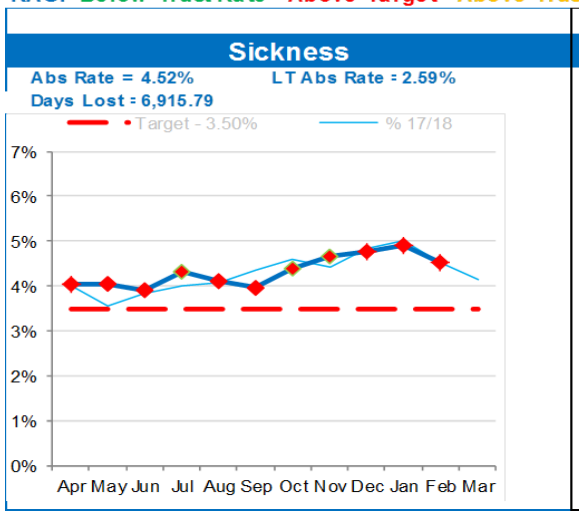
Staff in post

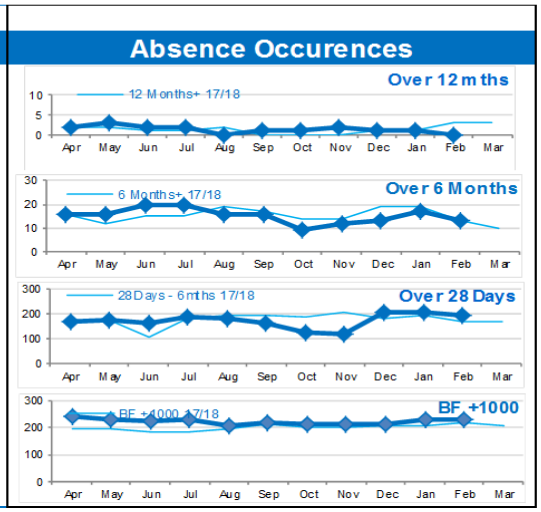
Please see attached tab covering staff in post by staff group. Vacancy rates are provided to both Finance & Performance and Quality & Effectiveness Committees.

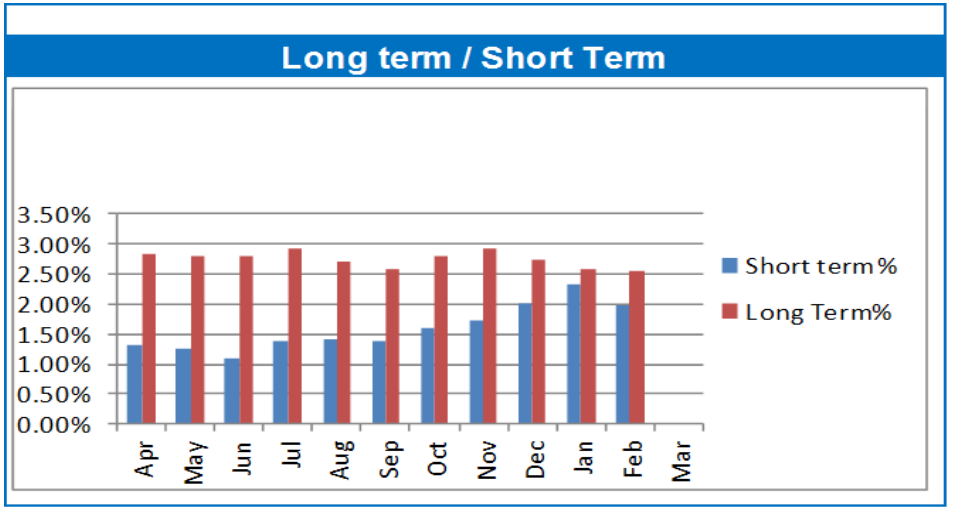
Workforce: Sickness Absence - February (Month 11)

CG & Directorate Sickness Absence - February 2019 (Q4)

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





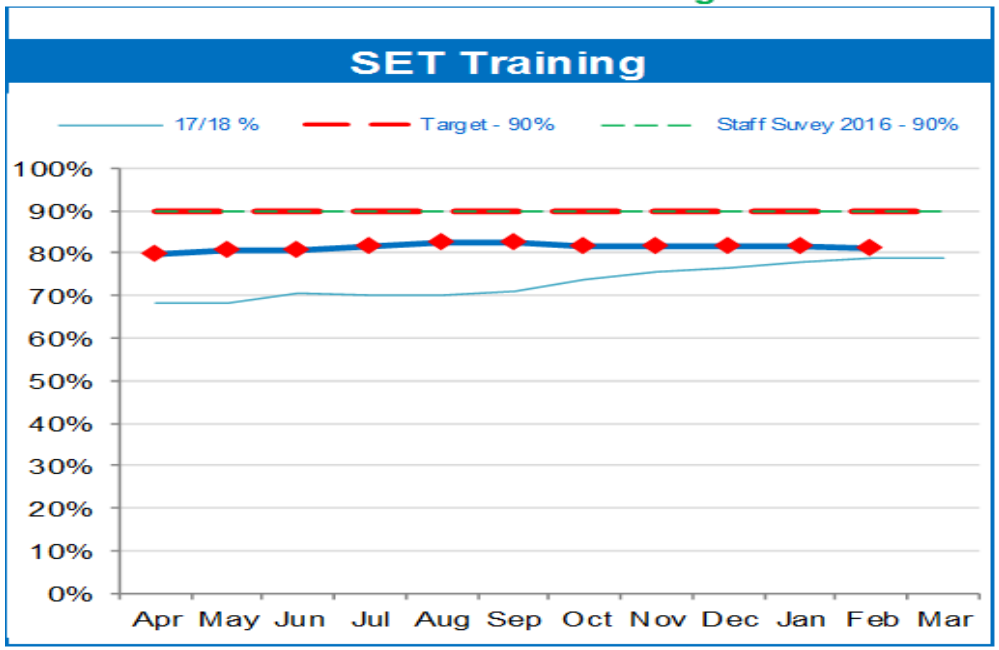


	Apr-18		May-18		Jun-18		Jul-18		Aug-18		Sep-18		Oct-18		Nov-18		Dec-18		Jan-19		Feb-19		Cumulative	
	Days Lost	% Rate	Days Lost	% Rate	Days Lost	% Rate	Days Lost	% Rate	Days Lost	% Rate	Days Lost	% Rate	Days Lost	% Rate	Days Lost	% Rate	Days Lost	% Rate	Days Lost	% Rate	Days Lost	% Rate	Days Lost	% Rate
Doncaster & Bassetlaw Teaching Hospitals NHS FT	6966.07	4.30%	6852.91	4.09%	6610.26	4.08%	7244.35	4.34%	6993.67	4.16%	6462.26	3.96%	7420.23	4.39%	7621.25	4.66%	8063.14	4.76%	8309.57	4.91%	6915.79	4.52%	80,266.50	4.43%
Chief Executive Directorate	14.00	2.67%	27.76	5.12%	18.80	3.58%	0.00	0.00%	2.00	0.36%	0.91	0.17%	0.00	0.00%	0.00	0.00%	0.00	0.00%	0.00	0.00%	3.00	0.62%	73.74	1.28%
Children & Families Division	840.01	4.65%	851.44	4.60%	608.47	3.43%	769.74	4.21%	843.46	4.62%	666.99	3.77%	867.01	4.71%	913.96	5.15%	1018.74	5.60%	1038.91	5.73%	944.11	5.79%	9,694.68	4.92%
Clinical Specialist Division	1932.19	4.51%	1682.42	3.81%	1650.39	3.88%	2000.43	4.57%	1854.48	4.22%	1768.63	4.16%	2066.21	4.72%	2100.29	4.97%	2251.10	5.17%	2058.78	4.74%	1749.96	4.46%	21,301.19	4.52%
Directorate Of Strategy & Improvement	0.00	0.00%	2.00	1.72%	0.00	0.00%	1.00	0.80%	0.00	0.00%	0.00	0.00%	0.00	0.00%	0.00	0.00%	2.00	0.62%	2.40	0.74%	0.80	0.27%	10.20	0.51%
Estates & Facilities	818.11	5.76%	772.80	5.24%	745.79	5.21%	878.47	5.94%	811.97	5.57%	895.99	6.37%	939.14	6.53%	861.69	6.16%	1040.58	7.11%	1103.50	7.51%	835.82	6.30%	9,637.53	6.11%
Executive Team Board	0.00	0.00%	1.00	0.08%	2.00	0.16%	0.00	0.00%	0.00	0.00%	0.00	0.00%	3.00	0.11%	30.60	1.13%	0.00	0.00%	6.00	0.21%	22.00	0.85%	64.60	0.27%
Finance & Healthcare Contracting Directorate	80.84	2.96%	42.00	1.52%	72.54	2.74%	31.07	1.16%	15.60	0.58%	12.00	0.48%	32.92	0.83%	29.48	0.76%	23.77	0.62%	48.69	1.20%	73.81	1.96%	705.98	1.59%
IT Information & Telecoms Directorate	71.46	2.22%	113.84	3.46%	143.69	4.46%	141.81	4.20%	125.97	3.72%	162.66	4.91%	114.08	5.66%	102.44	5.24%	47.12	2.32%	90.71	4.41%	40.64	2.20%	944.89	4.51%
Medical Director Directorate	3.60	0.64%	21.14	3.62%	23.40	4.22%	23.15	4.15%	23.15	4.15%	10.45	1.94%	1.00	0.18%	13.45	2.43%	46.05	8.07%	32.71	5.73%	31.20	6.05%	253.99	4.14%
Medicine Division	1901.44	4.53%	1967.12	4.49%	1750.43	4.14%	1832.66	4.20%	1783.53	4.07%	1655.56	3.90%	1924.36	4.28%	1994.65	4.60%	1902.06	4.24%	2111.32	4.70%	1691.34	4.17%	21,230.89	4.41%
Nursing Services Directorate	74.84	4.27%	58.53	3.27%	86.20	4.97%	87.04	4.81%	73.20	3.98%	39.60	2.27%	57.36	3.11%	107.31	5.76%	126.10	6.68%	146.10	7.67%	120.66	7.03%	822.19	4.14%
People & Organisational Directorate	118.60	3.97%	124.76	4.00%	112.95	3.79%	93.69	3.01%	2.65	0.09%	6.60	0.21%	50.41	1.53%	61.48	1.89%	101.43	2.98%	73.20	2.18%	62.40	2.06%	817.17	2.34%
Performance Directorate	236.65	4.47%	161.87	2.99%	301.99	5.79%	277.01	5.17%	200.33	3.81%	186.43	3.66%	258.43	4.93%	270.65	5.31%	295.23	5.52%	248.01	4.62%	216.51	4.44%	2,609.73	4.54%
Surgery & Cancer Division	874.34	3.29%	1026.23	3.72%	1093.61	4.07%	1108.29	4.01%	1257.34	4.54%	1056.45	3.93%	1106.31	4.08%	1135.25	4.31%	1208.96	4.45%	1349.25	4.96%	1123.54	4.57%	12,099.71	4.16%

Workforce: SET Training - February (Month 11)

CG & Directorate SET Training - February 2019 (Q4)

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

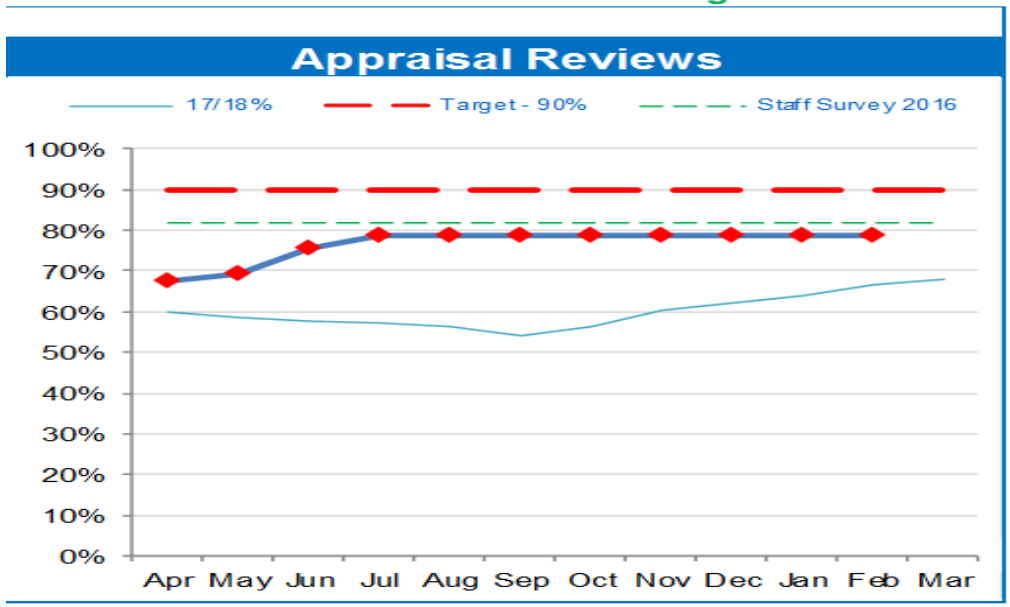


	% Compliance
Doncaster & Bassetlaw Teaching Hospitals NHS FT	**81.31%**
Chief Executive Directorate	**84.44%**
Children & Families Division	**82.02%**
Clinical Specialist Division	**85.16%**
Directorate Of Strategy & Improvement	**95.54%**
Estates & Facilities	**70.42%**
Finance & Healthcare Contracting Directorate	**95.69%**
IT Information & Telecoms Directorate	**88.84%**
Medical Director Directorate	**87.67%**
Medicine Division	**79.44%**
Nursing Services Directorate	**94.35%**
People & Organisational Directorate	**96.68%**
Performance Directorate	**82.38%**
Surgery & Cancer Division	**79.05%**

Workforce: Appraisals - February (Month 11)

CG & Directorate Appraisals - February 2019 (Q4)

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



Trust Total
AFC & M&D

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

Workforce: Staff in post -February (Month 11)

	FTE	Headcount	FTE	Headcount	FTE	Headcount	FTE	Headcount	FTE	Headcount	FTE	Headcount	FTE	Headcount	FTE	Headcount	FTE	Headcount	FTE	Headcount	FTE	Headcount
Staff Group	**Mar-18**		**Apr-18**		**May-18**		**Jun-18**		**Jul-18**		**Aug-18**		**Sep-18**		**Oct-18**		**Nov-18**		**Dec-18**		**Jan-19**		**Feb-19**	
Add Prof Scientific and Technic	172.21	189.00	168.86	187.00	160.58	177.00	169.69	187.00	170.63	188.00	172.02	190.00	172.07	190.00	172.89	190.00	175.49	191.00	175.23	193.00	175.23	193.00	169.56	186.00
Additional Clinical Services	1,131.05	1,367.00	1,145.20	1,384.00	1,133.01	1,370.00	1,158.83	1,401.00	1,171.05	1,414.00	1,172.67	1,415.00	1,179.29	1,421.00	1,164.05	1,405.00	1,165.06	1,409.00	1,166.15	1,417.00	1,166.15	1,417.00	1,179.19	1,422.00
Administrative and Clerical	1,064.98	1,296.00	1,058.77	1,289.00	1,034.25	1,261.00	1,046.56	1,275.00	1,047.67	1,278.00	1,045.17	1,272.00	1,045.71	1,274.00	1,033.17	1,259.00	1,033.15	1,258.00	1,048.69	1,329.00	1,048.74	1,276.00	1,049.10	1,276.00
Allied Health Professionals	331.95	385.00	329.92	381.00	311.78	360.00	324.52	377.00	321.56	375.00	323.12	376.00	322.84	375.00	323.24	376.00	323.81	375.00	323.76	387.00	325.26	377.00	321.74	373.00
Estates and Ancillary	488.71	695.00	488.71	695.00	483.68	688.00	478.88	680.00	485.34	692.00	480.84	686.00	476.40	680.00	474.36	678.00	474.06	676.00	478.66	682.00	481.56	690.00	482.56	686.00
Healthcare Scientists	125.70	141.00	125.50	141.00	121.30	137.00	124.92	141.00	122.66	139.00	120.78	137.00	122.78	139.00	123.72	140.00	123.72	140.00	123.03	139.00	123.03	139.00	122.59	139.00
Medical and Dental	509.11	600.00	510.17	600.00	500.36	574.00	510.07	583.00	508.07	581.00	554.01	633.00	551.15	633.00	559.68	642.00	561.04	639.00	559.44	591.00	557.81	590.00	555.43	587.00
Nursing and Midwifery Registered	1,598.70	1,861.00	1,591.07	1,856.00	1,530.70	1,792.00	1,578.72	1,846.00	1,573.47	1,840.00	1,564.47	1,828.00	1,570.41	1,835.00	1,603.36	1,868.00	1,599.93	1,863.00	1,581.97	1,873.00	1,578.21	1,845.00	1,580.60	1,848.00
Students	1.92	2.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	8.80	9.00	2.00	2.00	1.00	1.00	19.00	19.00	0.00	0.00	0.00	0.00
Grand Total	**5,424.31**	**6,536.00**	**5,413.18**	**6,526.00**	**5,270.87**	**6,351.00**	**5,398.65**	**6,502.00**	**5,395.95**	**6,501.00**	**5,428.64**	**6,531.00**	**5,447.40**	**6,554.00**	**5,456.17**	**6,558.00**	**5,461.86**	**6,558.00**	**5,478.83**	**6,638.00**	**5,471.05**	**6,529.00**	**5,461.47**	**6,519.00**

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Title	Staff Survey Report and Action Plan		
Report to	Board of Directors	**Date**	March 2019
Author	Karen Barnard, Director of People & OD		
Purpose			**Tick one as appropriate**
	Decision		
	Assurance		✔
	Information		

Executive summary containing key messages and issues

Our Due North statement states that we aim to be in the top 10% of Trusts for staff satisfaction in the next 5 years. The results from the 2018 staff survey have been shared widely with our leadership teams in order that they can develop their own action plans. The results are captured into themes which are equality, diversity & inclusion, health & wellbeing, immediate managers, morale, quality of appraisals, quality of care, safe environment – bullying & harassment, safe environment – violence, safety culture and staff engagement. The paper provides the Trust wide summary with those of each division and directorate. In addition the staff engagement questions are provided in its own table. At the last board meeting it was agreed that the priority areas of focus at Trust level would be:

- Living our Values
- Involvement
- Visibility of leaders
- Wellbeing into Action
- Leading to Outstanding
- Accountability

The paper details the proposed actions to be taken and timescales. The KPIs to be monitored will be:

- Vacancy rates
- Retention and turnover rates
- Sickness absence rates
- Staff survey questions which require particular attention

- Staff engagement questions around advocacy, motivation and involvement

In addition we will continue to utilise the pulse check data which is being obtained through the Qi programmes of work such as ED, Antenatal, Trauma & orthopaedics. These pulse check questions will be made available to all areas who may be undertaking service improvement pieces of work.

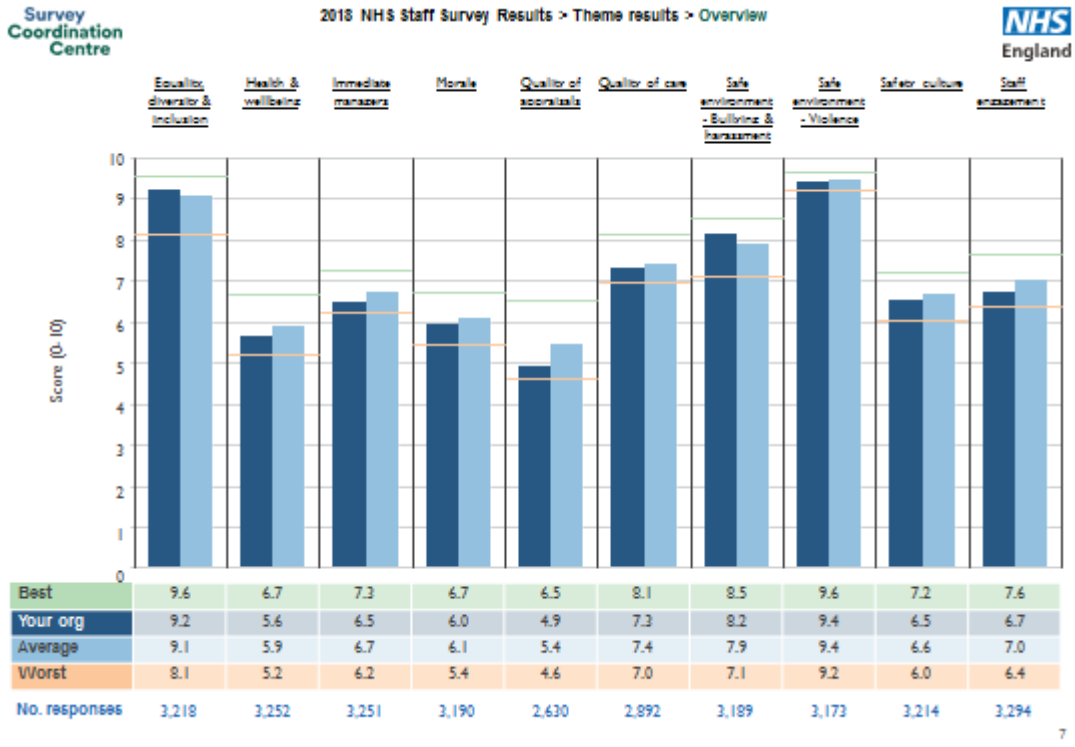
Regular feedback on progress against the action plan will be reported to QEC and divisional/directorate action plans will be monitored through visual management boards and the performance accountability framework.

