Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Board of Directors Meeting Held in Public
To be held on Tuesday 20th July 2021 at 09:30
Via StarLeaf Videoconferencing

Enc		Purpose		Time
A	**MEETING BUSINESS**			**09:30**
A1	Welcome, apologies for absence and declarations of interest *Suzy Brain England OBE, Chair* *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*		-	15
A2	Actions from previous meeting *Suzy Brain England OBE, Chair*	*Review*	5	
B	**PRESENTATION**			
	None			
C	**True North SA1 - QUALITY AND EFFECTIVENESS**			**09:45**
C1	Board Assurance Framework *David Purdue, Deputy Chief Executive and Chief Nurse / Dr T J Noble, Executive Medical Director*	*Assurance*	7	5
C2	Chief Nurse Update *David Purdue, Deputy Chief Executive and Chief Nurse*	*Assurance*	10	10
C3	Infection Prevention and Control Board Assurance Framework *David Purdue, Deputy Chief Executive and Chief Nurse*	*Assurance*	31	5
C4	Medical Director Update *Dr T J Noble, Executive Medical Director*	*Assurance*	79	10
D	**True North SA2 & 3- PEOPLE AND ORGANISATIONAL DEVELOPMENT**			**10:15**
D1	Board Assurance Framework *Karen Barnard, Director of People and Organisational Development*	*Assurance*	88	5
D2	Our People Update *Karen Barnard, Director of People and Organisational Development*	*Assurance*	90	10
	BREAK 10:30 – 10:40			

E	**True North SA4 - FINANCE AND PERFORMANCE**			**10:40**
E1	Board Assurance Framework *Jon Sargeant, Director of Finance & Rebecca Joyce, Chief Operating Officer*	*Assurance*	105	5
E2	Finance Update *Jon Sargeant, Director of Finance*	*Note*	107	10
E3	Estates Returns Information Collection (ERIC) Return *Jon Sargeant, Director of Finance*	*Approve*	113	5
E4	Premise Assurance Report *Jon Sargeant, Director of Finance*	*Approve*	132	5
E5	COVID-19 Update / Recovery of Elective Work – Looking Forward *Rebecca Joyce, Chief Operating Officer*	*Assurance*	-	10
E6	Performance Update *Rebecca Joyce, Chief Operating Officer*	*Assurance*	152	10
F	**STRATEGY**			**11:25**
F1	*No items*			
G	**GOVERNANCE AND ASSURANCE**			**11:25**
G1	Corporate Risk Register *Fiona Dunn, Deputy Director Corporate Governance/Company Secretary*	*Review*	181	30
G2	Terms of Reference for the Trust Executive Group *David Purdue, Chief Nurse*	*Approve*	185	
G3	Trust Annual Report 2020/21 including Annual Governance Statement *Richard Parker OBE, Chief Executive*	*Assurance*	188	
G4	Standing Financial Instructions, Standing Orders and Scheme of Delegation *Jon Sargeant, Director of Finance*	*Approve*	374	
G5	Audit and Risk Committee Annual Report *Kath Smart, Non-Executive Director and Chair of the Audit and Risk Committee*	*Note*	496	
G6	Terms of Reference for Finance and Performance Committee *Neil Rhodes, Non-Executive Director and Chair of the Finance and Performance Committee*	*Approve*	502	
G7	Terms of Reference for Quality and Effectiveness Committee *Pat Drake, Non-Executive Director and Chair of the Quality and Effectiveness Committee*	*Approve*	507	
G8	Terms of Reference for the Charitable Funds Committee *Mark Bailey, Non-Executive Director and Chair of the Charitable Funds Committee*	*Approve*	511	

H	**INFORMATION ITEMS (To be taken as read)**			**11:55**
H1	Chair and NEDs Report *Suzy Brain England OBE, Chair*	*Information*	513	5
H2	Chief Executives Report *Richard Parker OBE, Chief Executive*	*Information*	519	5
H3	ICS Update *Richard Parker OBE, Chief Executive*	*Information*	527	
H4	SYB ICS Acute Federation – Digital Transformation Strategy *Jon Sargeant, Director of Finance*	*Information*	534	
H5	Minutes of the Finance and Performance Committee – 15 April 2021 and 17 May 2021 *Neil Rhodes, Non-Executive Director*	*Information*	538	
H6	Minutes of the Audit and Risk Committee – 25 March 2021, 21 May 2021 and 09 June 2021 *Kath Smart, Non-Executive Director*	*Information*	561	
H7	Minutes of the Quality and Effectiveness Committee 06 April 2021 *Pat Drake, Non-Executive Director*	*Information*	592	
H8	Minutes of the Charitable Funds Committee 11 February 2021 *Mark Bailey, Non-Executive Director*	*Information*	607	
H9	Minutes of the Trust Executive Group – 10 May 2021 and 07 June 2021 *Richard Parker OBE, Chief Executive*	*Information*	616	
H10	Minutes of the People Committee – 04 May 2021 *Sheena McDonnell, Non-Executive Director*	*Information*	636	
H11	Minutes of the Council of Governors – 29 April 2021 *Suzy Brain England OBE, Chair*	*Information*	649	
I	**OTHER ITEMS**			**12:05**
I1	Minutes of the meeting held on 15th June 2021 *Suzy Brain England OBE, Chair*	*Approval*	659	
I2	Any other business (to be agreed with the Chair prior to the meeting) *Suzy Brain England OBE, Chair*	*Discussion*	-	
I3	Governor questions regarding the business of the meeting (10 minutes)* *Suzy Brain England OBE, Chair*	*Discussion*	-	10
I4	**Date and time of next meeting:** **Date:** Tuesday 21 September 2021 **Time:** 09:30 **Venue:** StarLeaf Videoconferencing	*Information*	-	

I5	**Withdrawal of Press and Public** Board to resolve: That representatives of the press and other members of the public be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest. *Suzy Brain England OBE, Chair*	*Note*	-

J	**MEETING CLOSE**	**12:15**

***Governor Questions**

The Board of Directors meetings are held in public but they are not 'public meetings' and, as such the meetings, will be conducted strictly in line with the above agenda.

For Governors in attendance, the agenda provides the opportunity for questions to be received at an appointed time. Due to the anticipated number of governors attending the virtual meeting, Hazel Brand, as Lead Governor will be able to make a point or ask a question on governors' behalf. If any governor wants Hazel to raise a matter at the Board meeting relating to the papers being presented on the day, they should contact Hazel directly prior to the meeting to express this. All other queries from governors arising from the papers or other matters should be emailed to Fiona Dunn for a written response.

In respect of this agenda item, the following guidance is provided:

- Questions at the meeting must relate to papers being presented on the day.
- Questions must be submitted in advance to Hazel Brand, Lead Governor.
- Questions will be asked by Hazel Brand, Lead Governor at the meeting.
- If questions are not answered at the meeting Fiona Dunn will coordinate a response to all Governors.
- Members of the public and Governors are welcome to raise questions at any other time, on any other matter, either verbally or in writing through the Trust Board Office, or through any other Trust contact point.

Suzy Brain England, OBE, Chair of the Board

Action notes prepared by: Katie Shepherd
Updated: 15th June 2021

Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

Action Log

Meeting:	Public Board of Directors
Date of latest meeting:	15th June 2021

KEY	
Completed	**On Track**
In progress, some issues	**Issues causing progress to stall/stop**

No.	Minute No.	Action	Lead	Target Date	Update
1.	**P21/03/C3**	**Committee Structures** Following the discussion of the Clinical Governance meeting structure. It was agreed that work would be undertaken with the Communications and Engagement Team to devise a clear and understandable outline of the committee structure and each committee's purpose.	**TN / ES**	**May 2021**	**Closed.** Included within item C3.
2.	**P21/04/G3**	**COVID-19 Business Continuity Terms of Reference – Trust's SO's** When the Standing Orders are reviewed in July 2021, the COVID-19 Business Continuity Terms of Reference addendum would be removed.	**FD**	**July 2021**	**Closed.**
3.	**P21/05/C3i**	**Review of National Examiners Report** The Medical Director would review the National Medical Examiners report, which would include a review of the cases scrutinised by the Medical Examiner, to identify how this could be reported as a key performance indicator in future reports.	**TN**	**July 2021**	**Closed.** Included within item C3.

Action notes prepared by: Katie Shepherd
Updated: 15th June 2021

No.	Minute No.	Action	Lead	Target Date	Update
4.	**P21/05/C3ii**	**Inclusion of Culture and Communication as part of Medical Director Report** It was agreed that future Medical Director reports to Board would include an update on culture and communication with the medical workforce.	**TN**	**July 2021**	**Closed.** Included within item C3.
5.	**P21/06/B1**	**CNST Actions Update** An update would be provided on the achievement and submission of CNST actions.	**DP**	**July 2021**	**Closed.** An update would be provided as part of item C2.

Appendix Level1

Board Assurance Framework – Risks to achievement of Strategic Aims

OUR VISION : To be the safest trust in England, outstanding in all that we do

True North Strategic Aim 1	True North Strategic Aim 2	True North Strategic Aim 3	True North Strategic Aim 4
To provide outstanding care and improve patient experience	**Everybody knows their role in achieving the vision**	**Feedback from staff and learners in top 10% in UK**	**In recurrent surplus to invest in improving patient care.**
Breakthrough Objective: Achieve measurable improvements in our quality standards & patient experience	**Breakthrough Objective:** Achieve a 5% improvement in our staff having a meaningful appraisal linked to our vision	**Breakthrough Objective:** The Trust is within the top 25% for staff & learner feedback	**Breakthrough Objective:** Every team achieves their financial plan for the year

Current Risk Level Summary

The entire current BAF was last reviewed in July 2021 reviewed alongside the corporate risk register.

The entire BAF and CRR were reviewed at Board Sub Committee meetings during June 2021 and by the Strategic aim sponsors in June 2021. The individual BAF sheets indicate the assurance detail.

COVID -19 BAF - The integrated pandemic governance process has been embedded and the trust is proactively managing the new and emerging risks identified as part of the restoration and recovery phase. Additional assurance continues to be sought internally and the evidence of this is referenced in the respective director reports to the March Sub Committee and Trust Board.

The key risks to outstanding patient experience remains workforce, the key risk to financial sustainability is underperformance against income plan, cost improvement plan and the underlying financial sustainability and the key risk to operational excellence remains RTT 18 and the 52 week breach position. Additional assurance continues to be sought internally and the evidence of this is referenced in the respective director reports to the July Trust Board .

There has been no change in the BAF risk level during quarter 1 2021/2022.

Heat Map of individual SA risks (identified 2019 -2020 BAF)

	No Harm 1	Minor 2	Moderate 3	Major 4	Catastrophic 5
Rare 1					
Unlikely 2		2 Q&E8, Q&E3	1 Q&E4	2 A&R1, F&P10	2 F&P18, Q&E10
Possible 3		1 Q&E7	3 Q&E5, Q&E2, F&P14	4 Q&E11, F&P5, F&P9, Q&E6	2 **F&P11**, F&P19
Likely 4			2 F&P12, F&P15	7 Q&E9, **F&P1**, F&P3, F&P6, F&P13, F&P8, Q&E1,	4 F&P4, F&P20 Q&E12, F&P12,
Certain 5				2664	COVID 2472

Overall change per Strategic Aim (SA)

	Q1 2021/22	Q2 2020/21	Q3 2020/21	Q4 2020/21	No of risks/SA	Change
SA1	⟺	⟺	⟺	⟺		⟺
SA2	⟺	⟺	⟺	⟺		⟺
SA3	⟺	⟺	⟺	⟺		⟺
SA4	⟺	⟺	⟺	⟺		⟺
COVID	⟺	⟺	⟺	⟺	several	⟺

COVID19 Major incident

Risk Owner: Trust Board **Committee: Q&E, F&P,**	**COVID19 - Addition to SA1**	**Date last reviewed : MAY 2021**	
Strategic Objective To deliver safe & effective service to patients and staff during a World-wide pandemic of Coronavirus which will infect the population of Doncaster and Bassetlaw (including staff) resulting in reduced staffing, increased workload due to COVID-19 and shortage of beds, ventilators.	**Risk Appetite:** The Trust has a **high appetite** for risks that impact on patients and staff during a worldwide pandemic.	**Initial Risk Rating** **Current Risk Rating** **Target Risk Rating**	5(C) x 5(L) = 25 extr 5(C) x 4(L) = 20 extr 3(C) x 3(L) = 9 low
Risks: • Impact on safety of patients • Impact on patient experience • Potential delays to treatment • Impact on patient harm • Impact on reputation • Adverse impact on Trust's financial position • Impact on staff & Inability to provide viable service	**Rationale for risk current score:** • Previous unknown pandemic: ○ Patients, staffing, resources etc • Data modelling predictions based on "best" guess principles from previous flu epidemics • Unknown timescale of outbreak	**Future risks:** • Impact of COVID on elective restoration **Opportunities:** • Change in practices, new ways of working by	

Controls / assurance (mitigation & evidence of making impact):
• Pandemic incident management plan implemented.
• Governance & Performance Management and Accountability Framework
• ~~Gold & Silver Command pandemic management structure (Strategic & Tactical) in place 24/7~~
• Individual work streams identified to deliver a critical pathway analysis
• Regular data modeling and analysis of trends and action to address shortfalls.
• Continued liaison with leads of operational work streams to identify risks to delivery.
• National reporting & monitoring eg PHE, NHSI/E, WHO etc
• Summary of Post Implementation Review undertaken
• Includes stabilization & recovery plans
• response to COVID wave3 plans
• 17/5/21: Operational Update / Delivery of Elective Restoration Update (Presentation)given to F&P Committee on monthly basis. Covers risk areas of Theatre staffing, Be Plan, Risk to patients & Oversight & Governance. Mitigation via high level actions from COO led Performance & Access Board.
• High level actions from Performance and Access Board
  ○ -Strengthening governance of "getting the basics right" (642, POA etc)
  ○ -OP Utilisation – implementation of 1 m rule to increase throughput
  ○ -Further COO/ Chief Nurse escalation meet 19/5 on theatre staffing pressure
  ○ -Bed plan – options paper w/c 17/5
  ○ -Cancer: Histopathology workforce planning meet with COO / MD – 18/5/21
  ○ -Imaging capacity risk – backlog
  ○ -Endoscopy - Throughput and utilisation plan – focused plan 21/5
  ○ -Ophthalmology recovery plan (review lists issue & clinical harm review)
  ○ -Short term validation plan to address PTL issue – before sustained plan in place
  ○ -Additional independent sector plan
• Finalisation of 52 week trajectories and wider issuing of IQPR
• Confirm & Challenge events on Annual Plan end of May
	Comments:
	• Temporary Site Reconfiguration
	• Reduction in Planned Care – Outpatients & Surgery
	• Vulnerable Patients
	• Emergency Pathways (Adult)
	• Increasing Critical Care Capacity
	• Consolidation of maternity and Delivery of Children's Services
	• Trauma Consolidation
	• Diagnostics and Pharmacy
	• Care of Deceased Patient
	• People Planning, Education and Research
	• Ethical Decision Making
	• Infection Control and Prevention Support
	• IT and Digital, Estates, Finance & Procurement
	• Partnerships, Communication and Engagement
	• Recovery Phase
		Assurance (evidence of making an impact):
		• See evidence of plans in link (Overall Plan)
		• Risk log (see link)
		• High Level COVID Narrative
		• Post implementation review
		• Internal Audit reviews on quality outcomes:
		  ○ Covid-19: Business Continuity, Pandemic Response Plan and Remote Working - October 2020 - Significant assurance with minor improvement opportunities
		  ○ COVID-19 Financial Governance and Controls - October 2020 - Significant assurance with minor improvement opportunities
		•	

		Gaps in controls / assurance (actions to achieve target risk score): • Overall delivery of work streams pandemic plans – link CRR Risk ID2472 on DATIX	

Appendix Level1

OUR VISION : To be the safest trust in England, outstanding in all that we do			
True North Strategic Aim 1 – To provide outstanding care & improve patient experience.			
Risk Owner: Trust Board **Committee: QEC**	**People, Partners, Performance, Patients, Prevention**	**Date last reviewed : JUL 2021**	
Strategic Objective To provide outstanding care and improve patient experience **Breakthrough Objective** Achieve measurable improvements in our quality standards & patient experience	**Risk Appetite:** The Trust has a **low appetite** for risks **Measures:** • Ward/department quality assessment scores, recommencement of the IQAT and DQAT • Evidence of "closing the loop", through sharing of learning from incidents and follow up from QI processes • Focus on key safety risks – IPC Outbreaks, Patient experience - waits, falls, milestones set through business planning for each division aligned to the divisions breakthrough objectives • Clinical effectiveness, processes to include the following of NICE guidance • IQPR measures • Co-production of changes with patients	**Initial Risk Rating** **Current Risk Rating** **Target Risk Rating**	4(C) x 5(L) = 16 extr 4(C) x 4(L) = 16 extr 3(C) x 3(L) = 9 low
Risks: • Risk of patient harm if we do not listen to feedback and fail to learn • Risk of not using available quality assurance data to best effect in order to identify areas to improve or manage patient care. • Risk to safety and poor patient experience as a result of failure to improve the estate and infrastructure. • Risk of non-delivery of national performance standards that support timely, high quality care	**Rationale for risk current score:** Impact: • Impact on performance • Impact on Trust reputation • Impact on safety of patients • Impact on patient experience • Potential delays to treatment • Possible Regulatory action	**Future risks:** • Impact of COVID on elective restoration • Staff engagement post covid • Patient expectations following Covid • Staff working in separate areas following the incident in the womens hospital. **Risk references:** Q&E9, F&P 6 and F&P 8. **Opportunities:** • Change in practices, new ways of working • Advent of more digital care • Greater opportunity for collaboration at place / system level • Implementation of National Safety Strategy • Restructure to focus on patient experience • Quality improvement processes focused on Falls in the 10 high risk areas • Workforce development plan	
Controls / assurance (mitigation & evidence of making impact): • BIR Data targets & exceptions • Clinical effectiveness measures • Quality framework outcomes ○ Quality control to Quality Assurance • Quality Improvement outcomes • Clinical Governance Review • Integrated Quality Performance Report • Accountability Framework • Annual planning process • External compliance review action plans	**Comments:** • Need to ensure Trust Values are effective • Need to develop quality/patient safety strategy • Need to sustain improvements in QI initiatives • Need to widen the focus on patient and user feedback	**Assurance (evidence of making an impact):** Output from Board sub committees Internal Audit reviews on quality outcomes, falls documentation compliance 20/21, DToC 2019/20, Complaint process 2020/21. Action plans completed against internal audit and reviewed at QEC in June. Positive feedback from people on the services BAF completion on specific areas, evaluated by CQC, IPC BAF reviewed at Board of Directors December 2020. BAF reassessed 14th July 2021 Trust plan against the Ockenden Report, plan reviewed at Board February 2021 and QEC April 2021. Ockenden information uploaded to national portal on 1st July 2021. CNST 10 elements to be uploaded on the 22nd of July. SNCT undertaken to ensure safe staffing completed in June 2021. **Gaps in controls / assurance (actions to achieve target risk score):** Uncertainty re COVID recovery outcomes Uncertainty re SYB ICS changes	

Report Cover Page					
Meeting Title:	*Board of Directors*				
Meeting Date:	*20th July 2021*	**Agenda Reference:**	**C2**		
Report Title:	*Chief Nurse Report*				
Sponsor:	*David Purdue – Chief Nurse and Deputy Chief Executive*				
Author:	Lois Mellor, Director of Midwifery Abigail Trainer, Director of Nursing Cindy Storer, Deputy Director of Nursing, Patient Safety Stacey Nutt, Deputy Director of Nursing, Patient Experience David Purdue, Chief Nurse and Deputy Chief Executive				
Appendices:	*0*				
Report Summary					
Purpose of report:	*To provide information and assurance on the key deliverables for patient experience and safety.* *To provide assurance against the outcome measures for Maternity Services* *To provide assurance against safe staffing numbers for nursing and midwifery*				
Summary of key issues/positive highlights:	• Good progress is being made in relation to objectives. • Ockenden Report key actions uploaded to the national portal • Learning areas from reports and incidents				
Recommendation:	To approve				
Action Require:	Approve	Information	~~Discussion~~	~~Assurance~~	~~Review~~
Link to True North Objectives:	**TN SA1:**	**TN SA2:**	**TN SA3:**	**TN SA4:**	
	To provide outstanding care for our patients	***Everybody knows their role in achieving the vision***	*Feedback from staff and learners is in the top 10% in the UK*	*The Trust is in recurrent surplus to invest in improving patient care*	

Implications	
Board assurance framework:	*BAF SA1 & SA2*
Corporate risk register:	*None*
Regulation:	*CQC – Safe Care and Treatment and Patient Centred Care. Achievement of Outstanding.*
Legal:	*Trusts licence to operate*
Resources:	*Nil*

Assurance Route			
Previously considered by:	*Board of Directors, Quality and Effectiveness Committee*		
Date:	*May/June2021*	**Decision:**	*Regular updates required to QEC*
Next Steps:	*Update progress to QEC*		
Previously circulated reports to supplement this paper:	None		

Patient Safety Report

In July 2019, NHS improvement launched the national patient safety strategy defining patient safety as maximising the things that go right and minimising the things that go wrong. It is integral to the NHS' definition of quality in healthcare, alongside effectiveness and patient experience.

The Trust action plan is tracking development of the national strategy and ensuring readiness for the implementation updates.

Safer Culture, Safer System

The national strategy translates the high level objectives for the safety culture and safety system strands into more tangible deliverables. Safety culture indicators should not be used to assess performance or for regulatory purposes, but more to support and enable Trusts to improve safety culture through embedding a continuous cycle of understanding the issue – developing a plan – delivering the plan – evaluating the outcome.

Questions for the Safety Culture index are now included in the Division Framework for the Quality and Effectives Committee.

INSIGHT

Serious Incidents

There were three serious incidents reported in June. One patient suffered suboptimal care and delayed diagnosis of complications after a vascular procedure. One patient suffered potential side effects from IV medication in the post-natal period and one patient fell and suffered a fractured hip.

After Action Review (AAR)

AAR is most commonly used as a means of framing a structured facilitated discussion of an event that has occurred. The outcome of the discussion enables the individuals involved in the event to understand what went well and why and what didn't go well and why. This allows them to agree of what they would do differently in the future and what learning can be identified to inform improvement. Following guidance from the National Patient Safety Team at NHS England, AAR is being tested across the Trust

There have been four After Action Reviews across the Trust, year to date. Early feedback has been positive, with evidence of some immediate learning and changes taking place within the clinical teams.

Falls

There were 123 inpatient falls in June. Of these, five resulted in moderate harm (FAU, SAW, Ward 32, CCU/C2 & St leger) and two resulted in severe harm (Resp. 21 and Ward A4).

The learning from falls is being collated on an infographic, which is circulated to Trust staff to raise awareness of the themes. The learning identified at the falls panel in June is focused on early referral and assessment by physiotherapy, walking aid provision, implementing and maintaining the assessed level of supervision/utilising next best options if the assessed supervision cannot be

achieved, and improving the knowledge and understanding of cohort and 1:1 supervision for trust staff and NHSP/agency staff.

Hospital Acquired Pressure Ulcers (HAPU)

There were a total of 79 HAPU this month, on 65 patients. There were no Category three HAPU.

The skin integrity team are now focusing the support on wards to reduce the incidents of grade 2 pressure ulcers.
Learning this month includes, documentation; including risk assessments, care plans and patient choice in repositioning. Prevention; where medical devices have been used and or documenting use of skin protection products. Equipment has also been a theme and ensuring the pressure relieving device is delivered and then put into use as soon as possible.

Infection Prevention and Control

Hospital onset COVID-19 cases

All hospital onset COVID-19 infections have been reported to the daily and weekly Hospital Onset Covid Infection (HOCI) SitRep. The Covid Patient Notification System (CPNS) has been used to report hospital acquired Covid deaths.

Guidance was released in March 2021 by NHS England to define hospital onset probable or definite healthcare associated COVID-19 and that patients who have subsequently died, should also be considered as a notifiable patient safety incident.

A Task and Finish group was formed to undertake the analysis of how many patients and staff had died after being exposed to Covid-19. Recommendations and actions have now been completed and the work to ensure the Duty of Candour with bereaved families and any learning from Covid-19 nosocomial infection will start in July 2021.

Clostridium difficile
There were two cases of Clostridium difficile in June. Both cases were Community onset, Hospital Acquired (COHA).

No lapses in care have been identified as yet, with patients appropriately being prescribed antibiotics.

This brings the total number of cases of Clostridium difficile to ten (6 HOHA and 4 COHA)

MRSA bacteraemia
There were no MRSA bacteraemia reported in June.

MRSA Colonisation
There were no reported MRSA colonisation in June, with a year to date total at one case.

INVOLVEMENT

The framework for involving patients in patient safety was released in June and is split into two parts

- Part A: Involving patients in their own safety
- Part B: Patient safety partner (PSP) involvement in organisational safety

Part B of the framework 'PSP involvement in organisational safety' relates to the role that patients, carers and other lay people can play in supporting and contributing to a healthcare organisation's governance and management processes for patient safety.

Roles for PSPs can include:

- membership of safety and quality committees whose responsibilities include the review and analysis of safety data
- involvement in patient safety improvement projects
- working with organisation boards to consider how to improve safety
- involvement in staff patient safety training
- participation in investigation oversight groups

The ambition is to have the PSs in place by the end of Q1 2022/23

Trust wide Learning Needs Analysis will soon be starting in readiness of the first NHS-wide Patient Safety Syllabus which applies to all NHS employees. Level one and two learning materials will be available on the E Learning for Health platform for staff to access and complete from August and September 2021.

IMPROVEMENT

Digital Transformation

As part of the DBTH Digital Transformation Programme, we are preparing to deliver Phase 2 of the programme by introducing the Core Risk Bundle of Nursing Assessments in the very near future. The move towards electronic patient records is welcome and builds on the success of the electronic observations and sepsis screening.

The roll out of EObs is being expanded to include paediatrics, which is more complex due to the observation escalations for the 3 age categories within sepsis screening for paediatrics.

Safety Standards for Invasive Procedures

A new policy has been written in order to comply with the NHS England mandate to implement the National Safety Standards for Invasive Procedures (NatSSIPs). The ultimate aim of NatSSIPs is to eradicate the occurrence of the Patient Safety Never Events, which occur around invasive procedures.

Training has been provided to ensure all staff involved in invasive procedures have an understanding of the correct checks.

EIDO Library upgraded

To improve the informed consent process, our EIDO library has now been upgraded to the full library. Clinicians now have access to all Procedure specific patient information leaflets available for download. Leaflets can be accessed to print out and send electronically to patients during remote consultations.

Transfusion Information

A new page on the Hive has been set up to share learning around blood transfusions with staff, including newsletters, anaemia guidance, SHOT resources and checklists

Maternity Dashboard

Ockenden evidence against the 7 must do actions, uploaded via the Portal on time.

Findings of review of all perinatal deaths using the real time data monitoring tool

Action Plan for Quarter 1

Case	Issue	Action	Implementation Plan	Person responsible & role	Target completion date
68790 69131 66665 70006 71421	This mother and her partner were not able to be cared for in either a sound proofed room or a room away from other mother and crying babies because the facilities were not available	Review of bereavement facilities has begun	Ongoing review	Julie Humphries Intrapartum Matron And Bereavement Midwives	11.11.2021
71421	Admission CTG in latent phase of labour not conducted	Guideline to be reviewed	To review and clarify guidelines	Maria Swiers Amy Smith	01.05.2021

Findings of review all cases eligible for referral to HSIB.

Executive summary

Cases to date	
Total referrals	15
Referrals / cases rejected	3
Total investigations to date	12

Total investigations completed	9
Current active cases	3
Exception reporting	0

Reports Received since last report

None

Completed investigations

Case No		Category	Date completed	Comments
	336	HIE / Cooling	24/10/19	6 recommendations
	538	HIE / Cooling	11/03/20	6 recommendations
	1110	HIE/Cooling	10/03/20	0 recommendations
	1551	HIE / Cooling	14/08/20	0 recommendations
	1573	NND	19/10/20	1 recommendation
	2263	MD	16/02/21	1 recommendation (YAS)
	2270	NND	26/04/21	3 recommendations
	2579	Still birth	23/03/21	1 recommendation
	2795	HIE / Cooling	24/05/21	2 recommendations

Training compliance

for all staff groups in maternity related to the core competency framework and wider job essential training

PROMPT Compliance

PROMPT Compliance

MDT Role	Number of staff available to train	Number of staff that have attended PROMPT	Compliance
Consultants & Staff Grades	17	17	**100%**
SPRs + SHOs	21	18	**85.7%**
Midwives	192	164	**85.4%**
Anaesthetists	32	20	**62.5%**
Maternity Theatre ODPs	24	11	
HCAs/MSWs	67	27	**40.2%**
DIVISIONAL	**330**	**247**	**74.8%**

CTG compliance

MDT Role	Number of staff available to train	Number of staff undertaken Intrapartum CTG training	Compliance %
Consultants & Staff Grades	17	9	**52.9%**
SPRs + SHOs	20	14	**70%**
Midwives	192	131	**68.2%**
DIVISIONAL	**229**	**154**	**67.2%**

SET E Day Compliance

MDT Role	Number of staff available to train	Number of staff SET Training	Compliance %
Consultants & Staff Grades	17	13	**76.4%**
Midwives	192	149	**77.6%**
HCAs/MSWs	67	38	**56.7%**
DIVISIONAL	**276**	**200**	**72.4%**

Actions being undertaken

PROMPT

- Anaesthetic staff now being rostered on to attend. Compliance increasing.
- All PROMPT training will be delivered via MS Teams until further notice.
  This gives us scope to have up to 40 attendees per session.
- MSW numbers very low – all managers given dates and asked to allocate staff to attend.
- New PROMPT material coming July 2021

CTG

- Escalation of non-compliance currently being discussed with SLT

Service User Voice feedback

The maternity service Facebook page receives lots of positive feedback.

Matrons are actively working with complainants to improve the service for women and their families.

There are discussion with the newly formed MVP's on both sites and there has been feedback and work ongoing on the following:

Doncaster MVP
Chair has stepped down and interim plan in place, no meeting since last report
MVP agreed to help with funding 4 x 30 sec films for engagement with women with a film company.
Engagement sessions planned in Frenchgate Shopping centre

Bassetlaw MVP
New chair for MVP
Survey Monkey on experiences in maternity services being launched

Utilising the films for engagement with Bassetlaw women.