Key questions posed by the report
Does the Board agree with the proposed actions and reporting methodology?
How this report contributes to the delivery of the strategic objectives
People – As a Teaching Hospital we are committed to continuously developing the skills, innovation and leadership of our staff to provide high quality, efficient and effective care
How this report impacts on current risks or highlights new risks
Staff morale – the actions contained within the report look to provide assurance that the Trust is taking steps to improve staff morale.
Recommendation(s) and next steps
Board members are asked to note this report and provide feedback.

Staff survey results 2018

In 2018 we undertook a mixed mode survey enabling staff within Estates and Facilities to complete paper copies of the survey. All other staff received an electronic copy. We saw an increase in response rate of 5% to 54% which is above the acute sector average by 10%. The response rate by division/directorate ranged from 46% within the Division of Medicine to 94% within Finance and Procurement.

The feedback provided by NHS England and the Survey Co-ordination centre has changed this year to the graphic below with ten themes.



Doncaster & Bassetlaw Teaching Hospitals' results are above average in respect of equality, diversity & inclusion and safe environment – bullying & harassment. Each theme has either remained static or improved by 0.1 apart from health and wellbeing which has declined by 0.1 – the questions which make up this score are opportunities for flexible working (which improved), whether the Trust takes positive action on health and wellbeing (5% point reduction in line with the best and worst performing Trusts), staff experiencing MSK problems (slight deterioration), feeling unwell as a result of work related stress (static) and coming to work despite not feeling well enough to perform duties (improvement). As members of the Board will be aware the Trust was recently awarded Nottingham Council's platinum health at work award, therefore Divisions will be encouraged to explore this question with their staff to understand how we can demonstrate that their health and wellbeing is important to us and to ensure we are directing our attention to those areas which are having an impact on staff. Divisions and Directorates have received a range of information regarding their results and are developing their action plans based on those results. Appendix 1 provides an analysis of each Division/directorate's results in the same format as the Trust level data above.

With regard to staff engagement this is made up of a number of questions comprising motivation (motivation), ability to make improvements (involvement) and recommending the Trust as place to work and receive treatment (advocacy). With regard to the latter questions we have seen the same

percentage improvement as the best performing Trusts, although there continues to be more that we need to do in order to achieve that step change. The table below provides an analysis by directorate/division as to which of the questions which should receive specific focus.

Comparisons with the Organisation average By Locality 1	Number of respondents	Staff Engagement Score	I would recommend my organisation as a place to work.	If a friend or relative needed treatment, I would be happy with the standard of care provided by this organisation.	Care of patients / service users is my organisation's top priority.	I am able to make suggestions to improve the work of my team / department.	There are frequent opportunities for me to show initiative in my role.	I am able to make improvements happen in my area of work.	I look forward to going to work.	I am enthusiastic about my job.	Time passes quickly when I am working.
			Advocacy			Involvement			Motivation		
Organisation Average	3,403	6.7	6.1	6.6	7.0	6.8	6.8	5.8	6.2	7.4	7.6
272 Chief Executive Directorate	18	8.0	7.1	8.2	8.2	8.2	8.5	8.1	6.9	7.9	8.7
272 Children & Families Division	395	6.4	5.4	6.2	6.7	6.5	6.7	5.3	6.1	7.3	7.4
272 Clinical Support Services Division	885	6.6	5.9	6.4	6.9	6.9	6.7	5.8	6.2	7.2	7.4
272 Estates & Facilities	321	6.1	5.7	6.2	7.0	5.3	5.8	4.4	5.9	6.7	7.4
272 Finance & Healthcare Contracting Directorate	88	6.7	6.1	6.4	7.3	7.1	6.7	6.4	5.6	6.8	7.6
272 IT Information & Telecoms Directorate	89	6.3	5.6	6.1	7.0	6.6	6.5	5.8	5.3	6.9	6.9
272 Medical Division	743	7.0	6.6	6.9	7.2	7.1	7.2	6.1	6.6	7.8	7.9
272 Nursing Services Directorate	61	7.0	6.2	6.5	7.6	7.4	7.1	6.8	6.3	7.5	7.4
272 People & Organisational Directorate	105	7.5	7.2	7.2	7.7	8.1	7.3	7.5	6.7	7.8	8.0
272 Performance Directorate	134	6.1	4.7	6.0	6.5	6.0	6.1	5.1	5.7	7.0	8.0
272 Surgical Division	552	6.8	6.3	6.8	7.0	6.9	6.8	5.8	6.5	7.5	7.8

As detailed within the staff engagement paper received by the Board last month the Trust wide areas of focus will comprise:

- Living our Values
- Involvement
- Leading to Outstanding
- Visibility of leaders
- Wellbeing into action
- Accountability

Theme	Action	Timescale	Lead
Living our values	Induction programme reviewed to incorporate Trust Values	Q1	Head of Leadership & OD

	Explicit discussion around values included within appraisals Integrate our We Care values into our communication methods to ensure we demonstrate that our values are at the heart of how we lead the Trust	Q1 Ongoing	Deputy Director of P&OD Head of Communications & Engagement
Quality Improvement	Qi programme of work Pulse check of staff involved in Qi programmes of improvement (before and after) Include stock set of questions from staff survey in quarterly staff friends and family test in order to gauge the feeling of staff on a regular basis	Ongoing Ongoing Each quarter	Director of Strategy & Improvement Head of Qi Head of Leadership & OD
Leading to Outstanding	Implement the Leadership development suite of programmes including the senior leaders programme Leading to Outstanding Shadow Board programme introduced Moving up programme for BAME staff	Q1 Q1 Q3	Head of Leadership & OD Ditto ditto
Visibility of leaders	All leaders will be required to visit their areas on a regular basis. In addition Executive Directors will undertake a programme of visits to their 'buddy' areas. Feedback will be provided to Management Board on a quarterly basis Regular 'coffee and cake' sessions with the Chair of the Board Establishment of staff experience groups within divisions and directorates to be complemented with Trust wide group to be chaired by the Chief Executive Fortnightly blog from Chief Executive to share with staff his thoughts and activities	Ongoing programme. Quarterly feedback Ongoing Q1 commenced	Divisional & corporate leadership teams Executive Directors Chair and Trust Board Secretary Leadership teams/ P&OD Chief Executive
Wellbeing into Action	Seek feedback from staff through divisional/directorates on what would make a difference – build this into the workplan for the	Q1	Leadership teams

	health and wellbeing group. Develop and implement a mental health and wellbeing plan Re-launch staff lottery and access to health and wellbeing fund	 Q2 Q1	 Deputy Director of P&OD Head of Communications & Engagement
Accountability	Development of objectives for all staff to be linked to Due North breakthrough objectives Performance assurance framework to include staff survey related KPIs Feedback from staff experience groups and leadership 'walkabouts' to be reported to Management Board on a quarterly basis Development of visual management boards with the support of the Qi team	Q1 Q1 Quarterly Q1	All leaders Director of P&OD All divisions/ directorates All divisions/ directorates

The staff engagement driver diagram presented at last month's meeting is repeated at Appendix 2 – this will be finalised along with driver diagrams associated with our other breakthrough objectives. As detailed within that driver diagram the KPIs to be monitored during the year will be:

- Vacancy rates
- Retention and turnover rates
- Sickness absence rates
- Staff survey questions which require particular attention
- Staff engagement questions around advocacy, motivation and involvement

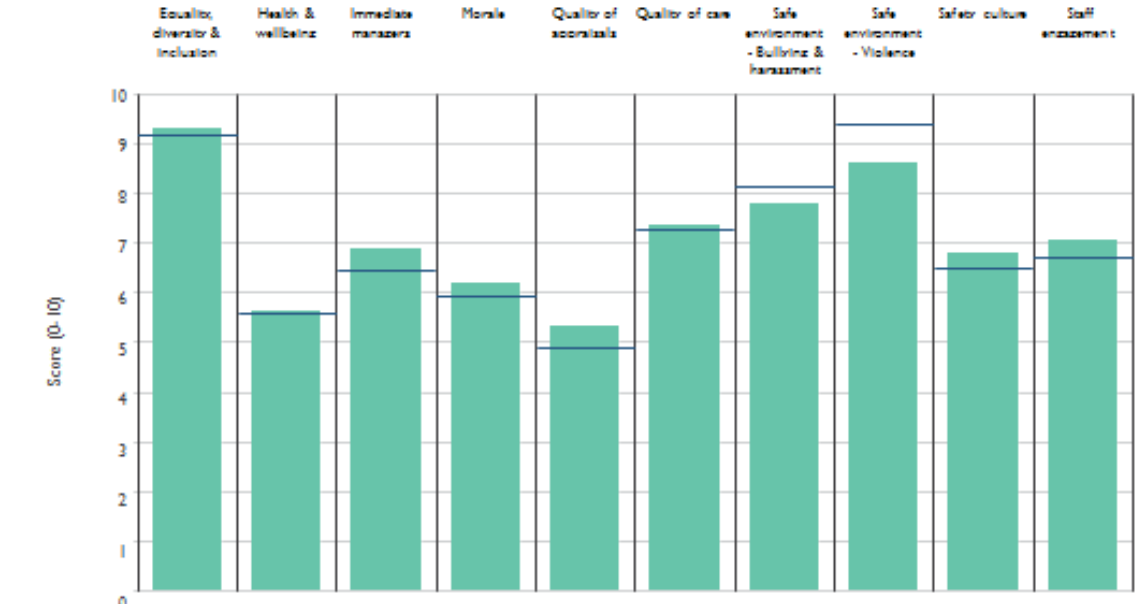
In addition to this plan Divisions and Directorates will develop their own action plans with the engagement of their staff. In order to support this process the approach adopted by Listening into Action of engaging with staff to seek their solutions is embedded within our Qi Lean programme. This will continue to be supplemented by pulse checks throughout the programme of improvement – this will ensure that leaders are sighted on how staff are feeling about their involvement and the changes being implemented.

Progress against the Trust level action plan will be monitored through reports to QEC. Divisional/directorate action plans will be monitored through visual management boards and the performance assurance framework.

Survey Coordination Centre

2018 NHS Staff Survey Results > Directorates 1 > 272 Medical Division

NHS England



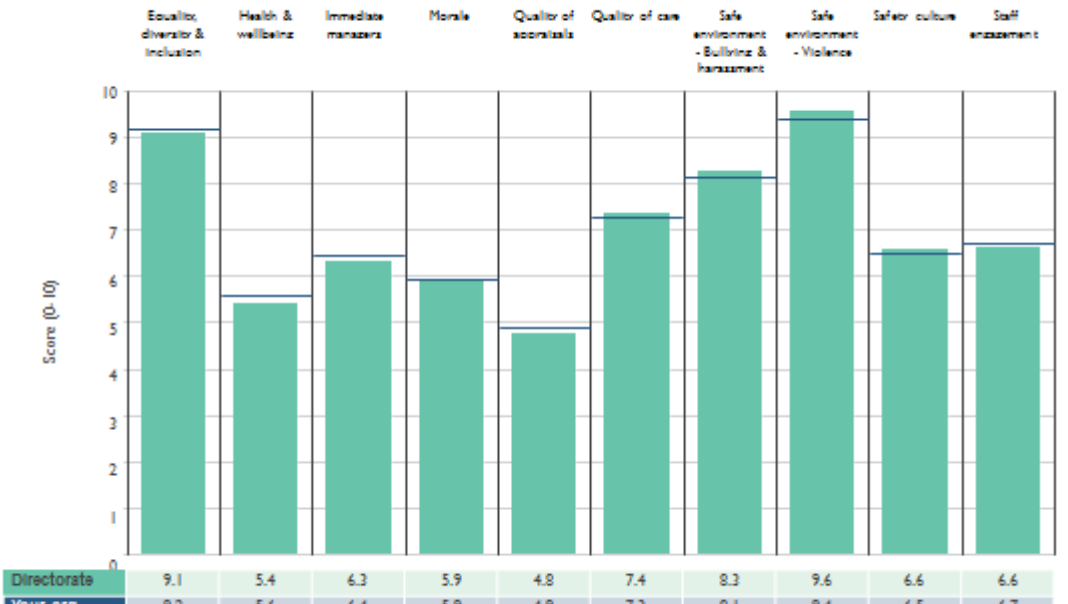
	Equality, diversity & inclusion	Health & wellbeing	Immediate managers	Morale	Quality of appraisals	Quality of care	Safe environment - Bullying & harassment	Safe environment - Violence	Safety culture	Staff engagement
Directorate	9.3	5.6	6.9	6.2	5.3	7.4	7.8	8.6	6.8	7.0
Your org	9.2	5.6	6.4	5.9	4.9	7.3	8.1	9.4	6.5	6.7
No. responses	698	707	708	699	550	686	694	686	703	719

8

Survey Coordination Centre

2018 NHS Staff Survey Results > Directorates 1 > 272 Clinical Support Services Division

NHS England



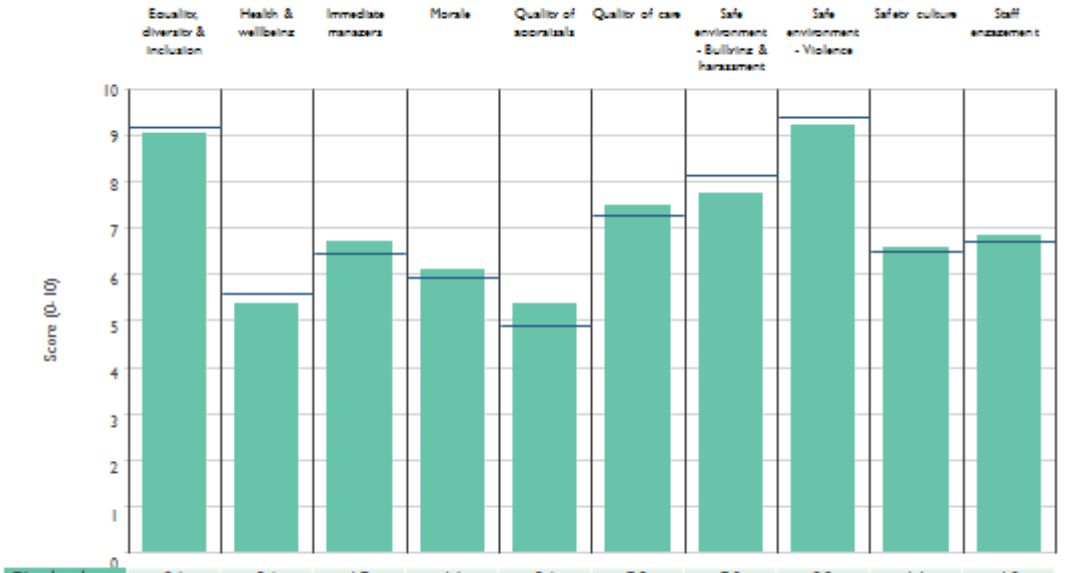
	Equality, diversity & inclusion	Health & wellbeing	Immediate managers	Morale	Quality of appraisals	Quality of care	Safe environment - Bullying & harassment	Safe environment - Violence	Safety culture	Staff engagement
Directorate	9.1	5.4	6.3	5.9	4.8	7.4	8.3	9.6	6.6	6.6
Your org	9.2	5.6	6.4	5.9	4.9	7.3	8.1	9.4	6.5	6.7
No. responses	841	848	850	831	743	824	835	839	837	859

9

Survey Coordination Centre

2018 NHS Staff Survey Results > Directorates 1 > 272 Surgical Division

NHS England



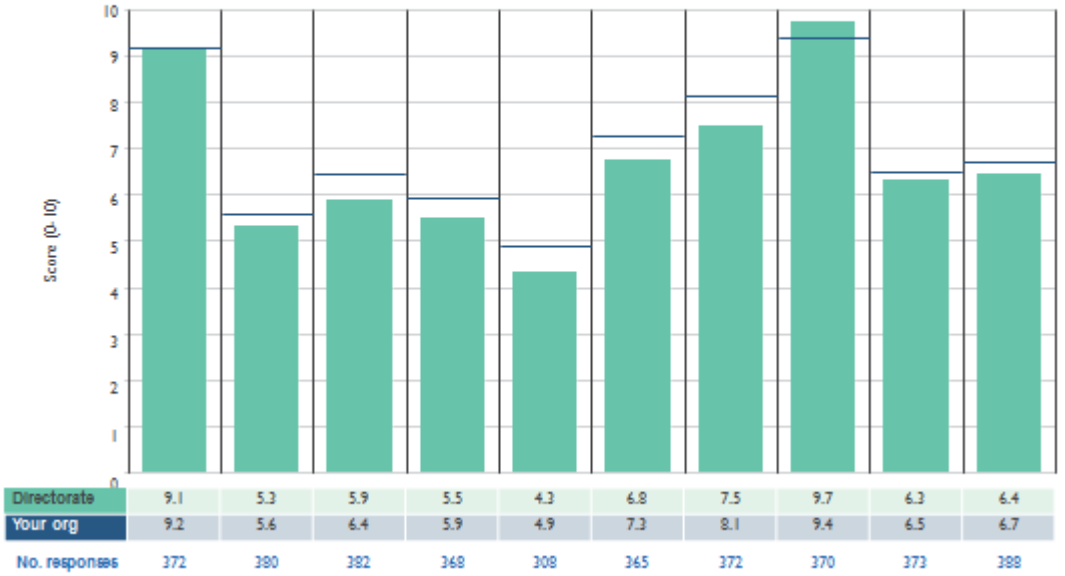
	Equality, diversity & inclusion	Health & wellbeing	Immediate managers	Morale	Quality of appraisals	Quality of care	Safe environment - Bullying & harassment	Safe environment - Violence	Safety culture	Staff engagement
Directorate	9.1	5.4	6.7	6.1	5.4	7.5	7.8	9.2	6.6	6.8
Your org	9.2	5.6	6.4	5.9	4.9	7.3	8.1	9.4	6.5	6.7
No. responses	527	530	532	523	389	500	518	513	530	540

2
0

Survey Coordination Centre

2018 NHS Staff Survey Results > Directorates 1 > 272 Children & Families Division

NHS England



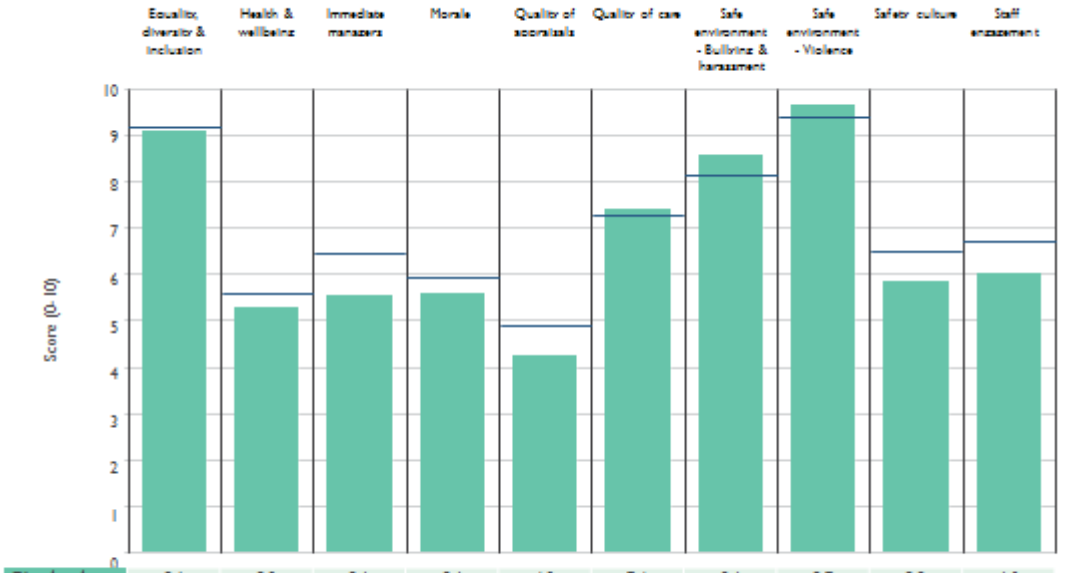
	Equality, diversity & inclusion	Health & wellbeing	Immediate managers	Morale	Quality of appraisals	Quality of care	Safe environment - Bullying & harassment	Safe environment - Violence	Safety culture	Staff engagement
Directorate	9.1	5.3	5.9	5.5	4.3	6.8	7.5	9.7	6.3	6.4
Your org	9.2	5.6	6.4	5.9	4.9	7.3	8.1	9.4	6.5	6.7
No. responses	372	380	382	368	308	365	372	370	373	388

2
1

Survey Coordination Centre

2018 NHS Staff Survey Results > Directorates 1 > 272 Estates & Facilities

NHS England



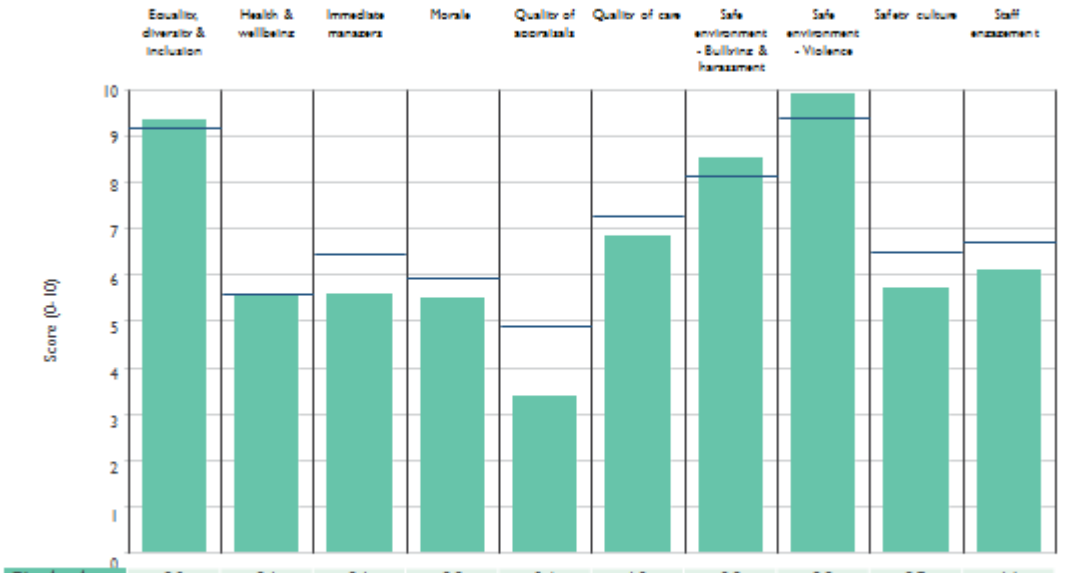
	Equality, diversity & inclusion	Health & wellbeing	Immediate managers	Morale	Quality of appraisals	Quality of care	Safe environment - Bullying & harassment	Safe environment - Violence	Safety culture	Staff engagement
Directorate	9.1	5.3	5.6	5.6	4.3	7.4	8.6	9.7	5.8	6.0
Your org	9.2	5.6	6.4	5.9	4.9	7.3	8.1	9.4	6.5	6.7
No. responses	288	293	288	283	198	237	283	281	283	291

22

Survey Coordination Centre

2018 NHS Staff Survey Results > Directorates 1 > 272 Performance Directorate

NHS England



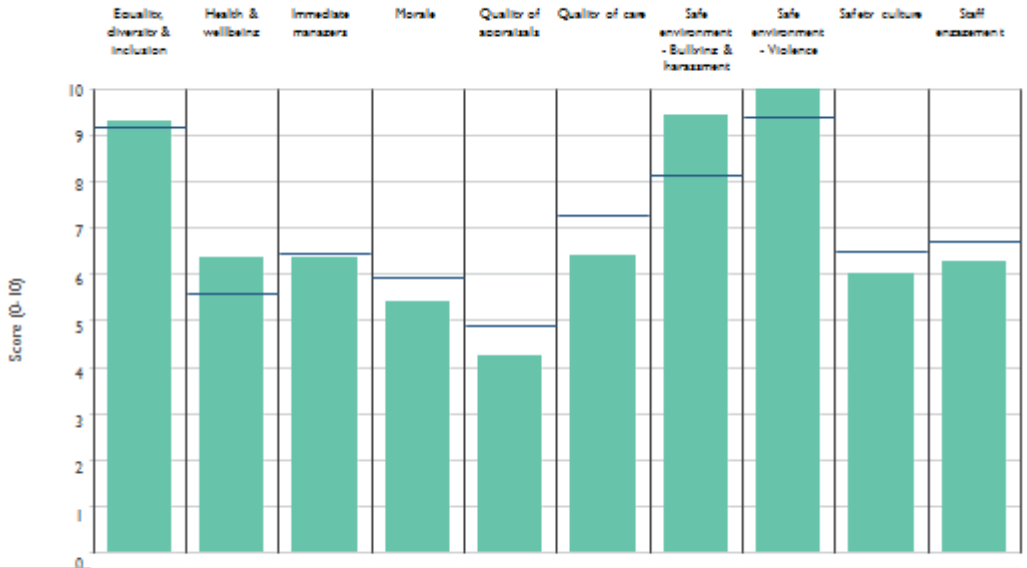
	Equality, diversity & inclusion	Health & wellbeing	Immediate managers	Morale	Quality of appraisals	Quality of care	Safe environment - Bullying & harassment	Safe environment - Violence	Safety culture	Staff engagement
Directorate	9.3	5.6	5.6	5.5	3.4	6.8	8.5	9.9	5.7	6.1
Your org	9.2	5.6	6.4	5.9	4.9	7.3	8.1	9.4	6.5	6.7
No. responses	124	125	122	121	106	99	124	123	121	127

23

Survey Coordination Centre

2018 NHS Staff Survey Results > Directorates 1 > 272 IT Information & Telecoms Directorate

NHS England



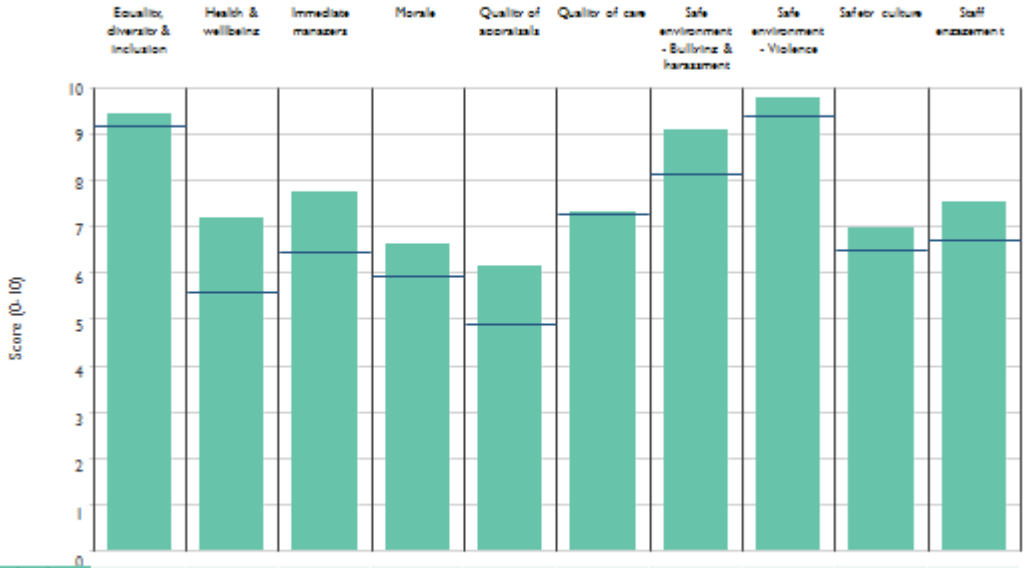
	Equality, diversity & inclusion	Health & wellbeing	Immediate managers	Morale	Quality of appraisals	Quality of care	Safe environment - Bullying & harassment	Safe environment - Violence	Safety culture	Staff engagement
Directorate	9.3	6.4	6.4	5.4	4.2	6.4	9.4	10.0	6.0	6.3
Your org	9.2	5.6	6.4	5.9	4.9	7.3	8.1	9.4	6.5	6.7
No. responses	88	89	89	86	74	28	87	87	87	89

24

Survey Coordination Centre

2018 NHS Staff Survey Results > Directorates 1 > 272 People & Organisational Directorate

NHS England



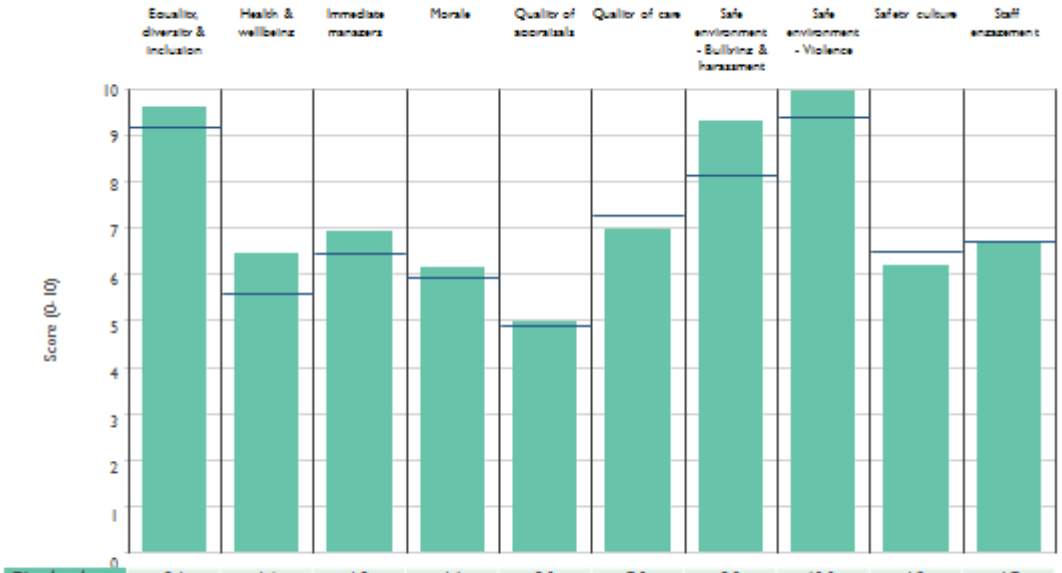
	Equality, diversity & inclusion	Health & wellbeing	Immediate managers	Morale	Quality of appraisals	Quality of care	Safe environment - Bullying & harassment	Safe environment - Violence	Safety culture	Staff engagement
Directorate	9.4	7.2	7.7	6.6	6.2	7.3	9.1	9.8	7.0	7.5
Your org	9.2	5.6	6.4	5.9	4.9	7.3	8.1	9.4	6.5	6.7
No. responses	104	103	103	103	94	62	104	104	104	104

25

Survey Coordination Centre

2018 NHS Staff Survey Results > Directorates 1 > 272 Finance & Healthcare Contracting Directorate

NHS England



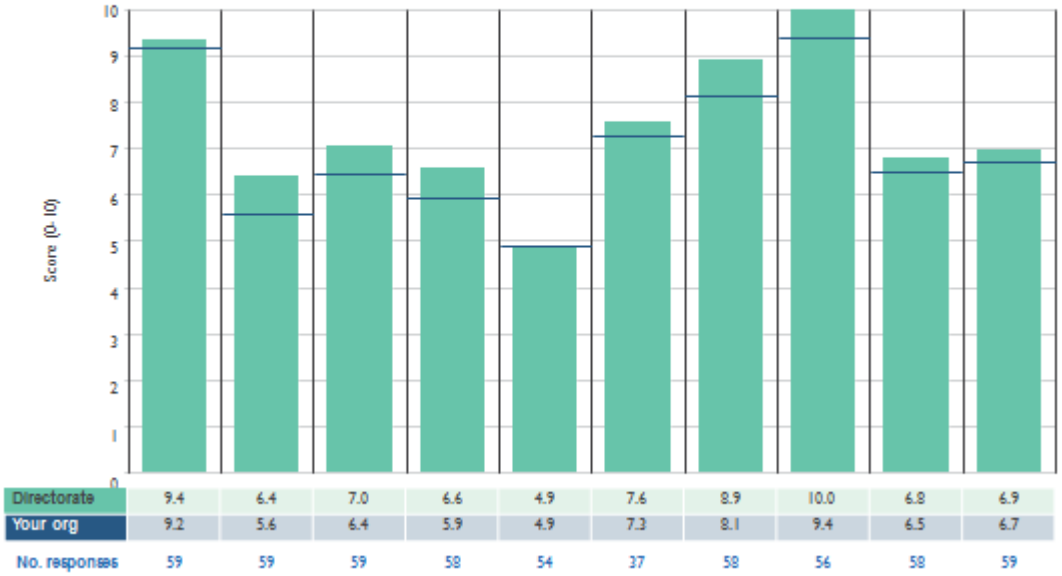
	Equality, diversity & inclusion	Health & wellbeing	Immediate managers	Morale	Quality of appraisals	Quality of care	Safe environment - Bullying & harassment	Safe environment - Violence	Safety culture	Staff engagement
Directorate	9.6	6.4	6.9	6.1	5.0	7.0	9.3	10.0	6.2	6.7
Your org	9.2	5.6	6.4	5.9	4.9	7.3	8.1	9.4	6.5	6.7
No. responses	87	88	89	88	86	34	84	84	88	88

26

Survey Coordination Centre

2018 NHS Staff Survey Results > Directorates 1 > 272 Nursing Services Directorate

NHS England



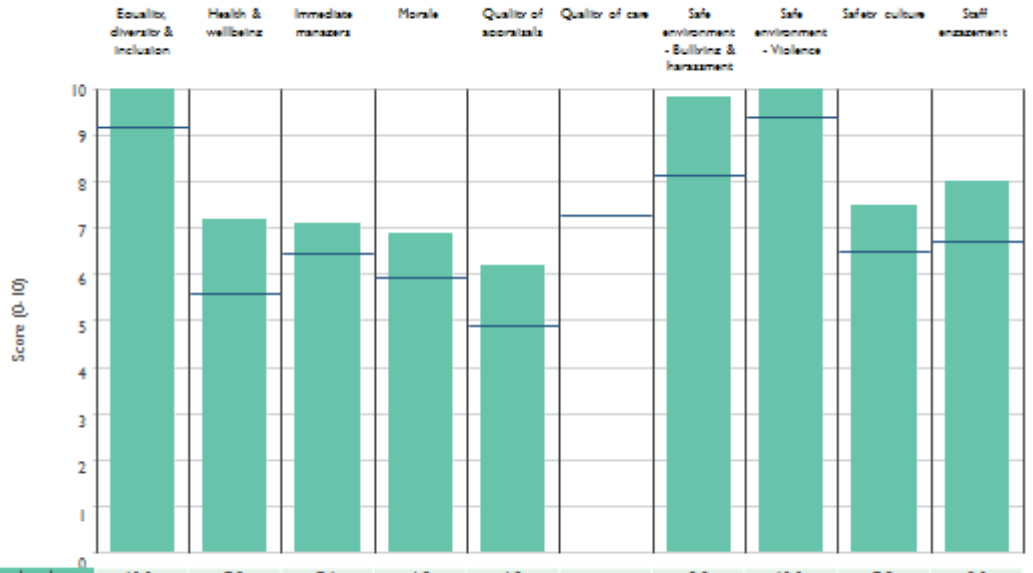
	Equality, diversity & inclusion	Health & wellbeing	Immediate managers	Morale	Quality of appraisals	Quality of care	Safe environment - Bullying & harassment	Safe environment - Violence	Safety culture	Staff engagement
Directorate	9.4	6.4	7.0	6.6	4.9	7.6	8.9	10.0	6.8	6.9
Your org	9.2	5.6	6.4	5.9	4.9	7.3	8.1	9.4	6.5	6.7
No. responses	59	59	59	58	54	37	58	56	58	59

27

Survey Coordination Centre

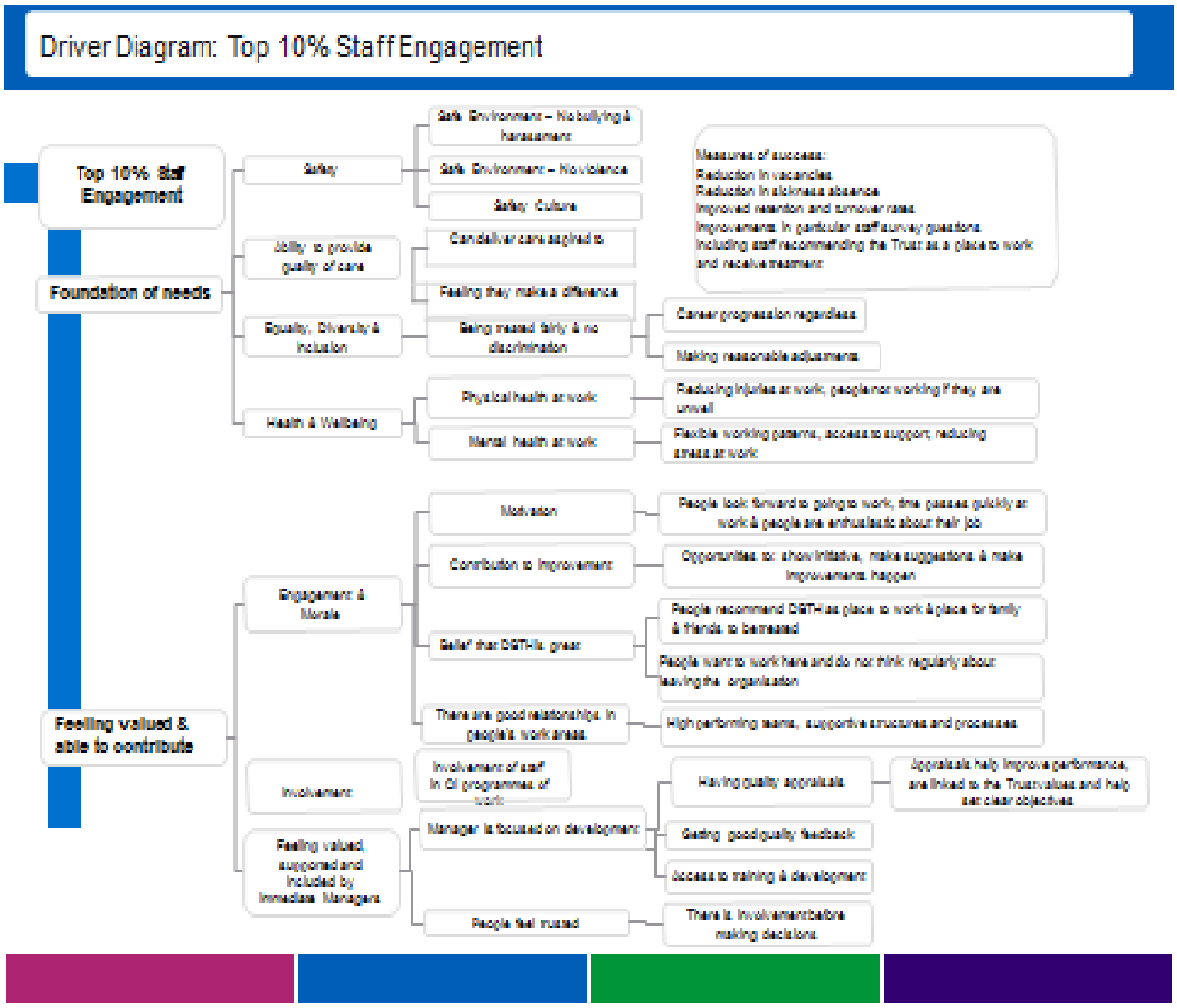
2018 NHS Staff Survey Results > Directorates 1 > 272 Chief Executive Directorate

NHS England



	Equality, diversity & inclusion	Health & wellbeing	Immediate managers	Morale	Quality of appraisals	Quality of care	Safe environment - Bullying & harassment	Safe environment - Violence	Safety culture	Staff engagement
Directorate	10.0	7.2	7.1	6.9	6.2		9.8	10.0	7.5	8.0
Your org	9.2	5.6	6.4	5.9	4.9	7.3	8.1	9.4	6.5	6.7
No. responses	18	18	18	18	16	10	18	18	18	18

28


Driver Diagram: Top 10% Staff Engagement
Top 10% Staff Engagement
Foundation of needs
Feeling valued & able to contribute
Safety
Safe Environment – No bullying & harassment
Safe Environment – No violence
Safety Culture
Ability to provide quality of care
Can deliver care as planned to
Feeling they make a difference
Equality, Diversity & Inclusion
Being treated fairly & no discrimination
Career progression regardless
Making reasonable adjustments
Health & Wellbeing
Physical health at work
Reducing injuries at work, people not working if they are unwell
Mental health at work
Flexible working patterns, access to support, reducing stress at work
Engagement & Morale
Motivation
People look forward to going to work, time passes quickly at work & people are enthusiastic about their job
Contribution to Improvement
Opportunities to: show initiative, make suggestions & make improvements happen
Belief that DBTHis great
People recommend DBTH as place to work & place for family & friends to be treated
People want to work here and do not think regularly about leaving the organisation
There are good relationships in people's work areas
High performing teams, supportive structures and processes
Involvement
Involvement of staff in QI programmes of work
Feeling valued, supported and included by Immediate Managers
Manager is focused on development
Having quality appraisals
Appraisals help improve performance, are linked to the Trust values and help set clear objectives
Getting good quality feedback
Access to training & development
People feel trusted
There is involvement before making decisions
Measures of success:
Reduction in vacancies
Reduction in sickness absence
Improved retention and turnover rates
Improvements in particular staff survey questions
Including staff recommending the Trust as a place to work and receive treatment

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Title	**CQC update Report**		
Report to	**Board of Directors**	**Date**	**26 March 2019**
Author	**Mr. Sewa Singh, Medical Director** **Moira Hardy, Director of Nursing, Midwifery and Allied Health Professionals**		
Purpose	To update Trust Board on the recently released CQC report following inspection visit to Urgent & Emergency Services November 2018		Tick one as appropriate
	Decision		
	Assurance		X
	Information		X

Executive summary containing key messages and issues

The CQC carried out a focussed unannounced inspection of the urgent and emergency care services at Doncaster Royal Infirmary and Bassetlaw Hospitals on 27-29 November 2018. This inspection was to follow up on issues identified at the previous inspection in December 2017 as required when the service is rated as Requires Improvement (RI). These specific issues included:

1. concerns around the management of queue time to the initial assessment process
2. paediatric nurse staffing levels in ED
3. paediatric advanced warning scores (PAWS) not always being completed
4. compliance with mandatory training, including adult and paediatric life support was low

Following the inspection the services remained at Requires Improvement, however the Safe domain at Doncaster Royal Infirmary was changed from "Requires Improvement" to "Inadequate." Full details of the reasons for the change can be found in the report (see link)
https://www.cqc.org.uk/sites/default/files/new_reports/AAAH9827.pdf

The inspectors did acknowledge that there had been some improvement since the last visit which included areas around:

- governance processes - structure & incident management
- key waiting times equalling or bettering the England average
- positive patient feedback

The CQC report contains actions which the Trust must take:

1. review their process for initial assessment to address the risks to adult and paediatric patients.
2. ensure that nurse staffing levels, including paediatric trained nurses, are increased to ensure

the safety of patients.