HSIB/NHSR/CQC or other organisation with a concern or request for action made directly with Trust None
Coroner Reg 28 made directly to Trust None
Progress in achievement of CNST 10 The service is on target to achieve the 10 safety actions

NE&Y Regional Perinatal Quality Oversight Group
Highlight Report

LMNS: South Yorkshire and Bassetlaw

Reporting period: April 2021

Overall System RAG:
(Please refer to key next slide)

	MW to birth ratio : BR+ recommendation 1:26	Vacancy rate (MW)	LW co-ordinator supernumerary (%)
April	1:28.7	15.6%	91.4%
May	1:28.7	15.6%	94.2%
June	1:28.9	16.3%	88.2%

Maternity unit DBTH – Doncaster

KPI (see slide 4)	Measurement / Target		Doncaster Rate		
			April	May	June
Caesarean Section rate	Elective	<10.4 %	10.5%	14.7%	12.9%
	Emergency	<15.2 %	25.6%	25.6%	23.4%
Preterm birth rate	≤26+6 weeks		0	0	0
	≤36+6 weeks	<6%	15%	8.3%	7.6%
Massive Obstetric Haemorrhage	≥1.5l	<3%	5%	2.8%	1.21%
Term admissions to NICU			2.52%	2.49%	2.02%
3rd & 4th degree tear	SVD (unassist'd)	<2.6%	3 2.2%	0 0%	0.7% 1
	Instrumental (assisted)	<5.6%	0	0	0
Right place of birth		All	100%	100%	100%
Smoking at time of delivery		<11%	13.1%	6.8%	11.4%
Percentage of women placed on CoC pathway			2.74%	2.75	0.94
Percentage of women on CoC pathway: BAME / areas of deprivation	BAME				
	Area of				

Month/Quarter		Red flag alert	Unactioned Datix / Open > 30 days		Maternity Serious Incidents	Maternity Never Events	HSIB cases	Still Births (All / Term / Intrapartum)			HIE cases (2 or3)	Neonatal Deaths (Early / Late)		Notification to ENS	Maternal Mortality (direct / indirect)	
2020/2021	April	2	0	0	1	0	1	1	0	0	1	0	0	1	0	0
	May	11	4	0	0	0	0	0	0	0	0	0	0	0	0	0
	June	1	0	0	1	0	0	1	0	0	0	0	0	0	0	0
	Qu1 T	14	4	0	2	0	1	2	0	0	1	0	0	0	0	0

Maternity Red Flags (NICE 2015)

		A	M	J
1	Delay in commencing/continuing IOL process	2	10	0
2	Delay in elective work	0	1	0
3	Unable to give 1-1 care in labour	0	0	1
4	Missed/delayed care for > 60 minutes	0	0	0
5	Delay of 30 minutes or more between presentation and triage (LWAU)	0	0	0

NE&Y Regional Perinatal Quality Oversight Group Highlight Report

LMNS: South Yorkshire and Bassetlaw

Reporting period: April 2021

Overall System RAG:

(Please refer to key next slide)

	MW to birth ratio : BR+ recommendation 1:26	Vacancy rate (MW)	LW co-ordinator supernumerary (%)
April	1:23.1	11%	100%
May	1:23.1	11%	99.2%
June	1:23.6	12.9%	96.6%

Maternity unit DBTH – Bassetlaw

KPI (see slide 4)	Measurement / Target		Bassetlaw Rate		
			April	May	June
Caesarean Section rate	Elective	<10.4 %	15.7%	12.2%	12.6%
	Emergency	<15.2 %	18.5%	21.4%	23.5%
Preterm birth rate	≤26+6 weeks	<6%	0	0	0
	≤36+6 weeks		7.4%	3.8%	4.34%
Massive Obstetric Haemorrhage	≥1.5l	<3%	1.9%	1.5%	3.4%
Term admissions to NICU			7.4%	4.5%	4.2%
3rd & 4th degree tear	SVD (unassist'd)	<2.6%	1.8%	0	1.5%
	Instrumental (assisted)	<5.6%	7.7%	7.7%	0
			2	1	1
Right place of birth		95%	100%	100%	100%
Smoking at time of delivery		<11%	14.2%	6.9%	8.4%
Percentage of women placed on CoC pathway		35%	81.1%	74.4%	68.8%
Percentage of women on CoC pathway: BAME / areas of deprivation	BAME	75%	15.7%	14.2%	
	Area of deprivation				

Month/Quarter		Red flag alert	Unactioned Datix / Open > 30 days		Maternity Serious Incidents	Maternity Never Events	HSIB cases	Still Births (All / Term / Intrapartum)			HIE cases (2 or3)	Neonatal Deaths (Early / Late)		Notification to ENS	Maternal Mortality (direct / indirect)	
2020/2021	April	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	May	0	2	0	1	0	1	0	0	0	1	0	0	1	0	0
	June	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Qu1 T	1	2	0	1	0	1	0	0	0	1	0	0	1	0	0

Maternity Red Flags (NICE 2015)

		A	M	J
1	Delay in commencing/continuing IOL process	0	0	0
2	Delay in elective work	0	0	0
3	Unable to give 1-1 care in labour	0	0	1
4	Missed/delayed care for > 60 minutes	0	0	0
5	Delay of 30 minutes or more between presentation and delivery (LW&U)	0	0	0

Assessed compliance with10 Steps-to-Safety

		April	may	June
1	Perinatal review tool			
2	MSDS			
3	ATAIN			
4	Medical Workforce			
5	Midwifery Workforce			
6	SBLCB V2			
7	Patient Feedback			
8	Multi-professional training	80%	80%	81% - 90% target removed for 2021
9	Safety Champions			
10	Early notification scheme (HSIB)			

Key	
Complete	The Trust has completed the activity with the specified timeframe – No support is required
On Track	The Trust is currently on track to deliver within specified timeframe – No support is required
At Risk	The Trust is currently at risk of not being deliver within specified timeframe – Some support is required
Will not be met	The Trust will currently not deliver within specified timeframe – Support is required

Evidence of SBLCB V2 Compliance

		A	M	J
1	Reducing smoking			
2	Fetal Growth Restriction			
3	Reduced Fetal Movements			
4	Fetal monitoring during labour			
5	Reducing pre-term birth			

Assessment against Ockenden Immediate and Essential Action (IEA)

	April	May	June
Audit of consultant led labour ward rounds twice daily			
Audit of Named Consultant lead for complex pregnancies			
Audit of risk assessment at each antenatal visit			
Lead CTG Midwife and Obstetrician in post			1 CTG mw left – out to afvert
Non Exec and Exec Director identified for Perinatal Safety			
Multidisciplinary training – PrOMPT, CTG, Obstetric Emergencies (90% of Staff)	80% of staff	80% of staff	81%
Plan in place to meet birth rate plus standard (please include target date for compliance)			Funded & ongoing recruitment
Flowing accurate data to MSDS			
Maternity SIs shared with trust Board			

Please include narrative (brief bullet points) relating to each of the elements:

Maternity unit	April	May	June
Freedom to speak up / Whistle blowing themes	None	None	None
Themes from Datix (to include top 5 reported incidents/ frequently occurring)	CDS: • Unexpected weight below the 10th centile • BBA • Shoulder dystocia LW: • Unexpected weight below the 10th centile • 3rd/4th degree tear • COC escalation	CDS: • Unexpected weight below the 10th centile • PPH • Midwives LW • Unexpected weight below the 10th centile • Unexpected admission to the neonatal unit • PPH	CDS: • Unexpected weight below the 10th centile • Shoulder dystocia • Unexpected re-admission LW • Unexpected weight below the 10th centile • Delay or difficulty in gaining clinical assistance • PPH
Themes from Maternity Serious Incidents (Sis)	CTG classification	• CTG Classification	• Reduced fetal movement information • Non SI – Pain management for instrumental deliveries
Themes arising from Perinatal Mortality Review Tool	Domestic violence risk assessment	• Partogram for 16-22 week gestation	• Reduced fetal movement information
Themes / main areas from complaints	Access to service for visitors Care delivery	Access to service for visitors Care delivery	Care delivery
Listening to women (sources, engagement / activities undertaken) CQC Women's Experience	MVP meeting Facebook feedback Complaints / Concerns addressed proactively by the matrons	MVP Meetings Facebook feedback	MVP Meetings Facebook feedback
Evidence of co-production			
Listening to staff (eg activities undertaken, surveys and actions taken as a result)	Board Level safety champion meeting DOM Q & A Sessions NED walkabout Safety Champion walkabout	Board Level safety champion meeting DOM Q & A Sessions NED walkabout Safety Champion walkabout	Board Level safety champion meeting DOM Q & A Sessions NED walkabout Safety Champion walkabout
Embedding learning (changes made as a result of incidents / activities / shared learning/ national reports)	WHATS HOT Emails to all staff Change to guidelines New face to face fetal monitoring study day	WHATS HOT Emails to all staff Looking at additional Situational awareness training Improving MDT working	Newsletter Emails DOM Update email Culture survey New DATIX review meeting led by Governance Midwife

Patient Experience

Complaints

There was a further increase in complaints in June with 65 (61 were 40 WD and 4 were 60 WD) and 2 MP complaints, giving a year to date figure of 150. Division of Medicine received 31 complaints and Surgery and Cancer 22. There continues to be an increase in the number of concerns with 55 this month (compared to 33 in May) however compliance with closing them within 5 days has deteriorated with 24 overdue. This has been escalated to the Divisional Directors of Nursing and will be added as an agenda item for the complaints panel.

The top themes of subjects for June complaints sees Diagnosis top (with 43 complaints), continuing with Patient Care (21) Values and Behaviours (15), Communication (11) and Admissions, Discharge and Transfer (5) as the top subjects. One of our aims is to try and be specific and to focus on the overall complaint subject and in June you can see that continued improvement.

In June 49 complaints (including MOP and ACQs) were closed. This has shown a vast improvement with compliance of recording an outcome with only 1 left with no outcome, giving a compliance rate of 98%. Of the 34 complaints (40/60/MP) that were either 'upheld' or 'partly upheld' 26 had learning recorded (76%) which is a significant improvement compared to 58% in May.

In June there have been 0 PHSO requests leaving just 1 ongoing investigation.

In June we recorded 204 compliments, this was largely contributed to the ability to enter a lot of the patient quality information from the FFT cards received

FFT

I am pleased to report that we saw an improvement in the number of FFT cards received in June with a monthly response rate of 17.7% for in patients. Due to a poor return rate in the first couple of months this brings the year to date response rate to 6.97%. We are expecting the first national benchmarking results to be published anytime and these will be for the month of April.

Volunteers

The Trust has signed an agreement to work with St John's Ambulance in hosting 20 NHS Cadets. The cadets will join in January and will be aged between 16 and 18 and be from backgrounds associated with health inequalities. This presents an excellent opportunity to develop a sustainable workforce for the future.

Carers Strategy

Working with NHSE and the local authority we are going to be a pilot site for developing a strategy for carers. The strategy will use patient engagement and feedback to focus on areas of improvement, such as discharge planning and processes. The Trust are also participating in the PACT research study with the aim of the research being to improve the safety and experience of care transitions for older people (age 75+). Returning home from hospital can be a difficult time, particularly for older people. The period of preparing to be discharged from hospital to settling in back at home is called a transition. Sometimes transitions can be so difficult for people that they end up back in hospital again. It is thought that many hospital readmissions could be avoided. The aim of this research is to improve the safety and experience of care transitions for older people (age 75+)

Care Quality Commission

The Trust will take over the management of the Bassetlaw Hospice and community palliative care service from the 1st of October 2021. The service will be added to our existing CQC remit and be part of the End of Live service line when the Trust is inspected in the future.

Nursing and Midwifery Staffing

All NHS Trust providers are required to publish Nursing and Midwifery staffing data on a monthly basis. The data describes planned hours for staffing based against the actual hours worked. In addition to this the care hours per day (CHPPD) are reported as a monthly metric. In the last 12 months the on-going Covid 19 pandemic has created additional workforce challenges across the breath of the organisation, with particular pressure in areas such as respiratory and critical care. This has been reflected in our safe staffing data with a number of areas 10% under their planned versus actual.

June 2021 data

In June 39 inpatient wards were open.

- ***14 (35.9%) were on green for planned versus actual staffing***
- ***10 (25.6%) wards were on amber for being 5% under planned versus actual staffing (NNU, CHW, ATC, C1, A4, S12, S11, S10, 1&3, B5)***
- ***3 (7.7%) wards were amber for being 5% over planned versus actual staffing (A5, SAW, 18/CCU).***
- ***9 (23%) wards were red for being 10% under planned versus actual staffing (CDS, M2, M1, G5, DCC, ITU, 32, Respiratory, 24).***
- ***3 (7.7%) wards were red due to being 10% over planned versus actual staffing (Rehab 1, Ward 19, Ward 17).***

Despite a number of areas reporting 10% reduction against planned versus actual there had been a continual decline in the number of wards reporting this deficit. However the data for June is a worsening position due to factors that are described further in the report. All areas are risk assessed using professional judgement, staff redeployment or utilisation of other key roles such as therapy staff to ensure patient safety isn't compromised. Also to note that three of these areas had less than 40% (average) of patients occupying beds at midnight. Therefore although nurse staffing levels were below their planned trajectory the number of patients in their care was also significantly reduced. All known gaps were reviewed and all shifts are sent to bank and agency. Due to on-going pressures from the pandemic fill rates for bank and agency shifts continue to be compromised due to availability of workforce. This is closely monitored with NHSP colleagues and the senior nursing team. Across June we have seen an increase in staff isolating due to Covid, this has had an impact on nurse staffing levels across all areas in the Trust.

As the pandemic has continued the surgical elective programme has been reinstated to ensure patients receive the care they require. Essential training has also been reinstated to support staff development.

There continues to be some areas of risk in nurse and ODP staffing in theatres, due to vacancies and sickness, this is being addressed with the division and the executive nursing team. This includes

redeploying staff from other areas with theatre experience and reviewing agency usage for this area to maintain patient safety. There had been a planned approach to utilise the first cohort of international nurses in theatres as they have the relevant background and are due to commence in the Trust in August 2021. This staff group will need to undertake their OSCEs and obtain their NMC pin number so would be a midterm solution to the risks in theatres.

The impact of the major incident in the Women's and Children block (flood damage to the estate) has had a detrimental impact on nurse staffing in all services. Due to the relocation of Paediatric services onto the main site this has put some pressure on nurse staffing due to services not being co-located. Work is ongoing to ensure the estate is fit for purpose and the senior nursing leadership team in paediatrics are continually risk assessing staffing to ensure patient demand is met.

Mitigation

The on-going risk around nurse and midwifery staffing remains a constant challenge for the nursing leadership teams however mitigation has been put in place to support clinical areas and the risk is reviewed as part of the x4 daily operational site meetings that take place. Nurse staffing is also reported monthly via our mandated safe staffing return and at the Trust QEC committee.

The mitigation includes:

- Senior nurse oversight for the wider staffing picture from the duty matron 7 days per week
- Scrutiny by Divisional Nurse Directors to assess risk in their areas and staff redeployment put in place to mitigate the risk
- Incentivised pay rates for registered and unregistered nurses working additional bank hours
- Active on going recruitment campaigns including alternative roles such as Trainee Nurse Associates and RN apprenticeship roles
- Redeployment of clinical staff from teams such as education and out patients as required
- Utilisation of agency nurses in discreet areas, this is balanced against the quality metrics to ensure patient care isn't compromised
- Supporting critical care around GPICs guidance around nurse to patient ratios to aim to maintain 1:1 or 1:2 nurse to patient ratio
- Cross site working to ensure staffing is flexed to meet the demands in service
- Reduction in ward managers supervisory time to support clinical hands per shift
- Support from Enhanced Care Nurse to ensure complex patients receive the correct plan of care
- Rapid cohorting of Covid 19 patients to minimise outbreaks and reduce risk to patients and staff

Future Developments

DBTH remains committed to providing outstanding care and it is recognised that having the correct workforce in place is key to this.

As part of the future developments for 2021/22 the senior nursing leadership team are looking to utilise the Allocate SafeCare model to support how nurse staffing is managed.

SafeCare is x3 times a day staffing software that matches staffing levels to patient acuity, providing control and assurance from bedside to board. It allows comparison of staff numbers and skill mix alongside actual patient demand in real time, allowing you to make informed decisions and

create acuity driven staffing. Recruitment to the workforce matron wasn't successful so a hybrid role is being developed by the Director of Nursing. The post would lead on workforce and ward accreditation. This will be at 8B level and initially a secondment for 12 months. The workforce matron funding would be utilised for this post and the difference between the 8A to 8B met by back fill monies from the Chief Nurses secondment to NHSI. It is anticipated this post will be advertised in August 2021.

The Trust has also entered into a partnership with NHS Professionals to recruit 50 international nurses by the end of the calendar year. This cohort of nurses are predominantly from India. Due to the impact on Covid in India the recruitment pipeline was temporarily paused by NHSI in May, but this has now been reactivated and the first 10 nurses arrive In the Trust early August 2021. There will be 4 more cohorts of 10 nurses that will all arrive by the end of the calendar year.

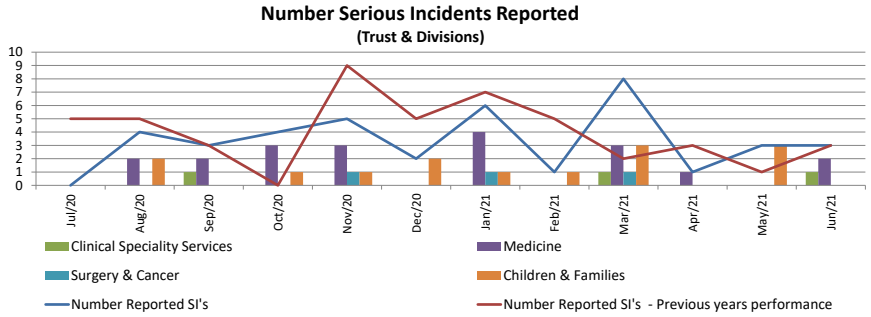
The Director of Nursing is leading a workstream around enhanced care and bed watch allocation. The aim is to ensure patient assessments are robust, requests for enhanced care and bed watches are scrutinised by a senior nurse before being approved and that patient safety is maintained. There is an expected financial return from this work as the current model isn't always cost effective. A business case planning session has taken place with key stakeholders and it's expected that the business case will be shared at the relevant internal forums in September 2021.

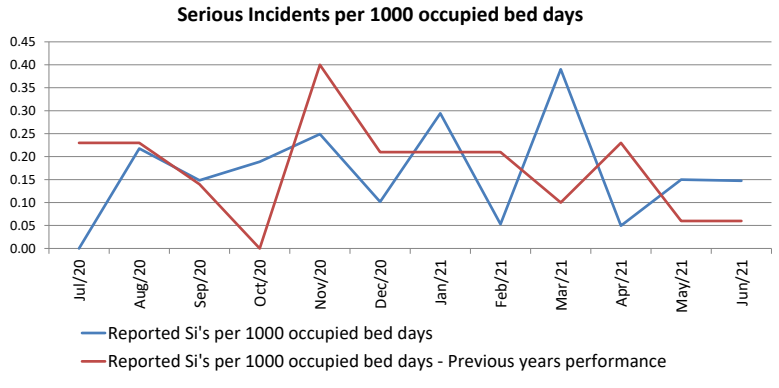
Serious Incidents - June 2021 (Month 3)

(Data accurate as at 16/07/2021)

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



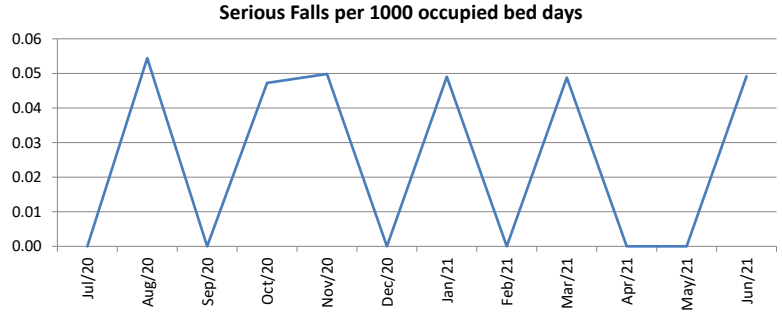


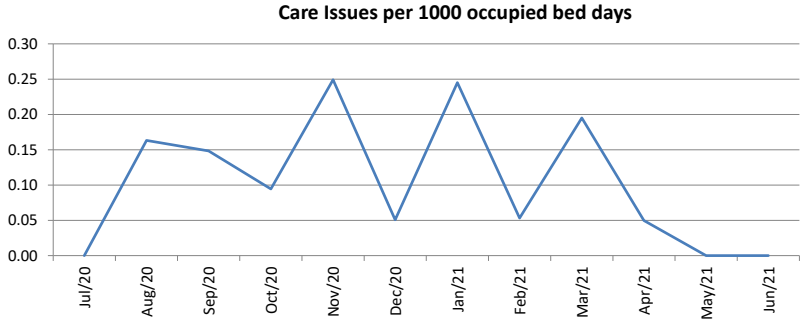
Current YTD reported SI's (April - June 21)	3	Number reported SI's (Apr 20 - June 20)	3
Current YTD delogged SI's (April - June 21)	0	Number delogged SI's (Apr 20 - June 20)	0

Maternity Serious Incidents

There was 1 Serious Incidents in Maternity which was in incident potentially linked to deterioration & eclamptic seizure resulting in admission to ITU

Serious Incident Themes

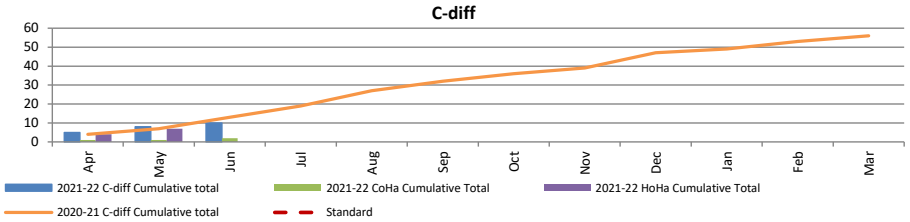


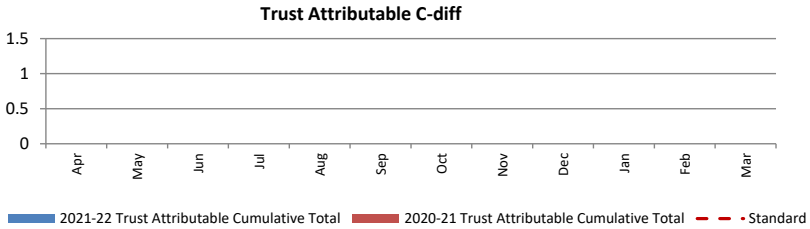


Infection Control C.Diff - June 2021 (Month32)
(Data accurate as at 16/07/2021)

	Standard	Apr	May	Jun	Jul	Aug	Sep	YTD
2021-22 Infection Control - C-diff	44 Full Year	5	3	2				10
2020-21 Infection Control - C-diff	39 Full Year	4	3	6				13
2021-22 Trust Attributable	12	0	0	0				0
2020-21 Trust Attributable	12	0	0	0				0

	Apr	May	Jun	Jul	Aug	Sep	YTD
2021-22 - HOHA	4	3	0				7
2020-21 - HOHA	3	2	5				10
2021-22 COHA	1	0	2				3
2020-21 COHA	1	1	1				3

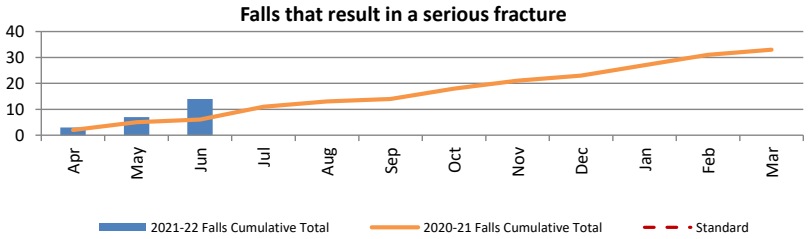




Pressure Ulcers & Falls (Moderate/Servere Harm) - June 2021 (Month 3)
(Data accurate as at 08/07/2021)

	Standard	Apr	May	Jun	Jul	Aug	Sep	YTD
2021-22 Serious Falls (moderate/severe harm)	TBC	3	4	7				14
2020-21 Serious Falls (moderate/severe harm)	40	2	3	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	Apr	May	Jun	Jul	Aug	Sep	YTD
2021-22 Pressure Ulcers	TBC	83	70	79				232
2021-22 Pressure Ulcers (Cat 4)		0	0	0				0
2021-22 Pressure Ulcers (Cat 3)		4	3	74				81
2021-22 Pressure Ulcers (DTI Low Harm/Cat 2)		77	67	0				144
2021-22 Pressure Ulcers (UNS)		2	0	5				7

	Standard	Apr	May	Jun	Jul	Aug	Sep	YTD
2021-22 Number of patients with Pressure Ulcers	TBC	66	60	65				191
2021-22 Number of patients - Pressure Ulcers (Cat 4)		0	0	0				0
2021-22 Number of patients - Pressure Ulcers (Cat 3)		3	3	0				6
2021-22 Number of patients - Pressure Ulcers (DTI/low Harm/Cat 2)		61	57	61				179
2021-22 Number of patients - Pressure Ulcers (UNS)		2	0	4				6

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Report Cover Page					
Meeting Title:	*Board of Directors*				
Meeting Date:	*July 2021*	**Agenda Reference:**	**C3**		
Report Title:	*Board Assurance Framework for IPC*				
Sponsor:	*David Purdue – Chief Nurse and Deputy Chief Executive*				
Author:	David Purdue, Chief Nurse and Deputy Chief Executive				
Appendices:	*0*				
Report Summary					
Purpose of report:	*Quarterly update to Board of Directors, on IPC assurance*				
Summary of key issues/positive highlights:	All elements under control of the Trust now rated as compliant.				
Recommendation:	None				
Action Require:	~~Approval~~	Information	~~Discussion~~	~~Assurance~~	~~Review~~
Link to True North Objectives:	**TN SA1:**	**TN SA2:**	**TN SA3:**	**TN SA4:**	
	To provide outstanding care for our patients	*Everybody knows their role in achieving the vision*	*Feedback from staff and learners is in the top 10% in the UK*	*The Trust is in recurrent surplus to invest in improving patient care*	

Implications	
Board assurance framework:	*None*
Corporate risk register:	*None*
Regulation:	*CQC – Safe Care and Treatment and Patient Centred Care. Achievement of Outstanding.*
Legal:	*Trusts licence to operate*
Resources:	*Nil*

Assurance Route			
Previously considered by:	*Board of Directors*		
Date:	*December 2020*	**Decision:**	*Regular updates required to QEC*
Next Steps:	*Update progress to QEC*		
Previously circulated reports to supplement this paper:	None		

Infection Prevention and Control board assurance framework

1. Systems are in place to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks posed by their environment and other service users			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure: • local risk assessments are based on the measures as prioritised in the hierarchy of controls. The risk assessment needs to be documented and communicated to staff;	 4.-COVID-19-Safe-Working-Risk-Asses  2.-COVID-19-Safe-Working-Risk-Asses  1a-1b.-COVID-19-Safe-Working-Risk-Ass **Flowchart lays out expected actions including making the risk assessment accessible to staff and clear documentation.**	Formal use of hierarchy of controls documentation is not used.	**Local risk assessments are completed using the templates (embedded) considering principles of elimination, substitution, engineering controls and PPE and are communicated to staff.**
• the documented risk assessment includes: ○ a review of the effectiveness of the ventilation in the area; ○ operational capacity; ○ Prevalence of infection/variants of concern in the local area.	**Template used incorporates section on ventilation, operational capacity. There are joint and individual walk arounds across the organisation with Estates and IPC colleagues reviewing ventilation and operational capacity considering local intelligence obtained through**	There is no formal documented section on the risk assessments addressing variants of concerns.	**Local and regional prevalence of infection/variants of concern are communicated and cascaded daily from PH/LA via DIPC. Advice given regarding IPC is given with the**

	the DIPC and IPC team from PH. **The IPC team are reviewing wards and departments using the 'every action counts' checklist.**  PRINTABLE Checklist and Monit		**knowledge of local intelligence data.**
• triaging and SARS-CoV-2 testing is undertaken for all patients either at point of admission or as soon as possible/practical following admission across all the pathways;	**Since November 2020 as Point of care testing for SARS-CoV-2 has been developed nationally, DBTH has been involved in trialling the DNA Nudge in areas where patients are admitted. Alongside this the ABBOTT ID NOW POCT testing machines that have previously been used for Flu testing in admission areas has been used to test all patients admitted through ED and many areas where patients are admitted directly for example SAW, Trauma admissions (not via ED). All admitted patients receive a PCR test on admission as well as a swift (10-20 minute) result from ABBOTT ID NOW POCT. In addition POCT**	Due to faults with the machines and poor user experience with the DNA Nudge, these machines have been returned to the company.	**More ABBOTT ID machines have been obtained with requests for more submitted. This is a vital component of our triaging and timely segregation of those with COVID-19 and those without.**

	ABBOTT ID Now machines are being used to support visiting and admission of partners within maternity and Paediatric admission.  COVID testing updated flowchart.p **Pathways in ED updated to manage flow, separate Yellow and Blue pathways for ambulance patients, now only 1 resus as spacing and PPE allows for improved working.** **1 flexible area available for Yellow or Blue depending on flows into both departments.**		
• when an unacceptable risk of transmission remains following the risk assessment, consideration to the extended use of Respiratory Protective Equipment RPE for patient care in specific situations should be given;	**On review of cases by clinical teams, DIPC and IPC, where following risk assessment there are increased risks of transmission, wards will step up their level of PPE to include RPE. Staff are fit tested on reusable RPE regardless of risk area and issued with their own mask.**		

• there are pathways in place which support minimal or avoid patient bed/ward transfers for the duration of admission unless clinically imperative;	**Where there are increased cases staff are permitted to step up their RPE if they feel safer in doing so.**  DBTHFT Flow chart (30) January 21.pdf **There are yellow and blue pathways through sites and services to minimise any patient movement other than for clinical reasons.** **Those patients who require admission to hospital are then transferred via the Yellow corridor to the Yellow part of the Acute Medical Unit (AMU) or the Assessment Treatment Centre (ATC). Patients who require admission but are not suspected of having COVID-19 are transferred via the Blue route both at DRI and BH.** **Yellow areas are differentiated from Blue areas by signage, floor and wall stickers. If a Patient is considered to be aerosol**		

• that on occasions when it is necessary to cohort COVID-19 or non-COVID-19 patients, reliable application of IPC measures are implemented and that any vacated areas are cleaned as per national guidance;	**generating, (e.g. high flow nasal oxygen (HFNO), Non-invasive ventilation) they are transferred via the yellow route/lift.** **Trained hotel Service staff are assigned to COVID-19 areas. PHE donning and doffing of PPE videos are available for all staff to access. Project Echo IPC training sessions have been accessed by service department. PPE training sessions have been facilitated by IPC team. IPC team are out and visible on the ward reinforcing IPC measures.** **IPC lead and Deep clean lead have developed cleaning RAG rate to reinforce cleaning regimes, roles and responsibilities. New HPV and UV equipment has been purchased and hotel services staff have been trained in use.**		

• resources are in place to enable compliance and monitoring of IPC practice including: ○ staff adherence to hand hygiene;	 2021_POSTER_DON CASTER_RAG_A3.pdf **Frequent cleaning regimes have been put in place in ward areas and also in non-ward/department areas for frequent touch services.** **Staff undertake hand hygiene using the WHO 5 Moments concept, using either alcohol hand rub and/or soap and water. Alcohol hand rub is available at the point of care. 52 extra sinks had been to put in place at exits and entrances across three sites (33 at DRI, 14 at BH and 5 at MMH). Hand hygiene pull up banners have been put in place to encourage hand hygiene.** **Hand hygiene audits are conducted by the IPC teams, and by ward teams. Hand hygiene audits are included in the IPC accreditation and as part of the quality dashboard and Hard Truths data.**		

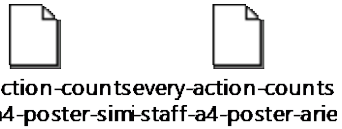
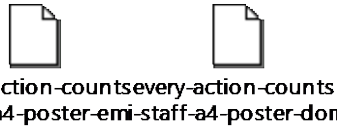
○ patients, visitors and staff are able to maintain 2 metre social & physical distancing in all patient care areas, unless staff are providing clinical/personal care and are wearing appropriate PPE;	**Staff providing direct care within 2 metres of any patient are wearing gloves, apron, Fluid repellent surgical mask and eye protection. Guidance requires that this level of PPE is used for those patients who are suspected or confirmed of having COVID-19. DBTH staff are wearing this level of PPE for all patients regardless of their COVID-19 status.** **Hands face space posters are displayed around the trust. 2 metre distancing is marked out using floor and wall signs and chairs/spaces have been marked out to ensure 2 metres distancing.**		
○ staff adherence to wearing fluid resistant surgical facemasks (FRSM) in: ▪ a) clinical; ▪ b) non-clinical setting;	**All DBTH staff are advised to wear FRSM on all sites whether clinical or non-clinical.**	Some staff have been allergic to FRSM or cannot wear them due to exemption, dermatitis etc.	**Where this is the case, reviews have occurred with OH and consideration for alternative areas of work or alternative masks have been scoped. If giving direct patient care FRSM must be worn.**

			An alternative mask is being scoped by the IPC team for those staff who have suffered Dermatitis from wearing masks.
○ monitoring of staff compliance with wearing appropriate PPE, within the clinical setting;	**The IPC team monitor through audit and feedback on compliance of PPE wearing. This is feedback at the time of the audit and themes have been discussed at IPCC.**	Some restlessness regarding the expected announcement of easing of restrictions has occurred	**Regional/National IPC guidance is expected to support continued restrictions whilst in NHS services.**
• that the role of PPE guardians/safety champions to embed and encourage best practice has been considered;	**Redeployed staff were trained as patient safety officers early in the pandemic. This was successful.**	As services were stepped up again, redeployed staff have returned to their original roles.	**As time has gone on, staff have been more familiar with wearing of PPE. All information is on the HIVE and the IPC team visit areas and reinforce this on an ongoing basis.**
• that twice weekly lateral flow antigen testing for NHS patient facing staff has been implemented and that organisational systems are in place to monitor results and staff test and trace;	**Lateral flow testing is in place for all staff at DBTH whether patient facing or otherwise. This is reported through Trust systems and discussed at Lateral flow steering group. The Trust has COVID advice team and provides an excellent test**	Some unquiet is occurring currently due to pending changes to supply of Lateral flow devices for Trust staff.	**Staff will order LFTs through Government portal in the future once existing supplies have been used up.**

	and trace service to staff and their families. Members of OH staff work above and beyond to provide this service, supported by the DIPC and IPC team also. Staff report any absence through a central absence line and receive support through the Trust TLC service supporting physical, psychological and emotional support for staff and their families affected by COVID.		
• additional targeted testing of all NHS staff, if your location/site has a high nosocomial rate, as recommended by your local and regional Infection Prevention and Control/Public Health team;	**Throughout the pandemic, enhanced surveillance has occurred weekly (swabbing) in staff groups, where nosocomial and local population rates of COVID-19 are high. In addition to this enhanced surveillance has occurred as part of outbreak investigation. Weekly screening has also occurred for high risk patient groups such as those who are immunocompromised, those who have haematology conditions and those with cancer diagnoses.**		

• training in IPC standard infection control and transmission-based precautions is provided to all staff; • IPC measures in relation to COVID-19 are included in all staff Induction and mandatory training;	 DBTH outbreak management.pdf **PPE training sessions have been facilitated by the IPC team which includes safe donning and doffing. PHE training materials and videos are put on the HIVE for all staff to access. Ad hoc training on donning and doffing and the appropriate use of PPE is given on an ad hoc basis also. Support for staff in relation to skin integrity that may be compromised by wearing of PPE for long periods of time is given by the skin integrity team.** **Standard and transmission based precautions are provided as part of SET/Mandatory training, through link nurse programmes and through IPC team to groups of staff. COVID-19 specific training is provided through all forums, face to face, trust induction,**		

• all staff (clinical and non-clinical) are trained in: ○ putting on and removing PPE; ○ what PPE they should wear for each setting and context;	**adhoc and recorded sessions.** **Donning and doffing training is being provided on an ongoing basis face to face and has happened throughout the pandemic both in clinical practice and through classroom/virtual forums. Donning and doffing posters are displayed and PHE videos are available on the HIVE.**		
• all staff (clinical and non-clinical) have access to the PPE that protects them for the appropriate setting and context as per national guidance;	 DBTHFT Flow chart (30) January 21.pdf **There are no shortages of PPE in the organisation. Reusable FFP3 RPE is provided for each individual to keep. Hoods are available for those who cannot wear any FFP3 masks. Fit testing is currently being provided for staff to have an alternative mask available to them. DBTH DIPC has advised higher levels of**		

	protection than national guidance at times.  every-action-countsevery-action-counts -staff-a4-poster-simi-staff-a4-poster-arie  every-action-countsevery-action-counts -staff-a4-poster-emi-staff-a4-poster-don  every-action-counts -staff-a4-poster-lexi.		
• there are visual reminders displayed communicating the importance of wearing face masks, compliance with hand hygiene and maintaining physical distance both in and out of the workplace;	**Above posters displayed taken from 'every action counts toolkit'. In addition Cough etiquette(Catch it, bin it, kill it) and hands, face , space posters in place**	Will need further visible posters following new guidance expected Monday 19th July.	**IPC to explore purchase of pull up 'every action counts' posters at entry points across the organisations following confirmation of guidance.**
• IPC national guidance is regularly checked for updates and any changes are effectively communicated to staff in a timely way;	**PHE guidance is reviewed regularly by members of the IPC team and the Director of Infection Prevention and control and cascaded through governance processes as well as via the Hive and through face to face contact between members of the IPC team and staff in the clinical areas.**		