3. ensure the room used to care for patients with mental health needs conforms to the Psychiatric Liaison Accreditation Network (PLAN) standards.
4. ensure that there is effective monitoring and escalation of deteriorating paediatric patients and that staff complete relevant training including paediatric life support.
5. ensure all staff have completed relevant safeguarding training. Safeguarding training must meet the recommendations of the intercollegiate guidance for level three.
6. ensure medications are stored appropriately and staff comply with trust guidance.
7. The provider must ensure that all staff have completed appraisals.

In addition the CQC identified actions the Trust should take:

1. ensure there are robust actions taken to achieve optimal clinical outcomes for patients as indicated by the RCEM audits.
2. ensure the environment provides patient's privacy, dignity and confidentiality.
3. ensure the risks on the risk register match all the risks identified during the inspection.

At the time of the inspection, and post Inspection the Trust took steps to respond to the specific points:

- The Trust changed the initial assessment process and provided an initial action plan detailing the actions to be taken to address the risks to patients. This action plan (Attached) will also capture the evidence required for the MUSTs and SHOULDs above.
- Formation of a working group to address the concerns raised – *(weekly review of action plan)*
- Continued assurance updates and liaison with CQC - *(fortnightly update of action plan to CQC)*
- Scheduling of spot audit checks (*feedback via weekly review action plan meetings)*
- Scheduling of mock inspections to ensure all corrective action has been implemented and is effective
- Involvement of the Trust Qii team in the ED - improvement project identified and currently underway

In addition the Trust intends to take further actions to improve compliance with CQC standards ahead of future inspections:

- Introduce effective cross discipline mock inspections
- Schedule of independent internal audit inspection
- Ensure governance process includes regular spot check audits and is documented
- Recent appointment of quality and compliance analyst to support the setting up of an electronic dashboard for CQC compliance. This dashboard will store all the domains and services inspected, with the Key Lines of Enquiry (KLOE) and action plans embedded. This will ensure some consistency with the progression of the CQC action plans and have a live database for key staff to be able to access CQC compliance.
- Work with all divisional CQC leads to have some consistency with the action plans and RAG with supply of evidence.

Key questions posed by the report

Is the Board assured that the actions set out in this report address the concerns and recommendations made by the CQC in relation to the unannounced inspection of November 2018?

How this report contributes to the delivery of the strategic objectives
This report provides the Board of Directors with information on actions taken and work proposed to enhance the Trusts self-assessment process to ensure that quality issues and risks related to the Trust CQC ratings are identified through triangulation of externally reported data, local intelligence and exposure.
How this report impacts on current risks or highlights new risks
The Trusts Board Assurance Framework and Risk Register has been updated to reflect the CQC Report. The Board is asked to note that the Trust Board Secretary has met with Executives to undertake a review of controls and assurance for all risks with particular updates given to the two CQC risks Q&E13 and Q&E14: Q&E7 - Failure to adequately prepare for CQC inspection F&P6 - Failure to achieve compliance with performance and delivery aspects of the Single Oversight Framework, CQC and other regulatory standards Q&E13 – Failure to provide full initial ED triage assessment processes Q&E14 – Failure to provide sufficient staffing for registered children's nurses in ED on DRI and BDGH sites
Recommendation(s) and next steps
(1) To note the report.

Action Plan for UEC announced inspection by CQC 27-29 November 2018 (*lasted updated 21/3/19*)

	Recommendation	Action	Implementation by:	Target Date	Completion Date	Evidence of Progress & Completion
1.1	We require the trust to conduct an urgent review of triage/initial assessment in the urgent and emergency care (ED) service to address the immediate risks to adult and child patients.	An urgent of review of the triage and initial assessment process has been conducted. This has included discussion with: • NHS Doncaster CCG • The Emergency Department Management team, including Clinical Service Lead, Matron and Service Manager in relation to changing the commissioned model "Front Door Assessment and Streaming Service". Whilst this discussion remains ongoing the following immediate steps have been implemented: • A revised model using a reception check-in has been implemented. • A full initial assessment by a registered nurse with triage skills, utilising a recognised and evaluated triage tool, will be conducted within a targeted 15 minute interval following check-in registration. • The triage will include relevant assessments for physiological observations where indicated. • There will be referral for initial assessment tests, imaging and administration of pain relief where patients require it. • Triage will take place in a cubicle that will enable sufficient privacy to enable undressing and visual	ADoN/ General Manager	11/12/ 2018	11/12/2018	Discussed with DCCG 7/12/18 Review with ED Management Team 10/12/18 Immediate steps designed and implemented. 10/12/18 Support provided for staff with making change. Workforce adjustments made to facilitate check-in and triage 11/12/18 **CLOSED**

	Recommendation	Action	Implementation by:	Target Date	Completion Date	Evidence of Progress & Completion
		assessments and examination for adults and children. • The outcome of the assessment will be allocation of patients to a relevant patient pathway, for example Urgent Treatment Centre (FCMS), Minor Injury Unit, Ambulatory Care, radiology, or escalation for an early senior medical review within the ED. • A responsive escalation process to ensure receptionist and triage nurse availability to achieve prompt check in followed by initial assessment triage within 15 minutes, which will be described in the Standard Operating Procedure (SOP) for Triage (see 1.2). • Triage times to be monitored by the Nurse in Charge and highlighted at the 4 times a day operational meeting or as required by activity, in line with SOP (see 1.2). • Triage nursing staff will provide clinical oversight of the waiting area and the queue in between their assessment of patients and through the escalation process to identify additional support if this is required, which will be described in the SOP for the waiting room oversight (see 2.1). The above actions have been conducted in order to address any immediate risks to unwell children and adults				

	Recommendation	Action	Implementation by:	Target Date	Completion Date	Evidence of Progress & Completion
1.2		A Standard Operating Procedure ("SOP") for Triage will be created in order to take account of the new model of care, building on the previous FDASS SOP.	Matron/ Service Manager	21/12/ 2018	21/12/2018	SOP CLOSED
2.1	Confirm that appropriate clinical oversight (over 24 hours, seven days) is in place for the assessment and monitoring of patient risk in the urgent and emergency care service. The clinical oversight is required to ensure all relevant staff are able to provide safe care and treatment for child patients.	A SOP for waiting room oversight by Triage Nurses will be created in order to ensure that there is appropriate clinical oversight in the waiting room area.	Matron/ Service Manager	21/12/ 2018	21/12/2018	SOP CLOSED
2.2		Staff will be supported to undertake revised roles and responsibilities, which will include making refresher training available, based on staff and management requirements.	ADoN/ General Manager	21/12/ 2018	17/01/2019	Anecdotal positive response from staff with no training needs identified CLOSED
2.3		A working group will be established in order to oversee the front door assessment processes and patient flow, and to ensure appropriate clinical oversight over 24 hours and every day of the week.The working group will: • Establish appropriate reporting arrangements and timeframes for internal and external scrutiny. • Ensure engagement, with membership from DCCG, clinical leaders from the Emergency Department, Quality Improvement Team with Executive leadership from the Chief Operating Officer. • Utilise NHSI Improving Practice methodologies, including staff engagement in the redesign of services. Reporting arrangements will include weekly reporting of Key Performance Indicators covering robust and auditable patient safety standards and other quality indicators to	COO	21/12/ 2018	21/12/2018	Weekly action notes submitted to ET and CQC CLOSED

	Recommendation	Action	Implementation by:	Target Date	Completion Date	Evidence of Progress & Completion
		monitor progress and provide assurance, will be provided to the Executive Team. Additionally, monthly reports to the Executive Team, Clinical Governance Committee and Urgent Emergency Care Steering Group will be provided. With the minutes and assurance of these meetings being undertaken by the Quality and Effectiveness Committee.				
3.1	Ensure effective triage assessment and early warning score for children is in place in ED.	An audit tool will be developed in order to monitor compliance with Paediatric Advance Warning Score and National Early Warning Score observations being completed. This audit will include review of the timeliness of observations, whether the observations are complete, whether there has been an appropriate response and clinical escalation, and use of sepsis screening tools. (Triage component described in section 1.1 above)	Matron/ Service Manager	18/12/ 2018	Jan 2019	Audit results reported via dashboard CLOSED
3.2		A rapid improvement audit process on compliance to standards of adequacy and timeliness pf physiological observations will be undertaken from both DRI and BDGH ED's, for both Adult and Children in order to feedback to staff on their process outcomes and actions for improvement. This will occur at an initial frequency of >2 times week until reaching the target of 95% compliance.	Matron/ Service Manager	January 2019	January 2019	Audit results reported via dashboard CLOSED
3.3		Compliance will be monitored as part of the KPI's and reported through a quality dashboard for ED.	DDQ&G	~~19/12/2018~~ 31/1/2019	~~January 2019~~ March 2019	Action notes evidence dashboard discussion. Data source flows being modified with partial completion to date. Pops training

	Recommendation	Action	Implementation by:	Target Date	Completion Date	Evidence of Progress & Completion
						programme developed Paeds educator identifying block times to train the trainer
4.1	An urgent review of competency of staff to manage a sick child in ED to ensure that children are escalated in a timely and appropriate way.	A review of the workforce training needs analysis (TNA) in line with RCPCH and RCN guidance, so as to provide competencies for the management of a sick child, is being undertaken by existing and future recruited staff.	ADoN/ DD Education	31 January 2019		Training needs analysis completed. Business case to be reviewed for clinical educators. CLOSED
4.2		In line with the revised TNA, a training plan utilising internal and external resources to support the development of skills for all staff will be established. Linking in with Barnsley to coordinate training for ED staff across the region.	ADoN/ DD Education	31 January 2019		Staff on both sites enrolled on course with SHU CLOSED
4.3		A specialist working group that will involve clinical leaders from paediatrics, ED, and educational leads will be established. This will be led by the Chief Operating Officer. The working group will: • Collectively build a framework to support best practice guidance with an appropriate workforce model • Oversee development and implementation of the training needs analysis for the workforce. • Maximise the recruitment of registered children's nurses, locally, nationally and internationally if available.	COO	21/12/ 2018	21/12/2018	Weekly action notes submitted to ET and CQC CLOSED

	Recommendation	Action	Implementation by:	Target Date	Completion Date	Evidence of Progress & Completion
		• Explore opportunities to work collaboratively with Sheffield Children's Hospital NHSFT, to look at rotation of staff between organisations. • Undertake work to maximise retention and reduce staff turnover. • Develop and implement KPI's, robust and auditable patient safety standards and other quality indicators to monitor progress and provide assurance. • Establish appropriate reporting arrangements and timeframes for internal and external scrutiny. The reporting arrangements are as described in 2.3.				
5.1	An urgent review of competency for prescribing and administering medicines to children.	A baseline assessment of practice in respect of prescribing and administration of medicines for children will be undertaken, in order to review existing KPI's to ensure that existing practices are consistent across the Trust, meet best practice standards, and that staff members prescribing and administering medicine have relevant competency and training.	ADoN	31 March 2019		SOP completed for single person administration of medications for Pediatric nurses in ED. Review competency packages for drug administration-check and check compliance with spot audit Reviewed incidents from paediatric drug administration-none

	Recommendation	Action	Implementation by:	Target Date	Completion Date	Evidence of Progress & Completion
						Medication & walk around audit checks to be reported on dashboard.
6.1	A recruitment plan with timelines.	An advertisement for a Band 5 and 6 registered children's nurse has been placed.	ADoN	30 November 2018	30 November 2018	Interviews undertaken and appointments made CLOSED
6.2		Our temporary staffing arrangements will be strengthened by engaging with a different nursing agency as part of our cascade beyond NHS Professionals.	ADoN	12/12/ 2018	12/12/ 2018	Cascade system in place, shifts on NHSP and available to agency with 7 day lead time. CLOSED
6.3		A bank-share model with ICS partners will be explored, including Sheffield Children's Hospital.	DDNMAHP's	January 2019	24/01/2019	ICS Working Group model agreed in principle CLOSED
6.4		Acuity assessments (BEST/SNCT for ED) will continue to be undertaken to ensure safe staffing levels can be provided in ED, in line with national guidance.	ADoN	January 2019	February 2019	Data presented to QEC 20.02.2019 Next assessment planned for May/June CLOSED

	Recommendation	Action	Implementation by:	Target Date	Completion Date	Evidence of Progress & Completion
7.1	A profile of when infants, children and young people are likely to attend the ED should be developed so that the rota enables two registered children's nurses to be present during peak times.	A review of clinical activity for infants, children and young people will be conducted, to align children's nursing staffing resources and optimisation of the use of registered children nurses. This will reflect the expected update to RCN guidance and RCPCH standards.	ADoN/ General Manager	January 2019	February 2019	Band 6 Paeds Nurses commence in post on 25.2.19 CLOSED
8.1	Collaborative and flexible rotation training and planning – so that during peak periods and when there may only be one registered children's nurse present in the ED, children's nurses are available to be brought in from other areas of the hospital.	All opportunities for recruiting to the Paediatric service will be pursued, building on the recruitment of 4 nurses, in the last 3 weeks. This will enable more opportunities for rotational posts and resilience in both Paediatric and ED services.	ADoN Medicine /Head of Paediatric Nursing	January 2019		Rotation plan between ED and paedatrics completed Band 6 Paeds Nurses commenced in post on 25.2.19. Band 5 paeds nurses are currently in recruitment process following interviews in February **CLOSED**
8.2		Further develop existing rotation posts through ED and Paediatric wards for registered children's nurses, play leaders and support workers to provide a workforce that is equipped to support ED on a planned basis and when the need arises.	ADoN Medicine /Head of Paediatric Nursing	March 20191qwsx		Joint advert for rotational post between ED and childrens wards completed for both sites– and advertised 11.2.19

	Recommendation	Action	Implementation by:	Target Date	Completion Date	Evidence of Progress & Completion
						3 new band 5 paediatric nurses appointed March 2019 Continuous recruitment to support paediatric staff across the site **CLOSED**
9.1	Evidence of discussions with higher education institutions to ensure training programmes are available to registered adult nurses to gain the child focused knowledge, skills and competencies to care for infants, children and young people and for children's nurses to gain post-registration trauma and emergency training	Contact will be made with the University of Sheffield and Sheffield Hallam University to establish opportunities for further education and training to support adult nurses and registered children's nurses to develop the skills to provide care for children who present when acutely unwell and following trauma.	DD Education	11/12/ 2018	11/12/2018	Emails and Letter provided to CQC. CLOSED
10.1	Ensure effective governance and assurance processes for the service changes and quality improvements intended through this action plan.	Weekly reporting arrangements of KPI's which are inclusive of patient safety and quality indicators will be provided to the Executive Team. Monthly reporting will be provided through the Executive Team, Clinical Governance Committee and Urgent Emergency Care Steering Group. Minutes and assurance of these meetings will be undertaken by the Quality and Effectiveness Committee, which is a formal sub-committee of the Board of Directors ensuring escalation to the Board to Directors on any	DDQ&G	19/12/ 2018	January 2019	Minutes from ET, CGC and QEC as appropriate Email updates fortnightly to CQC CLOSED

	Recommendation	Action	Implementation by:	Target Date	Completion Date	Evidence of Progress & Completion
		element of the planned improvements which are not being delivered to plan, or which require further assurance on action. Two weekly reports to CQC until agreed to reduce to monthly with CQC Inspection Manager.				
10.2		A self-assessment using the RCPCH audit toolkit (70 criteria covering the RCPCH standards) will be conducted to provide a gap analysis and inform ongoing priorities that will be led through the working groups in 2.3 and 4.3 above.	ADoN/ Clinical Director/ General Manager	January 2019		RCPCH toolkit reviewed and completed – to discuss with Consultant with Lead for Paeds in ED re action plan
10.3		Unannounced mock inspections will be periodically undertaken to assess progress against the action plan and service standards.	DNMAHP	March 2019		Plans in place for mock inspections.
10.4		A schedule for reporting the weekly and monthly qualitative and quantitative data will be developed, with targets that meet the requirements of best practice standards, including RCPCH standards, incorporating activities of 10.1.	DDQ&G	~~21/12/2018~~ 31/01/2019		Action notes evidence dashboard discussion. Data source flows being modified with partial completion to date

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Title	**New Case Assignment Definitions – Clostridium Difficile**		
Report to	**Board of Directors**	**Date**	**26 March 2019**
Author	**Moira Hardy, Director of Nursing, Midwifery & Allied Health Professionals** **Dr Ken Agwuh, Director of Infection Prevention and Control (DIPC)**		
Purpose			Tick one as appropriate
	Decision		
	Assurance		
	Information		✠

Executive summary containing key messages and issues
This paper updates Board of Directors on the new case assignments definitions to be introduced from 1st April 2019 on Healthcare Associated Infection recommended definitions used to attribute/apportion Clostridium Difficile Infections. The paper shows the rate of CDI that would have been reported in the year 2018/19 had the new definitions been in force and describes action to be taken to support achievement of the objective to have no more than 44 CDI cases in 2019/20.
Key questions posed by the report
N/A
How this report contributes to the delivery of the strategic objectives
Patients – Work with patients to continue to develop accessible, high quality and responsive services **People –** As a Teaching Hospital was are committed to continuously developing the skills, innovation and leadership of our staff to provide high quality, efficient and effective care **Prevention -** We will support the development of enhanced community based service, prevention and self care

How this report impacts on current risks or highlights new risks
F&P6 Failure to achieve compliance with performance and delivery aspects of the Single Oversight Framework, CQC and other regulatory standards leading to; (i) Regulatory action (ii) Impact on reputation
Recommendation(s) and next steps
The Board of Directors are asked to note the content of the paper in regard to the new case assignment definitions and the actions being taken to support achievement of the CDI objective 2019/20.

Introduction

Clostridium difficile infection (CDI) remains an unpleasant, and potentially severe or even fatal infection that occurs mainly in elderly and other vulnerable patient groups, especially those who have been exposed to antibiotic treatment.

The NHS has made great strides in reducing the number of CDIs, but the rate of improvement has slowed over recent years and some infections are a consequence of factors outside the control of the NHS organisation that detected the infection.

New case assignment definitions are to be introduced as advised by the Advisory Committee on Antimicrobial Resistance and Healthcare Associated Infection recommended definitions used to attribute/apportion CDIs to align them with other recognised international definitions; in particular those from the Centres for Disease Control and the European Centre for Disease Control.

Background

NHS Improvement (NHS I) set CDI objectives each year and our objective for 2018/19 has been to have less than 39 cases of CDI. Where the Trust does not meet the CDI objectives, there is the potential for the Trust to be fined £10k for each CDI case above the CDI objectives. Objectives for 2019/20 have been set using data from 1st April 2018 to 31st December 2018. This data has been annualised and a count of cases calculated using the new case assignment definitions in the reporting algorithm below.

Changes to the CDI reporting algorithm

The changes to the CDI reporting algorithm for financial year 2019/20 are:

- Adding a prior healthcare exposure element for community onset cases
- Reducing the number of days apportioned to hospital-onset healthcare associated cases from three or more (day 4 onwards) to two or more (day 3 onwards) days following admission. For 2019/20 cases reported to the data capture system will be assigned as follows:

    - **Hospital onset healthcare associated (HOHA)**: cases that are detected in the hospital three or more days after admission
    - **Community onset healthcare associated (COHA)**: cases that occur in the community (or within two days of admission) when the patient has been an inpatient in the trust reporting the case in the previous four weeks
    - **Community onset indeterminate association**: cases that occur in the community (or within two days of admission) when the patient has been an inpatient in the trust reporting the case in the previous 12 weeks but not the most recent four weeks
    - **Community onset community associated**: cases that occur in the community (or within two days of admission) when the patient has not been an inpatient in the trust reporting the case in the previous 12 weeks

Trust objectives for 2019/20 have therefore been set using the two categories

- Hospital onset healthcare associated: cases that are detected in the hospital three or more days after admission

- Community onset healthcare associated: cases that occur in the community (or within two days of admission) when the patient has been an inpatient in the trust reporting the case in the previous four weeks

Guidance for testing and reporting CDI cases remains unchanged and the safety and care of patients remains the over-riding concern for everyone.

While NHS I do not expect any increase in the total number of cases, there will be a shift in numbers of cases that are trust assigned, particularly as healthcare associated cases will include those with recent (last four weeks) hospitalisation. Based on PHE data, current estimates are that the proportion of healthcare associated cases will increase to around 65% of the total number of cases.

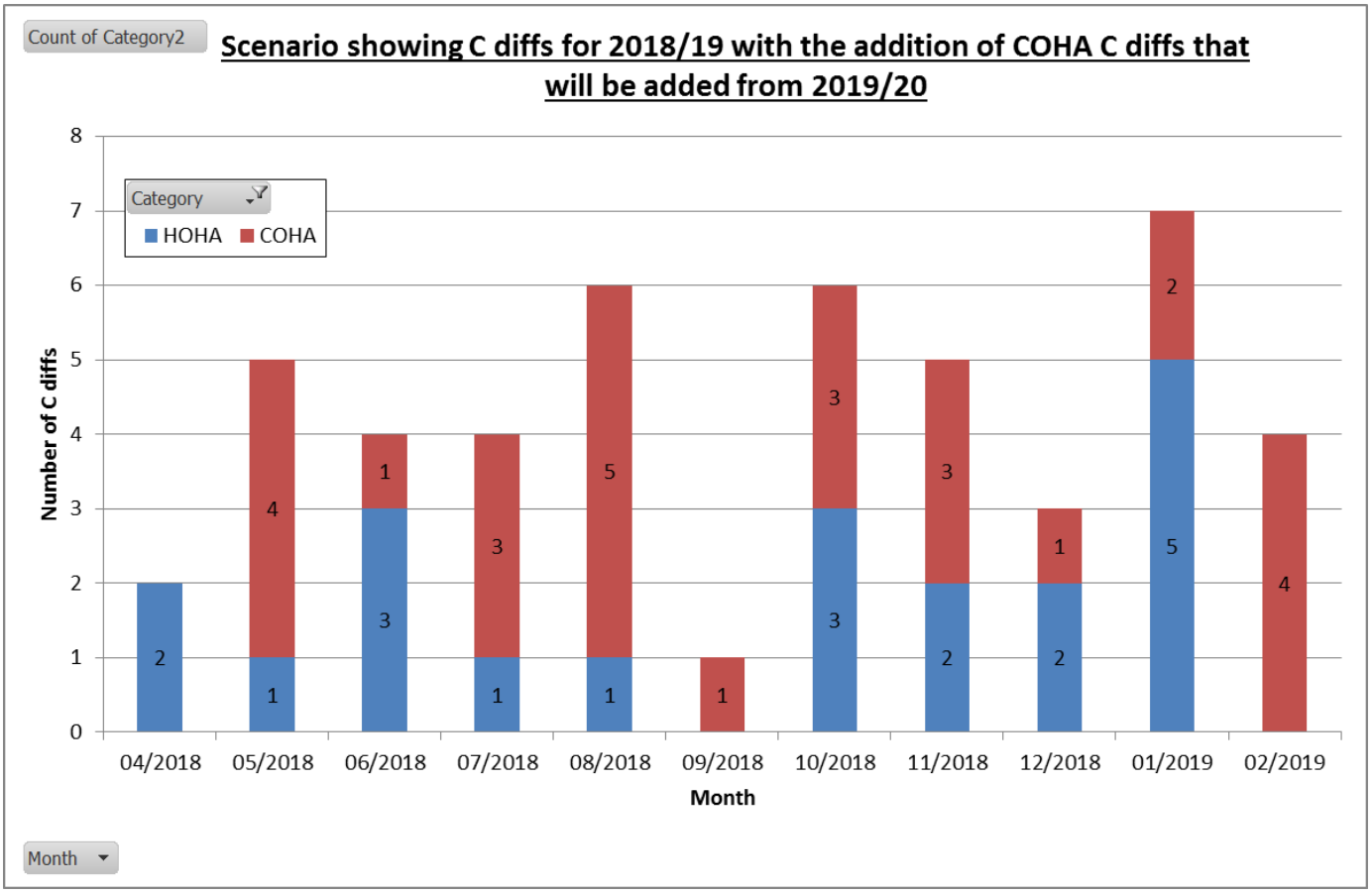
CDI objectives

Set out below are the current and new trajectories

C diff trajectory 2018-19		39 cases	
C diff trajectory 2019-20		44 cases	

With the addition of COHA cases and the changes to the days counted had the new definitions been in place in 2018/19 the number of C diff cases would be;

Current cases		20 cases	
COHA cases		27 cases	
Changes to days counted		3 cases	
C diff cases for 2018-19 would be		50 cases	



Actions to be taken:

It can be seen in the above tables that based on our current cases, if the new definitions had been set in 2018/19 we would have reported 50 cases. In addition to the patient safety concerns this also presents a financial concern, as the Trust could potentially be fined £10k per CDI case over the CDI objective; therefore a potential fine of £60k in this scenario.

It is important that we aim to make improvements year on year, but this is more so in order to meet the objective of no more than 44 cases in 2019/20.

The following actions are therefore being implemented by the infection prevention and control team led by the Director of Infection Prevention and Control (DIPC);

I. Proactive and Zero tolerance to the management of patients known to be positive for Clostridium difficile infection or carriers of Clostridium difficile showing symptoms, within the Trust and the wider communities.
   A new procedure is to be piloted to attempt to monitor patients' positive in the community involving microbiologists and IPC practitioners.
II. Updated Trust guideline for the management of Clostridium difficile Infection in place and cascaded via IPC link nurses and through Buzz and IPC website.
III. Working with the microbiology laboratory reinforce following the system already in place to manage unnecessary duplication/testing of samples in patients with confirmed CDI.
IV. Update the Trust environmental fogging/decontamination equipment to improve on turn-around-time for effective decontamination of contaminated in-patient care areas across the Trust, thereby reducing the risk of patient's acquisition of Cdiff spores during any time of admission.
V. Continue to improve on hand hygiene compliance trust-wide. Observation of practice and micro teaching targeting areas of poor compliance.
VI. Antimicrobial monitoring and reviews; providing feedback as appropriate to increase learning and change prescribing practice.
VII. Faecal transplant consideration as treatment option to be expanded for relapse cases.

Recommendation

The Board of Directors are asked to note the content of the paper in regard to the new case assignment definitions and the actions being taken to support achievement of the CDI objective 2019/20.

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Title	**Chair's Assurance Logs – March 2019**		
Report to	**Board of Directors**	**Date**	**26 March 2019**
Author	**Kath Smart, Non-executive Director** **Neil Rhodes, Non-executive Director**		
Purpose			Tick one as approp riate
	Decision		
	Assurance		X
	Information		

Executive summary containing key messages and issues
Attached as an appendix is the reports from the chair of the following board committees held in march 2019: 19 March 2019 – Audit & Risk Committee 22 March 2019 - Finance and Performance Committee The report sets out assurances obtained during the meeting plus any new risks and escalations to Board.
Key questions posed by the report
Is Board able to take confidence from the various assurances given in the attached document?
How this report contributes to the delivery of the strategic objectives
N/A
How this report impacts on current risks or highlights new risks
As highlighted in the paper.
Recommendation(s) and next steps
To note the reports

Chair's Log – Audit and Risk Committee (ARC) – 19th March 2019

Overview

This meeting had a large agenda, with a slightly new format to accommodate and protect time for Governor questions.

The Chair was unfortunately called away part way through the meeting, so thanks to Sheena for Chairing the rest of the meeting.

Assurance area – Internal Audit progress

a) Internal Audit – Significant assurance was given regarding progress of the delivery of the Internal Audit Plan to date

b) Internal Audit Reports Issued – One out of the five Audit Reports issued, Complaints, had only a "partial assurance" rating given. The DoN updated the Audit Committee in response to the disappointment at the partial level of assurance given by the Audit review. Concerns were raised at the Committee regarding the timeliness of responses to complaints and the importance of this in terms of patient confidence and the opportunity to learn from the feedback. It was agreed that this action would be revisited once the action plan was in place. and the DoN gave assurances on the role of PEEC in overseeing progress in this area. Dates have been agreed for all actions.
The reviews given "significant assurances", especially Emergency Planning and IG were commended by the Audit Committee.

Audit Report Issued	Assurance Opinion Given
Committee Effectiveness	Significant Assurance with minor improvement opportunities
Complaints	Partial assurance with improvements required
Emergency Planning	Significant Assurance with minor improvement opportunities
Core Financial Controls	Significant Assurance with minor improvement opportunities
Information Governance (Data Security & Protection Toolkit)	Significant Assurance with minor improvement opportunities

c) Internal Audit Recommendations Follow up – The Committee continues to follow up overdue "high & medium" recommendations and verbal re-assurances were given about the 2 longest standing overdue Recommendations. The Committee also noted progress on reviewing "low" recommendation implementation, and agreed further work to take place to give assurances.

d) Internal Audit Plan 2019/2020 – The plan has been developed based on risk and identified approx. 12 audit reviews to utilise 190 days of audit work. The plan has been to Executives and subject to some changes agreed at Audit Committee, including allocating some time to review the use and implementation of ESR. The draft plan is shown in Appendix A.

e) Draft Internal Audit Report 2018/2019 – The draft HOIA concluded "significant assurance with minor improvement opportunities to reflect there is generally a system of sound internal control which is designed to meet objectives". It was identified there are four "high" recommendations which would require consideration for inclusion in the Annual Governance Statement.

Assurance area – DBTHFT Effectiveness of Trust Audit Functions

Audit Committee considered performance against the required standards for both Internal and External Audit.
Internal Audit – The Committee concluded that overall the required standards for performance were met by KPMG, and that the Trust continue with the auditors
External Audit – The Committee concluded that overall the required standards for performance were met by EY and would make a Recommendation to Council of Governors

The Committee pressed both auditors on added value they have brought to the Trust and examples were provided by both internal and external of times they had supported the Trust. It was noted by the Committee whilst the relationships with both auditors were professional both teams had strong working relationships with the Finance Team.

Assurance area – External Audit

EY presented their progress and update on their Audit work and risk / areas of focus for the 2018/2019 audit. The outcome will be reported to July Audit Committee.

Assurance Area – Risk Mgt Policy, BAF and Corporate Risk register

The BAF & RR were reviewed and changes noted and the DoF noted that the Fraud risk needs to be updated to identify key areas as outlined in the fraud operational plan for 2019/20.

The Committee also noted the review of the Risk Management Policy was underway and expected to be completed by July 2019 to ensure appropriate consultation and inclusion of risk appetite.

Assurance area –Standing Financial Instructions, Standing Orders and Scheme of Delegation

The updated and refreshed SFI's, SO's and SoD were presented and discussed, having previously been circulated for comments and amendments. It was agreed these would be approved and Recommended to Board for approval.

Assurance Area – Security Management

Significant Assurance was given to the Committee that workplans and standards in relation to security management are being delivered, and risks are being appropriately managed. The number of break ins was considered as well as colleague concerns about security at park and ride's and the mitigating actions including improvements to CCTV coverage and the improvements that will take place as a result of the new contract having been awarded. Incidents reported in relation to Security and Violence and Aggression were reviewed and the subsequent ongoing actions being taken to address. Feedback is being acknowledged through a range of channels so that colleagues know their safety and security concerns are taken seriously and being addressed. The positive partnership working was also acknowledged with a range of partners including the Local Authority to address Place related issues collectively.

Assurance area – Counter Fraud (LCFS)

Significant Assurance was given to the Committee that workplans, standards & outcomes in relation to LCFS are being delivered, including the Operational plan for 2019/2020.
The Committee also approved the recently updated Fraud, Bribery and Corruption Policy & response plan.

The standards for Counter fraud were reported as being met and self-assessed as "Green", the SET training levels for Fraud were reported as 96% and the Trust is participating in the National Fraud Initiative, designed to prevent and detect fraud across public services. A number of referrals into the LCFS are under investigation, and outcomes will be reported to future Committee meetings.

Assurance Area – Health, Safety & Fire

The Committee received a revised report in response to recent requests to ensure the Committee was discharging it role in relation to its Terms of Reference in relation to Health & Safety & Fire. It also received assurances on asbestos, electrical safety and water safety, as well as any Riddor reports.

Board members are asked to note the 2 Fire Enforcement notices in place for the East Ward Block & Womens & Children's Hospital with an expiry date going forward for a number of years which the capital programme over the next five years will address. The Trust is also submitting a case for emergency capital to NHSI to bring some of this work forward if the bid is successful.

The premises assurance model was discussed and agreed it provides a range of usual at a glance performance information, its usefulness as an assurance tool to be determined following a demonstration at a future meeting.

It was agreed that consideration as to where the Health and Safety strategy currently under review would go for sign off.

Actions in relation to the incidents reported were detailed within the report.

Assurance area –Compliance with Standing Financial Instructions and Standing Orders

Reports on Losses, Compensations and Single Tender Waivers showed compliance with those areas of SFI's/SOs

Kath Smart & Sheena McDonnell
Chair – Audit and Risk Committee

Chair's Log - Finance and Performance Committee 22 March 2019

Overview

On the whole my March report is pretty positive. Although I set it out in more detail below the headlines are –

- We are probably now going to hit our control total for 2018/19 – no small achievement in the circumstances.
- We are probably going to be able to accept our control total for 2019/20, having put in place demanding but achievable plans to deliver CIP in support of that; although there still remains work to be done on closing the final gap.
- Performance remains broadly strong and improving across key indicators and in comparison to the rest of the system.

Additionally, the new performance reporting approach was properly received for the first time and we look forward to rolling out to Board next month after agreeing how the measures tracked by QEC might best be incorporated.

A visit to examine first-hand the patient experience with the meals prepared under the Sodexo contract went well.

A very strong and encouraging presentation was received from Dr Bushra Ishmael and General Manager Helen Burroughs, in relation to Community Paediatrics and non-clinical waits.

The final hour of the meeting was chaired on my behalf by Pat Drake (Thanks Pat!)

Assurance area – Performance

Performance Report

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

As mentioned above, the new performance reporting approach was properly received for the first time and we look forward to rolling out to Board next month after agreeing how the measures tracked by QEC might best be incorporated. F&P saw a cut down 'at-a-glance' table incorporating trends as well as key metrics and comparative, traffic lighted data. There was an independent analysis supported by subject matter expert comments on the questions raised by that analysis.

The volume of material received, as a consequence, was considerably reduced. Although the underpinning raft of data will always be available to committee members and board members, it will not routinely be circulated with papers, being seen as principally a tool for our managers to manage with.

In broad terms Trust performance once again remains sound. Two week wait continues to improve and RTT is now exceeding trajectory after very positive moves in February. There was, however, an increase in cancelled operations owing to a lack of HDU availability.

A very helpful overview of proposed changes to Emergency Department targets, that made headlines recently, was shared with F+P and is available to any other board member who might be interested. The NHS intends to pilot the approach across a number of sites in the months ahead and we will follow it with interest.

Assurance area – Workforce Management

We considered the Workforce report that addressed –

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

We have a vacancy rate of 7.1% against a target of 5%; when taking into account the use of temporary staff we have a 1.7% vacancy rate, although this does vary by staff group.

Agency targets have been set for each Division which, importantly, have also been split by staff group. Management grip is tightening as a consequence. To date, the Agency target has been exceeded but 2 million pounds less has been spent this financial year compared with last.

Updated benchmark data has been provided from the model hospital portal for both vacancies and agency and bank spend which on the whole indicates that we benchmark

favourably although there are areas which require focus. Within the refreshed efficiency programme the workforce work stream will focus on recruitment to vacancies, reduction in sickness absence, reduction in need to cover enhanced care needs, and agency prices (and demand).

Importantly, last month, sickness rates have returned to October levels.

Assurance area – Overall Financial Picture and Closing the Financial Gap

A more detailed picture of finances is set out in the separate finance paper. However, F&P heard with approval that the Trust could now probably meet its control total for the year. That is a significantly stronger position that had been achieved through a combination of factors including improved delivery of income across divisions, successful negotiations with CCG partners, delivery of certain CIPs and better control of agency spend.

Our focus now changes to planning for the year ahead. The Director of Finance is currently mapping out the route that will hopefully enable us accept the planned control total for the financial year 2019/20. At the time of writing negotiations with partner CCGs were at a critical stage. Over the past year DBTH had to operate predicting significantly greater demand from CCGs than they were prepared to commission us for and then retrospectively negotiate reparation as that demand materialised. We are working towards a more mature and mutually beneficial approach for the year ahead and look for an oral update on progress at Board.

Outpatient Pharmacy Contract

The Committee received an update concerning the contract for the outpatient pharmacy, currently being run by Well for the Trust. Well have given notice on the contract and the Trust is currently assessing a number of options including working with external companies or setting up subsidiary to run the service for the Trust. A business case will be submitted to the next Trust Board. The committee noted progress made and will see the final case before it goes to the Trust Board.

Assurance area – Governance and Risk

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

In relation to oversight of the Sodexo contract the Chair was able to report having had a walk-through accompanied by governor Mike Addenbrooke, earlier in the week. They were able to track the patient meal from order receipt, through assembly, to ward service and gained considerable reassurance from what they saw. A future visit is being discussed to have a similar look at the retail offer from Sodexo on site for patients and visitors. Considerable assurance was gained from the visit.

Neil Rhodes **Chair – Finance and Performance Committee** **22.3.19**

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Title	**Chair's and NEDs' Report**		
Report to	**Board of Directors**	**Date**	**26 March 2019**
Author	**Suzy Brain England, Chair of the Board**		
Purpose			Tick one as appropriate
	Decision		
	Assurance		
	Information		x

Executive summary containing key messages and issues
The report covers the Chair and NEDs' work in February and March 2019.
Key questions posed by the report
N/A
How this report contributes to the delivery of the strategic objectives
The report relates to all of the strategic objectives.
How this report impacts on current risks or highlights new risks
N/A
Recommendation(s) and next steps
That the report be noted.

Chair's and NEDs' Report – March 2019

DBTH's Platinum Award for Wellbeing at Work

At the beginning of March I attended the awards ceremony for the Wellbeing at Work Programme. The Trust secured the highest possible level of recognition, the platinum award, for its continued development of staff health and wellbeing services. A great achievement for team DBTH.

Staff are able to access a range of resources, including assistance with physical, mental and financial wellbeing. As a happy and healthy workforce remains a key priority for the Trust, we will continue to develop our offer, to meet the needs of our team and to allow them to deliver outstanding care and service to all.

Official Opening of the Patient Advice and Liaison Service (PALS) Office

This month I was delighted to officially open the relocated, purpose-built PALS office. As part of a range of improvements at gate 4 the office is well located for patients and their families. The team are on hand Monday to Friday, to answer a broad range of questions, to signpost services and receive feedback or concerns relating to a patient/family's experience in hospital. The newly constructed space provides a good balance between an open office environment and the provision of private meeting rooms for confidential discussions.