• changes to national guidance are brought to the attention of boards and any risks and mitigating actions are highlighted;	**Changed to guidance are discussed at management and governance meetings and escalated appropriately.**		
• risks are reflected in risk registers and the board assurance framework where appropriate;	**Risks are reflected in risk assessments and through discussion at governance meetings and escalated to Exec team through usual processes**		
• robust IPC risk assessment processes and practices are in place for non COVID-19 infections and pathogens;	**Patients are risk assessed on admission regarding their condition and also existing alert, policies and practices are followed. This has not been compromised throughout the COVID 19 pandemic. Flags are placed electronically on CAMIS and Nerve Centre to allow timely and accurate notification to clinical teams. Further work through nerve centre is being worked through regards IPC flags and information.**		
• the Trust Chief Executive, the Medical Director or the Chief Nurse approves and personally signs off, all daily data submissions via the daily nosocomial sitrep;	**This is done through surveillance and information systems, led by the DIPC**		

• the IPC Board Assurance Framework is reviewed, and evidence of assessments are made available and discussed at Trust board; • the Trust Board has oversight of ongoing outbreaks and action plans; • there are check and challenge opportunities by the executive/senior leadership teams in both clinical and non-clinical areas.	**Completed BAF** **Any outbreaks and action plans are escalated via the DIPC through to board.** **Walk arounds are conducted with senior leaders, operations managers and specialist teams regularly to check and challenge practice and processes.**		
2. Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure: • designated nursing/medical teams with appropriate training are assigned to care for and treat patients in COVID-19 isolation or cohort areas; • designated cleaning teams with appropriate training in required techniques and use of PPE, are assigned to COVID-19 isolation or cohort areas;	**Ward teams use the principles of cohorting as per outbreak management, dedicated teams to care for group of patients to minimise the risk of cross contamination. For example Respiratory ward donning and doffing areas and additional training on PPE.**		

• decontamination and terminal decontamination of isolation rooms or cohort areas is carried out in line with PHE and other national guidance; • assurance processes are in place for the monitoring and sign off following terminal cleans as part of outbreak management and actions are in place to mitigate any identified risk; • cleaning and decontamination is carried out with neutral detergent followed by a chlorine-based disinfectant, in the form of a solution at a minimum strength of 1,000ppm available chlorine as per national guidance. If an alternative disinfectant is used, the local infection prevention	**The designated COVID-19 ward is respiratory ward with respiratory specialist medical and nursing expertise. This is also the case for those patients needing a higher level of intervention and support in critical care.** **Frequent cleaning regimes have been put in place in ward areas and also in non-ward/department areas for frequent touch services. This is done by service assistants but also by nursing staff. Terminal cleaning is undertaken in accordance with guidance on decontamination of the environment and Trust policy.**  2021_POSTER_DON CASTER_RAG_A3.pdf **Peracide solution is used in all areas. This meets the criteria listed. In addition HPV and UV machines have been purchased and staff are trained to use them**		

and control team (IPCT) should be consulted on this to ensure that this is effective against enveloped viruses; • manufacturers' guidance and recommended product 'contact time' is followed for all cleaning/disinfectant solutions/products as per national guidance; • a minimum of twice daily cleaning of: ○ areas that have higher environmental contamination rates as set out in the PHE and other national guidance;	**(referring to the RAG rate above).** **This is followed using Peracide and HPV and UV processed in accordance with manufacturers guidance for contact time.** **Environments have been reviewed and clutter removed to enable enhanced cleaning to take place in those areas that have COVID-19 positive patients and non COVID-19 areas. Environments have also been reviewed by estates staff for modification to areas to reduce the risk of transmission of COVID-19 and other pathogens. The opportunity has been taken to progress the Deep Clean programme to reduce environmental contamination of COVID-19 but also other pathogens.**		

○ ‘frequently touched’ surfaces e.g. door/toilet handles, patient call bells, over bed tables and bed rails; ○ electronic equipment e.g. mobile phones, desk phones, tablets, desktops & keyboards; ○ rooms/areas where PPE is removed must be decontaminated, ideally timed to coincide with periods immediately after PPE removal by groups of staff; • reusable non-invasive care equipment is decontaminated: ○ between each use ○ after blood and/or body fluid contamination ○ at regular predefined intervals as part of an equipment cleaning protocol ○ before inspection, servicing or repair equipment;	**Increased frequency of touch point cleaning throughout areas is in place.** **Staff are advised to ensure that individual workstations are cleaned down each day. Shared equipment is cleaned frequently by housekeeping/nursing staff** **Donning and doffing rooms are cleaned and decontaminated regularly at periods of less activity.** **Cleaning checklists are in place at ward/department levels. Peracide is used to clean and decontaminate all equipment. Validation audits are undertaken by IPC team and feedback through management and governance processes.** **Equipment is decontaminated before returning to medical technical services.**	**Donning and doffing rooms are used continually at times of increased COVID-19 prevalence and admissions.** **This can be challenging when services are busy.**	**Cleaning of rooms is done when staff movement through the areas is less.** **IPC team are commencing a trial of Peracide wipes to increase compliance is due to commence by the end of July.**

	New national cleanliness (May 2021) standards are being reviewed and a gap analysis completed. Meeting planned between IPC and E&F in August to review.		
• linen from possible and confirmed COVID-19 patients is managed in line with PHE and other national guidance and the appropriate precautions are taken;	**All linen is treated in accordance with national guidance. Any linen used in areas where there are COVID-19 positive patients is treated as infectious. Disposable gloves and apron are worn when handling infectious linen. This is completed in the cohort areas or single room and taken to the ward disposal room for collection. Linen skips are taken to the bedside when required and are put away when not being used.**		
• single use items are used where possible and according to single use policy;	**Single use items are used as policy. This has not changed through COVID-19. Excepting some items of PPE such as FRSM and gowns which are worn sessionally and in accordance with PHE guidance.**		

• reusable equipment is appropriately decontaminated in line with local and PHE and other national guidance and that actions in place to mitigate any identified risk; • cleaning standards and frequencies are monitored in non-clinical areas with actions in place to resolve issues in maintaining a clean environment;	**Reusable equipment is appropriately decontaminated with Peracide as policy.** **Cleanliness audits are completed by E&F staff and IPC in accordance with current NHS cleanliness standards. Deep clean programme is ongoing.**		
• where possible ventilation is maximised by opening windows where possible to assist the dilution of air.	**External ventilation is maximised throughout the organisation. External doors and windows are opened.**	**Ventilation is not optimal across the organisation. Current ventilation systems do not create adequate air changes. Some windows and doors are in poor state of repair**	**Estates are making as many repairs and adjustments as possible to optimise ventilation. Doors and windows are opened as much as possible.**
3. Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and process are in place to ensure: • arrangements for antimicrobial stewardship are maintained	**Antibiotic stewardship information is on the Hive. Antibiotic audits are conducted by Consultant Microbiologists and antibiotic pharmacist. Medicines management and antibiotic usage is provided to divisions and**		

• mandatory reporting requirements is adhered to and boards continue to maintain oversight	**disseminated through governance processes. Microbiologist conduct a daily walk round on DCC/ITU to review all antimicrobials. Extended use of Procalcitonin (test carried out in the laboratory) for all confirmed COVID19 as a bio-marker for bacterial infections. There is also a clinical management pathway with incorporated antibiotic policy for COVID-19 patients.**  Pathway for Clinical Management of Susp **Mandatory reporting is always completed and the Director of Infection Prevention and Control completes a report for board on a monthly basis**		
4. Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing/ medical care in a timely fashion.			
• **Key lines of enquiry**	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure:			

• national guidance on visiting patients in a care setting is implemented;	**Visiting has been restricted in all areas during periods of high prevalence of COVID-19 cases. This is to reduce the risk of transmission of COVID-19 and to ensure that social distancing can be adhered to wherever possible.** **Recognising the impact that restrictions in visiting has on patients and staff, particularly at the end of a patient's life, the Trust has been responsive in providing video calling via iPad, facilitating letters to loved ones and initiating knitted hearts, one to stay with the person at the end of their life and one to stay with the relative of the patient. This has been facilitated by the End of Life Team. Visiting for EOL and patients with enhanced care needs is allowed at the discretion of ward managers. A further compassionate visiting protocol has been completed recognising the importance of family/carer support networks on the wellbeing of patients and minimising the risk of transmission of**		

	infection. During the summer months restriction on visiting were lifted a little more but as cases in the local population increased, visiting was again restricted for the safety of our patients.  Compassionate Visiting Guidance.doc		
• areas where suspected or confirmed COVID-19 patients are being treated have appropriate signage and have restricted access; information and guidance on COVID-19 is available on all trust websites with easy read versions;	**Areas treating COVID-19 patients are clearly signed. Pull up banners have been purchased and are being used.** **Clear signage is in place to indicate blue and yellow areas, for example AMU (blue) and CT (yellow). All COVID-19 resource material us available on the Trust website.**		
• infection status is communicated to the receiving organisation or department when a possible or confirmed COVID-19 patient needs to be moved;	**Infectious status of the patient is communicated via handover to any receiving destination. COVID-19 status is also flagged on the Nerve centre and CAMIS. A protocol has been developed for appropriate screening and**		

	safe movement of patients who are or have been COVID-19 positive (see above DBTH flowchart) to ensure that patients are moved through appropriate pathways. COVID-19 status is available on electronic systems for receiving departments to see. This is also communicated on ICE when requesting tests. Staff in departments are obtaining COVID-19 status before sending for the patient, e.g. imaging department. POCT testing machines have made this timelier.		
• there is clearly displayed, written information available to prompt patients' visitors and staff to comply with hands, face and space advice.	**There are visible posters and notices available regarding hands, face, and space. Further information is available on the Trust sites.**		**It would be beneficial for further pull up posters to be put in place using the 'every action counts' toolkit. Once updated guidance regarding easing of restriction is finalised, IPC will pursue this.**
• Implementation of the Supporting excellence in infection prevention and control behaviors Implementation Toolkit has been considered C1116-supporting-excellence-in-ipc-	**This has been considered and the department/ward checklist is in use as well as posters.**		

behaviours-imp-toolkit.pdf (england.nhs.uk)			
5. Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure: • screening and triaging of all patients as per IPC and NICE guidance within all health and other care facilities is undertaken to enable early recognition of COVID-19 cases; • front door areas have appropriate triaging arrangements in place to cohort patients with possible or confirmed COVID-19 symptoms and to segregate from non Covid-19 cases	**Mandatory Screening programmes for MRSA and other alert organisms have continued throughout the pandemic. COVID-19 screening regimes are in place, day 0, 3, 5, 7 and 28 if patient remains negative. If a positive result is found, patients are screened again at 14 days and then every 7 days thereafter until a negative result is returned. There are several POCT machines available in admission areas for timely receipt of COVID-19 status.** **On both sites (DRI and BDGH) there are both Yellow and Blue areas/routes. Yellow is designated for those patients who are suspected or confirmed as**		

to minimise the risk of cross-infection as per national guidance;	**having COVID-19. The Blue areas are primarily for those patients who are not suspected of having COVID-19 symptoms.** **Those who walk into the department are booked in and triaged by the navigation nurse and are directed to either the blue or yellow pathway. This happens at both Bassetlaw Hospital and Doncaster Royal Infirmary.** **Updated 30.10.20** **Pathways in ED updated to manage flow, separate Yellow and Blue pathways for ambulance patients, now only 1 resus as spacing and PPE allows for improved working.** **1 flexible area available for Yellow or Blue depending on flows into both departments.** **Those patients who require admission to hospital are then transferred via the Yellow corridor to the Yellow part of the Acute Medical Unit (AMU) or the Assessment Treatment Centre (ATC).**		

	Patients who require admission but are not suspected of having COVID-19 are transferred via the Blue route both at DRI and BH. **Yellow areas are differentiated from Blue areas by signage, floor and wall stickers. If a Patient is considered to be aerosol generating, (e.g. high flow nasal oxygen (HFNO), Non-invasive ventilation) they are transferred via the yellow route/lift.**		
• staff are aware of agreed template for triage questions to ask;	**Staff are aware of screening questions. These are asked on entry to services including outpatient areas and are asked of visitors to inpatient areas.**		
• triage is undertaken by clinical staff who are trained and competent in the clinical case definition and patient is allocated appropriate pathway as soon as possible;	**Please see above point**		
• face coverings are used by • all outpatients and visitors;	**The requirement to wear a face covering whilst entering DBTH sites is communicated through signage, website, and verbally. The expected**	**It is envisaged that from July 19th there may be challenge from service users/visitors, when restrictions are eased.**	**Clear communications have gone out regarding the expectation that face coverings must still be worn. Further**

	standard is that face coverings are worn unless patients/visitors are medically exempt where a visor must be worn.		**communications will be published when the guidance is finalised on July 19th.**
• individuals who are clinically extremely vulnerable from COVID-19 receive protective IPC measures depending on their medical condition and treatment whilst receiving healthcare e.g. priority for single room isolation;	**Side room accommodation is prioritised for those patients with known infectious organisms or patients who need to be reverse barrier nursed for their protection.**	**Most of the inpatient population would meet the criteria for being clinically extremely vulnerable. There are not enough side room accommodation across the organisation to make provide side room accommodation for all who require it.**	**Side room allocation is prioritised according to the level of risk the infection presents to the patient and to others.**
• clear advice on the use of face masks is provided to patients and all inpatients are encouraged and supported to use surgical facemasks (particularly when moving around the ward) providing it is tolerated and is not detrimental to their (physical or mental) care needs;	**All patients and inpatients are respectfully asked verbally or through posters to wear surgical face masks where they can be tolerated and where they are not detrimental to their care needs. Dispensers are being fitted at entry points in outpatient areas to provide surgical masks to patients and others who are attending. This will have clear communication on the requirement to wear surgical**	**Not all are in place yet**	**They have been purchased for installation.**

	masks on entry to the service.		
• monitoring of Inpatients compliance with wearing face masks (particularly when moving around the ward) providing it is tolerated and is not detrimental to their (physical or mental) care needs;	**This is encouraged and monitored by the staff in the clinical areas.**		
• patients, visitors and staff are able to maintain 2 metre social & physical distancing in all patient care areas; ideally segregation should be with separate spaces, but there is potential to use screens, e.g. to protect reception staff.	**The requirement to social distance of 2m is in place throughout the organisation wherever it can be. There have been Perspex screens installed in reception areas and in offices following risk assessment.**		
• isolation, testing and instigation of contact tracing is achieved for patients with new-onset symptoms, until proven negative;	**Screening regimes are in place. If patients have been exposed to COVID-19 and staff know about it, these patients are considered 'contacts' and are flagged as such on electronic systems. They are also screened weekly for two weeks following any exposure. They are cohorted together wherever possible to minimise risks of transmission.**		

• patients that test negative but display or go on to develop symptoms of COVID-19 are segregated and promptly re-tested and contacts traced promptly;	**See above point. In addition if symptoms develop patients are promptly screened and isolated. Contacts are then electronically flagged and tested as described above.**		
• there is evidence of compliance with routine patient testing protocols in line with Key actions: infection prevention and control and testing document;	**In addition to testing regimes described above, further testing is performed on patients pre operatively or pre procedure in accordance with PHE guidance. All patients being discharged to care homes are screened within 48 hours prior to transfer/discharge.**		
• patients that attend for routine appointments who display symptoms of COVID-19 are managed appropriately.	**In all outpatient areas, patients are asked screening questions on arrival and have their temperature recorded. If they have symptoms or high temperature, they are immediately (discreetly) segregated to an consultation area where a PCR screen is taken before consulting the doctor for the best course of action guided by the clinical context of the appointment.**		

	SOP OPD final.doc		
6. Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure: • patient pathways and staff flow are separated to minimize contact between pathways. For example, this could include provision of separate entrances/exits (if available) or use of one-way entrance/exit systems, clear signage, and restricted access to communal areas;	**Yellow and blue pathways exist throughout the organisation (as described above) where patients who are suspected or are confirmed to have COVID-19 (yellow pathway) are segregated from those who are not suspected or confirmed as having COVID-19. (blue pathway). This consists of different entrances, and different routes wherever possible.**		
• all staff (clinical and non-clinical) have appropriate training, in line with latest PHE and other national guidance to ensure their personal safety and working environment is safe;	**Line managers cascade any information and training to staff in their areas. This training can also be provided by IPC. The HIVE has all the latest guidance and information and**		

	communications team ensure that all current guidance is published for everybody's safety. Information is shared via videos, written information, virtual platforms and social media.		
• all staff providing patient care and working within the clinical environment are trained in the selection and use of PPE appropriate for the clinical situation and on how to safely put it on and remove it;	**The IPC team have facilitated PPE training for staff from all departments. PPE Safety Officer role has been developed to support appropriate use of PPE in clinical areas. Ad hoc training, advice and reassurance for staff is done daily by the IPC team on walk arounds and visiting the clinical areas. IPC team have facilitated training via Project Echo (virtual platform) for all staff. Induction and updates are facilitated using Microsoft Teams. Training is ongoing and responsive to what the departments and the organisation need.**		
• a record of staff training is maintained;	**Staff training is recorded on ESR. Registers are taken where face to face ad hoc training is provided.**		

• adherence to PHE national guidance on the use of PPE is regularly audited with actions in place to mitigate any identified risk;	**Adherence to national guidance on the use of PPE is audited by the IPC team and fed back to teams. Corrective action is taken at the time.**		
• hygiene facilities (IPC measures) and messaging are available for all patients/individuals, staff and visitors to minimise COVID-19 transmission such as:	**In place**		
○ hand hygiene facilities including instructional posters;			
○ good respiratory hygiene measures;	**In place (catch it, kill it, bin it).**		
○ staff maintaining physical and social distancing of 2 metres wherever possible in the workplace unless wearing PPE as part of direct care;	**Staff are aware that this is a requirement. Posters are displayed as well as floor signs and floor markings at 2 metre distancing in some areas. This is promoted on the HIVE, on social media and verbally throughout the organisation.**		
○ staff are maintaining physical and social distancing of 2 metres when travelling to work	**Staff are aware about the risks of car sharing. When there is no other alternative, masks, open windows and**	**Dining room areas in the Trust are allowing groups of 6 staff to share a table to eat and drink with no mask on.**	**The DIPC has escalated this through the safer working group**

(including avoiding car sharing) and remind staff to follow public health guidance outside of the workplace; o frequent decontamination of equipment and environment in both clinical and non-clinical areas; o clear visually displayed advice on use of face coverings and facemasks by patients/individuals, visitors and by staff in non-patient facing areas. • staff regularly undertake hand hygiene and observe standard infection control precautions;	**position in the car is promoted.** **Regular and enhanced cleaning is in place (see earlier section for more detail)** **See detail in previous sections** **Staff undertake hand hygiene using the WHO 5 Moments concept, using either alcohol hand rub and/or soap and water. Alcohol hand rub is available at the point of care. 52 sinks had been requested to put in place at exits and entrances across three sites (33 at DRI, 14 at BH and 5 at MMH). Hand hygiene pull up banners have been put in place to encourage hand hygiene.** **Hand hygiene audits are conducted by the IPC teams, and by ward teams. Hand hygiene audits are included**	**This is a significant risk of transmission of COVID-19 to the workforce**	

• the use of hand air dryers should be avoided in all clinical areas. Hands should be dried with soft, absorbent, disposable paper towels from a dispenser which is located close to the sink but beyond the risk of splash contamination as per national guidance; • guidance on hand hygiene, including drying should be clearly displayed in all public toilet areas as well as staff areas; • staff understand the requirements for uniform laundering where this is not provided for onsite;	**in the IPC accreditation and as part of the quality dashboard and Hard Truths data.** **Hand dryers have been disabled and disposable paper hand towels dispensers are available.** **Signage is located near hand washing facilities** **Scrubs provided in some locations. Staff encouraged to change at work, not to travel in uniform and to launder uniform on its own as per uniform policy.** **Staff swabbing hub is in place. Drive through**	**Sometimes signage is removed from time to time**	**The Trust change over to SCJ hand hygiene products which have wall mounted dispensers with pictorial hand hygiene instructions permanently displayed on the dispenser**

• all staff understand the symptoms of COVID-19 and take appropriate action (even if experiencing mild symptoms) in line with PHE and other national guidance if they or a member of their household display any of the symptoms; • a rapid and continued response through ongoing surveillance of rates of infection transmission within the local population and for hospital/organisation onset cases (staff and patients/individuals);	**swabbing is facilitated at the Lodge in BDGH. A staff sickness absence telephone line regarding self- isolation and instruction for when staff can return to work. Telephone advice is given regarding the process for staff swabbing by the IPC admin team or by the Occupational Health Department. Enhanced psychological support has been established to provide a place for staff to leave the clinical areas and take some time out when dealing with difficult situations during the pandemic. Individual risk assessments are completed by line managers and Occupational Health Departments.** **Regular updated rates from Public Health are provided via email and disseminated appropriately. Local prevalence is considered as part of any changes in guidance. Laboratory systems report results in a timely manner several times**		

	per day to the IPC team who act on the results and ensure that the clinical teams have appropriate advice		
• positive cases identified after admission who fit the criteria for investigation should trigger a case investigation. Two or more positive cases linked in time and place trigger an outbreak investigation and are reported;	**Cases are monitored and where identified as being potentially an outbreak. An outbreak investigation is initiated which involves enhanced surveillance. Where an outbreak is identified this is reported through NHS England electronic outbreak system and communicated to Chief Nurse, Chief executive, medical director and other appropriate managers.**  DBTH outbreak management.pdf		
• robust policies and procedures are in place for the identification of and management of outbreaks of infection. This includes the documented recording of outbreak meetings.	**Outbreak procedures are followed in accordance with the policy. Outbreak summaries are produced and shared.**		

7. Provide or secure adequate isolation facilities			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure: • restricted access between pathways if possible, (depending on size of the facility, prevalence/incidence rate low/high) by other patients/individuals, visitors or staff;	**Yellow and blue pathways exist (as described in previous sections). At times where there have been low numbers, pathways have still existed but have had minor adjustments that could be easily stood back up in response to increasing numbers of COVID-19.**		
• areas/wards are clearly signposted, using physical barriers as appropriate to patients/individuals and staff understand the different risk areas;	**Signage is displayed to identify routes and pathways and where there are 'no entry' points and one systems. Some physical barriers exist and extra doors have been installed on wards and on routes across the sites.**		
• patients with suspected or confirmed COVID-19 are isolated in appropriate facilities or designated areas where appropriate;	**This is in place as described in previous section.**		
• areas used to cohort patients with suspected or confirmed COVID-19	**Designated COVID ward have donning and doffing rooms,**	**Ventilation is not optimal**	**Estates have made adjustments where possible. External**

are compliant with the environmental requirements set out in the current PHE national guidance; • patients with resistant/alert organisms are managed according to local IPC guidance, including ensuring appropriate patient placement.	**extra doors to allow for compartmentalisation and cohorting as well as isolation.** **All patients with alert/resistant organisms are managed in accordance with policies. This has not been compromised through the pandemic**		**windows and doors are opened wherever possible**
8. Secure adequate access to laboratory support as appropriate			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
There are systems and processes in place to ensure: • testing is undertaken by competent and trained individuals;	**Swabbing of patients and staff is done by competent and trained staff. Information on how to perform the swab is available on the hive. Testing is completed in the Trust laboratory by biomedical scientists, over seen by Consultant Microbiologists. Notification of test results is via electronic systems. Advice and guidance is provided by Microbiologists, IPC team**		

• patient and staff COVID-19 testing is undertaken promptly and in line with PHE and other national guidance; • regular monitoring and reporting of the testing turnaround times with focus on the time taken from the patient to time result is available; • regular monitoring and reporting that identified cases have been tested and reported in line with the testing protocols (correctly recorded data); • screening for other potential infections takes place;	**and the Occupational Health Team on request.** **Once notification has been received that a member of staff has symptoms, they are booked in for testing via the Sickness absence line. Appointment slots are either on the same day or the next day. The team of staff swabbing are accommodated in the Lodge at BDGH.** **Monitoring is completed by laboratory systems and is reported through governance processes** **Reporting is undertaken in the laboratory. The POCT testing data is downloaded daily and sent to laboratory staff to input and report to PHE.** **Screening is performed for other alert organisms. This is ongoing and has not been compromised during the pandemic.**	**This is a manual process Currently.**	**Electronic system of Linking the machines To laboratory systems has been purchased and is being installed.**

• that all emergency patients are tested for COVID-19 on admission;	**All patients admitted have a PCR test as minimum. Where there are POCT machines they also receive a quicker result whilst in the department but this is always confirmed by PCR in addition.**		
• that those inpatients who go on to develop symptoms of COVID-19 after admission are retested at the point symptoms arise;	**This is done as described in previous section**		
• that emergency admissions who test negative on admission are retested on day 3 of admission, and again between 5-7 days post admission;	**Patient who test negative are tested on day 0, 3, 5, 7 and 28 whilst at DBTH.**		
• that sites with high nosocomial rates should consider testing COVID negative patients daily;	**Weekly testing has been implemented. This may be considered at times when nosocomial rates are high.**		
• that those being discharged to a care home are tested for COVID-19 48 hours prior to discharge (unless they have tested positive within the previous 90 days) and result is communicated to receiving organisation prior to discharge;	**This is in place**		
• that patients being discharged to a care facility within their 14 day isolation period are discharged to a designated care setting, where they	**This is in place**	**Some designated settings Have been stood down in**	**DBTH have good links with CCG Colleagues if this Service is needed**

should complete their remaining isolation; • that all Elective patients are tested 3 days prior to admission and are asked to self-isolate from the day of their test until the day of admission.	**This is in place for elective patients for some diagnostic tests and for surgery.**	**the community as rates Have been low.**	
9. Have and adhere to policies designed for the individual's care and provider organisations that will help to prevent and control infections			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure: • staff are supported in adhering to all IPC policies, including those for other alert organisms; • any changes to the PHE national guidance on PPE are quickly identified and effectively communicated to staff; • all clinical waste and linen/laundry related to confirmed or suspected COVID-19 cases is handled, stored and managed in accordance with current national guidance;	**IPC team are visible and reinforcing good practice in the wards and departments. The IPC team are supporting 'Place' working with the care homes in Doncaster.** **Please see previous section** **Waste from COVID-19 positive patients is treated as infectious clinical waste in accordance with current national guidance. Handled**	**The IPC team is resourced For pre COVID-19 service This is not enough drive 'Place' working**	**PHE have provided equivalent funding of 2 band 6 IPC nurses but only on fixed Basis.**

• PPE stock is appropriately stored and accessible to staff who require it.	**as category B waste. See previous section for Linen.** **PPE stock is centrally stored and sent out to wards and departments based on the level of PPE that is required in the clinical areas. Daily stock takes are completed to ensure that wards/departments have the necessary stock of PPE and the point of use.** **As an ICS we are working together to order PPE to ensure good stock levels are in place for future months. The ICS also work together on the supply of PPE with ICS wide stock takes and help each other with mutual aid.**		
10. Have a system in place to manage the occupational health needs and obligations of staff in relation to infection			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Appropriate systems and processes are in place to ensure: • staff in 'at-risk' groups are identified using an appropriate risk assessment tool and managed appropriately including ensuring their physical and wellbeing is supported;	**Department/ward managers complete a risk assessment for individuals to ascertain the level of risk associated with their position in the organisation. This is**		

	overseen by divisional leaders. Staff who are at higher risk have been redeployed during the COVID-19 pandemic to minimize risk of infection to those members of staff. Individuals have met (virtually) to discuss the risks associated with BAME group of staff and a way forward. Risk assessments are completed for all members of staff who may be at increased risk of transmission of infection. Rainbow rooms are currently available for staff to take 'timeout' during their shift.		
• that risk assessments are undertaken and documented for any staff members in an at risk or shielding groups, including Black, Asian and Minority Ethnic and pregnant staff; • staff required to wear FFP reusable respirators undergo training that is compliant with PHE national guidance and a record of this training is maintained and held centrally; • staff who carry out fit test training are trained and competent to do so;	**Individual risk assessments are completed and reported (as described above).** **All staff expected to attend FIT test training and this is recorded on ESR.** **IPC team and education team provide Fit test training.**		

• all staff required to wear an FFP respirator have been fit tested for the model being used and this should be repeated each time a different model is used;	**The preferred option is that all staff have and are fit tested with a GVS mask. Where they fail fit testing, they are fit tested on other models of disposable FFP3 masks. If Fit testing fails on all mask, hoods are available for use. Fit testing is repeated for all models of masks to be worn. DBTH does not rely on just a 'huff test'.**		
• a record of the fit test and result is given to and kept by the trainee and centrally within the organisation;	**The person fit tested is provided with a fit test passport.**  mask passport blank.docx		
• those who fail a fit test, there is a record given to and held by trainee and centrally within the organisation of repeated testing on alternative respirators and hoods;	**All passes and fails on Fit testing are recorded on ESR.**		
• members of staff who fail to be adequately fit tested a discussion should be had, regarding re deployment opportunities and options commensurate with the staff members skills and experience and in line with nationally agreed algorithm;	**Staff who cannot wear FFP3 masks who work in high risk areas are referred to OH and options explored for redeployment.**		

• a documented record of this discussion should be available for the staff member and held centrally within the organisation, as part of employment record including Occupational health;	**Any redeployment considerations are documented via OH processes.**		
• following consideration of reasonable adjustments e.g. respiratory hoods, personal re-usable FFP3, staff who are unable to pass a fit test for an FFP respirator are redeployed using the nationally agreed algorithm and a record kept in staff members personal record and Occupational health service record;	**See above point.**		
• boards have a system in place that demonstrates how, regarding fit testing, the organisation maintains staff safety and provides safe care across all care settings. This system should include a centrally held record of results which is regularly reviewed by the board;	**All results are recorded on ESR as described above. This is held centrally by education and training department.**		
• consistency in staff allocation should be maintained, reducing movement of staff and the crossover of care pathways between planned/elective care pathways and urgent/emergency care pathways as per national guidance;	**Staff movement to cross cover is kept to a minimum**	**At times it is necessary for staff to cross cover to maintain patient safety.**	**Where this occurs, it is not as a matter of routine that staff are moved mid shift. They would be expected to work the whole shift in one area and shower and change uniform before attending the next shift in another**

			area. Consideration is always given to keeping staff groups separate for example elective and emergency pathways.
• all staff to adhere to national guidance and are able to maintain 2 metre social & physical distancing in all patient care areas if not wearing a facemask and in non-clinical areas;	**This is a repeated question and is answered previously**		
• health and care settings are COVID-19 secure workplaces as far as practical, that is, that any workplace risk(s) are mitigated maximally for everyone;	**Workplace risk assessments are completed. Please see templated embedded at the start of this document.**		
• staff are aware of the need to wear facemask when moving through COVID-19 secure areas;	**All staff are aware of the requirement to wear face masks whilst on site in any area.**	**There is a risk of some confusion regarding need to wear mask when guidance on easing restrictions is published.**	**The expectation is that face masks will be worn when on NHS sites. This has been communicated locally. Formal steer from regional colleagues is expected.**
• staff absence and well-being are monitored and staff who are self-isolating are supported and able to access testing;	**There are systems in place to monitor staff sickness. Staff swabbing process is in place and visible on the Hive for staff to access.**		
• staff who test positive have adequate information and support to aid their recovery and return to work.	**Standard advice based on PHE guidelines are given to HCWs and when they can return back to work and on isolation precautions for their**		

	entire household. They are also requested to ensure their line mangers aware of the results, while pointing the staff towards health and wellbeing if needed. Occupational Health teams and IPC teams give advice and guidance following tracing with those individuals who test positive. Guidance is given for clinical areas and for those who have been in contact outside of the Trust premises.		

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Report Cover Page					
Meeting Title:	Board of Directors				
Meeting Date:	20 July 2021	**Agenda Reference:**	**C4**		
Report Title:	Medical Director Update				
Sponsor:	Dr Timothy Noble, Medical Director & Responsible Officer				
Author:	Dr Timothy Noble				
Appendices:	n/a				
Report Summary					
Purpose of report:	To update the Board on work led by the Medical Director's Office				
Summary of key issues/positive highlights:	▪ As of 12th July 2021, 95% of patients on the admitted RTT active waiting list (excluding planned waiters & diagnostics) have been stratified using the guidance issued by the Royal College of Surgeons, using categories 1a (consistent with last month) ▪ Current activity and a review of future expectations of the national changes in terms of the Medical Examiner service ▪ Progress in terms of the Medical Director's office re-structure				
Recommendation:	The Board is asked to note the update.				
Action Require:	~~Approval~~	Information √	Discussion	Assurance √	~~Review~~

Link to True North Objectives:	**TN SA1:**	**TN SA2:**	**TN SA3:**	**TN SA4:**
	To provide outstanding care for our patients	*Everybody knows their role in achieving the vision*	*Feedback from staff and learners is in the top 10% in the UK*	*The Trust is in recurrent surplus to invest in improving patient care*

Implications	
Board assurance framework:	No change
Corporate risk register:	No risk identified.
Regulation:	
Legal:	n/a
Resources:	n/a

Assurance Route	
Previously considered by:	▪ Mortality and Medical Examiner service report to the Mortality Governance Group and Clinical Governance Committee. ▪ RSAB reports directly to the Clinical Governance Committee ▪ Progress on the Clinical Governance review is reported to Clinical Governance Committee

		▪ Progress on Medical Director's office is shared with the Executive Team	
Date:		**Decision:**	
Next Steps:			
Previously circulated reports to supplement this paper:			

EXECUTIVE SUMMARY

The Board is asked to note the update on work led by the Executive Medical Director's office.

1. Risk Stratification

As of 12th July 2021, 95% of patients on the admitted RTT active waiting list (excluding planned waiters & diagnostics) have been stratified using the guidance issued by the Royal College of Surgeons, using categories 1a – 4 (see table 1 below). This is consistent with last month.