Chief Operating Officer Vacancy

The recent Chief Operating Officer vacancy attracted a great deal of interest, and from a significant number of applications we were able to shortlist six strong candidates for interview. Along with other senior colleagues, I conducted one to one pre-interview discussions ahead of the multi panel process. The interview panels were place and gender balanced and included representation from executive, non-executive, divisional directors, governor and external partners. I am pleased to report an appointment was made, details of which will be shared in due course, following completion of the necessary pre-employment checks. The day was well executed and my thanks go to everyone who supported the process.

Governor Brief

The topic of this month's brief was the Patient Advice and Liaison Service, which linked nicely to the official opening ceremony earlier that day. Governors received an excellent presentation from Cindy Storer, Deputy Director of Quality and Governance and her team. The informative brief demonstrated the Trust's approach to improving patient experience, the mechanisms available to monitor performance and a range of initiatives to drive improvements in standards of care and associated services.

Colleagues were able to observe improving standards of performance in the reported number of compliments, concerns and complaints and hear about identified themes and plans to address these. A sharing of knowledge, a desire to learn from experiences and facilitating patient and colleague feedback, were all recognised as crucial to delivery of an enhanced service.

As usual at the close of the session an open discussion on the content and Q&A sessions took place.

G**overnor Timeout**

A well-attended governor timeout this month, which included the following presentations:

- The Path to CQC Outstanding - Sewa Singh, Medical Director
- The NHS Long Term Plan - David Purdue, Chief Operating Officer
- The UK's First Foundation School in Health - Kelly Turkhud, Vocational Education Manager

I was a little delayed in joining this session due to an off-site early morning commitment with our commissioners, so thanks to Sheena McDonnell for chairing on my behalf, and also for giving us an insight into her skills, experience and role within the Trust as part of the meet the Non-executive Director session.

Star of the Month Award

Finally, I had the pleasure of presenting a star of the month award to Kate Wright, Therapy Assistant. Kate had been nominated by her manager for her positivity, support and influence on her colleagues' health and wellbeing. Kate has organised a number of initiatives, including mindfulness, reiki and meditation sessions to ensure staff take good care of themselves and are well placed to deliver the best possible service to their patients. **#TeamDBTH**

NED Reports

Alan Chan

Due to the unavailability of other directors, Alan attended the Finance and Performance Committee in February to form the quorum. Alan found it useful to take part and to see how discussions in the meeting correlated with those at Board. It was also interesting to observe and consider the different styles of the Committee Chairs.

Kath Smart

In her role as Audit Committee Chair, Kath attended the agenda planning meeting to ensure the work plan remains on track for delivery, plus attended a conference call with the Director of Finance and Internal Audit to review progress. Kath also had a 1:1 with the Trust Board secretary to discuss audit committee actions, risk management and health and safety assurances.

As part of her continued buddying arrangements with the Medicine Division, Kath has met with Dr Stott to better understand the specialties within the division, plus visited the DRI Renal Unit. Following up on the Qi work undertaken in the Emergency Department, Kath attended ED's Fractured Neck of Femur weekly huddle, which reviews the implementation of new pathways, following the improvement events.

Kath also had a 1:1 with the newly appointed Efficiency and Effectiveness Director, Paul Mapley, to discuss the developing programme PMO arrangements and CIP plans for the forthcoming year.

Linn Phipps

Linn met with two further Trust Clinical Governance Leads to discuss quality issues; she also discussed risk management governance with Internal Audit.

She participated in the national Empowering People in a Digital World Conference on 12 February 2019 and attended the Trust's first Masterclass "The Art of Being Brilliant", which was truly brilliant – Well Done People & OD.

Sheena McDonnell

This month I chaired the Governors Timeout, on behalf of Suzy; we looked at the journey to CQC outstanding, heard about our partnership with Hall Cross Academy – a Foundation School in Health, and I delivered a presentation to introduce myself to Governors.

I was lucky enough to attend a half day workshop with the People and Organisational Development teams, hearing all about their plans to support the Trust to achieve CQC outstanding.

Along with Linn Phipps I attended the first of the Leadership masterclasses – The Art of Being Brilliant, the session organised by the Leadership and Organisational Development team was very well attended and was a very inspirational event.

I have attended ARC this month, the newly named Audit and Risk Committee replacing ANCR (Audit and Non Clinical Risk Committee) and have caught up with Suzy for a 1:1. Last but by no means least I met up with Emma Challans, Deputy Chief Operating Officer, to talk all things leadership and to understand all about the good work happening in relation to missed appointments and to discuss how NEDS can better show our support for activities and initiatives throughout the Trust.

Neil Rhodes

Since Neil's last update he has held discussions with our auditors in relation to an audit of the risk assessment process. He has also held a 1:1 financial planning telephone conference with the Director of Finance, Jon Sargeant. Neil chaired the Finance and Performance Committee on 25 February and took part in the Board of Directors on 26 February.

On 12 March Neil took part in the interviews to recruit a new Chief Operating Officer and looks forward to working with the successful candidate, who emerged from a strong field.

Together with governor, Mike Addenbrooke, Neil visited the Sodexo catering provision to better understand the systems and processes in place to ensure our patients receive the correct, high quality meals in a timely manner.

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Chief Executive's Report

26 March 2019

New office for Patient support service

I am delighted to announce that the Patient Advice and Liaison Service (PALS) at Doncaster Royal Infirmary has been relocated to a brand new office nearby the site's gate four entrance, making it much more accessible to visitors. PALS offers confidential assistance to the public and is the first point of contact for patients and their families.

The PALS office is open every weekday from 9am to 5pm and can be contact in person, over the phone at 01302 642 769 or by email at dbth.pals.dbh@nhs.net This recent renovation has been one of a number of projects at the Trust recently including the new living wall at the main entrance and cash machine facilities.

Skin Integrity Team clinches third place at the Journal of Wound Care's 2019 Awards

I am proud to share the news that the Trusts Skin Integrity Team have clinched third place at the Journal of Wound Care's 2019 awards under the category of 'most innovative'.

The team which specialises in the prevention and treatment of wounds were selected by the publication for their creative, innovative and novel approach to the care of lower-leg skin tears. Recognising the good work of the team, the JWC awarded the team third place at an awards ceremony late February 2019.

Doncaster's Rapid Response Service recognised as an exemplar service

Doncaster's Rapid Response Service, a partnership between DBTH, Rotherham Doncaster and South Humber NHS Foundation Trust, Fylde Coast Medical Services, Doncaster Council and NHS Doncaster Clinical Commissioning Group has been shortlisted under the 'Improving Value in the Care of Older Patient's Award' of the Health Service Journal (HSJ) awards.

The Rapid Response Service ensure that just one integrated health and social care assessment is completed in a patients home as a result of a fall, illness or injury, helping to reduce the number of hospital admissions that could be avoided. The Integrated Doncaster Care Record has been central to the success of this service to date. The Health Service Journal Value Awards will take place on Thursday 23rd May 2019 in Manchester.

Cannula mittens and traffic light hats for babies

We have launched an appeal asking for knitted traffic light hats and cannula mittens to support the care and treatment of our neonatal and new-born babies. The hats serve an observational purpose, with each colour (green, orange and red) signalling the level of care required

for the infant, while the cannula mittens stop the youngsters from interfering with the aforementioned device.

Support for this appeal has been astounding so far, with residents in Doncaster, Worksop and surrounding areas sending in their knitted garments, with items coming as far afield as Canada, Australia and New Zealand.

Primary School Pupils promote Eye Clinic Appointments

Last month it was great to see the partnership working with students at Grange Lane Infant Academy and the Trust's Ophthalmology Team in stressing the importance of attending eye screen appointments. The Ophthalmology Team delivered an interactive session to students at the Academy, organised a number of rotating workshops and finishing the session with a poster competition.

Having been arranged in collaboration with colleagues from across the local area, including Doncaster CCG and Healthwatch Doncaster, the event tied into the ongoing NHS 100 day challenge. This is a scheme that is all about driving positive change within healthcare, by revising current processes and increasing efficiency. The current 100-day Improvement Challenge is focussing on Ophthalmology, Spinal and Fibromyalgia and builds on the excellent work of the previous programme that looked at Urology, Cardiology and ENT.

'Shh' Campaign at DBTH

We are hoping our patients will have a silent night as we launch the Sleeping Helps Healing (or Shh campaign) begins.

The main object of this initiative is to minimise, as much as possible, all noise, and ensuring individuals can snooze peacefully and without interruption, such as:

Lights will be dimmed from 11pm, and patients asked to switch all devices to silent and headphones used where possible

- All equipment will be placed within easy reach for staff and all buzzers, alarms and bleeps addressed as quickly as possible
- Staff will wear soft-soled footwear to reduce any noise from movement
- Upon entry to the ward, patients will be asked about their sleeping routine, with their care plan tailored to fit preferences.

With these simple, yet all-important, changes, Trust staff are hoping that patients will benefit from a restful night's sleep, potentially speeding up recovery and helping them get home much sooner.

The Trust earns 'platinum' award for staff health and wellbeing

It gives me great pleasure to announce that the Trust has been recognised for achieving the highest possible standards in their 'Wellbeing at Work' programme.

The Trust's platinum award, presented by Nottinghamshire County Council, acknowledges the organisation's continued development of staff health and wellbeing services and support to keep members of team DBTH happy and healthy.

The Trust will continue to review its staff health and wellbeing offer and engage with colleagues to identify what support they need to be happy and healthy whilst working at DBTH.

DBTH achieves 500 days without 'superbug'

I am pleased to report that the Trust celebrated 500 days without a Meticillin-resistant Staphylococcus aureus blood stream infection (also known as MRSA bacteraemia).

The Trust's Infection Prevention and Control (IPC) Team have worked tirelessly throughout the past number of years with clinicians to ensure that the bug is kept in check. This includes screening all patients for the bacteria, isolating those with a positive result and immediately beginning what is known as a 'decolonisation' process in order to stop it spreading any further and causing harm.

As an organisation we are also 50 days without incidence of hospital-acquired Clostridium difficile (C.diff). A similarly unpleasant infection that can lead to serious bowel problems and diarrhoea.

Local hospital rating remains unchanged following inspection

Between 27 and 29 November, we were host to an unannounced Care Quality Commission (CQC) inspection focused upon our urgent and emergency care services.

The Emergency Departments at Doncaster and Worksop care for an average of 103,000 and 50,000 patients respectively each year and are some of the busiest units of their kind in the region. Despite this, the services routinely performs within the top 20 for the four hour access target, with the Trust reaching 92.12% in quarter three of the year.

Following a wider visit in 2017, the most recent inspection maintains the Trust's rating of 'Requires Improvement'. Some 'domains' inspected by the CQC have changed, with Bassetlaw Hospital's Emergency Department's score improving overall, however the 'Safe' domain at Doncaster Royal Infirmary has moved to 'Inadequate' .

The final report is available on the CQC's website.

UNAPPROVED

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

Present:

Richard Parker (Chair)	Chief Executive
David Purdue	Deputy Chief Executive & Chief Operating Officer
Karen Barnard	Director of People & Organisational Development
Antonia Durham Hall	Divisional Director – Surgery & Cancer
Eki Emovon	Divisional Director - Children and Families (Part)
Moira Hardy	Director of Nursing, Midwifery and Allied Health Professionals
Sewa Singh	Medical Director
Jon Sargeant	Director of Finance
Jochen Seidel	Divisional Director – Clinical Specialities

In attendance:

Kirsty Edmondson-Jones	Director of Estates & Facilities
Gareth Jones	Trust Board Secretary
Lesley Hammond	General Manager
Ken Anderson	Head of IT Programmes and Development
Marie Purdue	Director of Strategy & Improvement
Jennifer Simpson	Emergency Department Consultant (For item x)
Khairul Shahdan	Emergency Department Consultant (For item x)
Donna Smith	Operational and Business Manager (For item x)
Emma Adams	Research Unit Research Governance Manager (For item x)

Apologies:

Nick Mallaband	Divisional Director – Medicine
Simon Marsh	Chief Information Officer

Action

Apologies

MB/19/2/1 Apologies as recorded above were noted.

Actions last meeting

MB/19/2/2 The action log was discussed and updates acknowledged. Action 3 relating to the risk identified of a leaking roof had been confirmed as mitigated and the board agreed the action was closed.

Presentations

Emergency Care Standards

MB/19/2/3 Management Board received a presentation from Donna-Marie Smith, Jennifer Simpson and Khairul Shahdan, of the Emergency Department. It set out the details of partnership working to improve performance against the 4 hour access target for the Trust.

MB/19/2/4 The presentation outlined the emergency care standards, the nine principles of effective emergency care, the ED BEST mission statement, the work that had been undertaken already and identified next steps to a collaborative trust approach.

MB/19/2/5 Following a question from the Director of People and Organisational Development around staff involvement, Khai reported that staff involvement had taken place with all levels of the organisation and specialities and included email communication, listening sessions, you said we did, survey monkey and escalation tools.

MB/19/2/6 Ken Anderson asked what learning had been identified from other trusts that had undertaken forward similar work to which the team responded that the Emergency Care Standards had been in existence since September 2018 and learning had been taken from the James Cook University Hospital.

MB/19/2/7 Following a question from Eki Emovon around the four hour wait and admissions from ED to wards, Richard responded that the responsibility is with specialities to ensure beds are available should admission be needed. The current process of ensuring a bed is available before moving a patient to the ward will remain in place.

MB/19/2/8 The Medical Director welcomed the collaborative approach to ED and expressed the importance of the need to continue to monitor and review the principles. It was suggested that an oversight group be set up for ongoing monitoring.

MB/19/2/9 The Emergency Care Standards Presentation was NOTED and the Board SUPPORTED the approach.

2019/20 Planning

MB/19/2/10 The Director of Strategy and Transformation, in partnership with the Director

of Finance, provided an update on the current Annual Planning requirements and reminded members of the need to complete the Divisional Plans for 2019/20. Marie Purdue reminded the team that their plans are to be presented at the March meeting of Management Board.

MB/19/2/11 The update was NOTED.

STRATEGY

Research and Development Strategy

MB/19/2/12 The Director of Nursing, Midwifery and Allied Health Professionals, in partnership with Emma Adams, Research and Governance Manager, presented the Research and Development Strategy Deep Dive and provided details of work being undertaken to deliver the key milestones.

MB/19/2/13 A detailed update on activities was provided, along with an overview of enabling strategy milestones, intended actions, progress to date, the key challenges and risks, key interdependencies, opportunities and next steps.

MB/19/2/14 Following a question raised by the Director of Strategy and Transformation around clinical trials and educational research, Emma advised that all research activities should be registered with the Research and Development Team and agreed that further work could be undertaken with the Qi Team to deliver research roadshows.

MB/19/2/15 The update was NOTED.

Quality, Improvement and Innovation Strategy

MB/19/2/16 The Director of Strategy and Transformation presented the update and provided details of the Quality, Improvement and Innovation Strategy along with the key milestones and work being undertaken to deliver.

MB/19/2/17 It had been positively reported that the introduction of Qi visual management boards had seen an increase in staff engagement and involvement and would be used as the vehicle by which the divisions track plans and performance to create a shared vision of the trusts journey to outstanding.

MB/19/2/18 The update was NOTED.

Corporate Issues

ICS Update

MB/19/2/19 The Chief Executive provided an update on recent ICS meetings. There was a focus on the year-end financial position that had been further raised in the

Finance report received by the committee. The Board was reminded of their responsibility in supporting the trust to deliver the efficiency targets.

MB/19/2/20 The Chief Executive confirmed that an allocation of the hosted networks had been suggested on a SRO basis and the Trust had been assigned gastro. Further work was to be undertaken on the position of a Clinical Lead and the next steps of objective setting and governance developments. An expected roll out date had been confirmed for 01st April 2019.

MB/19/2/21 The Chief Executive confirmed that the 26 week patient choice offer and the delivery of key constitutional standards of the NHS Long Term Plan should be shared with Divisions.

MB/19/2/22 The update was NOTED.

Finance Report

MB/19/2/23 Management Board considered a detailed Finance Report presented by the Director of Finance which set out the Trusts financial position as at 31 December 2018.

MB/19/2/24 The Trust's surplus for month 9 (December 2018) was £59k, which is a favourable variance against plan of £1,512k and a favourable variance against forecast of £233k in month. The cumulative position to the end of month 9 is a £11.5m deficit, which is £35k favourable to plan and £844k favourable against forecast YTD. The Trust needs to achieve a £6.6m deficit to deliver the year end control total, and therefore needs to achieve a better than break even position for the rest of the year.

MB/19/2/25 At the previous F&P Committee and Board a range of forecast scenarios were presented which showed a potential £7.1m gap to the control total (before PSF) as a realistic case. The Committee and Board agreed that if no further mitigations could be identified then a change in forecast of £7.1m would be submitted to NHSi at Month 9. Since the last Board meeting discussions about additional funding from the CCG and ICS have been made.

Whilst discussions are ongoing regarding these (an update will be provided at the Board meeting), in the Month 9 forecast submitted to NHSi the Trust has assumed these funds are received based on the progress of these discussions and offers received. Thereby the year end forecast in the NHSi return submitted at Month 9 showed a forecast position of a £3.72m gap to the control total before PSF impact (£9.4m gap including impact of not achieving Q4 PSF).

MB/19/2/26 Jochen Seidel sought assurance that no financial issues will occur from previous years that would need to be accounted for in the next financial year

to which the Director of Finance advised confidence in the major ledger had been resolved and asset registers had been reviewed.

MB/19/2/27 Management Board NOTED:

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

Corporate Risk Register

MB/19/2/28 Management Board considered a report of the Trust Board Secretary which set out the latest corporate risk register for consideration. Four risks had been escalated via Datix in the month and Management Board was asked to consider whether these should be escalated to the risk registers: Risks 2003 was to be escalated to the corporate risk register managed jointly by the Medical Director, Director of People and Organisational Development and Jochen Seidel with an update on progress to be provided at the next meeting. Risks 2120 and 2123 was not agreed for inclusion on the corporate risk register and agreed to be reviewed and managed locally by the Divisions. Risk 2124 had been mitigated and therefore not required for inclusion on the corporate risk register. **SS,KB,JS**

MB/19/2/29 Management Board received an update from the Director of Nursing, Midwifery and Allied Health Professionals on the CQC risks detailing the need to increase the risk threshold due to the potential change in ratings following the most recent review of ED. The Director of Nursing, Midwifery and Allied Health Professional to meet with the Trust Board Secretary to amend the corporate risk register. **MH,GJ**

MB/19/2/30 The Corporate Risk Register was NOTED.

Divisional Issues

Recruitment of Consultants

ENT Consultant in Otolaryngology

MB/19/2/31 Management Board considered a paper from the Divisional Director of Surgery and Cancer seeking approval for the recruitment of 1.00wte Consultant in Otolaryngology. It was noted that this position was a like for

like replacement and was within existing funded resources. The VCF for this post was approved by VCF Panel on 06th February 2019.

MB/19/2/32 Management Board discussed the paper and considered the key risks to the Trust and its services of non-recruitment. These included:

- Inability to deliver a high quality Otolaryngology service within ENT
- Continued agency costs in an effort to meet demand
- Adverse impact on contract, waiting times and ASIs
- Adverse impact on nephrology waiting position
- Adverse impact on patient care and outcomes

MB/19/2/33 Management Board SUPPORTED the recruitment of 1.00wte ENT Consultant in Otolaryngology with special interest in Otology and Paediatric ENT.

Information Items to note

MB/19/2/34 The Business Intelligence Report, Chief Executives Report, minutes from the Corporate Investment Group meeting in December 2018, Children and Families Steering Group Report were all NOTED.

Minutes of the meeting held on 11 January 2019

MB/19/2/35

The Minutes of the meeting held on 11 January 2019 were to be shared with the committee for review and to return any comments to the Corporate Governance Officer. **ALL,KS**

Any Other Business

MB/19/2/36 EU Exit – The Chief Operating Officer provided an update of the current position of EU Exit and the implications for the Trust which were being managed via Emergency Preparedness Resilience and Response in case of a no deal scenario on 29 March 2019. Issues included FOI's responses, pharmacy lines, access to medication, budget lines, equipment serviced by EU parts and fuel plans. Management Board agreed to undertake an EU Exit scenario to be arranged by the Chief Operating Officer. **DP**

MB/19/2/37 Clinical Administration Review – The Chief Operating Officer reported that the review had been completed however a number of vacancies still existed in the surgical unit but advertisements had been published.

Items for escalation to the Board of Directors

MB/19/2/38 It was agreed that the CQC Risk was to be escalated to Board of Directors.

Items for escalation from sub-committees

MB/19/2/39 None.

Date and time of next meeting

MB/19/2/40 The next meeting of Management Board would take place 11 March 2019 at 2pm in the Boardroom at Doncaster Royal Infirmary.