Table 1

Specialty	Not Categorised	Categorised	Total	% Categorised	Oldest Date
GENERAL SURGERY	57	571	628	90.92%	11/09/2020
UROLOGY	3	188	191	98.43%	24/03/2021
BREAST SURGERY	14	68	82	82.93%	17/08/2021
UPPER GASTROINTESTINAL SURGERY	26	59	85	69.41%	26/11/2019
VASCULAR SURGERY	1	88	89	98.88%	29/08/2021
TRAUMA & ORTHOPAEDICS	62	2553	2615	97.63%	04/03/2020
ENT	4	403	407	99.02%	10/08/2021
OPHTHALMOLOGY	12	282	294	95.92%	20/03/2021
ORAL SURGERY	2	286	288	99.31%	03/08/2021
PAIN MANAGEMENT	20	102	122	83.61%	07/01/2021
GENERAL MEDICINE	14	6	20	30.00%	23/05/2021
DIABETIC MEDICINE	3	2	5	40.00%	10/12/2020
CARDIOLOGY	41	7	48	14.58%	08/03/2021
MEDICAL OPHTHALMOLOGY	21	35	56	62.50%	17/02/2021
GYNAECOLOGY	3	292	295	98.98%	20/01/2020
PODIATRY	1	79	80	98.75%	29/08/2021
TOTAL	284	5021	5305	95%	

Exceptions

- Medical Ophthalmology will be removed from the cohort over the next few weeks due to a counting / coding change being implemented – these patients will no longer be recorded as 'admitted' therefore not included in the current risk stratification guidance. With the patients removed, the achievement would remain at 95%.
- Regarding the low rates, eg cardiology the data is being reviewed to verify the position. All specialities have been asked to review their longest waiting patients (awaiting risk stratification) to identify any reporting anomalies and confirm the accurate position in terms of stratification delay.

National Clinical Prioritisation Programme

There have been no further submissions to reflect the current Trust position of priority 5 and priority 6 recording.

Priority 2 Patients – Waiting 4 Weeks + (from date of listing or P2 Categorisation)

As of 4th July 2021, 282 priority 2 patients have been waiting for surgery for 4+weeks following date of listing or priority 2 categorisation (upgrades). 276 due to hospital capacity and 6 due to patient choice. See table 2 below.

Table 2

Specialty	Number of Priority 2 Patients Waiting			
	May 2021	**June 2021**	**July 2021**	**August 2021**
General Surgery	11	12	2	
Upper GI Surgery	1	0	1	
Urology	25	27	25	
Breast Surgery	3	4	2	
Vascular	15	23	31	
Trauma & Orthopaedics	107	139	144	
Cardiology	3	2	0	
ENT	13	15	24	
Ophthalmology	29	34	31	
Medical Ophthalmology	5	5	14	
Oral Surgery	2	1	1	
Podiatry	3	2	1	
Gynaecology	9	9	6	
TOTAL	**292**	**273**	**282**	

For context, the Trust is undertaking approximately 368 category 2 procedures per week.

Patient Letters / Communication Plan

Following agreement from all stakeholders, the patient communication plan commenced on Monday 8th March 2021, with letters being sent to the agreed cohorts of patients. It has been agreed that following the final letters due to be sent out in July 2021, no further letters will be sent as part of this project. A final position will be reporting in August 2021.

The response to date is summarised below in table 3.

Table 3

Week Commencing	Number of Letters Sent	Week Range	Number of Calls to Discharge Service	Number of Patients Requesting Discharge
March 2021	4561	34+ weeks	128	38
April 2021	4630	21+ weeks	183	84
3.5.2021	1348	18+ weeks	43	26
10.5.2021	1498	17+ weeks	53	28
17.5.2021	-	-	61	23
24.5.2021	1468	11+ weeks	62	24
31.5.2021	1106	9+ weeks	51	18
7.6.2021	1198	7+ weeks	65	31
14.6.2021	1236	5+ weeks	66	24
21.6.2021	1551	3+ weeks	61	25
28.6.2021	1815	1+ weeks	20	12
Cumulative Total	**20411**		**793**	**333**

Management of Diagnostic Patients

The Trust has received additional national guidance for the prioritisation and management of long waiting patients for diagnostics, this includes a new set of stratification categories (D1-6). A proposal is currently being written by the Department with recommendations for the most safe & effective process for managing the backlogs while ensuring national guidance is being followed.

The process will be taken through the appropriate governance structure for sign off.

Weekly Report (Covid)

The following link / icon can be used to access the document and will be updated by close of play every Tuesday. If you have any issues accessing the document, please e-mail Julie Thornton, Head of Performance. julie.thornton1@nhs.net

B:\Performance Assurance Framework\Weekly Performance\NEW 2021-22 Weekly Review.xlsm

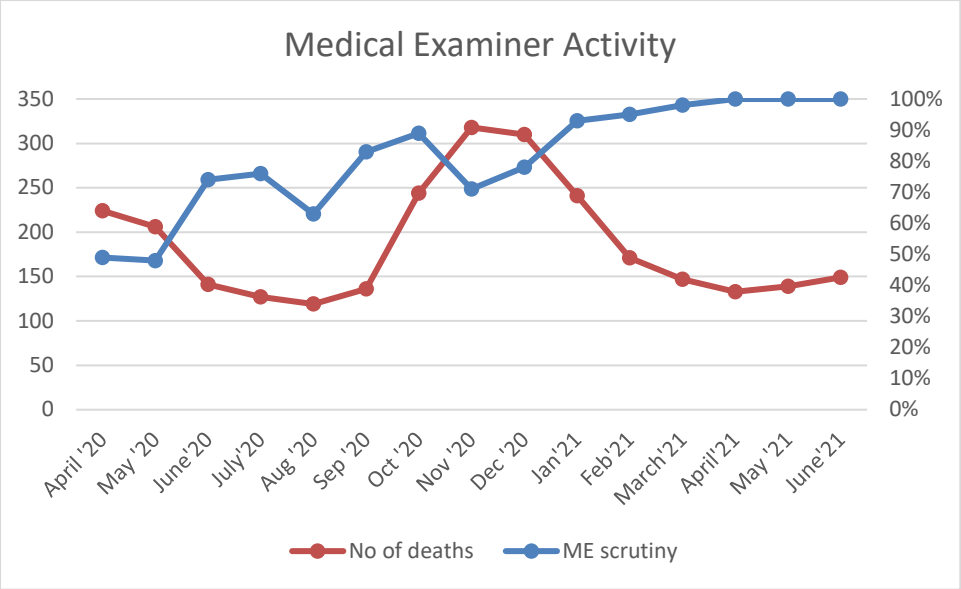
NEW 2021-22
Weekly Review.xlsm

Escalations from Risk Stratification Assurance Body

Escalation / Risk	Mitigation	Comments
No escalations identified		

2. Medical Examiner Service - Extending the Medical Examiner Service to include deaths in non-acute settings.

The Medical Examiner Team at DBTH was established in December 2019 and has been working towards the scrutiny of all adult deaths occurring within the Trust. Good progress was being made towards this goal in early 2020 when the coronavirus pandemic was declared. Despite the challenges encountered causing a significant increase in the number of deaths seen within the Trust as well as bringing in new changes in death certification as laid out in the Coronavirus Act 2020, the medical examiner team along with the bereavement team were able to support the attending medical teams to write accurate and timely death certificates and continue to increase the number of deaths independently reviewed. In May 2021 the ME team scrutinised 100% of hospital deaths for the first time and this level of scrutiny has been maintained to date. This was a huge achievement in such unprecedented times. The graph below demonstrates number of deaths and percentage of deaths scrutinised by the ME team over the last 12 months.



Following the successful implementation of the ME system in acute trusts we have now been tasked with expanding the service to cover all deaths within the geographical area. This includes deaths within the community, hospices and eventually mental health trusts.

In June 2021 a letter was sent to all care providers setting out the plans for the expansion of the ME scrutiny to non-acute settings.

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dical-examiner-scrutir

The Chief Medical Examiner and Lead Medical Examiner Officers have now had preliminary meetings with key stakeholders at Bassetlaw CCG. They have also met with the information governance team which covers both Doncaster and Bassetlaw CCGs. An educational session is being planned for GPs at both Doncaster and Bassetlaw CCG via their "TARGET" and forum sessions.

The service will pilot with one or two practices within each CCG and then roll out to other practices once the pathway for scrutiny of non-acute deaths has been well established.

A number of challenges have been identified which could impact on the ability to deliver the proposed plan. A number of actions have been undertaken to date and include:

- **Private office space at Bassetlaw Hospital is essential to proceed with this expansion**. Currently the shared space is not sufficiently private for the sensitive discussions with bereaved families. This can prove difficult in a busy shared office environment. *An application to the space utilisation group has been made and will be attending a meeting on 19/7/21 to present the case.*

- **Additional IT equipment**. It is anticipated that an additional 5 or 6 PC workstations across the two hospital sites to accommodate the proposed increase in the number of MEs and MEOs needed to extend the ME scrutiny to non-acute deaths. A *business case to cover these additional costs is being prepared for CIG.*

- **Access to the GP records**. Having met with the IG team at the CCG we require our own SystemOne and EMIS account within the ME office to access the GP records.
    - *We have raised the matter within the Trust IT team including the Information Governance lead and Chief Clinical Information Officer.*
- **Recruitment of additional MEs and MEOs**
    - *Job advert for MEs advertised*
    - *An additional MEO post is awaiting approval by finance team. Approval of and recruitment to this post will be essential for the planned expansion of the team.*

In summary the Trust is well poised to deliver on this next step of a wider and comprehensive scrutiny of deaths subject to addressing the above. This will be a further step in enhancing the good reputation the Trust has in the field of Medical Examiner scrutiny of deaths with its contribution to good quality patient care as well as providing support to bereaved families.

3. Caldicott Guardian Activity

The Executive Medical Director is the Trust's appointed Caldicott Guardian and has responsibility for safeguarding patient confidential data. Below is a summary of recent activity in terms of the role.

	Mar	Apr	May	Jun	Work undertaken
Data protection impact assessments	**5**	**1**	**4**	**13**	A DPIA is a legal requirement of the UK GDPR Article 25: Privacy by Design and is the forerunner to most new Trust projects or tasks involving the "processing of patient or staff confidential data". The Caldicott Guardian has a knowledge of and an active interest in the signing-off of every DPIA
Data processing/information sharing agreements	**8**	**4**	**5**	**5**	All data or information processing agreements require review and sign-off by the Caldicott Guardian.
Confidentiality agreements	**0**	**0**	**0**	**0**	As above.
Policy reviews	**2**	**0**	**4**	**3**	All IM&T Policy reviews fall under the stewardship and authority of the Information Governance Committee which is overseen by the Caldicott Guardian and Trust SIRO
Externally reported issues requiring Trust input	**0**	**0**	**0**	**1**	As above, notified by a 3rd party.
Datix incidents requiring SIRI action	**0**	**0**	**0**	**0**	As above

Datix incidents requiring ICO action	**0**	**0**	**0**	**0**	As above

4. Mortality

The overall rate continues to show an improvement (111.2) and particularly so in non-elective patients (110.8). Crude mortality has flattened after a steep fall reflecting a more accurate position in relation to pre-pandemic levels.

Elective admissions continue to show an upward trend and is reflective of elective work not having yet picked up sufficiently to affect the denominator. This figure therefore does not generate any immediate concerns particularly as all elective deaths are scrutinised on a monthly basis allowing any issue to be picked up promptly. Please see attached for further detail.

5. Culture & Communication with Medical Staff

The Medical Directors office has continued to engage with the clinical staff via the monthly Medical Advisory Committee. The programme of topics continues to be varied and of a broad general interest. The Medical Directors office attends and fully engages with the Trust Medical Committee and the Local Negotiating Committee. These provide opportunities ot display and promote the Trusts values.

6. Clinical Governance Review

A meeting was held 21st June 2021 resulting in a final review of the clinical governance structure and agreement of the terms of reference for the Clinical Governance Quality Board (formerly Clinical Governance Committee).

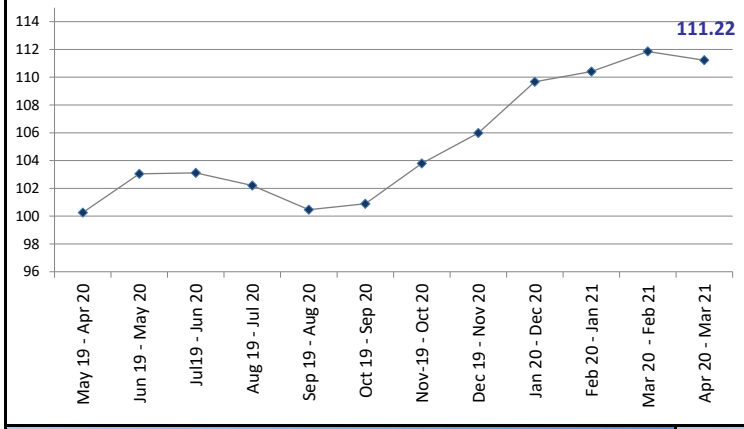
A review of the terms of reference for the three main reporting committees is underway. Upon completion these will be approved in Quality & Effectiveness Committee with a view to launching the new structure in September 2021.

7. Medical Directors office re-structure

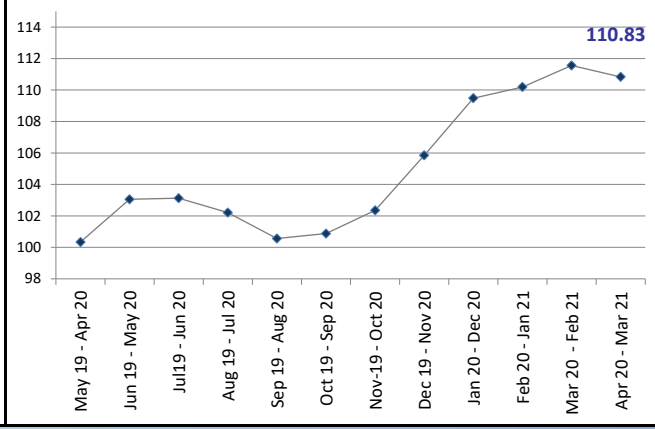
- Interviews for the two Medical Director roles were held 13th July 2021 and offers made subject to references.
- Expressions of interest have been received for the two Associate Medical Director roles in relation to Professional Standards (to include Revalidation) and Patient Safety. Shortlisting is ongoing.
- The Senior Manager post has been advertised on a secondment basis and has attracted a significant interest. Shortlisting is ongoing.

Hospital Standardised Mortality Ratio (HSMR) - March 2021 (Month 12)

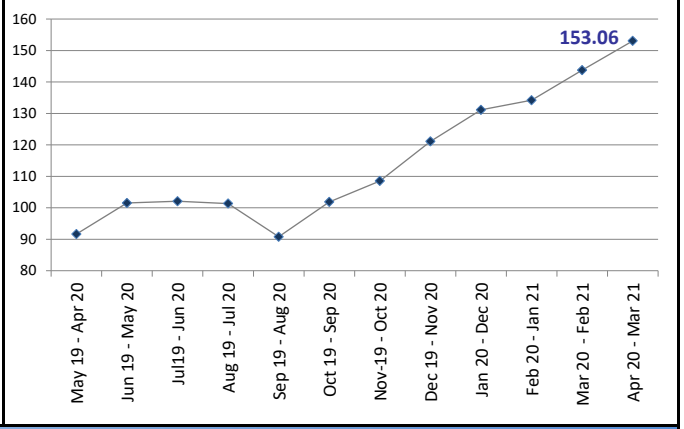
Overall HSMR (Rolling 12 months)



HSMR - Non-elective Admission (Rolling 12 months)



HSMR - Elective Admission (Rolling 12 months)

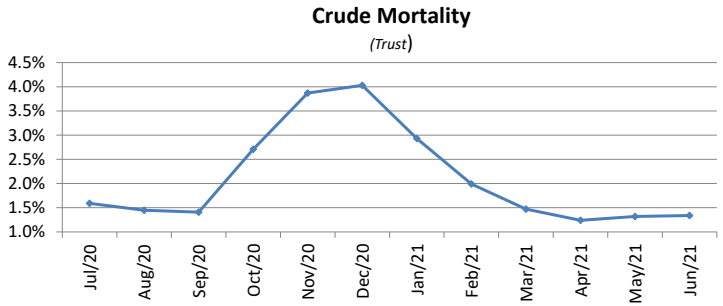


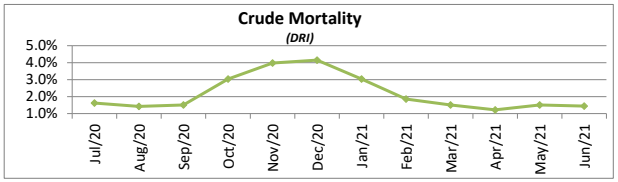
HSMR Trend (monthly)

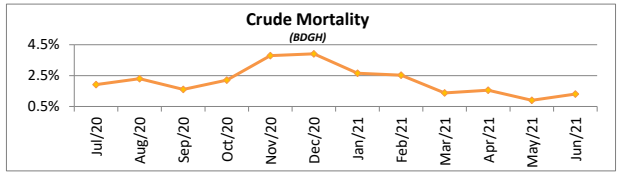
	2017	2018	2019	2020	2021
January	99.21	94.86	105.78	110.26	118.93
February	97.73	105.44	98.13	92.56	104.21
March	97.37	88.42	101.87	102.51	93.32
April	88.50	98.37	100.70	118.40	
May	96.60	91.20	91.36	132.00	
June	93.67	89.98	98.32	97.72	
July	97.73	107.07	104.77	91.35	
August	87.52	94.65	112.17	87.99	
September	95.34	90.09	83.64	87.36	
October	88.66	96.74	100.24	117.17	
November	82.30	99.04	88.64	131.21	
December	93.52	80.45	103.24	144.31	

Crude Mortality (monthly) - June 2021 (Month 3)

(number of deaths/number of patient discharged)







	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21
Trust	**1.59%**	**1.46%**	**1.41%**	**2.71%**	**3.87%**	**4.03%**	2.93%	1.99%	1.47%	1.24%	1.32%	1.34%
DRI	1.62%	1.42%	1.51%	3.04%	3.98%	4.15%	3.04%	1.86%	1.51%	1.22%	1.51%	1.44%
BDGH	1.92%	2.30%	1.61%	2.21%	3.79%	3.91%	2.65%	2.53%	1.38%	1.55%	0.90%	1.30%

Appendix Level1

OUR VISION : To be the safest trust in England, outstanding in all that we do			
True North Strategic Aim 2 – Everybody knows their role in achieving our vision			
Risk Owner: Trust Board **Committee: People**	**People, Partners, Performance, Patients**	**Date last reviewed : July 2021**	
Strategic Objective Everybody knows their role in achieving our vision **Breakthrough Objective** **At least 90% of colleagues have an appraisal linked to the Trusts Values and feel able to contribute to the delivery of the Trust vision.**	**Risk Appetite:** The Trust has a **low appetite** for risks TBC **Measures:** • At least 90% of colleagues have an appraisal linked to the Trust's objectives and values • 5% improvement in colleagues reporting they are able to make suggestions to improve the work of their team/department. • Delivery of a 5% improvement in the number of colleagues who have the opportunity to show initiative in their area and make improvements in their area of work. • 90% of the Divisional and Directorate leaders will have undertaken QI training as part of leadership development programme.	**Initial Risk Rating** **Current Risk Rating** **Target Risk Rating**	4(C) x 4(L) = 16 extr 4(C) x 4(L) = 16 extr 3(C) x 3(L) = 9 low
Risks: • Risk of disconnect between ward and Board leading to negative impact on staff morale and patient care • Failure of people across the Trust to meet the need for rapid innovation and change • Ongoing impact of restoration of services post Covid	**Rationale for risk current score:** Impact: • Impact on performance • Impact on Trust reputation • Impact on safety of patients & experience • Possible Regulatory action • Recruitment and retention issues • Increased staff sickness levels • Deterioration in management-staff relationships	**Future risks:** • Morale and resilience of colleagues as we move into recovery phase **Risk references:** PEO1 & PEO2 **Opportunities:** • Change in practices, new ways of working • Increase skill set learning	
Controls / assurance (mitigation & evidence of making impact): • Monitoring uptake of appraisal through accountability meetings • Staff survey action plans to ensure appraisal conversations are meaningful as defined by the staff survey • Listening events held on regular basis • Use of team brief • Extended Trust Executive Group development sessions • Wellbeing built into core appraisal process • Leadership development programmes to include QI	**Comments:** Considerations – capacity & capability of workforce including our leaders	**Assurance (evidence of making an impact):** Feedback from the appraisal season and quarterly staff survey results **Gaps in controls / assurance (actions to achieve target risk score):** • Regular feedback on appraisal discussions • Impact on COVID of appraisals not taking place during the year • Impact of recovery phase post covid • Impact of long covid	

Appendix Level1

OUR VISION : To be the safest trust in England, outstanding in all that we do

True North Strategic Aim 3 – Team DBTH feel valued and feedback from staff and learners in top 10% in UK

Risk Owner: Trust Board **Committee: People**	**People, Partners, Performance, Patients**	**Date last reviewed : July 2021**	
Strategic Objective Team DBTH feel valued and feedback from staff and learners in top 10% in UK **Breakthrough Objective** Team DBTH feel valued and the Trust is within the top 25% for staff & learner feedback	**Risk Appetite:** The Trust has a **low appetite** for risks TBC **Measures:** • Delivery of a 5% improvement in colleagues and learners recommending the Trust as a place to work and learn in the 2021/2022 staff survey results. • Delivery of a 5% improvement in how valued colleagues feel by managers and the Trust in the 2021/ 2022 staff survey results • Delivery of 5% improvement in health and wellbeing feedback in the 2021/2022 staff survey results • Delivery of 5% improvement in WRES and WDES feedback in the 2021/2022 staff survey results	**Initial Risk Rating** **Current Risk Rating** **Target Risk Rating**	4(C) x 4(L) = 16 extr 4(C) x 4(L) = 16 extr 3(C) x 3(L) = 9 low
Risks: • Failure to provide appropriate learner environment that meets the needs of staff and patients • Failure to enable staff in self actualization • Failure to deliver an organizational development strategy that allows implementation of trust values	**Rationale for risk current score:** Impact: • Impact on Trust reputation • Impact on safety of patients & experience • Possible Regulatory action • Recruitment and retention issues • Increased staff sickness levels • Deterioration in management-staff relationships • Financial impact for the Trust	**Future risks:** • Morale and resilience of colleagues as we move into recovery phase **Risk references:** PEO1 & PEO2 **Opportunities:** • Change in practices, new ways of working • Future new build • Focus on wellbeing and EDI across the Trust	
Controls / assurance (mitigation & evidence of making impact): • Introduction of People committee and sub committees • Work programme to implement the People Plan • Staff survey results and action plan • PPQA feedback • GMC trainee survey • Delivery of health and wellbeing action plan • Improvement in payroll KPIs	**Comments:** • Requires good OD plan “fit for purpose” • Staff survey impact • Need good data • Recruitment & retention	**Assurance (evidence of making an impact):** Feedback from staff and learner networks Junior doctor forum **Gaps in controls / assurance (actions to achieve target risk score):** COVID response impacted on development work	

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Report Cover Page					
Meeting Title:	Board of Directors				
Meeting Date:	July 2021	**Agenda Reference:**	D2		
Report Title:	Our People update				
Sponsor:	Karen Barnard, Director of People & OD				
Author:	Karen Barnard, Director of People & OD				
Appendices:	None				
Executive Summary					
Purpose of report:	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				
Summary of key issues:	The report this month provides an update to the Board in relation to: • newly qualified recruitment • staff survey approach going forward • the health and wellbeing diagnostic recently completed • Covid absence and swabbing data, including lateral flow testing • Covid and flu vaccination programme.				
Recommendation:	Members are asked to receive this report.				
Action Require:	Approval	**Information**	Discussion	**Assurance**	Review
Link to True North Objectives:	**TN SA1:**	**TN SA2:**	**TN SA3:**	**TN SA4:**	
	To provide outstanding care for our patients	***Everybody knows their role in achieving the vision***	***Feedback from staff and learners is in the top 10% in the UK***	*The Trust is in recurrent surplus to invest in improving patient care*	
Implications					
Board assurance framework:	SA2 & 3 – future risks in relation to morale and resilience of colleagues as we move into the recovery phase				
Corporate risk register:	PEO1 – Failure to engage and communicate with staff and representatives in relation to immediate challenges and strategic development PEO2 – Inability to recruit right staff and have staff with right skills leading to: (i) Increase in temporary expenditure (ii) Inability to meet and Trust strategy (iii) Inability to provide viable services.				
Regulation:	None				
Legal:	None				

Report Title: Our People Update **Author:** Karen Barnard **Report Date:** July 2021

Resources:	None		
Assurance Route			
Previously considered by:	People Committee		
Date:	6th July 2021	**Decision:**	Assurance
Next Steps:	Ongoing discussions at People Committee		
Previously circulated reports to supplement this paper:		None	

GENERAL UPDATE

1. **PEOPLE PLAN – STAFF SURVEY**
2. **RECRUITMENT**
3. **HEALTH & WELLBEING**
4. **JUST CULTURE**

COVID UPDATE

5. **STAFF ABSENCE**
6. **STAFF TESTING**
7. **LATERAL FLOW TESTING**
8. **COVID AND FLU VACCINATION**

List of figures included with this report:

Figure 1 – High level overview of Trust status against Health & wellbeing framework
Figure 2 – Absence Graph, March 2020 – May 2021
Figure 3 – Covid Related Absence
Figure 4 – Swabbing data March 2020 to April 2021
Figure 5 – Total number of Covid 19 Positive results, Mar 20 – current

List of tables included in this report:

Table 1 – Appointments by area
Table 2 – Staff Testing Figures
Table 3 – Number of Covid 19 Positive Test Results, by Staff Group

GENERAL UPDATE

1. PEOPLE PLAN – STAFF SURVEY

The People Plan 2020/21: action for us all, set out how we intend to enhance activities to better understand employee experience, which included the introduction of a quarterly survey. 'We each have a voice that counts' is one of the seven elements of the People Promise – our ambition to make our NHS the workplace we all want it to be by 2024.

With this in mind, a National Quarterly Pulse Survey, which was previously referred to as the Quarterly Staff Survey, will replace the paused Staff Friends and Family Test (SFFT), providing a more robust and valid data set on capturing employee experience.

Organisations are expected to implement the National Quarterly Pulse Survey in July 2021. The National Staff Survey will take place in quarter three 2021/22, using a refreshed set of questions which align with the seven elements of the People Promise.

The National Quarterly Pulse Survey will provide an opportunity to hear from our people to help understand employee experience on a more regular basis than the annual National Staff Survey. This will support decision making and actions for improvement with the ambition of making the NHS the best place to work.

The survey consists of the nine engagement theme questions which are the same as those included in the National NHS Staff Survey, and measures motivation, advocacy, and involvement. The reason why we want to measure staff engagement in the survey is that it has been researched in detail over the last few decades and has been proven to have strong links with positive individual and organisational outcomes including lower patient mortality, lower sickness levels and lower patient complaints.

Advocacy

- Would recommend organisation as place to work
- If friend/relative needed treatment would be happy with standard of care provided by organisation
- Care of patients/service users is organisation's top priority.

Involvement

- Able to make suggestions to improve the work of my team/department
- Opportunities to show initiative frequently in my role
- Able to make improvements happen in my area of work.

Motivations

- Often/always look forward to going to work
- Often/always enthusiastic about my job
- Time often/always passes quickly when I am working.

Listening well to all our NHS people, learning from what they tell us, and acting on what is learnt is essential if we are to support all our NHS people through recovery, encourage those in our current workforce to stay and stay well, and attract new people to join us in providing high-quality care for patients and service users.

People promise (annual from staff survey)

- We are a team
- We work flexibly
- We are always learning
- We are safe and healthy
- We each have a voice that counts
- We are recognised and rewarded
- We are compassionate and inclusive.

As detailed previously the annual staff survey will be adapted in order that each of these themes are monitored.

Staff experience - Monthly pulse survey

We understand that there will also be an expectation around monthly surveys - the pulse survey was introduced during covid but with limited take up – we therefore await the approach to be taken going forward and the extent to which we can adapt the questions.

2. RECRUITMENT

Newly qualified

Nursing & Midwifery

The Trust has invested much time in developing the recruitment of newly qualified staff, initially this was provided mainly for newly qualified nurses but recently this has been extended to other staff groups with the Allied Health Professional Groups. A cohort recruitment campaign has been adopted for newly qualified roles which enables the Trust to plan and coordinate all recruitment activity at a Trust level and undertake the publishing of a single advert in advance of the dates that the nurses are due to qualify. Applicants are then invited to attend assessment days at which they undergo a range of recruitment selection stations. The applicants are then selected and allocated based on overall scoring. This is much more streamlined approach to recruitment and involves clinical colleagues from across specialities and Divisions in the Trust in reaching decisions on appointments.

As part of the process, once offers have been made, the successful candidates are invited to meet with senior nursing colleagues in advance of their start dates to be welcomed to the Trust and have an opportunity to meet colleagues in a more informal and relaxed setting. This 'afternoon tea' approach has received very positive feedback and when candidates have options in which Trusts to work for, has significantly improved the numbers of people recruited.

To date at the time of compiling this report the Trust has offered 38 Newly Qualified Nurse posts. The posts have been offered across a range of areas across the Trust, including; ED (BGH & DRI), Respiratory Unit, AMU, Theatres Recovery, Ward 16 and Ward 24.

Unified Recruitment Process for Midwives

The four Trusts in South Yorkshire and Bassetlaw have agreed to work together to implement an LMS/MHN wide recruitment process for NQM's. This approach is to provide a more consistent approach, improving the recruitment experience for students, reducing the number of 'duplicated' applications across all of the Trusts and reducing the risk of having to re-advertise roles causing delays in recruiting to vacant band 5 posts.

It has been agreed by SYB HR Directors, Chief Nurses and LMS/MHN that TRFT will be the host Trust to undertake the administrative element of the HR process. There is one single job description and person specification (which will be job matched by TRFT on behalf of all SYB trusts) and one advert that TRFT will advertise on NHS jobs, on behalf of the four Trusts. All four Trusts are in the shortlisting, interviewing and allocation of places to applicants; then each individual Trust will pick up the administrative HR process as employer of the NQM.

To date, utilising the new process outlined above, the Trust has offered 27 Newly Qualified Midwife posts. All posts offered are rotational band 5 posts. These NQMs have all been offered Band 3 roles pending their registration.

Radiographer and AHP

To date, the Trust has offered 11 newly qualified radiographer positions this summer to fill 13 vacancies. Of those 11, four are working for the Trust as AP until registration and the remaining seven will start throughout the summer depending on when their registration with the HCPC come out and when they want to start (with some taking a break over summer and starting in September). In addition, there are two degree apprentices who have started in March this year on a three year degree course.

Seven new qualified physiotherapists have been recruited to, of which three have been filled and four currently going through the vacancy control process. In addition, one dietitian has been recruited.

Overseas

International Nurse Recruitment

The Trust is currently undertaking the recruitment of 50 nurses from India in conjunction with NHS Professionals. The nurses are being recruited throughout the year with the aim of completion of the recruitment process by the end of the calendar year.

The impact of the pandemic in India resulted in the nurses recruited to date unable to come over to the UK to commence in post. We have since been informed that we can now plan for recruited nurses from India being able to travel to the UK to take up roles, with the first cohort due to arrive on 29 July 2021.

To date the Trust has successfully recruited a total of 20 nurses in the current financial year. Despite the restrictions placed on the Trust regarding successfully recruited nurses being able to travel to the UK, the Trust continued with the recruitment process of interviewing and selecting candidates, enabling the Trust to make appropriate arrangements with appointed nurses to commence employment with the Trust now the restrictions have been lifted. The initial cohort of 10 nurse are being placed in the following areas:

Table 1 – Appointments by area

Appointed Candidates	Site	Area
2 x Nurses	DRI	Ward 25
2 x Nurses	DRI	Ward 24
2 x Nurses	DRI	Respiratory Unit
1 x Nurse	DRI	Ward 16
1 x Nurse	DRI	Ward 19
2 x Nurses	DRI	Main Theatres

The Central Recruitment Team are in the process of planning the arrival of further cohorts, our newly appointed nurses are due to arrive on the dates outlined below, however at this point, in conjunction with the Central Nursing Team, we are reviewing allocation for the new recruits and this is yet to be finalised.

The planned cohort arrival dates are:

- 10 Nurses – 16th August 2021
- 10 Nurses – 28th October 2021
- 10 Nurses – 18th November 2021
- 10 Nurses – date to be confirmed

As colleagues will see from the above detail, the model of delivery currently in operation is to support the nurse's arrival in the UK is divided into five cohorts of ten nurses at a time. This is to ensure that the Trust has appropriate resources in the Central Nursing, Recruitment and Education and Research teams to provide the required pastoral and clinical educational support required to facilitate the nurse's arrival in the UK and obtaining NMC registration. There are also limits to available Trust on site accommodation which forms part of the recruitment package.

3. HEALTH & WELLBEING

The Board will be aware from the last health and wellbeing update that as an organisation we hold a strong and resolute focus on the wellbeing of our people. This includes physical, emotional, and psychological wellbeing. This section provides an update from the diagnostic undertaken by the health and wellbeing committee at which Mark Bailey, Wellbeing Guardian was present.

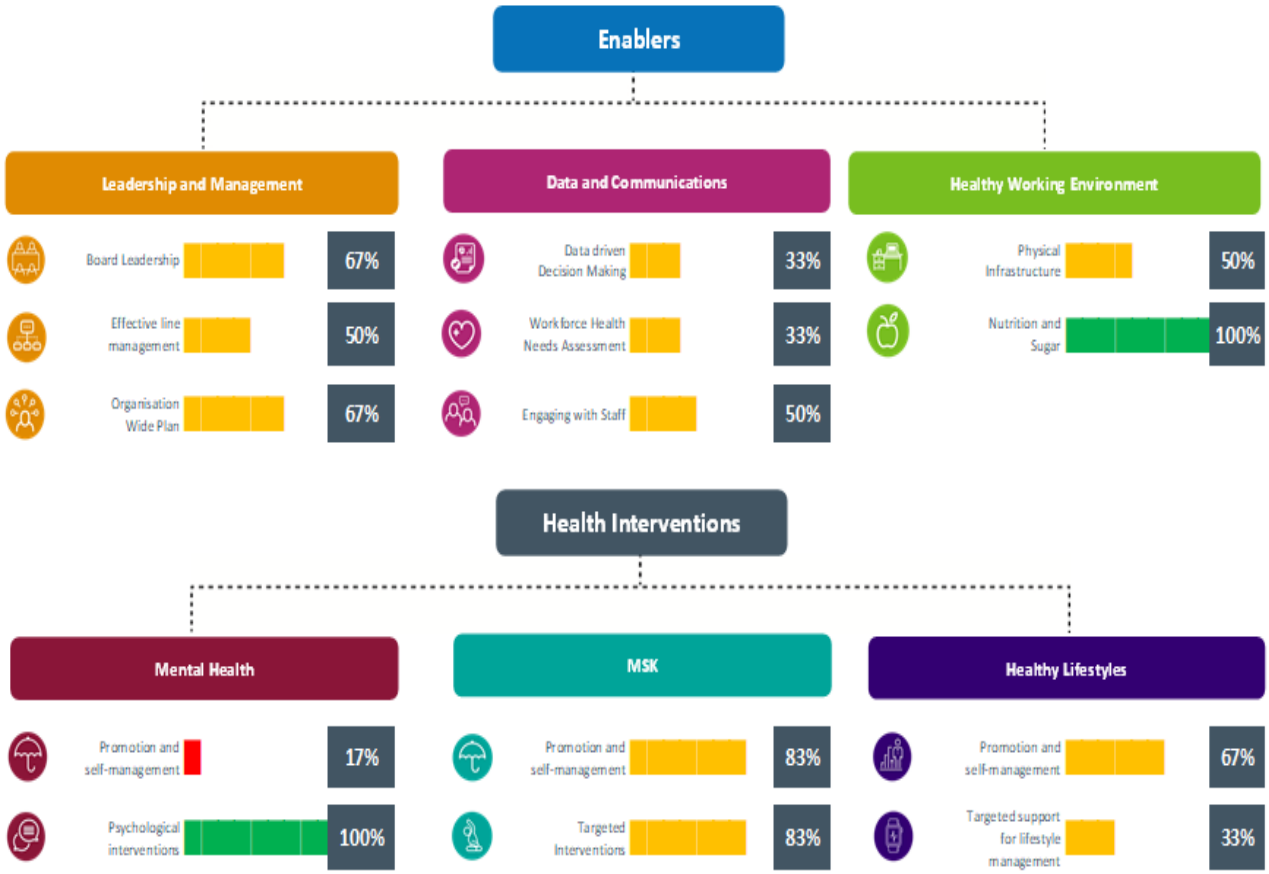
Diagnostic Framework Self-Assessment

At the recent DBTH Health and wellbeing committee with support from our Wellbeing Guardian we undertook a review of our wellbeing approach utilising the NHS Workforce Health and Wellbeing Framework Diagnostic Tool. This tool enables us to undertake a:

- Comprehensive, relatively easy self-assessment of our organisational approach to health and wellbeing
- Quick understanding of our status against the Framework
- Prioritisation and ordering of our areas of focus.

The following dashboard infographic gives the committee a high-level overview of the areas where we are strong and areas where more focus is required.

Figure 1 – High level overview of Trust status against Health & wellbeing framework



It is apparent from the above dashboard overview the areas that require continued focus are:

Enablers

- Effective line management – development of our leaders
- Physical infrastructure – space and access to wellbeing areas
- Data driven decision making – strategic management of the data
- Workforce health needs assessment
- Engagement of staff – organisational wide wellbeing conversations.

Health Interventions

- Promotion and self-management of wellbeing – taking action for yourself
- Targeted Healthy lifestyles interventions and management – support to change and make healthy choices.

The above information will inform the focus of the health and wellbeing committee and the work and activity of the health and wellbeing team. Going forward the wellbeing team will drive and continue to promote:

- Wellbeing Conversations
- Wellbeing Appraisals
- Access to support and interventions to change

- Development of line managers to support inclusive cultures and wellbeing through initiatives like Team Time, TRiM, Team Huddles, Start well End well, Team development and engagement activity.
- Promotion of self-care through access to change support and proactive lifestyles advice and support
- Recognition and acknowledgement initiatives like Raise a Smile campaign.

These are therefore being built into an action plan which along with the feedback we anticipate from our Wellbeing at Work submission will determine the committee's workplan.

4. JUST CULTURE

In May 2019 all Trusts received a letter from Baroness Dido Harding, Chair of NHSI entitled Learning lessons to improve our people practices. Subsequently a report from was issued in July 2019 entitled *'A fair experience for all'.* This report, with a foreword from Prerana Issar, detailed stretching but achievable goals and recommendations to address inequalities in the experience of BAME staff in relation to disciplinary proceedings.

In November 2019, Prerana Issar wrote to healthcare professionals and regulatory bodies, encouraging review and examination of any guidance and standards provided to members and registrants to address the issues highlighted to support compassionate leadership and improvement across the healthcare system.

In December 2020 Prerana Issar wrote to ask that by the end of March 2021 the Trust should have reviewed all disciplinary policies and procedures against the recommendations issued in May 2019 (in a letter from the Chair of NHSI about improving our people practices). Specifically asking that:

- Our disciplinary policy is reviewed and discussed at a public Board or equivalent; and
- Our updated policy is made available on your organisation's public website.

Prerana Issar also cited as a good practice reference point the policy Imperial College Hospitals NHS Trust has published on its website. Since Prerana wrote in December, the pandemic reached unprecedented levels and the organisation has been busy ensuring we are fully responding to Covid-19.

Prerana Issar wrote again to NHS Organisations on 1st April 2021 acknowledging that the pandemic may well have delayed intentions to review disciplinary policies by the end of March 2021. In the letter dated 1st April 2021 Prerana Issar has asked that as NHS organisations think about staff recovery and prioritising their health and wellbeing, it's important we ensure that HR policies and processes are compassionate, supportive and inclusive. Prerana's letter has requested that the Trust update their Regional Director of Workforce and OD with progress by the end of April, and confirm to them your status on completing the stated actions by end of June 2021.

The P&OD Casework Team has undertaken a review of our current disciplinary policy and practice in light of the guidance contained within the letter from Dido Harding detailing where they consider improvements could be made. The team has identified some improvements that can be made to our policy and significant work has already progressed to develop and update record keeping and KPIs, and to commence development of supporting documents for example the implementation of a suspension risk assessment.

Actions that have already been completed include:

- Review of internal assessment against guidance as set out by Dido Harding (24 May 2019), and as contained in the Board paper presented in July 2019
- Review of the "a fair experience for all" WRES strategy paper July 2019 and in particular the table 6 *"Four models of good practice for reducing the disproportionate gap in BME and white staff entering the formal disciplinary process"*
- Review of the Imperial College Healthcare Trust Disciplinary Policy and Procedure
- Review of the GMC Principles of a Good Investigation
- Review of the NMC Guidance on managing concerns locally (https://www.nmc.org.uk/employer-resource/managing-concerns/managing-concerns-locally/)
- Review of the NHS Improvement Just Culture Guide. This guide updates and replaces the incident decision tree (IDT) developed by the National Patient Safety Agency (NPSA) around the work of James Reason, an expert in human error and its drivers.
- Quarterly reporting and auditing of case data regarding disciplinary cases identifying any concerns within the data and any trends that may require further review or action.
- A paper to executive team regarding good practice for a policy framework for staff experiencing domestic abuse which has been given agreement and a new policy is in development
- A risk assessment framework and guidance document has been developed to support more robust and evidenced decision making for suspensions to help minimise and find alternative solutions
- A review framework has been developed and implemented to support robust suspensions reviews were there is no alternative to suspension
- Template letters have been reviewed, updated and implemented to support the above
- Updated and cleansed the casework tracker to enable better tracking and reporting of open case work
- Updated and revised the initial communication letter templates to the individual under investigation to ensure greater transparency can clarity regarding the process and support options available
- Practice implemented to identify an independent manager to undertake the role of pastoral support for any individuals undergoing a formal process in addition to the support available through their union, Vivup, investigating manager and P&OD
- Greater focus on triaging case work to determine at an earlier stage whether cases require a full investigation or can be managed through informal processes or through a sanction outside of a hearing
- The sourcing of a casework database which will enhance capabilities for the tracking, reporting, monitoring and evidencing of case work, and which will improve administrative efficiencies within the process with planned procurement by end of June 2021.

The Case Team have produced an action plan which identifies any outstanding actions as identified through a review of the documentation and recommendations as set out in the literature and guidance listed above. Having reviewed the above sources, the outstanding actions to be implemented have been set out into the following sections:

1. Pre formal action
2. Principles for a formal process
3. Post outcome action

4. Health and Wellbeing
5. Training and Development.

The action plan is a substantial piece of work and will be broken down into stages:

1. Actions involving policy document review
2. Actions involving creation of templates and toolkits
3. Actions involving development of training and competency packages.

Future reporting will be provided with a greater level of detail with regards to breakdown of equality, diversity and inclusion data and associated analysis to provide further assurances to the committee regarding the Trust approach to casework management and the journey towards the implementation and development of the work associated with the 'just culture' programme. The launch meeting of the Just Learning and Culture Programme was held on Tuesday 29 June and will draw on the work and progress that has already been undertaken in the Casework Team which is a key element of the broader workstream.

COVID UPDATE

5. STAFF ABSENCE

As can be seen Covid related absence rose from August 2019 and was fairly static between November and March when it reduced due to shielding ceasing. During June we are experiencing a small rise both in terms of colleagues self isolating but also testing positive. It should be noted that non Covid related sickness absence continues at a similar rate to previous years, with usual seasonal rise.

Figure 2 – Absence Graph, March 2020 – May 2021

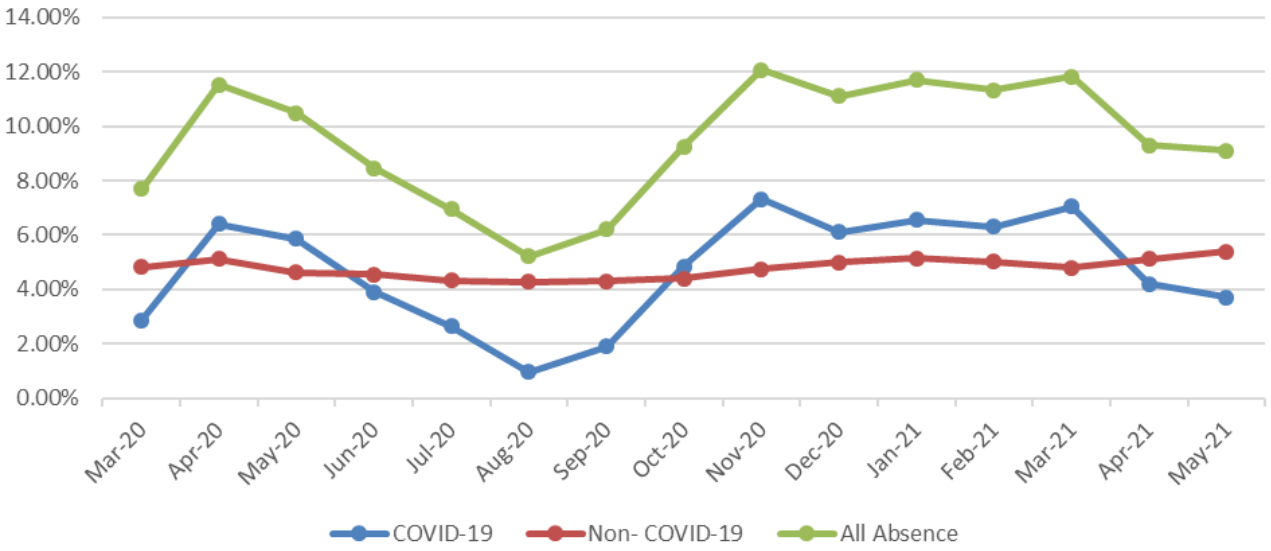
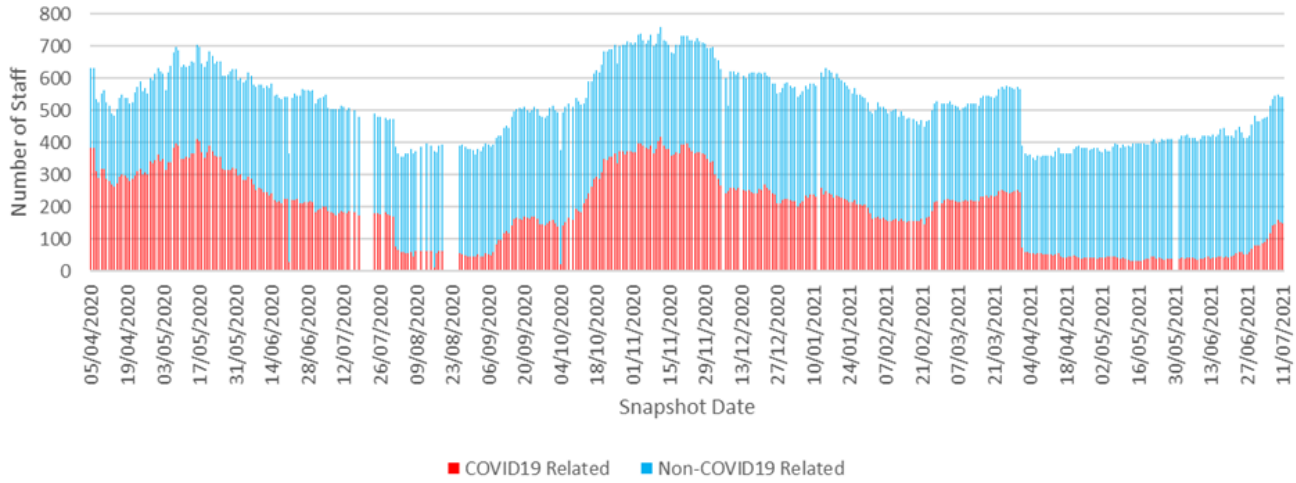


Figure 3 – Covid Related Absence



This graph shows the absolute number of absences across the Trust on a Day by Day basis. Reasons for absence such as Pregnancy, training, annual leave are not included within these figures. The recent cessation of shielding can be seen in the steep reduction in April with regard to covid related absences. There has been a gradual increase in absence since June as restrictions have been lifted and cases begin to rise in the wider community again.

6. STAFF TESTING

This section details the numbers of staff who have been swabbed whilst the figures following report the details on the levels of positive results. There was quite a fluctuation in the numbers requiring swabs with a rise in February and March linked to schools returning but generally with very few results being positive. More recently we are starting to experience a small increase in the numbers of colleagues testing positive.

Table 2 – Staff Testing Figures

Date	March	April	May	June	July	August	September
Total	363	805	869	437	447	286	593
Date	**October**	**November**	**December**	**January**	**February**	**March**	**April**
Total	1352	443	225	183	400	405	123
Date	**May**	**June**	**July**	**August**	**September**	**October**	**November**
Total	142	102					

Figure 4 – Swabbing data March 2020 to April 2021

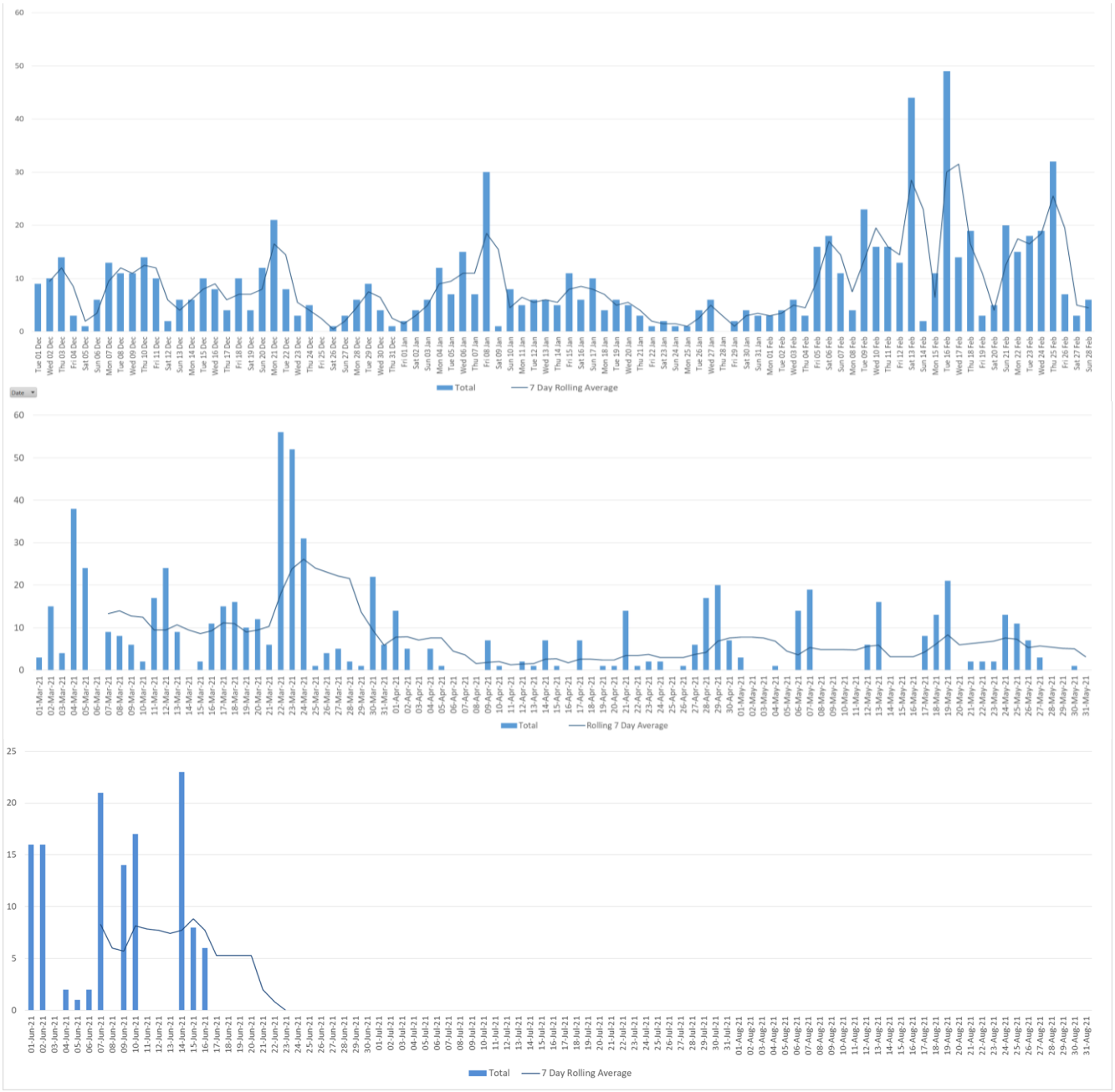
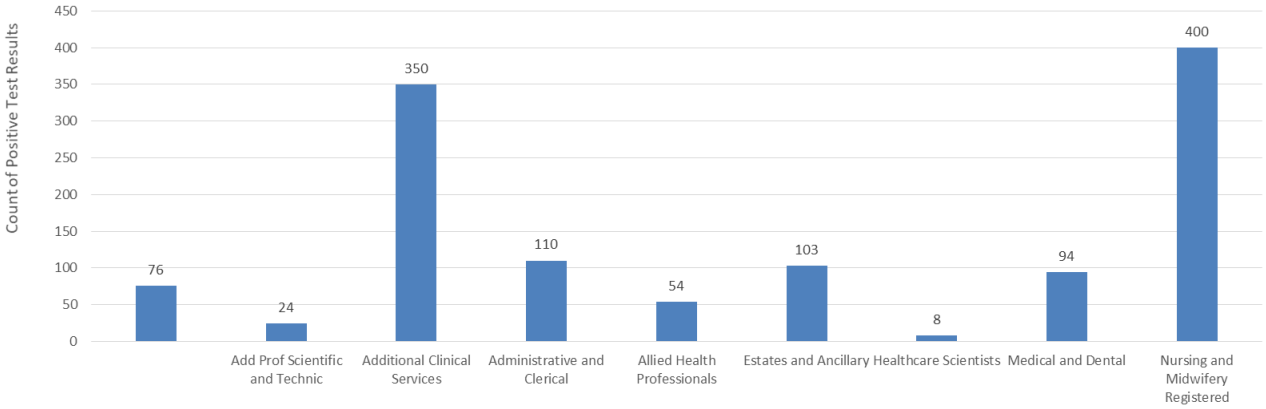


Table 3 – Number of Covid 19 Positive Test Results, by Staff Group

Count of PKAbsenceID	Colun																
Row Labels	2020/03	2020/04	2020/05	2020/06	2020/07	2020/08	2020/09	2020/10	2020/11	2020/12	2021/01	2021/02	2021/03	2021/05	2021/06	No Date	Grand Total
	7	17	7					11	13	11	3	3	4				76
Add Prof Scientific and Technic	3	4	3				1	3	2	4	3	1					24
Additional Clinical Services	5	41	53	24	2		3	80	58	54	21	7	2				350
Administrative and Clerical	4	17	6	1	1		1	18	22	20	8	6	6				110
Allied Health Professionals	3	4	15	1			1	6	9	7	5	3					54
Estates and Ancillary	2	11	15	6			1	22	12	15	16	3					103
Healthcare Scientists	2		2							1	1	2					8
Medical and Dental	20	16	10	1			1	10	7	20	5	1	1		1	1	94
Nursing and Midwifery Registered	16	68	62	13	4	1	5	70	62	47	25	16	9	1	1		400
Grand Total	**62**	**178**	**173**	**46**	**7**	**1**	**13**	**220**	**185**	**179**	**87**	**42**	**22**	**1**	**2**	**1**	**1219**

Figure 5 – Total number of Covid 19 Positive results, Mar 20 – current



7. LATERAL FLOW TESTING

Over 5,500 staff are reporting their test results with 0.31% of tests currently returning a positive result. Whilst we have had sufficient supply of testing kits to facilitate all staff working on site to have access to the tests this is now changing nationally to staff having to request future testing kits from the national portal.

To date we have had 221 positive Lateral Flow Test (LFT) results of which 169 have then been confirmed as Covid positive via a follow-up PCR test. 50 LFT's were negative and for two staff there is no PCR swab result. This equates to 76.5% of LFT's resulting in a positive PCR.

8. COVID AND FLU VACCINATION

All DBTH staff have now had the opportunity to have their vaccination with circa 90% of all staff having received a first vaccine and the same colleagues having had the opportunity to receive a second dose. As we are no longer vaccinating on site (having completed our vaccination programme) colleagues who do now wish to receive the vaccine are being directed to the national booking service and locally through the PCNs and their GPs. Discussions have now commenced about the flu vaccination and whether a booster covid vaccination is required.

The Joint Committee on Vaccination and Immunisation have now published their interim guidance on booster vaccinations which states:

> *'JCVI advises that any potential booster programme should begin in September 2021, in order to maximise protection in those who are most vulnerable to serious COVID-19 ahead of the winter months. Influenza vaccines are also delivered in autumn, and JCVI considers that, where possible, a synergistic approach to the delivery of COVID-19 and influenza vaccination could support delivery and maximise uptake of both vaccines.*

As such, pending further details we have started to plan to provide the third booster dose and flu vaccinations from September onwards.

Appendix Level1

OUR VISION : To be the safest trust in England, outstanding in all that we do

True North Strategic Aim 4 – In recurrent surplus to invest in improving patient care

Risk Owner: Jon Sargeant **Committee: F&P**	**People, Partners, Performance, Patients**	**Date last reviewed :July 2021**	
Strategic Objective In recurrent surplus to invest in improving patient care **Breakthrough Objective** Every team achieves their financial plan for the year	**Risk Appetite:** The Trust has a **low appetite** for risks **Measures:** • Delivery of in year financial plan/budgets • Underlying/recurrent financial position of the Trust • Trust Cash Balances	**Initial Risk Rating** **Current Risk Rating** **Target Risk Rating**	5(C) x 5(L) = 25 extr 5(C) x 4(L) = 20 extr 3(C) x 3(L) = 9 low
Risks: • Lack of clarity regarding the future NHS financial regime: ➢ Trust's underlying deficit financial position ➢ Limited capital funding • Uncertainty with regards to the future of Commissioning arrangements. • Culture Risk – Impact of COVID on re-engaging Divisions with financial processes and controls • Robust plans required for the delivery of operational activity requirements in H1 within baseline resource and funding. • Significant theatre staffing issues were not foreseen by the Division within the workforce plan, leading to expensive agency spend and presents a risk to the delivery of activity plans. • Some areas of delivery falling behind plans whilst the overall income is holding up, suggests that the Trust could be earning higher levels of income. • Significant issues surround CSS division maybe need considerable investment to rectify in the short-term. Lack of clarity of plans and reasons for changes in level of delivery require further investigation. • Delivery of ERF - Guidance (including those requirements that are not activity related) is not currently clear in terms how this will be measured or achieved). - ICS hold/manage all funding and are developing a financial framework for ERF which will likely lead to orgs who under-deliver against targets losing funding. - The change of the funding regime around the ERF means that the additional work to deliver the target will not be funded as previously was the case. This potentially incurs a £6m loss for the Trust, unless support comes from the ICS. • Lack of clarity in terms of the Trust's bed plan and therefore costs of workforce plans, against a background of increasing temporary staffing spending suggesting a lack of control with some areas of the Trust. • H2 – partial guidance provided for H2 now states that CIP will be required and that Covid Support will be tapered out. Final rules and absolute targets will not be available until potentially September 2021 leaving little time for implementation. • Impact of major incident at W&C on delivery of 21/22 capital and revenue plan. o The capital budget cost of £12.5m needs to be resolved with the ICS or NHSE/I. o The incident highlights significant risks concerning the funding route for and delivery of backlog maintenance costs. Specialist reports are being commissioned and will be discussed with the Trust Board.	**Rationale for risk current score:** • Currently the Trust is in a significant underlying deficit position with significant uncertainty regarding the future financial regime and availability of capital. This impacts on: • Trust's ability to invest in its services and infrastructure and maintain a sustainable site as its asset base ages further. • Delivery of safe and sustainable services for patients including any backlogs in activity due to COVID. • Ensuring the sustainability and safety of the Doncaster site. • Impacts on Trust reputation with potential regulatory action • Impacts on level of input and influence with regards to local commissioning.	**Future risks:** NHS Sector financial landscape Regulatory Intervention • National guidance is awaited regarding understand how the financial regime will impact the Trust this year and into future years. • Change in financial regimes in relation to ICS and Place budgets • Return to control totals and trajectories in future years • Increasing costs relating to old and poorly maintained buildings requiring increasing interventions to main the utility of the site **Risk references:** • **F&P1, 2 and 3** • **F&P2** • **F&P3** **Opportunities:** • Change in practices, new ways of working	
Controls / assurance (mitigation & evidence of making impact): • Budget setting and business planning • Key Financial Control Processes: Vacancy Control Panel, CIG, Grip and Control, Capital Monitoring Committee, Cash Committee. • External and Internal Audit • Reporting to Board, F&P and Audit Committee, ICS and NHSE/I • ICS DoFs and Contract Board with Commissioners • Accelerator Board review.	**Comments:** • The indications nationally are that previous years spend levels will be used as the basis of reviewing and setting financial positions. Since the Trust had not implemented a number of now agreed business cases/commitments (e.g. ED etc.) or recruited to establishment levels (e.g. nursing), these along with any other increase in the expenditure run rate above previous years levels will be challenged and likely not funded.	**Assurance (evidence of making an impact):** • Delivery of financial position • Improvement in underlying financial position • Improvement in site infrastructure • Internal and External Audit • Feedback from NHSI/E	

• Improved IQPRS and information governance process via the Finance, Information and Digital Committee • Working with the ICS through CEO's and DoFs regarding the rules on ERF and funding arrangements. Reporting back through F&P and Board.	• Currently there is no clear route to funding for significant builds. Limited capital will impact on the Trust's ability to invest in the Trust's infrastructure, especially with regards to ensuring the sustainability and safety of the Doncaster site.	**Gaps in controls / assurance (actions to achieve target risk score):** • Uncertainty regarding future financial regime

Report Cover Page					
Meeting Title:	**Trust Board**				
Meeting Date:	**20/7/21**	**Agenda Reference:**	**E2**		
Report Title:	**Financial Performance – Month 3 (June) 2021**				
Sponsor:	**Jon Sargeant - Director of Finance**				
Author:	**Alex Crickmar – Deputy Director of Finance** **Jon Sargeant - Director of Finance**				
Appendices:	N/A				
Executive Summary					
Purpose of report:	To report the Month 3 financial position to the Trust Board including any risks to the delivery of the Trust's financial plan.				
Summary of key issues:	The Trust's surplus for month 3 (June 2021) was £596k, which is £615k favourable to plan. The Trust's Year to Date (YTD) surplus is £1,287k, which is £1,049k favourable to plan. The favourable variance against plan YTD is mainly driven by a favourable position on ERF, which is £0.8m favourable to plan. Pay spend however continues to increase on previous months with pay spend increasing by £644k since April (£435k from May to June). The increase in spend over the previous months is due to bank and agency spend increasing, especially in Nursing. As part of a national update on potential funding arrangements for H2, the Trust has been informed that the ERF thresholds have now been increased from 85% in Q2 to 95%. This causes a significant risk to delivery of the Trusts financial plan as ERF will now be significantly lower than previously expected. This change in financial arrangements and also other potential changes in H2 (e.g. an efficiency requirement) are being reviewed by the Trust, with an initial impact assessment being presented to Finance and Performance Committee in July. Capital expenditure spend in month 3 is £3.9m. YTD capital expenditure is £6.0m against the plan of £2.7m. YTD capital expenditure is £3.3m ahead of the plan, mainly due to the Women's & Children's modular costs (£3.3m) and donated assets. The cash balance at the end of June was £38m (May: £44.5m). Cash has reduced by c £6.5m as a result of the Trust paying capital invoices totalling £3m in month, as well as non-NHS revenue spend of £3m. Some of this cash spend relates to expenses relating to previous periods (e.g. Sodexo). A review of the increase in cash spend in month is being undertaken as part of updating the cash flow cash forecast which will help determine whether any of the increase in the cash spend is recurrent.				
Recommendation:	The Board is asked to note: • The Trust's surplus for month 3 (June 2021) was £596k, which is favourable to plan by £615k. (£1,287k surplus YTD and £1,049k favourable to plan YTD).				
Action Require:	Approval	Information X	Discussion	Assurance	Review

Link to True North Objectives:	TN SA1:	TN SA2:	TN SA3:	TN SA4:
	To provide outstanding care for our patients	*Everybody knows their role in achieving the vision*	*Feedback from staff and learners is in the top 10% in the UK*	***The Trust is in recurrent surplus to invest in improving patient care***

Implications	
Board assurance framework:	This report relates to strategic aims 2 and 4 and the revised BAF risk F&P1.
Corporate risk register:	See above
Regulation:	No issues
Legal:	No issues
Resources:	No issues

Assurance Route			
Previously considered by:	N/A		
Date:		**Decision:**	
Next Steps:			
Previously circulated reports to supplement this paper:			

FINANCIAL PERFORMANCE

Month 3 – June 2021

Doncaster & Bassetlaw Teaching Hospitals NHS Foundation Trust

P3 June 2021

1. Income and Expenditure vs. Plan

Performance Indicator	Monthly Performance		YTD Performance		
	Actual £'000	Variance to budget £'000	Actual £'000	Variance to budget £'000	H1 Budget £'000
I&E Perf Exc Impairments & top up	(517)	(410) F	(1,332)	(1,038) F	0
Income	(39,879)	0 A	(120,137)	(1,834) F	(239,364)
Operating Expenditure	37,887	(423) F	114,370	760 A	230,628
Pay	25,031	72 A	74,024	(317) F	149,617
Non Pay & Reserves	12,857	(495) F	40,346	1,077 A	81,011
Financing costs	1,396	(193) F	4,480	26 A	8,786
I&E Performance excluding Donated Asset adjustment	**(517)**	**(410) F**	**(1,332)**	**(1,038) F**	**50**
Donated Asset adjustment	(79)	(205) F	45	(11) F	(50)
I&E Performance including Donated Asset Adjustment	**(596)**	**(615) F**	**(1,287)**	**(1,049) F**	**0**

F = Favourable A = Adverse

Financial Sustainability Risk Rating	Plan	Actual
Risk Rating	3	3

2. CIPs

Performance Indicator	Monthly Performance		YTD Performance		Annual
	Actual £'000	Variance to budget £'000	Actual £'000	Variance to budget £'000	Plan £'000
Local	329	218 A	758	218 A	2,705
Procurement & Commercial	23	(2) F	27	13 A	137
Nursing and AHP workforce	0	0 A	0	0 A	20
Outstanding Outpatients	1	(1) F	1	(1) F	0
Total	**353**	**216 A**	786	**230 A**	**2,862**

3. Statement of Financial Position

All figures £m	Opening Balance	Closing balance	Movement in year
Non Current Assets	**235,884**	**241,907**	**6,023**
Current Assets	74,793	69,537	**-5,256**
Current Liabilities	-72,376	-68,779	**3,597**
Non Current liabilities	-14,787	-13,969	**818**
Total Assets Employed	**223,514**	**228,696**	**5,182**
Total Tax Payers Equity	**-223,514**	**-228,696**	**-5,182**

4. Other

Performance Indicator	Monthly Performance		YTD Performance		Annual
	Plan £'000	Actual £'000	Plan £'000	Actual £'000	Plan £'000
Cash Balance		37,991		37,991	21,259
Capital Expenditure	884	3,917	2,739	5,964	18,900

5. Workforce

	Funded WTE	Actual WTE	Bank WTE	Agency WTE	Total in Post WTE
Current Month	6,241	5,707	258	300	6,265
Previous Month	6,240	5,766	160	106	6,032
Movement	-1	59	-98	-194	-233

Key

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

1. Month 3 Financial Position Highlights

Summary Income and Expenditure – Month 3

	Mth 3			YTD	
	Plan	Actual	Variance	Actual	Variance
	£000	£000	£000	£000	£000
Income	**-39,879**	**-39,879**	**0**	**-120,137**	**-1,834**
Pay					
Substantive Pay	22,984	22,480	-504	66,869	-1,481
Bank	621	1,021	400	2,796	945
Agency	778	932	154	2,520	108
Recharges	576	597	21	1,839	112
Total pay	**24,959**	**25,031**	**72**	**74,024**	**-317**
Non-Pay					
Drugs	880	928	48	2,632	150
Non-PbR Drugs	1,649	1,746	97	5,235	387
Clinical Supplies & Services	2,774	2,857	83	8,133	-131
Other Costs (including reserves)	6,746	5,536	-1,210	19,446	-323
Recharges	1,302	1,790	488	4,900	994
Total Non-pay	**13,351**	**12,857**	**-495**	**40,346**	**1,077**
Financing costs & donated assets	**1,588**	**1,396**	-193	**4,480**	**26**
(Surplus) / Deficit Position as at month 3	**19**	**-596**	**-615**	**-1,287**	**-1,049**

The Trust's surplus for month 3 (June 2021) was £596k, which is £615k favourable to plan. The Trust's Year to Date (YTD) surplus is £1,287k, which is £1,049k favourable to plan. The favourable variance against plan YTD is mainly driven by a favourable position on ERF, which is £0.8m favourable to plan.