UNAPPROVED DRAFT

DONCASTER & BASSETLAW TEACHING HOSPITALS NHS FOUNDATION TRUST

Minutes of the Audit & Risk Committee Meeting held at 9am on Thursday 22 November 2018 in the Boardroom, DRI

PRESENT : Kath Smart, Non-executive Director (Chair)
Linn Phipps, Non-executive Director *(dialled in)*
Alan Chan, Non-executive Director

IN ATTENDANCE : Mark Bishop, Local Counter Fraud Specialist
Rob Fenton, Internal Audit (KPMG)
Michael Green, External Audit (EY)
Jon Sargeant, Director of Finance
Kate Sullivan, Corporate Governance Officer
Matthew Bancroft, Head of Financial Control
Myra Knight, Head of Radiation *(part)*
Sewa Singh, Medical director *(part)*

OBSERVERS: George Webb, Public Governor

Action

Apologies for absence

Apologies were received from Sheena McDonnell, Non-executive Director, Bev Marshall and Simon Marsh. Introductions were made around the table.

Internal Audit Progress Report

Serious Incidents report

18/329 This audit report was issued with "Partial Assurance with improvements required". Members expressed their disappointment at the outcome and discussed the areas of concern within the report. Internal Audit updated members that they had reviewed a sample of closed SI's and although a range of recommendations had been made, there were some areas of good practice noted, including SIs being reported to commissioners within 48hrs. The main areas of concern, including actions outstanding from the 16/17 audit review, appeared to stem from changes and vacancies in the Patient Safety team.

18/330 The Committee sought assurances and updates from S.Singh who shared the Committees disappointment, but agreed the report was a fair assessment. He outlined one of the key issues (which was now addressed) was vacancies in the central clinical governance team. S.Singh was pleased to advise that those vacancies had now been filled and a wider SI action plan had been developed, incorporating all the recommendations from this IA review, which involved the entire team involved in SI's. This was following a recent Quality Improvement (QI) session where the full SI process was mapped. This would be monitored and tracked by the Clinical Governance Committee (CGC) and by exception would report to the Quality &

Effectiveness Committee (QEC) and the Audit & Risk Committee (ARC).

18/331 L.Phipps noted her concern that some outstanding actions from 16/17 reviews had not progressed in satisfactory time and asked if she could join an SI panel in the future.

ACTION: Sewa Singh welcomed this and agreed to arrange this outside of the Meeting. **LP/SS**

18/332 The Committee discussed the risks and considered the assurances received from Sewa Singh and agreed that delivery of the wider action plan would be overseen by QEC.

The Committee NOTED the Serious Incident Audit Report

Internal Audit Progress Report

18/333 R.Fenton presented the progress report highlighting the progress against plan and days delivered. He noted there was still work to do but the Terms of Reference (ToRs) for larger pieces of work on Data Quality & Management Information were close to finalisation. Internal audit were confident they were on track to complete the plan.

18/334 Following a query from G.Webb regarding the Committee Effectiveness Review timeframe, it was confirmed the management response was being finalised and would be presented to the March Audit Committee. He also queried Governor involvement in the audit and R.Fenton confirmed those Governors who were on the relevant Committees were invited to take part and complete a questionnaire.

18/335 The Committee discussed the Risk Management & BAF work due to be completed in Q4. In light of M.Kane leaving the Trust it was agreed that J. Sargeant, K. Smart, L.Phipps and S.Singh would need sight of the ToR to assist the new incoming Board Secretary.

ACTION: R. Fenton to share scope of Risk Management Audit **RF**

Internal Audit Recommendation Tracker

18/336 The Recommendations were discussed as follows:-

Ionising Radiation Regulations – M. Knight attended and in response to questions updated the Committee on why implementation dates had slipped, and new timescales. The Committee received verbal assurances regarding the Staff training matrix; and the risk assessment progress. The Committee discussed the supervisor role and then noted the revised deadlines, including the risk assessments being completed by the end of November 2018.

18/337 **Booking Management** – R.Fenton confirmed that evidence regarding the completed implementation of the 16/17 recommendation was received the night before Audit Committee and he would review this as soon as possible. It appeared there had

been an error on the part of Internal Audit as the email containing the evidence file had been too large and wasn't originally received.

ACTION: J.Sargeant commented regarding a Training Strategy for the Trusts Clinical Administration Review; he would discuss this with R.Fenton outside the meeting. **JS/RF**

18/338 Following a query from members, R.Fenton confirmed there was improvement in high & medium risk IA Recommendations being implemented, which was shown on the chart on page 11. However, it was noted that the low risk recommendations were to be followed up for March Audit Committee.

ACTION: Provide a report to the next Audit Committee on progress with "low" audit recommendations. **JS/TBS/ KS/RF**

18/339 It was also noted by R.Fenton that there were still delays in receiving evidence of implementation, despite taking reports to Executive Team (ET), and it shouldn't be necessary for the Audit Chair to intervene in Audit Recommendations implementation. Therefore it was agreed for J.Sargeant, K.Sullivan, R.Fenton and the new Board Secretary to review the governance process in place for timely closure of Audit Recommendations.

ACTION: J Sargent, K Sullivan, R. Fenton, G.Jones - Review the audit recommendations governance process for timely closure of recommendations. **JS/KS/ RF/TBS**

18/340 The Committee NOTED the internal audit progress report and recommendations update.

Terms of Reference and Work Plan

18/341 In presenting the revised Terms of Reference (ToRs), the Chair reminded members of the conversations at the September Audit committee and that tracked changes showed the revisions to the ToRs. The revisions were to ensure a holistic approach to risk management. The name of the Audit Committee had also been revised to Audit & Risk Committee (ARC). This was supported by members present.

Several queries on areas relating to Counter Fraud (Section 7.3) and responsibilities of the Council of Governors were raised. It was agreed these changes would be incorporated into the final version.

ACTION:
Suggested changes to be provided by M.Bishop for the matters relating to Counter Fraud. **MB**

18/342 On reviewing the workplan, the Committee noted a number of areas requiring clarification and Action:-

ACTIONS:
1.5 – SO/SFIs – It was agreed these would come to the March Audit Committee but would be circulated by the end of January 2019 for comments/feedback. **JS**
2.1 – Review of Effectiveness of IA – It was agreed this would come to the March **JS**

5.4 – Self Review Toolkit (SRT) – The SRT needed submitting to the Counter Fraud Authority & would need to come to the March 2019 Audit Committee **MB**

6.2 – Final Accounts – to be moved to the March 2019 Audit Committee **JS**

7.2 – Data Quality – J.Sargeant agreed to review if this was specifically required in the work plan. **JS**

8.7 – Whistleblowing – It was agreed this required clarity of Audit Committee's role as QEC & Board already had defined roles. **KSm**

The Chair pointed out that references to Health, Safety, Security & Fire assurances needed inclusion in the work plan. **K Sm**

18/343 Internal Audit had reviewed the ToRs in line with their review of Committee Effectiveness and their recommendation was to include assurances around Shared Business Services (SBS) Assurances. J.Sargeant advised there was an Annual Control Statement available from SBS in relation to payroll/ financial services provided.

ACTION. **SBS Annual controls report to be shared with Audit Committee.** **JS**

18/344 The Committee APPROVED the revised Terms of Reference and Work Plan subject to the agreed changes and noted it would need to go to Board for approval.

Matters arising and action notes

18/345 The Committee considered the Action Log and made the following comments:-

Actions 1, 3, 5 & 10 needed to be brought to the attention on the new incoming Board secretary **TBS**

Action 4 – It was clarified that wording had been agreed – Action to be closed.

Action 6 – J.Sargeant confirmed he had met with all new DDs and spoken about expectations in their new roles. The new Grip & Control (G&C) meetings had been re-instated and attended by Executives. Also, NEDs were attending the new Divisional meetings and the escalation process to the F&P Committee was also in place. It was agreed this action could be closed.

Action 11 – M.Bishop confirmed the new booking process for Agency staff on the wards had been implemented further to a Recommendation arising out of the Counter Fraud investigations. It was agreed this action could be closed.

The Committee NOTED progress with the Action Log.

External Audit - Update on Planned Timing of Audit Work

18/346 M. Green verbally updated that the audit cycle was commencing with planning work at the Trust commencing in the next 2 weeks. This interim audit visit would test month 9 transactions. Also the timing of the final accounts audit been agreed and was expected to run up to mid May 2019.

18/347 M.Green also gave an update on the charitable funds audit; although there had been

some issues identified, they were not material and EY were working with M.Bancroft and team to resolve the issues. EY were confident this year would be signed in advance of deadline.

The Committee NOTED the update.

ISA 260 Recommendations Update

18/348 K.Smart welcomed the report which gave an update on progress with those Recommendations made in the 2017/18 ISA260.

The Committee discussed the report and queried the following:-

Action 1 – Stock counting – A.Chan required assurances on whether the physical stocktakes had identified variances?

ACTION: MBa to check and advise **MBa**

Action 3 – Depreciation – G.Webb queried the £23m fully depreciated assets issue and J. Sergeant clarified that this was separate to the issue which had been reported to the Finance & Performance Committee (F&P) and Council of Governors (CoG). J. Sergeant gave a brief overview of the issue.

The Committee NOTED the report and that recommended actions had either been completed or were in the process of being completed.

Board Assurance Framework and Corporate Risk Register

18/349 Kate Sullivan presented the Board Assurance Framework and Corporate Risk Register which had been evaluated by executive leads prior to the meeting.

18/350 The Board Assurance Framework (BAF) contained all of the risks to the Trust's five strategic objectives. There had been no risks added to the Corporate Risk Register or Board Assurance Framework in the previous quarter 3 CRR risks had seen changes to their ratings in the quarter and there had been one change to the corporate risk register; Details of the changes which were set out in the covering report.

18/351 The Committee reviewed the report and discussed the following:-

BAF

- Fraud Risk Assurance (p.73) should be changed to reflect 94% Fraud Awareness Training plus reflect 17/18 operational fraud plan was being delivered. **TBS**
- Paediatric Services at Bassetlaw Hospital (BDGH) (p.75) – a discussion was held on the significance of the risk and whether it needed to be on the BAF as a lower level risk? **ACTION: To be reviewed as part of BAF review** **TBS**
- Reduction in hospital activity (p.75) – discussion was held regarding the decrease in day cases and activity, but increase in Emergency department (ED) attendance, both of which were monitored by F&P.
  ACTION: J.Sargeant to review the risk and decide if it needed changing to reflect the current position **JS**

CRR

- **F&P 1** – J. Sargeant confirmed the appointment of a replacement Efficiency Director from 1 January 2019.
- **F&P 1 / F&P 3** – The Committee felt although the report referred to additional G&C mechanisms in the 'new and developing controls', this didn't give a great level of assurance . The committee were looking for more detail & timelines as appropriate. **ACTION: J. Sergeant to review**. **JS**
- **F&P 5** – F&P had carried out a "deep dive" in to Medical Agency which needed to be added as additional assurance. **ACTION: G.Jones To add** **TBS**

The BAF and Corporate Risk Register were REVIEWED and NOTED.

LCFS Update

18/352 Mark Bishop summarised the key points of the report which included outline details of new referrals and the status of on-going investigations *(anonymised for reasons of confidentiality).*The details of four new referrals was included plus updates to eight ongoing referrals. In total during the quarter, four referrals had been closed, one was pending closure, three awaited sanction outcomes and four remained open. Details were provided in response to several queries relating to specific cases.

18/353 The Committee noted the key points from the report, including:-

- Counter Fraud awareness training compliance = 96%;
- National Fraud Initiative (NFI) data uploaded and M.Bishop would work on any matches identified and report to Audit Committee.
- As November was Fraud awareness month extra training and walk round sessions were occurring in the Trust.
- Fraud Bulletins – the main issue still related to bank mandate fraud. M. Bishop had sought assurances from SBS on their processes and was satisfied with the process.
- Investigations / actions – bank / agency staff would be required to sign on/off wards when they attended for work. This had been agreed with M. Bishop, J.Sargeant and R.Dickinson.
- The Newsletter was commended by L. Phipps who was keen to understand the outcomes. M.Bishop commented that the Fraud survey measured staff perception of fraud; his belief was reporting culture had improved since he arrived at DBTH, the SET training compliance was high and he was content with the level of referrals received.
- In response to K. Smart, M.Bishop confirmed he was linked into the Whistleblowing and Cyber Security processes within the Trust.

The LCFS Update was NOTED.

Losses and Compensation Payments

18/354 A summary of the information from the Loss & Compensation file, held within Financial Accounts, was presented.

A minor concern was raised relating to the level/value of stolen equipment and

there was a discussion around the accessibility of the hospital site.

JS

ACTION: Future reports to contain more detail on mitigating actions following theft.

18/355 The Losses and Compensation Payments report was NOTED.

Waiving of Standing Orders

18/356 The Waiving of Standing Orders quarterly report was NOTED.

Sub Committee Minutes - Health, Safety & Security / Information Governance

18/357 The Committee noted the minutes but noted it was difficult to draw out assurances from the minutes alone. K.Smart advised she planned to attend the sub-committees on a periodic basis and would be attending the Trusts Health & Safety Committee in January 2019.

Following discussion it was agreed that:-

- Each Sub-committee of ARC would be asked to add an agenda item for any items they wish to escalate to Audit Committee.
- Each Committee to provide a periodic report to Audit Committee

Action: K. Smart agreed to write to the Chairs of H&S and IG and discuss the above with them **K Sm**

Issues escalated from sub-committees

18/358 None.

Issues for escalation to Board of Directors

18/359

- IA Serious Incident (SI) report to be included in the Audit Committee report to Board.
- Board to approve revised ARC ToRs

Items referred to or from F&P and QEC

18/360 None

Any Other Business

18/361 None raised.

Minutes of the meetings held on 20 September 2018

18/362 The minutes of the meeting held on 20 September were APPROVED as an accurate record.

Evaluation of Meeting

18/363 **Positives:-**
Good meeting well chaired.
Good to have managers in to explain their audit reports.

Dialling in worked better.

Opportunities for improvement:-
Skype availability
It was discussed whether there was benefit in evaluating each meeting; the general consensus was that feedback at the meeting may be stifled and it was more productive and objective to carry this out anonymously, in the same way as the recent survey had been carried out.
Agreed to periodically (annually) evaluate the meeting using anonymous feedback.

Time and date of next meeting:

18/364 **Date:** Tuesday 19 March 2019
Time: 9:30am
Venue: DRI – Room TBC

Signed:

…….. …….
Kath Smart **Date**
Chair

Minutes of the meeting of the Charitable Funds Committee
Held on Friday 25 January 2019
In Members Room 1, Doncaster Royal Infirmary

Present:	Kath Smart	Non-executive Director (Chair)
	Suzy Brain England	Chair of the Board
	Richard Parker	Chief Executive
	Jon Sargeant	Director of Finance
In attendance:	Kate Sullivan	Corporate Governance Officer
	Adam Tingle	Acting Head of Communications and Engagement
	Matthew Bancroft	Head of Financial Accounts
	Michael Green	External Audit (EY)

ACTION

Welcome and apologies for absence

19/1/1 Apologies for absence were presented on behalf of Sheena McDonnell, Alan Chan, Pat Drake, Neil Rhodes, Linn Phipps, Sewa Singh, Moir Hardy, Phil Beavers, Peter Brindley and Gareth Jones.

Minutes of the meeting held on 25 September 2018

19/1/2 The minutes of the meeting of the Committee held on 25 September 2019 were APPROVED as a correct record subject to the following:

18/9/16 – Confirm the term of the appointment of Standard Life as the Trust's investment advisor. **JS**

19/1/3 The update was NOTED.

Annual Report and Financial Statements 2017/18

19/1/4 The Committee considered a report of the Director of Finance which presented the 2017/18 annual report and accounts for the Trust's charitable funds together with the ISA 260 and letter of representation. It was noted that the Committee had previously considered the draft 2017/18 annual report and financial statements at the September meeting.

19/1/5 **Corporate Trustees / Membership of the Charitable Fund Sub-Committee** – The Chief Executive was listed as an attendee, rather than a member of the Charitable Funds Sub-committee (the Committee) and it was felt this did not align with the fact that the Chief Executive was required to sign the report and the letter of representation on behalf of the Trustee (Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust). Clarification would be sought on whether or not the Chief Executive was a member of the Committee. **JS**

19/1/6 The Chair asked for assurance that in future the report would pick up changes made to committee structure and Non-executive Director membership.

19/1/7 **Individual funds and subsidiary charities** – The Charity had several subsidiary charities and consisted of a number of individual funds during *(different types of funds were distinguished in the notes to the financial statements)*. Reflecting on this the Committee considered the level of transparency of the use of individual funds and this was discussed. The DoF gave assurance that robust and auditable processes were in place for the use funds and details of the process were provided. From a communications perspective the Committee felt it was important to share news stories about how the use of the funds was benefiting patients and staff; the Chair of the Board asked colleges to think about how links with the communications team could be strengthened so this could be picked up. Looking forward to the 2018/19 Annual Report, Kath Smart raised a similar point suggesting that the report be more outcome focussed to include benefits to staff and patients in the future. The DoF and the Acting Head of Communications would reflect on this and consider how to improve links between the finance and communications team in respect of the use of charitable funds. **JS/AT**

19/1/8 It was noted that the accounts and annual return would be filed on time (31 January 2019) and the Committee commended colleagues for their hard work to achieve this.

19/1/9 **IAS 260 –** It was noted that an unqualified opinion had been given on the statements.

19/1/10 Michael Green presented the report and drew attention to significant findings from the audit:

19/1/11 **Accounting System and supporting processes –** During the year the fund implemented a new financial ledger system and processes which had improved the accounting records and audit trail supporting the financial statements. EY recommended an Internal Audit review of the new processes in the future and this was noted. **JS**

19/1/12 **Unadjusted misstatements** – EY had identified two unadjusted differences in the draft financial statements with an aggregated impact of £3k which management had chosen not to adjust. An overview of these was provided and was set out on page 2. Details were set out on page 2 of the report and Matthew Bancroft provided some background information on the reasons for the misstatements. EY agreed with management's assessment that the impact was not material, both individually and in the aggregate.

19/1/13 **Adjusted Errors** – 7 misstatements had been identified during the audit (set out on page 3); these had been corrected by management. The net

impact was £37k. The Chair asked if there was any learning to be taken from the corrections; the issues had related to the previous spreadsheet based accounting systems and understanding of cut off dates; The risk of this happening again had now been mitigated by the new system and processes.

19/1/14 **Internal control themes and observations –** The Committee reviewed each observation/risk and management response in detail and these were discussed. The following points were raised:

19/1/15 Testing of income had identified that the documentation retained by the Trust to support the nature of income and supporting detail could be improved. There was a risk that income is incorrectly classified within the financial ledger. The Chair asked for clarification on managements response to this and the matter was discussed. The charitable funds team were starting to follow up instances where insufficient detail had been provided; a review of progress would be included on the committee workplan. This led to discussion about processes for handling cash donations, particularly to wards and departments; it was agreed to review processes for handling cash out of hours (when the cashiers office was closed). **GJ** **JS**

19/1/16 **Follow up of prior year findings and recommendations -** It was noted that all previous year recommendations had been actioned/agreed and were closed.

19/1/17 It was noted that the audit of the 2018/19 financial accounts was planned for August 2019 it was intended to be able to present the report to the Annual Members Meeting (AMM) in September. The Chair suggested the AMM report include some case studies and this was agreed. **JS/AT**

19/1/18 A review of the 2017/18 recommendations would be moved to the work plan for the May 2019 meeting. **GJ**

19/1/19 The ISA 260 was NOTED and the Letter of Representation was ENDORSED.

The 2017/18 charitable funds annual report and financial statements were APPROVED for submission subject to clarification about whether or not the Chief Executive was a member of the Committee.

Date and time of next meeting

19/1/20 The next meeting of the Committee would take place at 9am on 26 February 2019, in the Boardroom at Bassetlaw Hospital, before the Board of Directors meeting.

Kath Smart **Date**

Chair of the Committee

Board of Directors – Work-plan
(Updated 22/03/19)

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

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

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

Minutes of the meeting of the Board of Directors
Held on Tuesday 26 February 2019
In the Boardroom, Bassetlaw Hospital

Present:	Suzy Brain England OBE	Chair of the Board
	Karen Barnard	Director of People and Organisational Development
	Alan Chan	Non-executive Director
	Moira Hardy	Director of Nursing, Midwifery and Allied Health Professionals
	Sheena McDonnell	Non-executive Director
	Richard Parker	Chief Executive
	Linn Phipps	Non-executive Director
	David Purdue	Chief Operating Officer
	Neil Rhodes	Non-executive Director
	Jon Sargeant	Director of Finance (part)
	Sewa Singh	Medical Director
	Kath Smart	Non-executive Director
In attendance:	Marie Purdue	Director of Strategy and Transformation
	Adam Tingle	Acting Head of Communications and Engagement
	Gareth Jones	Trust Board Secretary
	Hazel Brand	Governor
	Steve Marsh	Governor
	Phil Beavers	Governor
	David Cuckson	Governor
	Sheila Walsh	Governor

ACTION

Welcome and apologies for absence

19/2/1 Apologies were presented on behalf of Pat Drake. The Chair of the Board extended her welcome to the five members of public in attendance.

Declarations of Interest

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

Actions from the previous minutes

19/2/3 The list of actions from previous meetings were noted and updated.

A deep dive into cancelled operations took place at the February19 meeting of Quality and Effectiveness Committee and therefore the Board agreed to remove this item from the action log.

It was agreed that a discussion would be held at Finance and Performance Committee in May on the details of the cost to the Trust of transitioning Band 1 staff to Band 2. The Board agreed to remove this item from the action log and include on the F&P work plan.

Presentation slot – Data Security and Protection Toolkit

19/2/4 The Board considered a presentation from Roy Underwood, Head of Information Governance and Data Protection Officer at the Trust.

19/2/5 The presentation outlined the key requirements of the Data Security and Protection Toolkit with particular attention drawn to the training, guidance and good practice relating to Data Protection including Cyber Security and how this were being implemented within the Trust.

19/2/6 Mr Underwood expressed the importance of ensuring the Trust achieved an annual training compliance of 95% but recognised that expectations and training levels varied depending on the roles within the organisation.

19/2/7 In response to a question from Mr Parker around the 95% training compliance target and if this had been internally generated, Mr Underwood advised that this target was determined by the Toolkit and was a national requirement.

19/2/8 Mr Parker asked the opinion of Mr Underwood to whether the training compliance of 95% is realistically achievable for the Trust as it is noted that other mandatory training requirements reach an average of 83%. Mr Marsh replied that there was a level of uncertainty to whether the training compliance would affect the assurance rating given by internal audit. The Trust was on track to achieve 'significant assurance' for its audit of the toolkit by KPMG.

19/2/9 Mrs Barnard advised the Board that mandatory training could be broken down into specific topics and is reported to the sub committees of Board. Mr Marsh would review the mandated requirements of staff to undertake the training and undertake a deep dive into the current compliance rates and report on the findings by email to members of the Board. **SM**

19/2/10 Mr Underwood reported that many organisations are working towards the Cyber Essential Plus certification and DBTH would aim to achieve this as part of the 2019 toolkit audit.

19/2/11 In response to a question from Linn Phipps around the use of email for patient communications, Mr Marsh advised that this posed many challenges similar to the current postal system, in terms of information security due to the risk of sending to incorrect email addresses and the regularity of people changing their contact details. Mr Marsh advised that this form of communication could only take place if the patient had registered their consent and this method of communication had not been tested in a court of law.

19/2/12 Following a conversation around the work being undertaken to remove fax machines, reduce written letter correspondence and improved use of email and security, the Chair suggested that a future workshop would be

beneficial to Board and made a request of Mr Marsh to provide an update in the coming months. **SM**

19/2/13 The Board NOTED the presentation.

Car Parking and Security Contract

19/2/14 The Board considered a contracting proposal presented by the Director of Finance, on behalf of the Director of Estates and Facilities, relating to the Car Parking and Security provision at the Trust.

19/2/15 The Board of Directors were asked to consider the approval of the car parking, security, smoking enforcement and capital investment award to Indigo Parking Services.

19/2/16 Mr Sargeant advised that the proposal had been discussed at the Finance and Performance Committee who sought to gather further information on the qualitative benefits of the contract. The Board was advised that this contract was a replacement for the existing contract in place with Shield Security Services.

19/2/17 Members of the Finance felt it and Performance Committee that further scrutiny was required due to the moving of services and the allocation of staff, as well as the value of the contract and sensitivity of its services.

19/2/18 It was agreed at the Finance and Performance Committee that Mr Sargeant, Mr Chan and Mr Rhodes would seek to gain further data from Mrs Edmondson-Jones to enable an informed decision on whether to proceed with the newly proposed contract and therefore Mr Sargeant sought the agreement of Board of this way forward.

19/2/19 The Board AGREED for Mr Sargeant, Mr Chan and Mr Rhodes to seek further assurance and APPROVED for those members to be given delegated authority to confirm sign off the contract on behalf of the Board of Directors.

South Yorkshire and Bassetlaw Pathology Programme

19/2/20 The Board considered a report of the Chief Executive that set out the national programme for the consolidation of the pathology laboratory services in England into 29 networks, with an estimated saving of £200million.

19/2/21 The paper provided Board with the progress that had been made by the South Yorkshire and Bassetlaw Pathology Transformation Programme, via its Board and associated workgroups, to transform services across the area. The programme seeks to provide a centralised service on a 'hub and spoke' model.

19/2/22 Mr Parker advised that the proposal would be presented at all partners and

CCG's Boards in the coming months and sought the approval of Board to continue to the work to develop an outline business case that will assess a defined set of options for future service delivery.

19/2/23 The Board were advised of a large tender that had been commissioned in excess of £1billion to support the redesign of a core laboratory service. Mr Parker supported and commended the proposal to Board and provided the caveat that the Trust needed to ensure that the models put before them did not cause cost pressures going forward. The programme was expected to see savings of a minimum of 5%.

19/2/24 In response to a question from Karen Barnard around staff retention and engagement, Mr Parker said that staff would be part of a local and national network that should ensure additional opportunities. Communications colleagues were also members of the Pathology Board and a monthly newsletter was being shared across the system to ensure transparency to staff. Mr Parker advised that the Board recognised that workforce shortages were realistic and relevant and further work would be undertaken to address the shortages going forward.

19/2/25 Linn Phipps sought assurance of the programme meeting the needs of patient and their families to which Mr Parker advised that the programme was based upon maintaining, and improving laboratory services and would not provide frontline patient care or testing issues as this would be managed by General Practice.

19/2/26 Mr Singh provided his support to the business case but asked if consideration had been made for providers to develop a joint tender. Mr Parker responded that the managed service contract was a joint tender and that a number of management models would need to be considered as part of the development of the outline business case.

19/2/27 In response to a question raised by Sheena McDonnell around clearly articulating patient outcomes in the business case, Mr Parker advised that the business case would include success criteria and would include the care and time to test results perspectives.

19/2/28 Board was advised of national work taking place on accreditation and partnership pathways and that NHS Improvement would undertake a review of the system and its individual components.

19/2/29 In response to a question from Jon Sargeant on stakeholder involvement, Mr Parker advised that workshops had been set up to look at each section of the laboratory services, the quality indicators, workforce issues and infrastructure in order to set the criteria.

19/2/30 Following a lengthy debate and consideration of the key risks the Board resolved to:

- APPROVE to progress the pathology transformation programme to

outline business case as described within the paper

- AGREED that the implementation of a single organisational form for the South Yorkshire and Pathology Services should be subject to the completion of an outline and full business case

- SUPPORTED the resolution of the key enablers

Reports for Assurance

Finance Report as at 31 January 2019

19/2/31 The Board considered a report of the Director of Finance that set out the Trusts financial position at month 10 as a cumulative £21.5m deficit, which is £600k favourable against plan and £808k favourable against forecast.

19/2/32 The Director of Finance reported a surplus of £593k, which is favourable against plan of £596k before PSF. This was reported as favourable against a forecast of £64k in month.

19/2/33 The Trust is currently on target to deliver its revised forecast which is £3.72million adverse position to the control total.

19/2/34 Mr Sargeant reported significant income had been received in month 10 and initial indication showed that activity remained high in February with no reports of loss of elective activity. The Trust had recorded a £7.9million cash balance at the end of the month. A reduced rate of agency spend was maintained in month.

19/2/35 Mr Rhodes provided his support to Mr Sargeants report and gave assurance to Board of the conversation that had been held at the Finance and Performance Committee of 25 February 19. Mr Rhodes remained confident in the management of the Trust's finances and commended the team for the work that had been undertaken to ensure a strong financial position.

19/2/36 The Board NOTED:

(1) The Trust's surplus for month 10 (January 2019) was £593k, which is a favourable variance against plan of £569k before PSF (£1,325k adverse after PSF, as the Trust is not forecasting to achieve its year end control total). The cumulative position to the end of month 10 is an £21.5m deficit before PSF, which is £600k favourable to plan (£1,294k adverse to plan including PSF) and £808k favourable to forecast.

(2) The achievement with regard to the Cost Improvement Programme.

(3) The forecast presented and reported to NHSi, of a £3.72m gap from delivering the control total before PSF (£9.4m gap including impact of not achieving Q4 PSF).

(4) The risk set out in the paper.

EU Exit

19/2/37 The Board considered a report from the Chief Operating Officer that set out the Trusts response and preparation for EU Exit. The paper outlined the next steps should a no deal EU Exit agreement be reached in the coming weeks.

19/2/38 The EU Exit process was being undertaken by the Emergency Preparedness Resilience and Response Team with Mr Purdue identified as the Senior Responsible Officer for the Trust. It was noted that the requests for the reporting of information is expected to increase immediately prior to Brexit to twelve times per day through a twelve-hour period with comprehensive updates given on staffing, equipment and medicine shortfalls. The Board was assured that regular contact was being maintained with NHS England and the Yorkshire Area Team but contact had been extended to colleagues in the East Midlands.

19/2/39 Mr Purdue reported that work continued with colleagues across PLACE and the ICS in ensuring partnership working takes place to mitigate the risks and impact on service provision. Social Care partners in Doncaster and Bassetlaw had declared a low risk impact on staffing due to a very small number employed from the EU.

19/2/40 Mr Purdue reported that the biggest risk was around access to medication, particularly insulin; however, the impact was more prevalent for Primary Care than Acute Trusts. The risk related to the transportation of medication rather than its production. Mr Purdue provided assurance to Board that risk assessments had been undertaken and assurance given to CCG's that services can continue in the event of a no deal scenario.

19/2/41 Mr Purdue advised that the Executive Team would undertake scenarios around EU Exit in the coming weeks and these would test the on call management arrangements. If the outcome is no deal, the corporate control and command would be enacted and the control room staffed 12 hours per day.

19/2/42 In response to a question from Sheena McDonnell around the timescales and content of scenarios testing, Mr Purdue advised that one exercise had been undertaken relating to medication supplies three weeks post EU Exit, one related to social care staffing six weeks post EU Exit and one related to equipment and the servicing of equipment. Mr Purdue agreed to share sample reports with the Board. A further scenario was anticipated around national fuel shortages. However, the Government had not anticipated issuing a national fuel plan. **DP**

19/2/43 In response to a question raised by Alan Chan around the financial support available, Mr Purdue advised that the Trust was awaiting a national

response to the request for financial support but it was expected that national monies would be made available.

19/2/44 Linn Phipps asked what review of staffing capacity had been undertaken to manage the additional workload and the management of personal pressures during the enactment of the command and control, to which Mr Purdue advised that the Trust were awaiting the national reporting requirements before reviewing its feasibility for staffing. The Government were expected to publish their risk assessment on 26 February 19 on the scenario of a no deal exit.

19/2/45 The Board NOTED the update and next steps.

CQC Update

19/2/46 The Director of Nursing Midwifery and Allied Health Professional provided Board with an update on the current progress of the unannounced CQC inspection of 27 – 29 November 2018.

19/2/47 Moira Hardy reported that two main areas of concern had been raised from the report, which related to paediatric nurse staffing and the front door assessment streaming service model. The Trust had taken immediate responsive action to address the issues raised.

19/2/48 Mrs Hardy advised of the weekly meetings that had been arranged with key stakeholders to progress the CQC action plan and provided assurance of the monitoring and reporting arrangements that had been put in place from a managerial and governance perspective. Fortnightly reporting to the CQC continued to take place with the last report being provided on Thursday 21 February 19. No further challenges had been given to the Trust.

19/2/49 The report of the inspection had been received on 8 February 19 with a deadline for factual accuracy checks of the 21 February 19. Mrs Hardy reported that the Trust responded within the required deadlines with a number of inaccuracies challenged and a request to the CQC to consider a more balanced approach across the two sites. Mrs Hardy reported that an acknowledgement had been received from the CQC stating careful consideration would be given to the comments made by the Trust.

19/2/50 The Board NOTED the update.

Performance Report at 31 January 2019

19/2/51 The Board considered a report of the Chief Operating Officer, Medical Director, Director of Nursing, Midwifery and Allied Health Professionals and Director of People and Organisational Development that set out the operational and workforce performance at month 10, 2018/19.

19/2/52 Performance against metrics included:

- RTT – The Trust remained below target at 87.4%, which is an improved position compared to month 9 reporting.

- Diagnostic wait is 99% against the standard of 99.5%.

- 2 week waits – The Trust achieved 91.1% and was non-compliant with the national target of 93%.

- The 62-day performance achieved 85.3%, increasing against last month's reporting of 84.8%.

- 4 Hour Access Target – The Trust achieved 90.3% against national standard of 95% but with an improvement in performance of 2.6% compared to 2018/19. It was acknowledged that the Trust was the 14th best performing Trust nationally

- HSMR – The Trusts rolling 12 month was lower than the expected level at 93.43.

- Appraisals – The Trusts appraisal completion remained at 78.85%.

- SET Training – The Trust's SET training rate was 81.3%% at the end of January.

- Sickness Absence – The year to date figures has increased slightly at 4.42%.

19/2/53 In response to a question from Kath Smart on the impact on performance around the emergency department triage model, Mr Purdue reported that staff had been supportive of the new model and there had been no reported impact.

19/2/54 In response to a query from Kath Smart on historical reflections and future projections of care hours per day, Mrs Hardy advised that model hospital data is used and safe staffing data had been discussed at the Quality and Effectiveness Committee in February 19. Kath Smart requested that the conclusion of the discussion held needed to include transparency against local peers and nationally to which Moira Hardy agreed to include in future executive summaries of the performance report. Mr Rhodes suggested that the Quality and Effectiveness Committee should be responsible for the deep dive of the quality report detailing care hours and a lesser conversation held at Board unless concerns had been raised. Mrs Phipps advised that QEC would undertake a deep dive into the area and escalate to Board accordingly. **MH** **MH / LP**

19/2/55 Mr Singh highlighted three key areas from the performance report to include:

1. There had been an intention to share the metrics for the care of children. However, this would be review with the Clinical Governance Committee in the coming weeks. Mr Singh advised an **SS**

update would be given in the next month's report to Board.

2. HSMR had remained better than expected but an upward trend had been noted. It had been anticipated that the Trust would move into the 'expected' range in the coming months following a detailed benchmarking exercise.

3. It was acknowledged that NHS England have requested reports be received by Board on four key areas; time to consultant review, availability of diagnostic tests, availability of consultant interventions and consultant review. Agreement was sought from Board for QEC to have delegated responsibility to review these reports every six months with any concerns escalated to Board. The Board AGREED. **SS**

19/2/56 Mrs Barnard provided an overview of the sickness absence reasons for January 2019, which had been identified as cold / flu, related. It was noted that the Trust had been shortlisted by NHS Employers for the 'most creative and best team award' for the flu campaign. The Board acknowledged the progress and congratulated the team on their nomination.

19/2/57 Mrs Barnard reminded Board of the appraisal season that would take place April to June 19 and of the various soundbites training modules being held.

19/2/58 Board NOTED the report.

Executive Teams Objectives

19/2/59 The Board considered a report of the Chief Executive that outlined the progress of the Executive Teams Objectives at Q3, 2018/19.

19/2/60 Mr Parker advised that the objectives for 2019/20 would be set in March 19 following Executives appraisals.

19/2/61 In response to a question from Sheena McDonnell on Mr Parkers view of any key areas that are posing difficulties in achievement, Mr Parker stated that the objectives had been RAG rated against progress following Executives self-assessment and did not anticipate any turning to 'red' or not achieved.

19/2/62 Mr Parker spoke of the True North objectives that would be used as a basis to form part of the objectives for Executives in the coming year. Mr Parker also advised that the work of Qi would also be embedded and an assessment would be undertaken of each decision-making committee. The Board acknowledged the good examples of Qi work that had been undertaken throughout the Trust.

19/2/63 The Board NOTED the paper for assurance.

Staff Survey Report

19/2/64 The Board considered a report of the Director of People and Organisational Development that set out the progress on staff survey and engagement. The Embargo report was due to be published on 26 February 19, which was the same day as the Board, and therefore a detailed analysis and presentation of the results could not be undertaken. It was reported that the Quality and Effectiveness Committee would undertake a review of the report at the next committee.

19/2/65 Mrs Barnard provided background to the survey that had been undertaken through October and November of 2018. The paper set out the areas of concern and actions to address the lower scoring results over the next year.

19/2/66 Mrs Barnard spoke of the need to demonstrate accountability for the results of the survey and the delegation of actions to Divisions and Directorates. Part of this work would include engagement groups within each Division and Directorate with a Trust level group chaired by the Chief Executive.

19/2/67 Kath Smart reminded Board members of the recent statement released by the Health Secretary around staff support for wellbeing and stress and sought assurance that the Trust would be undertaking this review. Mrs Barnard provided assurance that the Trust had committed to reviewing its support for staff.

19/2/68 Kath Smart sought assurance from Karen Barnard around staff receiving feedback from the survey and their involvement in subsequent actions to which Mrs Barnard stated that the Qi Programme had seen a significant improvement in staff participation.

19/2/69 Karen Barnard advised that the Trust induction was a key part of the staff journey and a working group had been set up to review and improve the current induction offer.

19/2/70 The Board NOTED the report.

Guardian for Safe Working

19/2/71 The Board considered a report of Mr Jayant Dugar and received the annual report of the guardian for safe working, as per the Junior Doctors contract.

19/2/72 Mr Dugar provided Board with a background into the report and reminded members that the Guardian role were introduced with the responsibility of ensuring doctors are properly paid for all their work and by ensuring that doctors are not working unsafe hours. The contract continued to be implemented with 137 doctors current employed at DBTH on the 2016 contract and the Trust had recently become a lead employer for GP trainees.

19/2/73 Mr Dugar advised that exception reports within the quarter had been

submitted across surgical and medicine divisions with a total of 29 reports raised which one had related to education. Mr Dugar reported trainees had raised no gross safety issues with the Guardian.

19/2/74 The Trust had purchased an e-rostering system that the Mr Dugar felt needed to be implemented fully as this would provide assurance that none of the junior doctors would be breaching their hours of contract.

19/2/75 In response to a question raised by Kath Smart around engagement from Estates and IT in supporting the implementation of e-rostering, Mr Dugar said that e-rostering was a national driver and junior doctors felt disengaged as result of on call rooms and parking and had therefore requested the support of colleagues in Estates and IT. Mr Parker reported that the Director of Estates and Facilities had developed a list of estates work to be undertaken that took into consideration the concerns of junior doctors. Mrs Barnard reported that the e-rostering project had commenced.

19/2/76 Board NOTED the annual update together with the update from the third quarter of 2018/19 and was ASSURED that training doctors had safe working practices as envisaged by the 2016 contract.

Chairs Assurance Logs for Board Committee held 20 February 2019 and 25 February 2019

19/2/77 The Board considered an update from the Chair of the Finance and Performance Committee from the meeting held on 25 February 19. Mr Rhodes reported the committee had undertaken a detailed exploration of finance and performance with particular attention made to the car parking contract, annual plan and Trust efficiencies.

19/2/78 Mr Rhodes reported that good progress had been made with the Performance Assurance Framework that is hoped would deliver a shorter assurance report to Board and incorporates the workforce data. Mr Rhodes said Board should expect to see the new template at the meeting to be held in April 19.

19/2/79 Board NOTED the update.

Reports for Information

19/2/80 The following items were NOTED:

- Chair and NEDS' report
- Chief Executive's report
- Bassetlaw Integrated Care Partnership Bulletin
- Minutes of Management Board, 14 January 2019

- Minutes of Quality and Effectiveness Committee, 17 December 2018
- Minutes of the Fred and Ann Green Legacy Advisory Group 16 November 2018
- Minutes of Charitable Funds Committee 25 September 2019
- Integrated Care System Update

Items to Note

19/2/81 The following item was NOTED:

- Board of Directors Agenda Calendar

Minutes

19/2/82 The minutes of the meeting of the Board of Directors on 29 January 2019 were APPROVED as a correct record.

Any other business

19/2/83 No any other business were raised.

Governors questions regarding business of the meeting

19/2/84 In response to the discussion held around fax machines as part of the Data Security presentation, Hazel Brand made a request of a briefing session to Governors on the Trusts response to decommissioning faxes and becoming a 'paper less' organisation. The Chair of the Board supported this request.

Date and time of next meeting

19/2/85 9:15am on Tuesday 26 March 2019 in the Fred and Ann Green Boardroom, Mexborough Montagu Hospital.

Exclusion of Press and Public

19/2/86 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