Pay in month was £72k adverse to plan, and continues to increase on previous months with pay spend having increased by £644k since April (£435k from May to June). The overspend in month against budget is mainly driven by bank spend over and above the workforce plans, with the increase in spend over the previous months due to bank and agency spend increasing, especially in Nursing.

Non-pay (excluding reserves and recharges) was c.£0.5m overspent in month, however this was a reduction in spend on last month of £0.6m. The main reason for the reduction in spend month on month was due to the receipt of rates rebate in month of £0.6m. The overspend in month against budget was driven by:

- £145k on drugs which was mainly in the Medical Division, due to biologics/immunosuppressives that decreased during COVID but are now increasing.
- £82k on clinical supplies mainly in CSS who are £115k above budget in month. This is due to £110k additional spend in Theatres & Day Surgery, plus £58k additional spend in Pathology.
- £258k within other costs, which is driven by £84k of spend relating to the W&C major incident, £54k on CNST and £67k relating to an increase in bad debt (offset by increase in income on overseas).

Within reserves the Trust has included £1m of costs relating to the Women's and Children's incident and provides for an allowance for the temporary supply of facilities/buildings for lost capacity.

The vast majority of clinical income continues to be funded on block basis as per the national agreements for H1, and therefore there are no significant variances to plan. In month clinical income is £35.1m, which is a reduction compared to the previous month of £450k, which is primarily caused by a lower performance on

ERF funding (in part caused by the increase in the ERF target from 75% in month 2 to 80% in month 3). ERF has over-performed against plan by £809k YTD but under-performed against plan by £108k in month.

	Plan £	Actual £	Movement £
2019/20 Baseline	**10,658,951**	**10,658,951**	**0**
Capacity Plans	**9,378,132**	**9,269,836**	**-108,296**
% Achievement - Inc. ISP	88%	87%	-1%
Target Achievement	80%	80%	
Tariff Funding - Excluding Independent Sector	145,308	358,810	213,502
Tariff Funding - Including Independent Sector	850,970	742,675	-108,296

As part of a national update on potential funding arrangements for H2, the Trust has been informed that the ERF thresholds have now been increased from 85% in Q2 to 95%. This causes a risk to delivery of the Trusts financial plan as ERF will now be significantly lower than previously expected. This change in financial arrangements and also other potential changes in H2 (e.g. an efficiency requirement) are being reviewed by the Trust, with an initial impact assessment being presented to Finance and Performance Committee in July.

Non-Clinical income was c£0.2m adverse to budget in month (excluding recharges and donated assets) which was mainly due to a reduction in notified LDA funding (Education and Training) of £0.2m.

Capital expenditure spend in month 3 is £3.9m. YTD capital expenditure is £6.0m against the plan of £2.7m. YTD capital expenditure is £3.3m ahead of the plan, mainly due to the Women's & Children's modular costs (£3.3m) and donated assets.

The Trust delivered £353k CIPs in month 3 compared to an NHSI plan of £569k. This represents an under-delivery of £216k. Year to date the Trust's efficiency programme has delivered £786k against a plan of £1,016k an overall under-delivery of £230k. The major scheme delivering in month relates to the rates rebate.

The cash balance at the end of June was £38m (May: £44.5m). Cash has reduced by c £6.5m as a result of the Trust paying capital invoices totalling £3m in month, as well as non-NHS revenue spend of £3m. Some of this cash spend relates to expenses relating to previous periods (e.g. Sodexo). A review of the increase in cash spend in month is being undertaken as part of updating the cash flow cash forecast which will help determine whether any of the increase in the cash spend is recurrent.

2. Recommendations

The Board is asked to note:

- The Trust's surplus for month 3 (June 2021) was £596k, which is favourable to plan by £615k. (£1,287k surplus YTD and £1,049k favourable to plan YTD).

Report Cover Page			
Meeting Title:	Board of Directors		
Meeting Date:	20th July 2021	**Agenda Reference:**	**E3**
Report Title:	Estates Return Information Collection (ERIC) 2020/2021		
Sponsor:	Jon Sargeant – Director of Finance		
Author:	Kirsty Edmondson-Jones – Director of Estates and Facilities		
Appendices:	Appendix 1: ERIC Return Trust Level Report 2020/2021 Appendix 2: ERIC Return Site Level Report 2020/2021		

Report Summary	
Purpose of report:	This Estates Return Information Collection (ERIC) forms the central collection of Estates and Facilities data from all NHS organisations in England providing NHS funded secondary care during the fiscal year ending 31st March 2021. ERIC data provides the Government with essential information relating to the safety, quality, running costs and activity related to the NHS estates and also supports work to improve efficiency. It is critical that the data provided for the ERIC return is of the highest quality in terms of its accuracy as well as being consistent with other Trusts to deliver full confidence in the data submitted, which is used to: • Populate the Model Hospital and provide accurate benchmarks for NHS Trusts; • Support the Secretary of State's accountability to Parliament for the funds allocated to the NHS (which includes the running of the estate); and • Develop strategic plans for individual NHS estates. In addition, the Standard Contract requires the data to be collected in accordance with specific reporting criteria at Trust and Site level to ensure information provided is meaningful, usable and transparent.
Summary of key issues/positive highlights:	• Increase in backlog maintenance from £81,657,129 to £149,360,164 delivering an overall increase of 82.91%, with information provided by the new 6 facet survey undertaken by external consultancy Oakleaf. • Increase in Public Sector investment (Trust Capital Programme) from £16,754,000 to £32,634,000 delivering an overall increase of 94.78%, due to an increase in the size of the Capital programme, and funding through Public Dividend Capital (PDC). • Decrease in Management (Hard and Soft FM) costs on all three Trust sites due to revised categorisation of Director and Senior management positions and other management costs associated with individual services re-aligned, resulting in a reduction of £0.7m (58%). • Increase in Not functionally suitable occupied floor area at Doncaster Royal Infirmary (DRI from 39% to 96% and Mexborough Montagu Hospital M 24% to 54% assessed for physical condition and compliance ranking un-satisfactory below condition B (functionally suitable space) is provided by the new 6 facet survey undertaken by external specialist survey consultancy Oakleaf. • Increase in Not functionally suitable - clinical space at DRI from 29% to 68% and MMH 24% to 44% assessed for physical condition and compliance

	ranking un-satisfactory below condition B (functionally suitable space) is provided by the new 6 facet survey undertaken by Oakleaf. • Increase in Floor area - under used on all three sites due primarily to Covid restrictions and reduction in patient activity, within the reporting year delivering figures for DRI 18%, MMH 23% and Bassetlaw District General Hospital (BDGH) 22%. • Overall increase of £0.2m (19%) in Waste Management distribution of costs and volumes due primarily to the Covid 19 pandemic, main waste management contract costs, waste stream segregation and innovation.
Recommendation:	The Director of Finance is assured through internal audit that data provided is complete, accurate and up-to-date. Board of Directors note the information enclosed on the ERIC 2020/2021 submission which was required to be committed through EFM Information, HSCIC (NHS DIGITAL) on 01/07/2021 and released into the public domain in October 2021 as part of the full ERIC returns report.

Action Require:	Approval	Information	Discussion	~~Assurance~~	Review

Link to True North Objectives:	**TN SA1:**	**TN SA2:**	**TN SA3:**	**TN SA4:**
	~~*To provide outstanding care for our patients*~~	*Everybody knows their role in achieving the vision*	*Feedback from staff and learners is in the top 10% in the UK*	~~*The Trust is in recurrent surplus to invest in improving patient care*~~

Implications	
Board assurance framework:	N/A
Corporate risk register:	**F&P 4** Failure to ensure that estates infrastructure is adequately maintained and upgraded in line with current legislation, standards and guidance. Note: A number of different distinct risks are contained within this overarching entry. For further details please consult the E&F risk register. **F&P12** Failure to ensure that estates infrastructure is adequately maintained and upgraded in accordance with the Regulatory Reform (Fire Safety) Order 2005 and other current legislation standards and guidance. Note: a number of different distinct risks are contained within this overarching entry. For further details please consult the EF risk register. **F&P17/Q&E12** Risk of critical lift failure **E&F 2335** Failure to adequately meet the demand of PPM completion due to insufficient resource within the Estates department resulting in a risk of regulatory non-compliance. Note: Identified following an NHS/Qii review of the Estates workforce at DBTH. For further details please consult the EF risk register.
Regulation:	The ERIC return for 2020/2021 has received approval from the Standardisation Committee for Care Information (SCCI).
Legal:	Mandatory requirement to ensure compliance under the terms of section 259 of the Health and Social Care Act 2012.
Resources:	N/A

Assurance Route	
Previously considered by:	None

Date:	N/A	**Decision:**	N/A
Next Steps:		Data provision from the ERIC return to inform expenditure and provide evidence required to support business cases for that expenditure. ERIC provides such evidence in relation to estates & facilities, also including any local investment planning. Data collected through ERIC is also used to benchmark the Trust against other trusts to determine levels of efficiency, safety and quality.	
Previously circulated reports to supplement this paper:		N/A	

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Figure 2: Management Cost (Hard and Soft FM) Variance Report for 2020/2021
Figure 3: Waste Management Variance Report for 2020/2021

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Table 1: Public Investment Increase for 2020/2021

1. Executive Summary

The ERIC return forms the central collection of Estates and Facilities data from all NHS organisations in England providing NHS funded secondary care during the fiscal year ending 31st March. ERIC data provides the Government with essential information relating to the safety, quality, running costs and activity related to the NHS estates and also supports work to improve efficiency. It is therefore critical that the data provided is of the highest quality in terms of its accuracy as well as being consistent with other trusts.

The Department of Health and Social Care (DHSC) and Arm's Length Bodies (ALBs) - DHSC is accountable to the public and to Parliament for the NHS, including its funding, and therefore its estates & facilities. It therefore requires data to ensure this, including the ability to determine the level of efficient use of such funding. In addition to funding, data is also required by DHSC and its ALBs to make decisions on areas of policy, e.g. investment planning and income generation.

NHS Regulators - The NHS Constitution now includes the following: "You have the right to be cared for in a clean, safe, secure and suitable environment." The NHS Regulators, therefore, will include the environment, the estate and its facilities services in their review process. The ERIC data is a key element in the review of and making decisions on inspections.

The following report provides data collected for the 2020/2021 ERIC return for Doncaster and Bassetlaw Teaching Hospitals Foundation Trust (DBTH) at Trust Level (Appendix 1) and individual Site Level (Appendix 2). The data and financial information was provided for the return by the Trust Finance Department, Estates and Facilities responsible mangers and external consultants Oakleaf. The return has been verified by the Trust Finance department against the financial ledger, with a full Trust 6 facet survey providing accurate backlog maintenance information. The Key issues from the report include;

- Increase in backlog maintenance from £81,657,129 to £149,360,164 delivering an overall increase of 82.91%, with information provided by the new 6 facet survey undertaken by external specialist surveying consultancy Oakleaf.
- Increase in Public Sector investment (Trust Capital Programme) from £16,754,000 to £32,634,000 delivering an overall increase of 94.78%, due to an increase in the size of the Capital programme, and funding through PDC.
- Decrease in Management (Hard and Soft FM) costs on all three Trust sites due to revised categorisation of Director and Senior management positions and other management costs associated with individual services re-aligned, resulting in a reduction of £0.7m (58%).
- Increase in Not functionally suitable occupied floor area at DRI from 39% to 96% and MMH 24% to 54% assessed for physical condition and compliance ranking un-satisfactory below condition B (functionally suitable space) is provided by the new 6 facet survey undertaken by Oakleaf.
- Increase in Not functionally suitable - clinical space at DRI from 29% to 68% and M 24% to 44% assessed for physical condition and compliance ranking un-satisfactory below condition

B (functionally suitable space) is provided by the new 6 facet survey undertaken by external consultancy Oakleaf.

- Increase in Floor area - under used on all three sites due primarily to Covid restrictions and reduction in patient activity, within the reporting year delivering figures for DRI 18%, MMH 23% and Bassetlaw District General Hospital (BDGH) 22%.
- Overall increase of £0.2m (19%) in Waste Management distribution of costs and volumes due primarily to the Covid 19 pandemic, main waste management contract costs, waste stream segregation and innovation.

2. Report

2.1 Backlog Maintenance

Following commissioning of a full trust 6 facet survey providing accurate backlog maintenance information, space functionality and suitability previously estimated against the 2015 Nifes 6 facet survey, internal risk assessment and investment reviews; an overall increase in backlog maintenance for the trust from £81,657,129 to £149,360,164 delivering a percentage increase of 82.91% for the reporting period 2020/2021 has been provided by Oakleaf.

The Backlog maintenance increase is presented in Figure 1 illustrating a breakdown of the high value backlog items from the lower costed backlog items within the new Trust 6 facet survey.

The inflation increase for the reporting year is identified for BDGH and MMH, calculated by using the Building Cost Information Service (BCIS) PUBSEC Tender Price Index of Public Sector Building Non-Housing at 2.5%, in accordance with ERIC returns data requirements.

Capital investment to reduce Backlog maintenance for the reporting year is also presented figure 1 illustrating the impact of the NSHE/I funding for Critical Infrastructure Risk reduction with the overall back of figure for 2020/2021.

2.2 Main ERIC Return Variances

A decrease in Management (Hard and Soft FM) costs on all three trust sites to only include Director and Senior management positions is illustrated in figure 2, with all other management costs associated with individual services re-aligned. This delivers a reduction of 61.40% (£365,631) at DRI, 44% (£133,384) at BDGH and 54.68% (£46,396) at MMH.

An increase in public sector investment from £16.8m in 2019/20 to £32.6m in 2020/21 is illustrated in table 1. This is due to an increase in the size of the reporting year's capital programme; a majority of which was funded through PDC (£18.1m), with £9.4m of the funding relating to the Critical Infrastructure Risk funding provided by NHS England and NHS Improvement (NHSE/I).

Fictional suitability of space assessed for physical condition and compliance ranking un-satisfactory below condition B (functionally suitable space) is provided from the new 6 facet survey undertaken by Oakleaf. The 6 facet survey identified a large increase in Not functionally suitable occupied floor

area at DRI from 39% to 96% and MMH from 24% to 54%; Not functionally suitable clinical space also increased at DRI from 29% to 68% and MMH from 24% to 44%. An Increase in Floor area under used on all three sites due primarily to Covid restrictions and reduction in patient activity was identified from Divisional General Managers and E&F Management, resulting in increases at DRI of 18%, MMH 23% and BDGH 22% within the reporting year.

Finally both increase and decrease in Waste Management distribution of costs and volumes due primarily to the Covid 19 pandemic, main waste management contract costs, waste stream segregation and innovation is presented in Figure 3.

Figure 1: Backlog Maintenance Increase for 2020/2021 Including Investment to Reduce Backlog

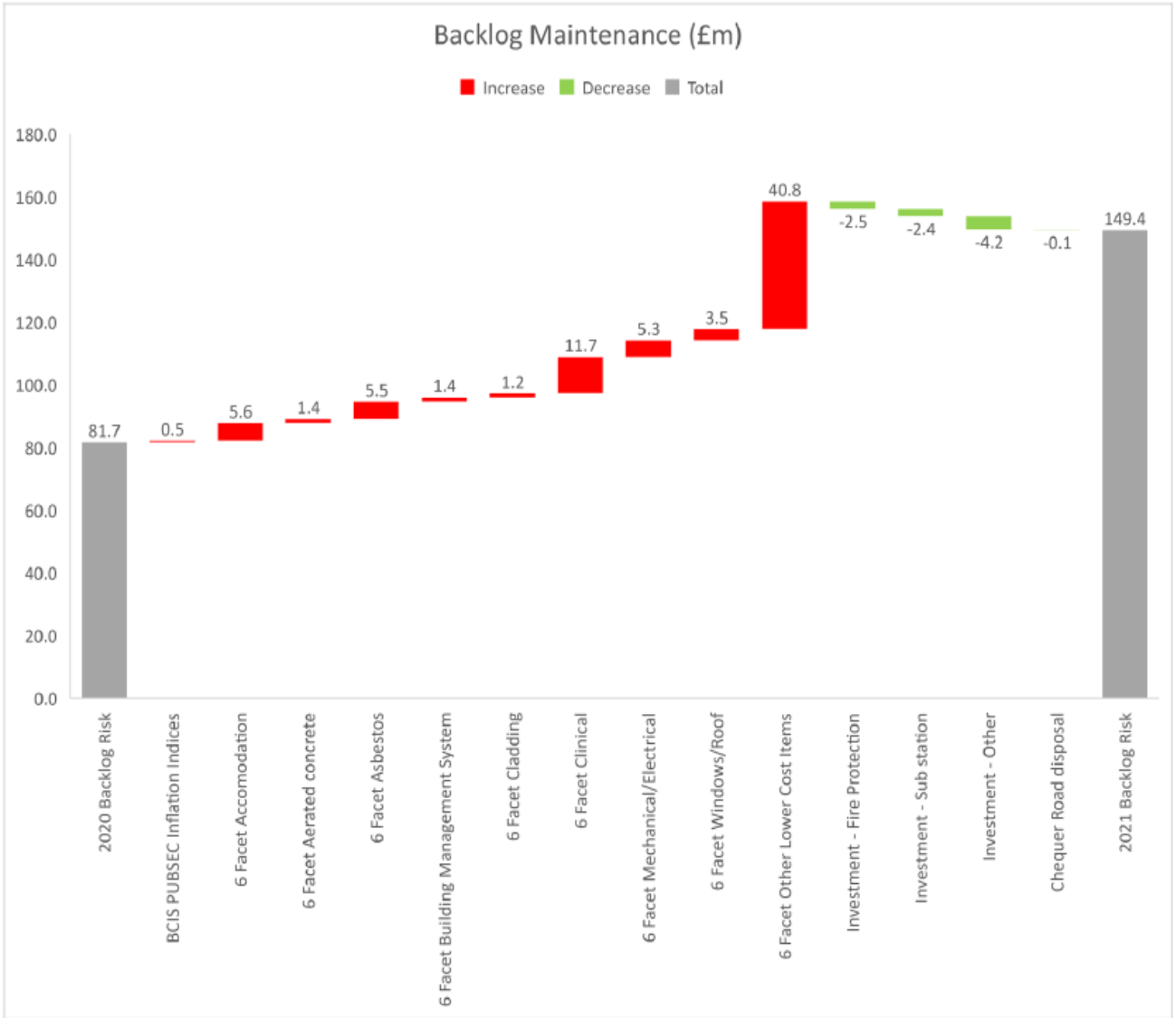


Figure 2: Facilities Management Costs Variance Report for 2020/2021

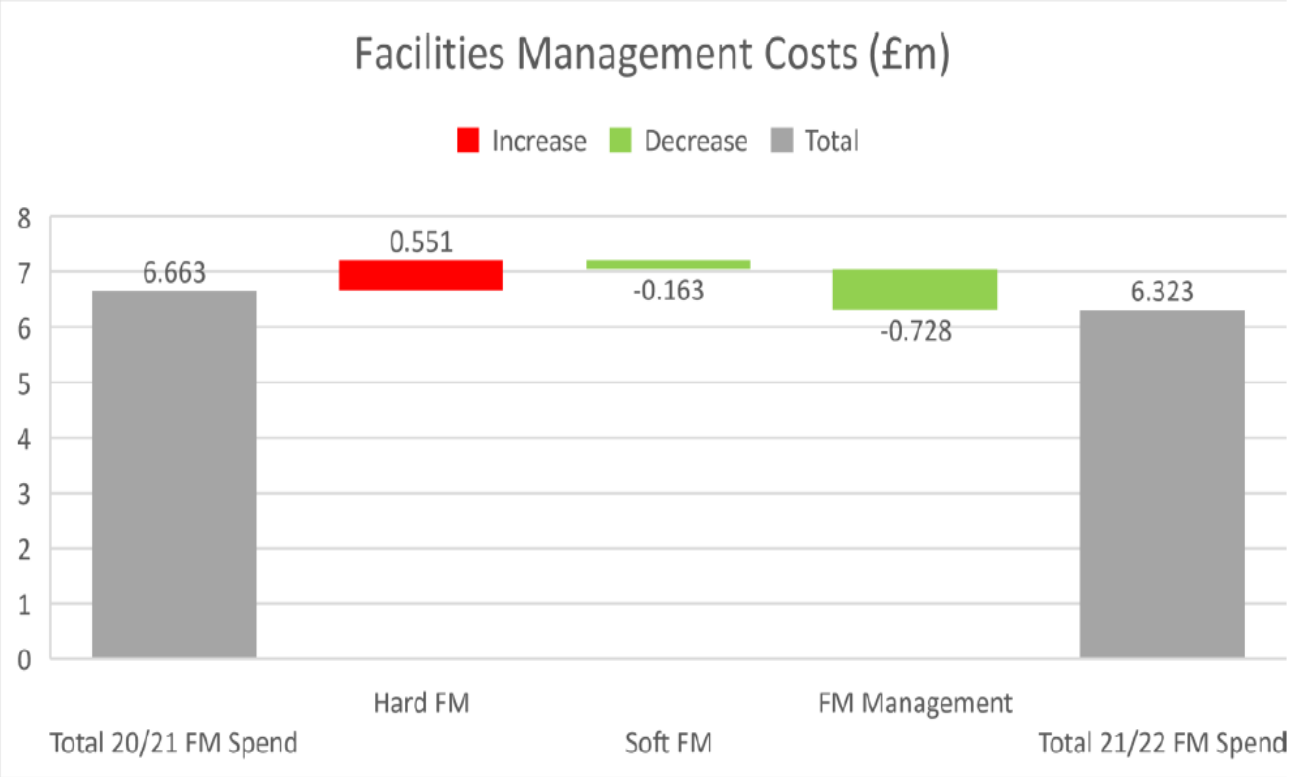
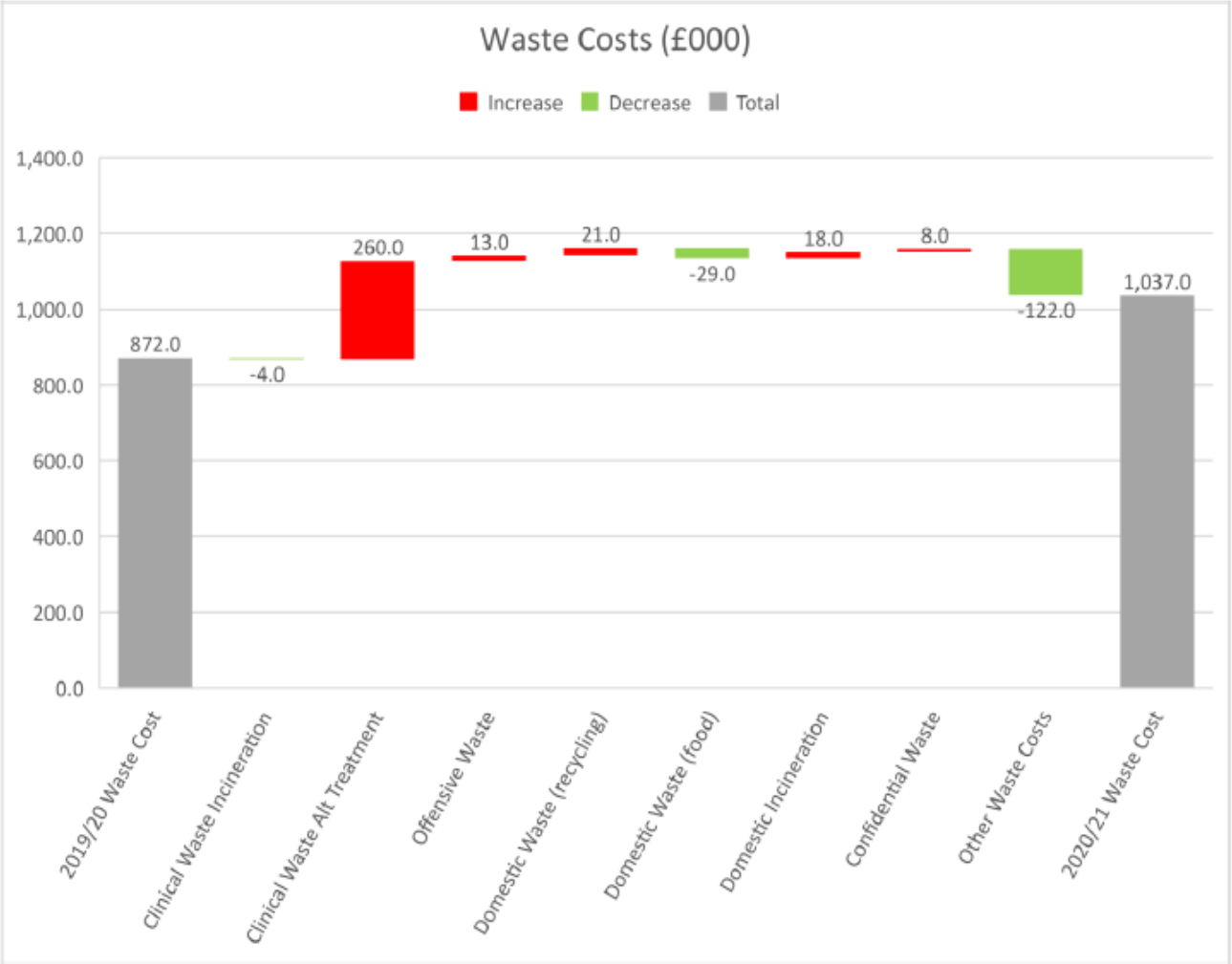


Table 1: Public Investment Increase for 2020/2021

ERIC Definition Classification	Capital Scheme	Investment
Capital investment for equipment	Equipment	£11,309,000
Capital investment for maintaining (lifecycle) existing buildings	Lifecycle Costs	£1,293,000
Capital investment for changing/improving existing buildings	Essential Estates Work	£15,713,000
Capital investment for new build	Building Improvement	£4,319,000
Total Investment		**£32,634,000**

Figure 3: Waste Management Variance Report for 2020/2021



3. Appendices

Appendix 1: ERIC Return Trust Level Report 2020/2021

Trust Profile	Unit	Value
Number of sites - Community hospital (with inpatient beds)	No.	0
Number of sites - General acute hospital	No.	3
Number of sites - Learning Disabilities	No.	0
Number of sites - Mental Health (including Specialist services)	No.	0
Number of sites - Mental Health and Learning Disabilities	No.	0
Number of sites - Mixed service hospital	No.	0
Number of sites - Non inpatient	No.	3
Number of sites - Other inpatient	No.	0
Number of sites - Specialist hospital (acute only)	No.	0
Number of sites - Support facilities	No.	0
Sites included above that are unreported	No.	0
Sites leased from NHS Property Services	No.	2
Sites occupied without charges	No.	0
Total number of sites	No.	6
Notes		
Strategies, Policies and Sustainability	**Unit**	**Value**
Does the trust have a waste manager	Yes/No	Yes
Does the trust have a waste reuse scheme	Yes/No	Yes
Does the trust have an energy manager	Yes/No	No
Estates Development Strategy	Yes/No	Yes
Green energy usage	Yes/No	No
WEEE waste cost	£	7,660
WEEE waste volume	Tonnes	69.42
Notes		
Finance	**Unit**	**Value**
Capital investment for changing/improving existing buildings	£	8,005,979
Capital investment for equipment	£	13,560,618
Capital investment for maintaining (lifecycle) existing buildings	£	12,838,328
Capital investment for new build	£	267,074
Charity and/or grant investment	£	2,038,000
Energy efficient schemes costs	£	0
Investment to reduce backlog maintenance	£	9,156,961
Number of energy efficient schemes	No	0
Private sector investment	£	0
Public sector investment	£	32,634,000
Notes		

Contribution to costs	Unit	Value
Contribution to expenditure from areas leased out for retail sales	£	-205,232
Contribution to expenditure from local authorities	£	0
Contribution to expenditure from NHS organisations	£	-706,861
Contribution to expenditure from non NHS organisations	£	-667,484
Income from car parking - patients and visitors	£	-99
Income from car parking - staff	£	-137,129
Notes		
Safety	**Unit**	**Value**
Clinical service incidents caused by estates and infrastructure failure	No.	4
Estates and facilities related incidents	No.	4
Overheating occurrences triggering a risk assessment	No.	10
RIDDOR incidents	No.	20
Notes		
Fire Safety	**Unit**	**Value**
Deaths resulted from fires	No.	0
False alarms - Call out	No.	48
False alarms - No call out	No.	85
Fires recorded	No.	3
Injuries resulting from fires	No.	0
Patients sustaining injuries during evacuation	No.	0
Notes		
Medical Records	**Unit**	**Value**
Medical Records cost - Offsite	£	50,864
Medical Records cost - Onsite	£	2,271,983
Medical Records service provision	Select	Internal
Type of Medical Records	Select	3. Mixed

Appendix 2: ERIC Return Site Level Report 2020/2021

Facilities Management (FM) Services	Unit	BASSETLAW DISTRICT GENERAL HOSPITAL RP5BA	DONCASTER ROYAL INFIRMARY RP5DR	MONTAGU HOSPITAL RP5MM	OTHER REPORTABLE SITES RP5ORS
Depreciation	£	2,717,000	6,033,000	1,078,000	0
PDC	£	1,305,000	2,897,000	518,000	0
Leases and rent	£	10,310	26,850	3,586	522,605
Rates	£	589,771	1,169,775	217,532	0
Interest on Capital	£	93,000	206,000	37,000	0
Other Estates and Facilities finance costs	£	0	0	0	0
Indirect accommodation subsidies	£				0
Estates and property maintenance	£	1,156,764	3,227,679	237,826	0
Grounds and gardens maintenance	£	15,327	48,543	1,394	0
Electro Bio Medical Equipment maintenance	£	185,992	1,313,247	0	0
Other Hard FM (Estates) costs	£	568,266	913,304	125,123	238,503
Other Soft FM (Hotel Services) costs	£	1,019,828	2,491,025	430,972	0
Management (Hard and Soft FM) costs	£	133,384	356,631	46,396	0
Notes					
Areas	**Unit**	**BASSETLAW DISTRICT GENERAL HOSPITAL RP5BA**	**DONCASTER ROYAL INFIRMARY RP5DR**	**MONTAGU HOSPITAL RP5MM**	**OTHER REPORTABLE SITES RP5ORS**
Gross internal floor area	m²	37,785	106,564	14,261	2,843
NHS estate occupied floor area	%	100.00	100.00	100.00	0.00
Site heated volume	m³	112,825	276,094	36,427	8,010
Land area owned	Hectares	10.70	11.24	3.30	
Land area not delivering services	Hectares	1.60	0.23	0.64	
Private patient	m²	0	0	0	0

Pathology	m²	372	3,068	33	0
Clinical Sterile Services Dept. (CSSD)	m²	0	527	0	0
Clinical space - other	m²	24,591	64,530	9,622	2,843
Medical records	m²	500	1,317	256	0
Human Resources	m²	18	468	0	0
Information Technology	m²	313	373	29	0
General Administration	m²	722	2,956	519	0
Restaurants	m²	1,061	1,368	429	0
Staff Accommodation	m²	1,637	5,623	53	0
Non-clinical space - other	m²	7,904	25,976	2,943	0
Retail sales area	m²	0	357	0	0
Clinical space	m²	24,963	68,125	9,655	2,843
Non-clinical space	m²	12,155	38,081	4,229	0
Occupied floor area	m²	37,118	106,563	13,884	2,843
Notes					

Function and Space	Unit	BASSETLAW DISTRICT GENERAL HOSPITAL RP5BA	DONCASTER ROYAL INFIRMARY RP5DR	MONTAGU HOSPITAL RP5MM	OTHER REPORTABLE SITES RP5ORS
Not functionally suitable - occupied floor area	%	34.00	96.00	54.00	0.00
Not functionally suitable - clinical space	%	22.00	68.00	44.00	0.00
Floor area - empty	%	0.00	0.00	0.00	0.00
Floor area - under used	%	22.00	18.00	23.00	0.00
Single bedrooms for patients with en-suite facilities	No.	26	115	23	0
Single bedrooms for patients without en-suite facilities	No.	23	92	6	0
Isolation rooms	No.	0	6	0	0
Notes					

Quality of Buildings	Unit	BASSETLAW DISTRICT GENERAL HOSPITAL RP5BA	DONCASTER ROYAL INFIRMARY RP5DR	MONTAGU HOSPITAL RP5MM	OTHER REPORTABLE SITES RP5ORS
Cost to eradicate high risk backlog	£	7,911,284	11,365,720	123,012	0
Cost to eradicate significant risk backlog	£	5,321,309	97,638,220	2,059,118	0
Cost to eradicate moderate risk backlog	£	13,353,110	8,050,401	1,700,641	0
Cost to eradicate low risk backlog	£	446,105	1,268,950	122,294	0
Percentage of GIA that has had a risk adjusted backlog review	Select	81 - 100%	81 - 100%	81 - 100%	0
Methodology used to review costs to eradicate backlog	Select	Formal 6 facet survey	Formal 6 facet survey	Formal 6 facet survey	No review undertaken
Methodology used to review costs to eradicate backlog - Reason	Notes				
Relevant occupied floor area	m²				0
Notes					

Age Profile	Unit	BASSETLAW DISTRICT GENERAL HOSPITAL RP5BA	DONCASTER ROYAL INFIRMARY RP5DR	MONTAGU HOSPITAL RP5MM	OTHER REPORTABLE SITES RP5ORS
Age profile - 2015 to 2024	%	0.00	0.10	0.00	0.00
Age profile - 2005 to 2014	%	6.60	0.10	11.80	0.00
Age profile - 1995 to 2004	%	13.60	2.10	28.00	25.00
Age profile - 1985 to 1994	%	39.20	9.60	24.70	0.00
Age profile - 1975 to 1984	%	25.00	0.00	0.00	0.00
Age profile - 1965 to 1974	%	3.10	49.90	17.20	57.00
Age profile - 1955 to 1964	%	1.90	24.70	3.30	0.00
Age profile - 1948 to 1954	%	0.00	0.00	0.00	0.00
Age profile - pre 1948	%	10.60	13.50	15.00	18.00
Age profile - total (must equal 100%)	%	100.00	100.00	100.00	100.00
Notes					

CHP	Unit	BASSETLAW DISTRICT GENERAL HOSPITAL RP5BA	DONCASTER ROYAL INFIRMARY RP5DR	MONTAGU HOSPITAL RP5MM	OTHER REPORTABLE SITES RP5ORS
CHP units operated on the site	No.	0	0	1	0
CHP unit/s size - electrical	kW			110	
CHP unit/s size - thermal	kW			177	
CHP unit/s efficiency	%			81	
Fossil energy input to CHP system/s	kWh			2,049,320	
Thermal energy output of CHP system/s	kWh			1,019,520	
Electrical energy output of CHP system/s	kWh			633,240	
Exported electricity	kWh			0	
Exported thermal energy	kWh			0	
Have you dumped/discharged energy in the last year	Yes/No			No	
How many kWh were discharged to waste	kWh				
Notes					

Energy	Unit	BASSETLAW DISTRICT GENERAL HOSPITAL RP5BA	DONCASTER ROYAL INFIRMARY RP5DR	MONTAGU HOSPITAL RP5MM	OTHER REPORTABLE SITES RP5ORS
Electricity costs	£	737,598	1,839,909	123,976	0
Electricity consumed	kWh	5,340,063	13,154,443	798,309	0
Gas costs	£	319,038	1,040,422	182,559	0
Gas consumed	kWh	5,777,102	34,679,680	5,777,102	0
Oil costs	£	0	0	0	0
Oil consumed	kWh	0	0	0	0
Coal costs	£	0	0	0	0
Coal consumed	kWh	0	0	0	0

Electricity costs - green energy tariff	£	0	0	0	0
Electricity consumed - green energy tariff	kWh	0	0	0	0
Electricity costs - third party owned renewable	£	0	0	0	0
Electricity consumed - third party owned renewable	kWh	0	0	0	0
Non-fossil fuel costs - renewable	£	0	0	0	0
Non-fossil fuel consumed - renewable	kWh	0	0	0	0
Other energy costs	£	1,469	114,883	3,462	0
Steam consumed	kWh	0	0	0	0
Hot water consumed	kWh	0	0	0	0
Electrical energy output of owned onsite renewables	kWh	0	0	0	0
Relevant occupied floor area	m²				0
Notes					

Water Services	**Unit**	**BASSETLAW DISTRICT GENERAL HOSPITAL RP5BA**	**DONCASTER ROYAL INFIRMARY RP5DR**	**MONTAGU HOSPITAL RP5MM**	**OTHER REPORTABLE SITES RP5ORS**
Water and sewerage cost	£	136,738	438,203	49,040	0
Water volume (including borehole)	m³	38,640	145,561	11,939	0
Relevant occupied floor area	m²				2,843
Notes					

Waste	**Unit**	**BASSETLAW DISTRICT GENERAL HOSPITAL RP5BA**	**DONCASTER ROYAL INFIRMARY RP5DR**	**MONTAGU HOSPITAL RP5MM**	**OTHER REPORTABLE SITES RP5ORS**
Incineration (clinical waste) cost	£	11,773	47,034	1,065	358
Incineration (clinical waste) volume	Tonnes	4.25	38.83	0.71	0.45

Alternative Treatment (clinical waste) cost	£	67,376	298,393	18,405	379
Alternative Treatment (clinical waste) volume	Tonnes	94.35	408.89	21.70	0.31
Offensive waste cost	£	23,192	94,916	8,021	980
Offensive waste volume	Tonnes	61.60	252.42	21.70	2.03
Clinical waste processed on site cost (excluding incineration)	£	0	0	0	0
Clinical waste processed on site volume (excluding incineration)	Tonnes	0.00	0.00	0.00	0.00
Domestic waste (landfill) cost	£	0	0	0	0
Domestic waste (landfill) volume	Tonnes	0.00	0.00	0.00	0.00
Domestic waste (recycling) cost	£	8,737	18,836	1,811	0
Domestic waste (recycling) volume	Tonnes	32.62	95.50	4.70	0.00
Domestic waste (food) cost	£	0	15,554	0	0
Domestic waste (food) volume	Tonnes	0.00	181.97	0.00	0.00
Domestic waste (textiles) cost	£	0	0	0	0
Domestic waste (textiles) volume	Tonnes	0.00	0.00	0.00	0.00
Domestic waste (incineration) cost	£	39,690	98,562	5,076	0
Domestic waste (incineration) volume	Tonnes	151.00	504.41	20.90	0.00
Domestic waste processed on site cost (excluding incineration)	£	0	0	0	0
Domestic waste processed on site volume (excluding incineration)	Tonnes	0.00	0.00	0.00	0.00
Confidential waste cost	£	13,273	26,749	2,320	0
Confidential waste volume	Tonnes	61.06	157.87	14.84	0.00
Other waste costs	£	46,197.00	165,206.00	24,881.00	0.00
Relevant occupied floor area	m²				2,843
Notes					
		BASSETLAW DISTRICT GENERAL HOSPITAL	**DONCASTER ROYAL INFIRMARY**	**MONTAGU HOSPITAL**	**OTHER REPORTABLE SITES**

Car Parking	Unit	RP5BA	RP5DR	RP5MM	RP5ORS
Car parking services cost	£	51,326	362,426	29,752	0
Parking spaces available	No.	669	1,560	280	0
Designated disabled parking spaces	No.	33	70	34	0
Electric vehicle charging points	No.	0	0	0	0
Average fee charged per hour for patient/visitor parking	£	1.40	1.40	1.40	0.00
Average fee charged per hour for staff parking	£	0.12	0.12	0.12	0.00
Is there a charge for disabled parking	Yes/No/None	No	No	No	No
Notes					

Cleanliness	Unit	BASSETLAW DISTRICT GENERAL HOSPITAL RP5BA	DONCASTER ROYAL INFIRMARY RP5DR	MONTAGU HOSPITAL RP5MM	OTHER REPORTABLE SITES RP5ORS
Cleaning service cost	£	1,121,079	3,926,191	510,974	0
Cleaning staff	WTE	50.28	138.75	22.54	0.00
Relevant occupied floor area	m²				0
Notes					

Patient Food Services	Unit	BASSETLAW DISTRICT GENERAL HOSPITAL RP5BA	DONCASTER ROYAL INFIRMARY RP5DR	MONTAGU HOSPITAL RP5MM	OTHER REPORTABLE SITES RP5ORS
Type of food service	Select	Inpatient meals only	Inpatient meals only	Inpatient meals only	No meal provision
Inpatient food service cost	£	949,265	2,902,777	279,768	
Inpatient main meals requested	No.	157,581	569,538	50,982	
Hostess meal service	Select	No hostess	No hostess	No hostess	
Other patient food services costs	£	2,220	7,446	0	0
Notes					

Laundry & Linen	Unit	BASSETLAW DISTRICT GENERAL HOSPITAL RP5BA	DONCASTER ROYAL INFIRMARY RP5DR	MONTAGU HOSPITAL RP5MM	OTHER REPORTABLE SITES RP5ORS
Laundry and linen service used	Select	1. Contracted – Full service	1. Contracted – Full service	1. Contracted – Full service	6. No service
Laundry and linen service cost	£	232,134	860,039	90,162	
Laundry service cost	£				
Linen service cost	£				
Laundered pieces per annum	No.	681,224	2,857,679	346,942	
Other laundry and linen costs	£	0	0	0	
Onsite laundry	Select	Not Applicable	Not Applicable	Not Applicable	
Relevant occupied floor area	m²				
Notes					

Portering Services	Unit	BASSETLAW DISTRICT GENERAL HOSPITAL RP5BA	DONCASTER ROYAL INFIRMARY RP5DR	MONTAGU HOSPITAL RP5MM	OTHER REPORTABLE SITES RP5ORS
Portering service cost	£	463,905	1,525,647	101,288	0
Portering staff	WTE	14.47	65.25	4.30	0.00
Relevant occupied floor area	m²				0

Report Cover Page			
Meeting Title:	Board of Directors		
Meeting Date:	20th July 2021	**Agenda Reference:**	**E4**
Report Title:	The Premises Assurance Model (NHS PAM) Assessment Report 2020/2021		
Sponsor:	Jon Sargeant – Director of Finance		
Author:	Kirsty Edmondson-Jones – Director of Estates and Facilities		
Appendices:	Appendix 1: Premises Assurance Visual Dashboard Summary – Safety 2020/2021 Appendix 2: Premises Assurance Visual Dashboard Summary – Patient Experience 2020/2-21 Appendix 3: Overall Summary Efficiency, Effectiveness and Organisational Governance 2020/2021		
Report Summary			
Purpose of report:	The NHS PAM has been developed to provide a nationally consistent basis for assurance for Trust Boards, on Regulatory and Statutory requirements relating to their estate and related services, and this NHS constitution right: *To be cared for in a clean, safe, secure and suitable environment.* This assurance can then be used more widely and be provided to commissioners, regulators, the public and other interested stakeholders. The NHS PAM aims to bridge the space between NHS Boards and the operational detail of its day-to-day estates and facilities operations. However, it should be noted that PAM relates to how the organisation manages its infrastructure, not the quality, condition, fitness for purpose or risks associated with the infrastructure. Therefor the PAM is providing assurance the organisation has systems and processes which aim to mitigate the risks associated with non-complaint infrastructure and major systems as documented on the Trust risk register, and is not a reflection of compliance of the infrastructure itself. The model can be used as a prompt for further investigation, and to stimulate better-informed dialogue as to how the premises can be more efficiently used, more effectively managed, and contribute to the overall strategic objectives of the organisation. Its purpose is to support the organisational aim of ensuring that the premises and associated services are as safe as possible.		
Summary of key issues/positive highlights:	• The Trust Overall Summary Position for 2020/2021 for the two mandated domains is 23% Good, 51% requires Minimal improvement and 15% requires Moderate improvement. The report outlines areas of deficiency that require further improvement and in some cases investment to achieve compliance with Legislation, Approved Codes of Practice (ACOP's) and Guidance, to bring the Trust up to an all-round Good rating. • A bi-monthly review of PAM (Appendix 1) is presented to the Trust H&S committee utilising the DBTH PAM electronic assurance dashboard and is also included within the 6 monthly H&S report presented to the Trust Audit and Risk Committee (ARC). • A number of reductions within the PAM Safety domain allocated scores for the reporting period 2020/2021 for the individual SAQ elements due primarily to NHS England and NHS Improvement (NHSE/I) evidence update requirements, and changes to the latest PAM scoring matrix centred around Planned Preventative Maintenance (PPM) and completion percentage rates		

	linked to agreed Service Level Agreements (SLA's) and Key Performance Indicators (KPI's). • Revenue consequences (costs) associated with the Trust being able to achieve the required 90% completion rate for scheduled PPM against SFG 20 and associated Health Technical Memorandums (HTM,'s), Health Building Notes (HBN's) and increase the number of Appointed Persons (AP's) and Competent Persons (CP's) required to deliver a good rating in all maintenance SAQ element fields. • Capital Costs for Compliance associated with SH1 Operational Management (maintenance SAQ element) identified through the 6 facet survey undertaken by external surveying consultancy Oakleaf. • Capital Costs for Compliance associated with SH4 Health and Safety at Work and requirement for the provision of an external audit of the Trust Health and Safety Management against the framework or similar adopted by the ISO 45:001 Occupational Health and safety (OH&S) Management system standards. • Suspension of the full Patient Led Assessment of the Clinical Environment (PLACE) programme and introduction of PLACE-Lite; which remained open for healthcare organisations to undertake assessments if they chose to do so. Due to Covid-19 the Trust were not able to participate due to service delivery pressure and patient safety, leading to the Trust requiring minimal improvement in all 4 PLACE related SAQ elements within the Patient Experience domain.
Recommendation:	The Director of Finance is assured through internal audit that data provided is complete, accurate and up-to-date. Board of Directors note the information enclosed on the PAM 2020/2021 submission required to be committed through

Action Require:	Approval	~~Information~~	Discussion	~~Assurance~~	Review

Link to True North Objectives:	**TN SA1:**	**TN SA2:**	**TN SA3:**	**TN SA4:**
	~~*To provide outstanding care for our patients*~~	*Everybody knows their role in achieving the vision*	*Feedback from staff and learners is in the top 10% in the UK*	*The Trust is in recurrent surplus to invest in improving patient care*

Implications	
Board assurance framework:	N/A
Corporate risk register:	**F&P 4** Failure to ensure that estates infrastructure is adequately maintained and upgraded in line with current legislation, standards and guidance. Note: A number of different distinct risks are contained within this overarching entry. For further details please consult the E&F risk register. **F&P12** Failure to ensure that estates infrastructure is adequately maintained and upgraded in accordance with the Regulatory Reform (Fire Safety) Order 2005 and other current legislation standards and guidance. Note: a number of different distinct risks are contained within this overarching entry. For further details please consult the EF risk register. **E&F 2335** Failure to adequately meet the demand of PPM completion due to insufficient resource within the Estates department resulting in a risk of regulatory non-compliance. Note: Identified following an NHS/Qii review of the Estates workforce at DBTH. For further details please consult the EF risk register.

Regulation:	• Health and Safety at Work Act 1974 (HASAWA) • Management of Health and Safety at Work Regulations 1999 • The Workplace (Health, Safety and Welfare) Regulations 1992 • The Health and Safety (Display Screen Equipment) Regulations 1992 • The Manual Handling Operations Regulations 1992 (as amended) (MHOR) • The Personal Protective Equipment at Work Regulations 1992 • The Provision and Use of Work Equipment Regulations 1998 • Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013(RIDDOR) • The Control of Substances Hazardous to Health Regulations 2002 • Safety Representatives and Safety Committees Regulations 1977 • Health and Safety (Consultation with Employees) Regulations 1996.
Legal:	• The essential standards of quality and safety consist of 28 regulations (and associated outcomes) that are set out in two pieces of legislation: the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. • Developing an Estate Strategy document • Health Building Note 00-08 • Health building Note 00-08: Land and Property Appraisal • Strategic Health Asset Planning & Evaluation (SHAPE) tool • Monitor: The asset register and disposal of assets: guidance for providers of commissioner requested services • Monitor: Strategy development: a toolkit for NHS providers • Monitor: Developing strategy What every trust board member should know
Resources:	Additional Resource to achieve the required 90% completion rate for scheduled PPM against SFG 20 and associated Health Technical Memorandums (HTM,'s), Health Building Notes (HBN's) and increase the number of Appointed Persons (AP's) and Competent Persons (CP's).

Assurance Route			
Previously considered by:		No	
Date:	N/A	**Decision:**	N/A
Next Steps:		Continual Annual reporting the PAM to Board. Continual bi-annual reporting to Audit and Risk Committee and the Trust Health and Safety Committee.	
Previously circulated reports to supplement this paper:		N/A	

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1. Executive Summary

The NHS PAM has been developed to provide a nationally consistent basis for assurance for Trust Boards, on Regulatory and Statutory requirements relating to their estate and related services, and this NHS constitution right:

To be cared for in a clean, safe, secure and suitable environment.

This assurance can then be used more widely and be provided to commissioners, regulators, the public and other interested stakeholders.

The NHS PAM aims to bridge the space between NHS Boards and the operational detail of its day-to-day estates and facilities operations. However, it should be noted that PAM relates to how the organisation manages its infrastructure, not the quality, condition, fitness for purpose or risks associated with the infrastructure. Therefor the PAM is providing assurance the organisation has systems and processes which aim to mitigate the risks associated with non-complaint infrastructure and major systems as documented on the Trust risk register, and is not a reflection of compliance of the infrastructure itself. The model can be used as a prompt for further investigation, and to stimulate better-informed dialogue as to how the premises can be more efficiently used, more effectively managed, and contribute to the overall strategic objectives of the organisation.

The PAM does this through a series of Self-Assessment Questions (SAQ's) and produces a summary report that can be used to demonstrate the overall state of the organisation to its service users, commissioners and regulators. Its purpose is to support the organisational aim of ensuring that the premises and associated services are as safe as possible.

The latest version of the PAM has now been included within the updated NHS Standard Contract; Section 17.9 for the reporting year 2020/2021 with an upload date of July the 23rd 2021 for the current report. This ensures Mandatory Status for the Safety domain and Patient Environment domain, with the remaining 3 domains Efficiency, Effectiveness and Organisational Governance receiving Mandatory status for the reporting year 2021/2022.

The following report provides an overview of PAM and the process and methodology utilised by the Trust Estates and Facilities management (E&F) team when undertaking the PAM assessment. The report provides information from the PAM assessment for 2020/2021 and covers the two mandated PAM domains; Safety and Patient Experience. The Key issues from the report include:

- The Trust Overall Summary Position for 2020/2021 for the two mandated domains is 23% Good, 51% requires Minimal improvement and 15% requires Moderate improvement. The report outlines areas of deficiency that require further improvement and in some cases investment to achieve compliance with Legislation, ACOP's and Guidance, to bring the Trust up to an all-round Good rating.
- A bi-monthly review of PAM (Appendix 1) is presented to the Trust H&S committee utilising the DBTH PAM electronic assurance dashboard and is also included within the 6 monthly H&S report presented to the Trust ARC.

- A number of reductions within the PAM Safety domain allocated scores for the reporting period 2020/2021 for the individual SAQ elements due primarily to NHSE/I evidence update requirements, and changes to the latest PAM scoring matrix centred around PPM and completion percentage rates linked to agreed SLA's and KPI's.
- Revenue consequences (costs) associated with the Trust being able to achieve the required 90% completion rate for scheduled PPM against SFG 20 and associated HTM,'s, HBN's and increase the number of AP's and CP's required to deliver a good rating in all maintenance SAQ element fields.
- Capital Costs for Compliance associated with SH1 Operational Management (maintenance SAQ element) identified through the 6 facet survey undertaken by external surveying consultancy Oakleaf.
- Capital Costs for Compliance associated with SH4 Health and Safety at Work and requirement for the provision of an external audit of the Trust Health and Safety Management against the framework or similar adopted by the ISO 45:001 OH&S standards.
- Suspension of the full PLACE programme and introduction of PLACE-Lite; which remained open for healthcare organisations to undertake assessments if they chose to do so. Due to Covid-19 the Trust were not able to participate due to service delivery pressure and patient safety, leading to the Trust requiring minimal improvement in all 4 PLACE related SAQ elements within the Patient Experience domain.

2. Introduction

The assessment of the DBTH PAM has been undertaken using the revised and updated 2020 model and reflects the Trust's position as at 2020/2021. The methodology utilised adopts the PAM 2020 approach and format in conjunction with the identified Estates and Facilities and Clinical responsible Trust management members of the DBTH PAM working groups.

This methodology takes the PAM SAQ's into a working group Evidence File and records responsibilities by named post holders along with evidence and commentary provided by the responsible Trust staff members against each of the SAQ working group documents. The working groups encourage open discussion where the rational and rating of an individual SAQ can be challenged, which ensures that the assessment is robust, accurate, and transparent and open to scrutiny.

Evidence for each SAQ is provided by the responsible Trust staff members by submitting Approved Procedural Document (APD) details linked to the Trust Intranet, procedures and documentation stored on the DBTH Shared drive locations and various Trust CAFM systems used by the E&F. Approval, Review and Expiry dates are also provided to enable an auditing process through the PAM working group Evidence file.

Once the evidence file is considered to be complete a review of the returns is conducted and each SAQ element given a score within the pre-determined Not Applicable, Inadequate, Requires Moderate Improvement, Requires Minimal Improvement, Good and Outstanding grades indicated within the PAM working document and online submission site.

Within the evidence file the SAQ responses have been split to reflect these disparate functionalities and then an overview taken as to the Organisational position in relation to the evidence provided from the different functional areas. This allows a Trust wide position to be established for the PAM responses.

3. The PAM Report

The following report provides information from the PAM assessment for 2020/2021 and covers the two mandated PAM domains including an overall summary position illustrated in figure 1 and distribution of SAQ Ratings (%) for Hard/Soft Facilities Management (FM) and Patient Experience 2020/2021 illustrated in figure 2. The Trust Overall Summary Position for 2020/2021 for the two domains is 22% Good, 51% requires Minimal improvement and 15% requires Moderate improvement. The report outlines areas of deficiency that require further improvement and in some cases investment to achieve compliance with Legislation, ACOP's and Guidance, to bring the Trust up to an all-round Good rating.

The PAM report itself, is included within the Director of Estates and Facilities/Chair of the Trust H&S Committees Estates and Facilities Management (EFM) KPI Board report as a declaration of Trust H&S compliance against the NHS PAM Safety Domain for 2020/2021 and ensures the Trust meets the current CQC KLOE.

A bi-monthly review of PAM (Appendix 1) is presented to the Trust H&S committee utilising the DBTH PAM electronic assurance dashboard and is also included within the 6 monthly H&S report presented to the Trust ARC.

The reporting features of PAM as issued by the Department of Health (DOH) are currently still somewhat limited and because of the complexity of the new online reporting system within which the responses are held, it is still difficult to add custom reports. Therefore the following report for 2020/2021 draws on the reports that are available within the PAM spreadsheet working documents and the commentary provided by the PAM working group exercises undertaken.

The current Trust PAM process commenced at the beginning of June 2020 due the Covid-19 Pandemic with a continual process now in place to regularly review the Safety Domain and Patient Experience SAQ working groups with agreed actions circulated to the responsible managers for each specialist SAQ including updates, progress notes and completion dates. The same process is undertaken for the three remaining PAM domains Efficiency, Effectiveness and Organisational Governance, although not currently mandatory, with an overall summary position and overall distribution of SAQ's provided in Appendix 3 for information.

For the areas requiring improvement in the overall PAM assessment, PAM allows for the entry of "Capital Costs for Compliance" and "Revenue Consequences". The capital cost to achieving the compliance figure provides the link to the Trust's Estates Strategy, business plan and budget. The intention is that any capital costs associated with reaching compliance can be identified against individual areas, and will provide additional granularity to the Trust's five-year plans, capital programme and Estates Strategy.

Revenue Consequences associated with individual domain summaries and resultant scores to enable the Trust to achieve compliance and an overall good rating are included with accompanying information to provide further additional granularity for the assessment.

Figure 1: Overall Summary Position - Hard/Soft FM, Patient Experience 2020/2021

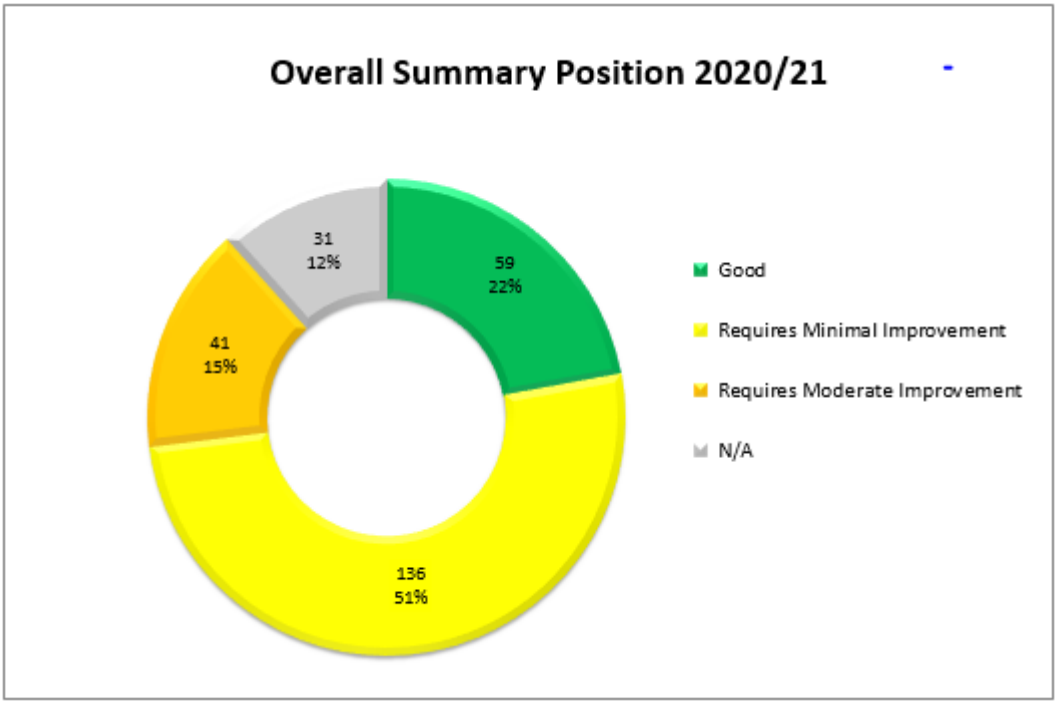
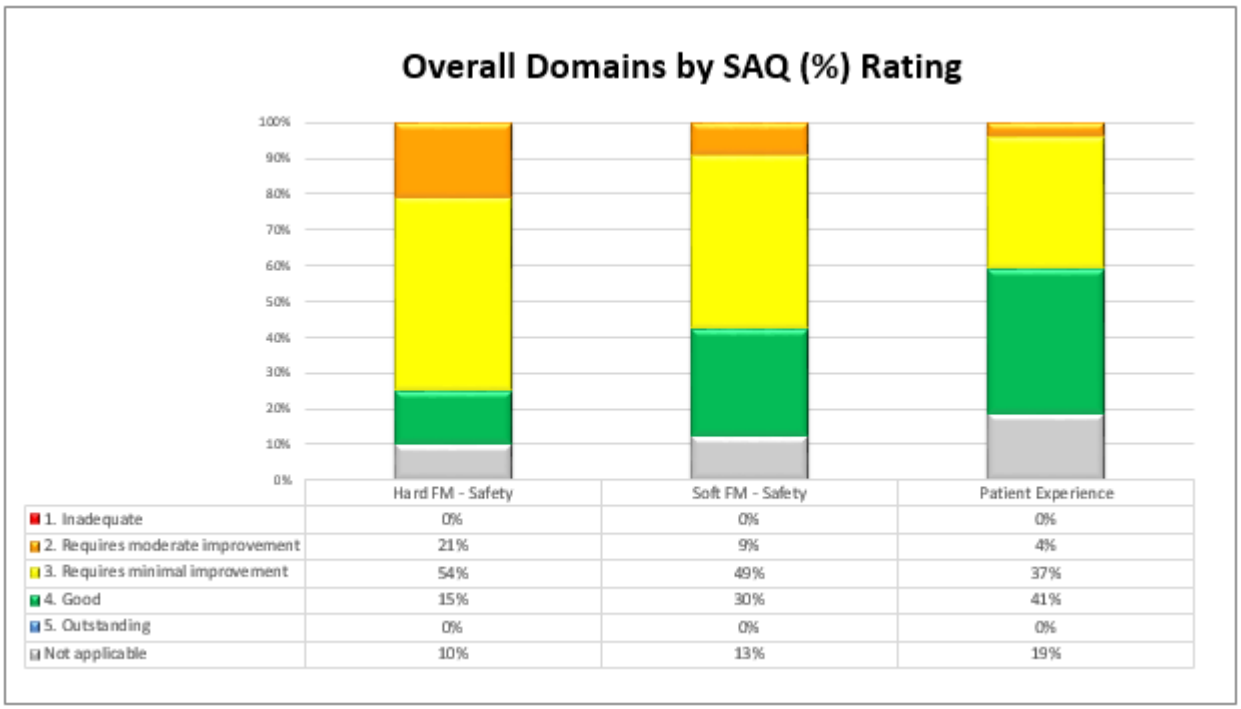


Figure 2: Overall Distribution of SAQ Ratings (%) for Hard/Soft FM, Patient Experience 2020/2021



	Hard FM - Safety	Soft FM - Safety	Patient Experience
1. Inadequate	0%	0%	0%
2. Requires moderate improvement	21%	9%	4%
3. Requires minimal improvement	54%	49%	37%
4. Good	15%	30%	41%
5. Outstanding	0%	0%	0%
Not applicable	10%	13%	19%

5. Safety Domain

The PAM Overall Distribution of SAQ Ratings for the Safety Domain which forms part of the mandatory return in 2020/2021 has illustrated the Trust to be Good in 48 elements, requiring Minimal Improvement in 126 elements, requiring Moderate Improvement in 40 elements and 26 Not Applicable. The evidence gained during the PAM assessment process has identified the need for Requires Moderate and Minimal Improvement in the majority of SAQ's within this Domain, which is split into two sections; Safety Hard 'Hard FM' and Safety Soft 'Soft FM'.

5.1 Safety (Hard FM)

Figure 3 presents the PAM distribution of Safety Hard SAQ ratings for 2020/2021 including individual domain statement, with figure 4 providing the DBTH PAM Distribution of SAQ Ratings for 2020/2021. Table 1 provides a legend listing the Hard FM SAQ's individual elements.

Figure 3: Safety Domain Hard FM Summary Position for 2020/2021

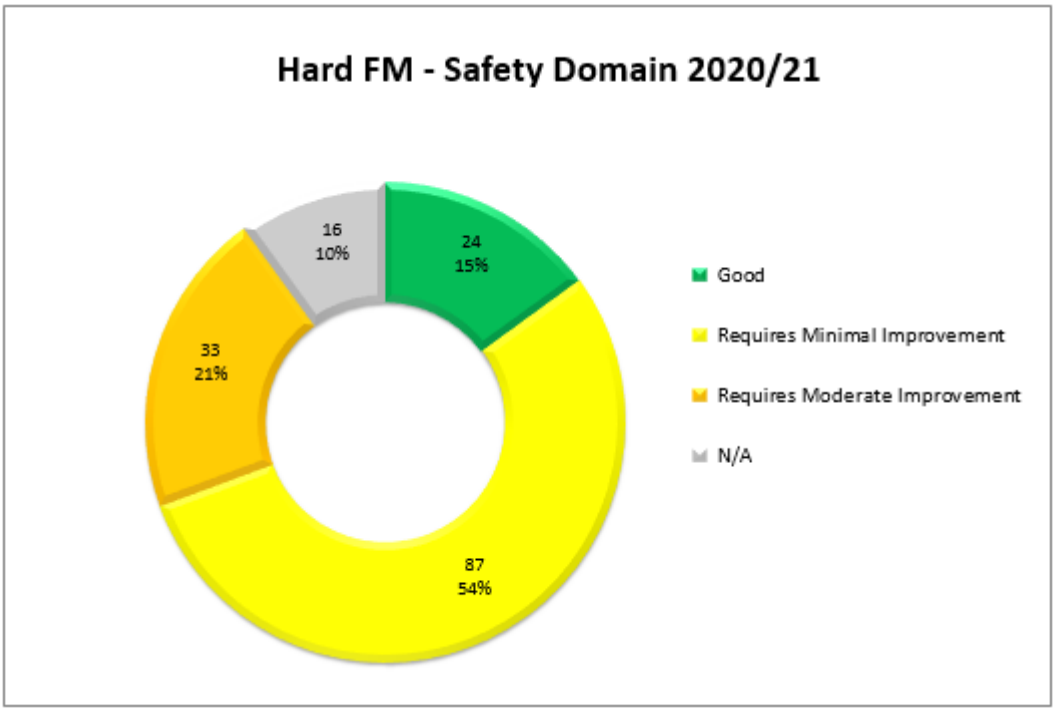


Figure 4: Distribution of SAQ Ratings (%) for Safety Hard 2020/2021

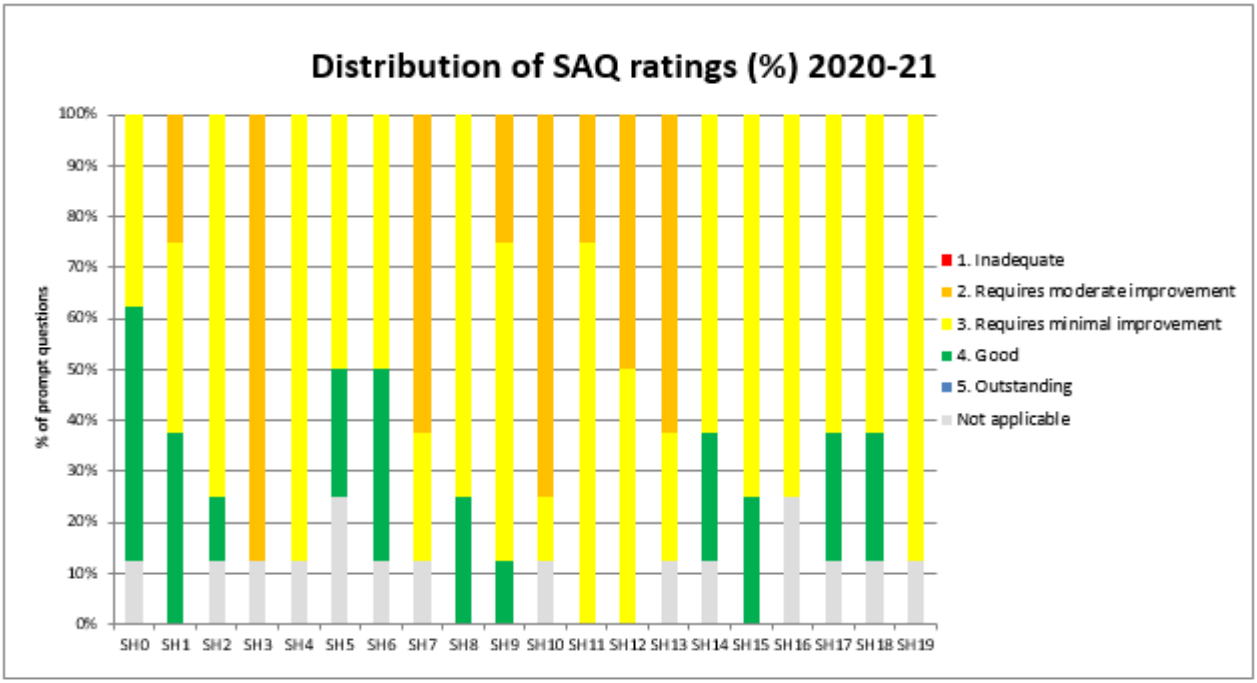


Table 1: Safety Hard FM Individual SAQ Element Legend 2020/2021

Legend	
SAQ Code	Self-Assessment Question – Is the Organisation/site safe and compliant with well managed systems in relation to:
SH1	Estates and Facilities Operational Management
SH2	Design, Layout and Use of Premises
SH3	Estates and Facilities Document Management
SH4	Health & Safety at Work
SH5	Asbestos
SH6	Medical Gas Systems
SH7	Natural Gas and specialist piped systems
SH8	Water Systems
SH9	Electrical Systems
SH10	Mechanical Systems e.g. Lifting Equipment
SH11	Ventilation, Air Conditioning and Refrigeration Systems
SH12	Lifts, Hoists and Conveyance Systems
SH13	Pressure Systems
SH14	Fire Safety
SH15	Medical Devices and Equipment
SH16	Resilience, Emergency and Business Continuity Planning
SH17	Safety Alerts
SH18	Externally Supplied Estate
SH19	Contractor Management

There have been a number of reductions within the PAM Safety domain allocated scores for the reporting period 2020/2021 for the individual SAQ elements due primarily to NHSE/I evidence update requirements, policy feedback by Authorising Engineers (AE's) within individual SAQ's, increased AP requirements to individual SAQ's and changes to the latest PAM scoring matrix centred around PPM

and completion percentage rates linked to agreed SLA's and KPI's, which are all reflected in the PAM electronic visual management dashboard illustrated in Appendix 1.

Revenue consequences (costs) associated with the Trust being able to achieve the required 90% completion rate for scheduled PPM against SFG 20 and associated HTM,'s, (HBN's and increase the number of AP's and Competent Persons CP's required to deliver a good rating in all maintenance SAQ element fields is provided in table 2. This information is extracted from the Estates Workforce Review Business case (2019), Medical technical Services Department Labour Force Re-structuring Business case (2021) and associated entry on the Trust Risk Register (E&F 2335).

Other main SAQ's requiring action in this domain are SH3, SH7, SH10, SH13, SH18; scoring requires moderate improvement in the majority of elements. The main elements of deficiency are the requirements for Draft Policy and Procedures to be reviewed and approved by the Authorised Engineers, presented to the E&F Health and Safety (H&S) committee and ratified at the Trust H&S committee, Clear Identification of Roles and Responsibilities, provision Improving Training and Development and Review Processes. These deficiencies will be reviewed through the PAM working group process for 2020/2021, with action and review dates including clearly defined timescales presented to the individual responsible managers enabling the development of costed actions plans against the revenue costs associated with training provided in table 3.

Capital Costs for Compliance associated with SH1 Operational Management (maintenance SAQ element) have been identified through the 6 facet survey undertaken by external surveying consultancy Oakleaf. Costs associated with Backlog maintenance identified through the High and Significant Backlog figure reported through the ERIC returns is provided in table 2 for granularity against the Trust's Organisational Strategy, Capital Programme and Estates Strategy to provide a compliant, clean, safe, secure and suitable environment.

Capital Costs for Compliance associated with SH4 Health and Safety at Work and requirement for the provision of an external audit of the Trust Health and Safety Management against the framework or similar adopted by the ISO 45:001 OH&S standards, identified through the individual PAM working group and documented at the Trust Health and Safety Committee is also illustrated in table 2.

Table 2: Capital Costs for Compliance and Revenue Consequence 2020/2021

SAQ Code	Capital Cost for Compliance	
SH 1.4	High and Significant Backlog Maintenance	£124,418,663
SH4.1	Health and Safety Management System Audit	£20,000
SAQ Code	Revenue Consequence	
SH1.4	Estates Workforce Review	£300,000
SH1.4	Medical technical Services Department Labour Force Re-structuring	£120,000
SH8.5	Water Safety Healthcare Technician Training	£18,366
SH9.5	Electrical Low Voltage (LV) Approved Person (AP) and Competent Person Training (CP)	£18,708
SH11.5	CP Heating, Ventilation and Air Conditioning (HVAC) training (HTM03)	£17,820
SH12.5	Passenger Lift Training	13,715

5.2 Safety (Soft FM)

Figure 5 presents the PAM distribution of Safety Soft SAQ ratings for 2020/2021 including individual domain statement, with figure 6 providing the DBTH PAM distribution of SAQ Ratings for 2020/2021. Table 2 provides a legend listing the Soft FM SAQ's individual elements.

Figure 5: Safety Domain Soft FM Summary Position for 2020/2021

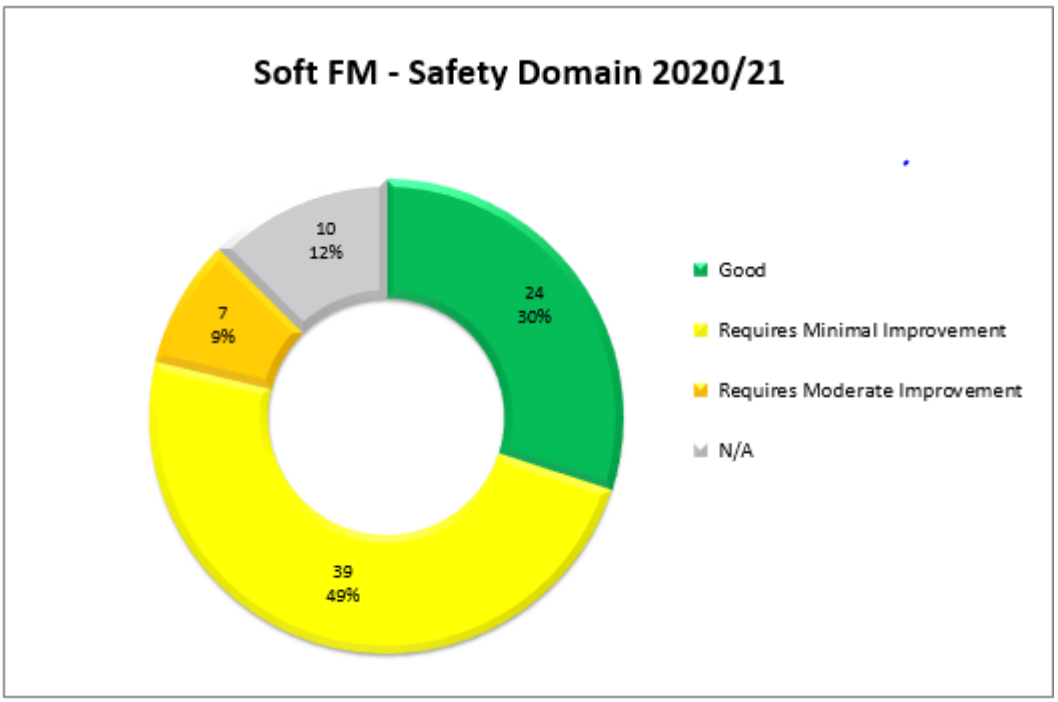


Figure 6: Distribution of SAQ Ratings (%) for Safety Soft 2020/2021

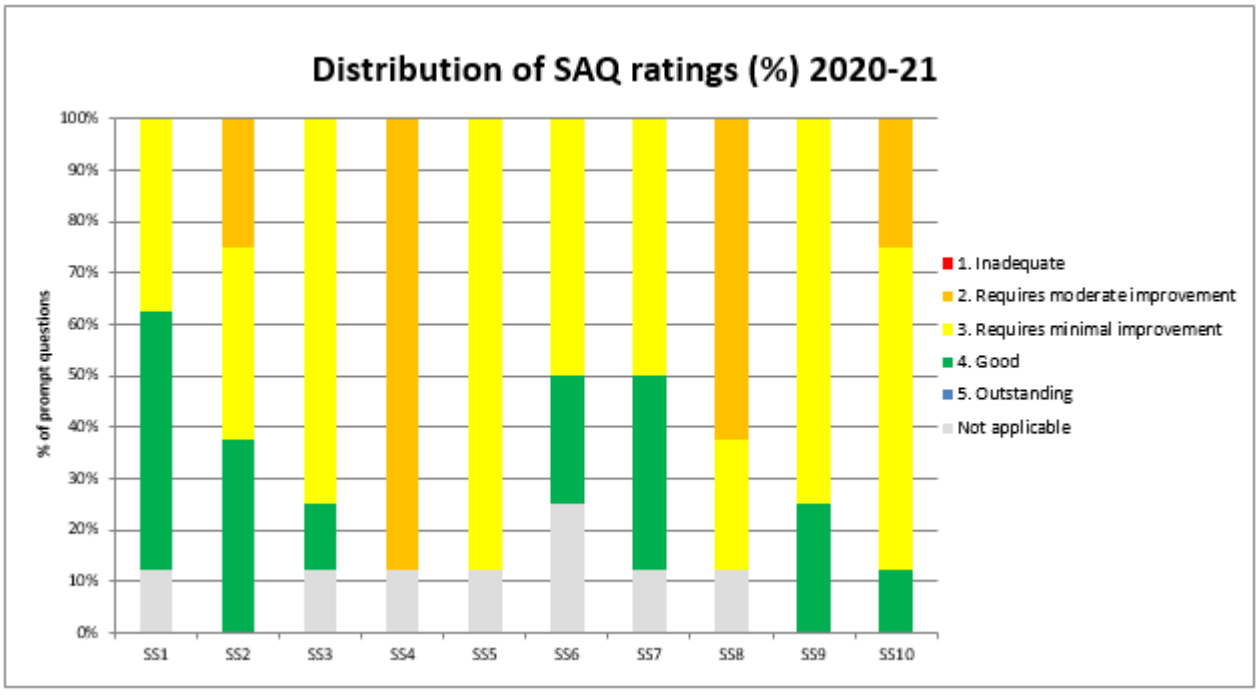


Table 3: Safety Soft FM Individual SAQ Element Legend 2020/2021

Legend	
SAQ Code	Self-Assessment Question – Is the Organisation/site safe and compliant with well managed systems in relation to:
SS1	Catering Services
SS2	Decontamination Processes
SS3	Waste and Recycling Management
SS4	Cleanliness and Infection Control
SS5	Laundry Services and Linen
SS6	Security Management
SS7	Transport Services and access arrangements
SS8	Pest Control
SS9	Portering Services
SS10	Telephony and Switchboard

The main SAQ requiring action in this domain is SS8 Pest Control scoring requires moderate improvement in the majority of elements. The main elements of deficiency are the requirements for Draft Policy and Procedures to be reviewed and approved by the E&F H&S committee and ratified by the Trust H&S Committee, Clear Identification of Roles and Responsibilities, provision Improving Training and Development and Review Processes. These deficiencies will be reviewed through the relevant PAM working group process for 2020/2021, with action and review dates including clearly defined timescales presented to the individual responsible manager.

All other elements within this domain requiring minimal improvement will be reviewed through the PAM working group process for 2020/2021 with action plans and review dates presented to the individual responsible managers.

6. Patient Experience Domain

The PAM Distribution of SAQ Ratings for Patient Experience shows DBTH to be Good in 11 elements, requiring minimal Improvement in 10 elements moderate improvement in 1 element and 5 not applicable.

The PAM Patient Experience summary position for the Trust illustrates in figure 7 the breakdown of the PAM SAQ score ratings for the assessment year 2020/2021 with figure 8 providing the PAM distribution of Patient Experience SAQ ratings. The PAM visual management summary dashboard for the Patient Experience SAQ (Appendix 2) provides a full overview of the current status for this domain.

For the reporting year a decision was taken by NHSE/I to suspend the full PLACE programme due to the operational difficulties and associated risks brought about by Covid-19. PLACE-Lite remained open for healthcare organisations to undertake assessments if they chose to do so. Due to Covid-19

the Trust were not able to participate due to service delivery pressure and patient safety, leading to the Trust requiring minimal improvement in all 4 PLACE related elements within the domain.

For the reporting period 2021/2022 Place Lite will again be utilised by the NHS, with the Trust now in a position to participate with a working group currently being arranged by the Trust Deputy Director of Nursing - Patient Experience along with the E&F management team.

Further SAQ's requiring moderate and minimal improvement include the requirement for improving other areas of internal assessment, staff and patient engagement through the introduction of patient participation focus groups. This will be reviewed through the PAM working group process for 2020/2021 with action plans and review dates presented to the individual responsible managers.

Figure 7: Patient Experience Domain Summary Position for 2020/2021

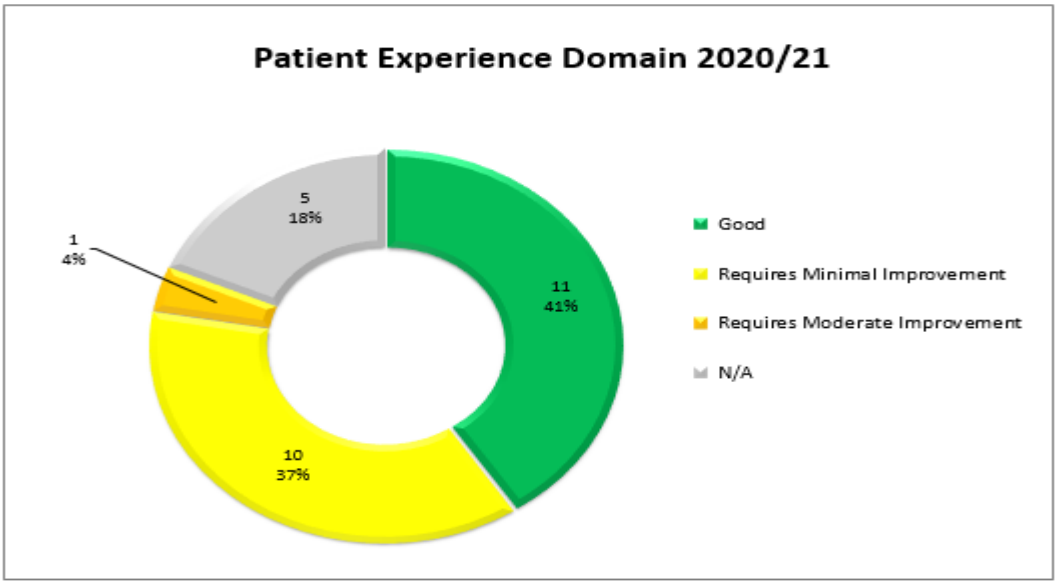


Figure 8: Distribution of SAQ Ratings (%) for Patient Experience 2019/2020

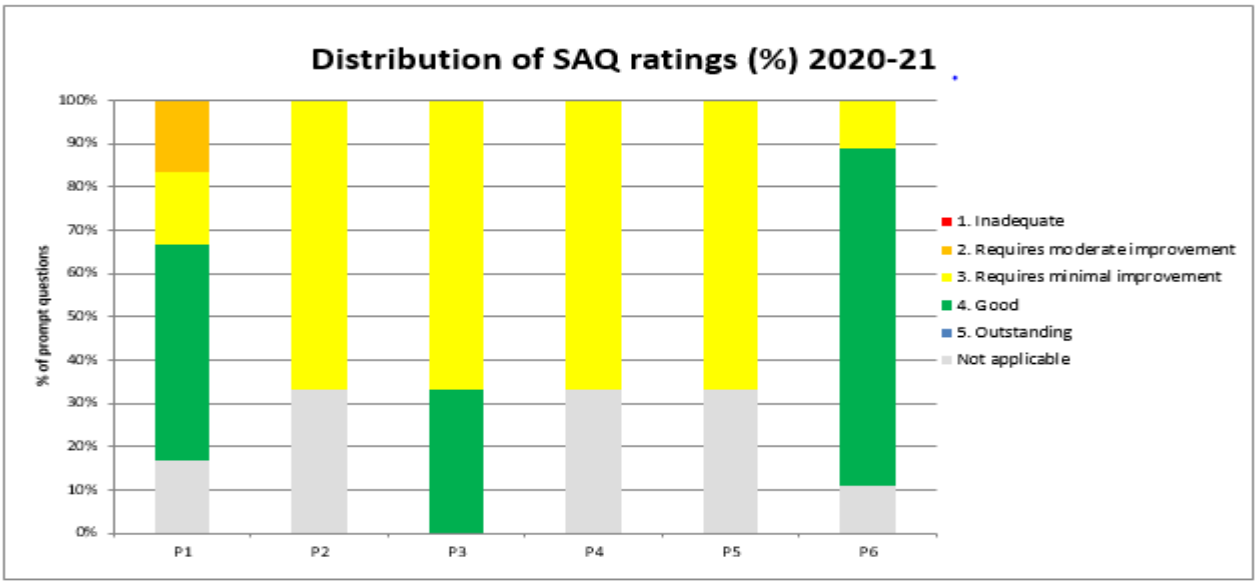


Table 4: Patient Experience Individual SAQ Element Legend 2020/2021

Legend	
SAQ Code	Self-Assessment Question – Does Your Organisation:
P1	With regards to ensuring engagement and involvement on estates and facilities services from people who use the services, public and staff can your organisation evidence the following?
P2	With regard to ensuring patients, staff and visitors perceive the condition, appearance, maintenance and privacy and dignity of the estate is satisfactory can your organisation evidence the following?
P3	With regard to ensuring ensure that patients, staff and visitors perceive cleanliness of the estate and facilities to be satisfactory can your organisation evidence the following?
P4	With regard to ensuring that access and car parking arrangements meet the reasonable needs of patients, staff and visitors can your organisation evidence the following?
P5	With regard to providing a high quality and supportive environment for patients, visitors and staff in relation to grounds and gardens can your organisation evidence the following?
P6	How does your organisation/site ensure that NHS Catering Services provide adequate nutrition and hydration through the choice of food and drink for people to meet their diverse needs?

7. Conclusion and Recommendations

The report has explained the PAM assessment process and requirement of an annual report to Board including national online submission, following inclusion within the NHS Standard Contract for the two mandated domains; Safety and Patient Experience. The repot has further explained that the remaining three domains; Efficiency, Effectiveness and Organisational Governance will also become mandated for the reporting year 2021/2022.

The report has provided information from the PAM assessment for 2020/2021 covering the two current mandated PAM domains Safety and Patient Experience including an Overall Summary Position for the two domains, which has been developed to deliver assurance for the Board on a consistent basis.

Reductions within the PAM Safety domain allocated scores for the reporting period 2020/2021 for the individual SAQ elements due primarily to NHSE/I evidence update requirements, and changes to the latest PAM scoring matrix centred around PPM and completion percentage rates linked to agreed SLA's and KPI's has been provided within the report.

The report has explained the suspension of the full PLACE programme and reason for the Trust not be able to participate in PLACE-Lite due to service delivery pressure and patient safety concerns during Covid-19, leading to the Trust requiring minimal improvement in all 4 PLACE related SAQ elements within the Patient Experience domain. The report has also explained that the Trust are now in a position to participate in PLACE-Lite with a working group currently being arranged by the Trust Deputy Director of Nursing - Patient Experience along with the E&F management team.

The report has outlined identified areas of deficiency that require further improvement and in some cases investment to achieve compliance with Legislation, ACOP's and Guidance, to bring the Trust up

to a target rating of 80% Good with a stretch target of Outstanding. These deficiencies will be reviewed through the PAM working group process for 2020/2021, with action and review dates including clearly defined timescales presented to the individual responsible managers, resulting in continual improvement.

It is recommended that the Trust approve Capital Costs for Compliance associated with the requirement for the provision of an external audit of the Trust Health and Safety Management against the framework or similar adopted by the ISO 45:001 OH&S standards.

Finally It is also recommended that the Trust review the Revenue consequences (costs) associated with the Trust being able to achieve the required 90% completion rate for scheduled PPM against SFG 20 and associated HTM,'s, HBN's and increase the number of AP's and CP's, Identified within the Estates Workforce Review Business case (2019) and associated entry on the Trust Risk Register (E&F 2335); required to deliver a good rating in all maintenance SAQ element provided within the report.

8. Appendices - Appendix 1: Premises Assurance Visual Dashboard Summary – Safety 2020/2021

Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

Front Screen | DBTH Policies | Scoring Criteria

NHS PAM-Safety-Hard & Soft FM Summary

Jun-21

Outstanding - 5
Good - 4
Req's Minimal Improvement - 3
Req's Moderate Improvement - 2
Inadequate - 1

SAQ/Prompt Questions

Progress: Up | Down | No Movement | Not Applicable

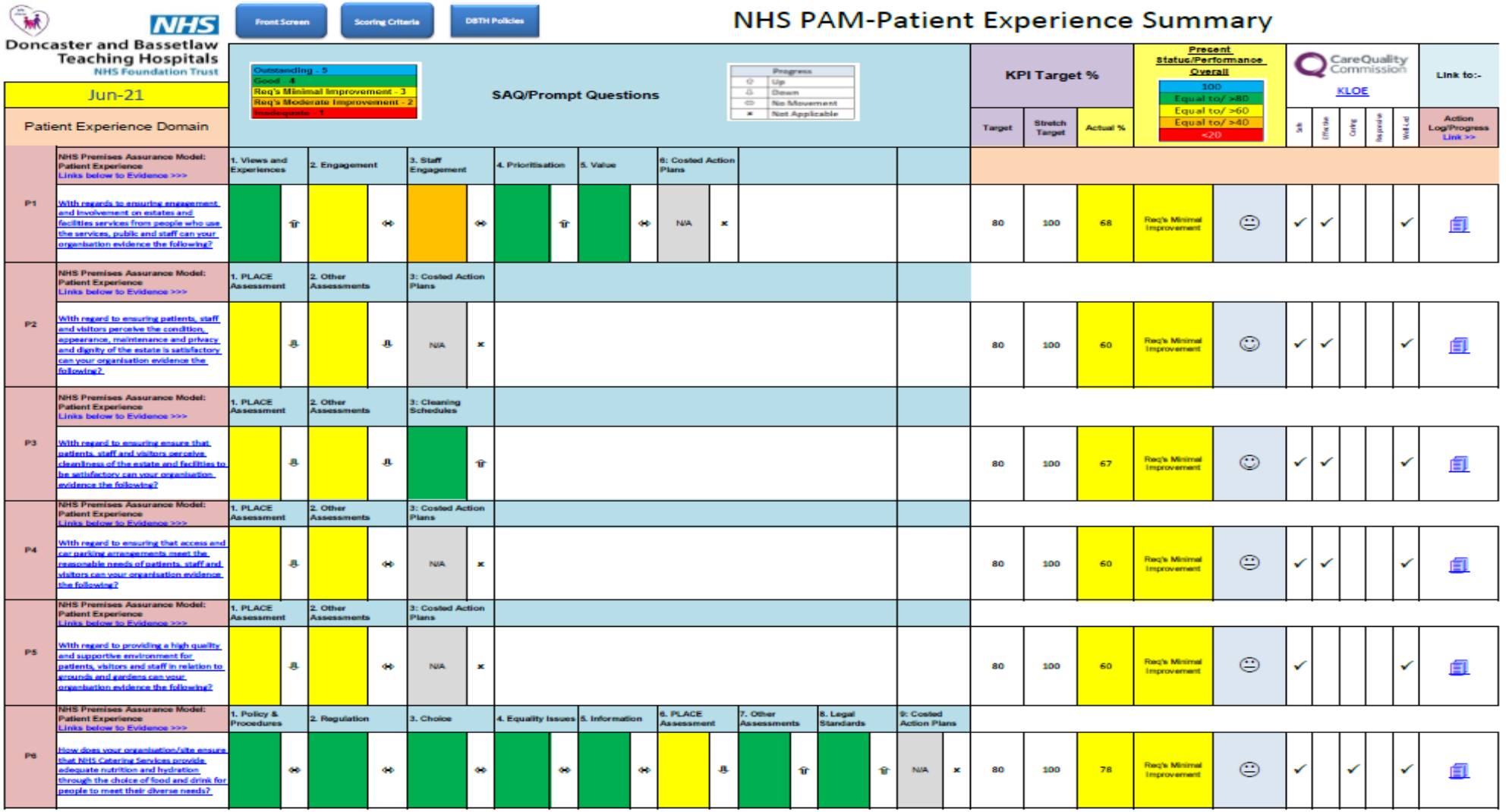
Present Status/Performance Overall: 100 | Equal to/ >80 | Equal to/ >60 | Equal to/ >40 | <20

Care Quality Commission – Key Lines of Enquiry

Link to:- NHS Premises Assurance Model - SAQ

Safety Domain (Combined Soft and Hard FM) Links below to Evidence >>>		1: Policy & Procedures	2: Roles and Responsibilities	3: Risk Assessment	4: Maintenance	5: Training and Development	6: Resilience, Emergency & Business Continuity Planning	7: Review Process	8: Costed Action Plans	Target	Stretch Target	Actual %	Present Status/Performance Overall	Safe	Effective	Caring	Responsive	Well-Led	Action Log/Progress Link >>	Commentary
SH0	Windows				N/A				N/A	80	100	71	Req's Minimal Improvement	✓				✓		All associated Planned Preventative Maintenance (PPM) information, reports and annual inspection programmes available from E&F CAFM System Planet
SH1	Estates and Facilities Operational Management									80	100	63	Req's Minimal Improvement	✓				✓		Overarching SAQ for the Safety Domain covering both Hard and soft FM services management.
SH2	Design, Layout and Use of Premises								N/A	80	100	63	Req's Minimal Improvement	✓		✓		✓		Trust 7 year Capital Programme and Estates and Facilities 5 year Strategy.
SH3	Estates and Facilities Document Management								N/A	80	100	40	Req's Moderate Improvement	✓				✓		
SH4	Health & Safety at Work				N/A					80	100	60	Req's Minimal Improvement	✓		✓		✓		Health and Safety Responsible person training externally provided by external H&S consultant. Consultant engaged to produce updated training programme. External gap analysis of Trust H&S management system required.
SH5	Asbestos				N/A				N/A	80	100	67	Req's Minimal Improvement	✓				✓		Asbestos Register Held on E&F CAFM system Micad electronically. Register available to all Estates staff on hand held devices for instant register interrogation
SH6	Medical Gas Systems								N/A	80	100	69	Req's Minimal Improvement	✓		✓		✓		
SH7	Natural Gas and specialist piped systems								N/A	80	100	46	Req's Moderate Improvement	✓				✓		All Natural Gas works undertaken by external gas safe contractors and large projects by utilities contractor.
SH8	Water Systems									80	100	65	Req's Minimal Improvement	✓				✓		All associated Planned Preventative Maintenance (PPM) information, reports and annual inspection programmes available from E&F CAFM System Planet
SH9	Electrical Systems									80	100	58	Req's Moderate Improvement	✓				✓		All associated Planned Preventative Maintenance (PPM) information, reports and annual inspection programmes available from E&F CAFM System Planet, including procedural documentation.
SH10	Mechanical Systems e.g. Lifting Equipment								N/A	80	100	43	Req's Moderate Improvement	✓				✓		
SH11	Ventilation, Air Conditioning and Refrigeration Systems									80	100	55	Req's Moderate Improvement	✓				✓		
SH12	Lifts, Hoists and Conveyance Systems									80	100	50	Req's Moderate Improvement	✓			✓	✓		
SH13	Pressure Systems								N/A	80	100	46	Req's Moderate Improvement	✓				✓		
SH14	Fire Safety								N/A	80	100	66	Req's Minimal Improvement	✓	✓			✓		All associated Planned Preventative Maintenance (PPM) information, reports and annual inspection programmes available from E&F CAFM System Planet
SH15	Medical Devices and Equipment									80	100	65	Req's Minimal Improvement	✓		✓		✓		
SH16	Resilience, Emergency and Business Continuity Planning						N/A		N/A	80	100	60	Req's Minimal Improvement	✓				✓		
SH17	Safety Alerts								N/A	80	100	66	Req's Minimal Improvement	✓				✓		
SH18	Externally Supplied Estate								N/A	80	100	66	Req's Minimal Improvement	✓				✓		The Central Alerting System is currently managed by an in house distribution and management system circulated by the CAS/MHRA Alert Officer for the Trust.
SH19	Contractor Management								N/A	80	100	60	Req's Minimal Improvement	✓				✓		Management and recording of Contractors onsite through RESET terminals and RESET electronic WEB system.
SS1	Catering Services								N/A	80	100	80	Good	✓		✓	✓			Service outsourced to SODEXO. Format presented to SODEXO Trust lead and H&S contact for future reporting
SS2	Decontamination Processes								N/A	80	100	63	Req's Minimal Improvement	✓		✓		✓		Hospital Sterile Services outsourced to Steris.
SS3	Waste and Recycling Management								N/A	80	100	71	Req's Minimal Improvement	✓				✓		Trust Total Waste Management (TWM) contract with provider Sharpsmart, including; clinical, domestic and confidential waste streams
SS4	Cleanliness and Infection Control								N/A	80	100	66	Req's Minimal Improvement	✓		✓		✓		Cleaning standards monitored and managed through the E&F CAFM System Micad - MICAC
SS5	Laundry Services and Linen								N/A	80	100	60	Req's Minimal Improvement	✓		✓		✓		Linen and Laundry currently outsourced through external contract to Synergy.
SS6	Security Management								N/A	80	100	66	Req's Minimal Improvement	✓			✓	✓		Externally outsourced Security, Car parking and Smoking Enforcement Contract to Saba Ltd.
SS7	Transport Services and access arrangements								N/A	80	100	66	Req's Minimal Improvement	✓		✓	✓	✓		
SS8	Pest Control								N/A	80	100	40	Req's Moderate Improvement	✓				✓		Pest control contract for all Trust premises with current provider Enserve. Information obtained in Estates and Facilities office DRI Room DRI29LG2R0012.
SS9	Portering Services								N/A	80	100	66	Req's Minimal Improvement	✓		✓		✓		Monitored and managed through the E&F CAFM System Tele-Tracking
SS10	Telephony and Switchboard								N/A	80	100	71	Req's Minimal Improvement	✓	✓			✓		Telephony Services managed through I.T. Services at DBTH. PAM information provided through same working group process with responsible person for the service delivery.

Appendix 2: Premises Assurance Visual Dashboard Summary – Patient Experience 2020/2021



Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

Front Screen | Scoring Criteria | DBTH Policies

NHS PAM-Patient Experience Summary

Jun-21

Patient Experience Domain

Outstanding - 5
Good - 4
Req's Minimal Improvement - 3
Req's Moderate Improvement - 2
Inadequate - 1

SAQ/Prompt Questions

Progress: Up | Down | No Movement | Not Applicable

		SAQ/Prompt Questions	KPI Target % Target	Stretch Target	Actual %	Present Status/Performance Overall	CareQuality Commission KLOE	Link to:- Action Log/Progress Link >>
P1	NHS Premises Assurance Model: Patient Experience Links below to Evidence >>>	1. Views and Experiences; 2. Engagement; 3. Staff Engagement; 4. Prioritisation; 5. Value; 6: Costed Action Plans						
	With regards to ensuring engagement and involvement on estates and facilities services from people who use the services, public and staff can your organisation evidence the following?		80	100	68	Req's Minimal Improvement	✓ ✓ ✓	
P2	NHS Premises Assurance Model: Patient Experience Links below to Evidence >>>	1. PLACE Assessment; 2. Other Assessments; 3: Costed Action Plans						
	With regard to ensuring patients, staff and visitors perceive the condition, appearance, maintenance and privacy and dignity of the estate is satisfactory can your organisation evidence the following?		80	100	60	Req's Minimal Improvement	✓ ✓ ✓	
P3	NHS Premises Assurance Model: Patient Experience Links below to Evidence >>>	1. PLACE Assessment; 2. Other Assessments; 3: Cleaning Schedules						
	With regard to ensuring ensure that patients, staff and visitors perceive cleanliness of the estate and facilities to be satisfactory can your organisation evidence the following?		80	100	67	Req's Minimal Improvement	✓ ✓ ✓	
P4	NHS Premises Assurance Model: Patient Experience Links below to Evidence >>>	1. PLACE Assessment; 2. Other Assessments; 3: Costed Action Plans						
	With regard to ensuring that access and car parking arrangements meet the reasonable needs of patients, staff and visitors can your organisation evidence the following?		80	100	60	Req's Minimal Improvement	✓ ✓ ✓	
P5	NHS Premises Assurance Model: Patient Experience Links below to Evidence >>>	1. PLACE Assessment; 2. Other Assessments; 3: Costed Action Plans						
	With regard to providing a high quality and supportive environment for patients, visitors and staff in relation to grounds and gardens can your organisation evidence the following?		80	100	60	Req's Minimal Improvement	✓ ✓	
P6	NHS Premises Assurance Model: Patient Experience Links below to Evidence >>>	1. Policy & Procedures; 2. Regulation; 3. Choice; 4. Equality Issues; 5. Information; 6. PLACE Assessment; 7. Other Assessments; 8. Legal Standards; 9: Costed Action Plans						
	How does your organisation/site ensure that NHS Catering Services provide adequate nutrition and hydration through the choice of food and drink for people to meet their diverse needs?		80	100	78	Req's Minimal Improvement	✓ ✓ ✓ ✓	

Appendix 3: Overall Summary Efficiency, Effectiveness and Organisational Governance 2020/2021

The PAM Distribution of SAQ Ratings for Efficiency, Effectiveness and Organisational for 2020/2021 shows the trust to be Good in 31 elements, requiring Minimal Improvement in 14 elements, requiring Moderate Improvement in 11 elements, Inadequate in 5 elements and N/A in 12 individual elements. The evidence gained during the PAM assessment process has identified the need for Minimal and moderate Improvement in the majority of sections within the individual PAM SAQ's, with focus on the 5 inadequate elements within the effectiveness domain (sustainability). All elements requiring Improvement will be picked up in detail within the review of each individual domain through the PAM working group process for 2021/2022 with action plans and review dates presented to individual responsible managers.

Figure 9: Overall Summary Position - Efficiency, Effectiveness, Organisational Governance 2020/2021

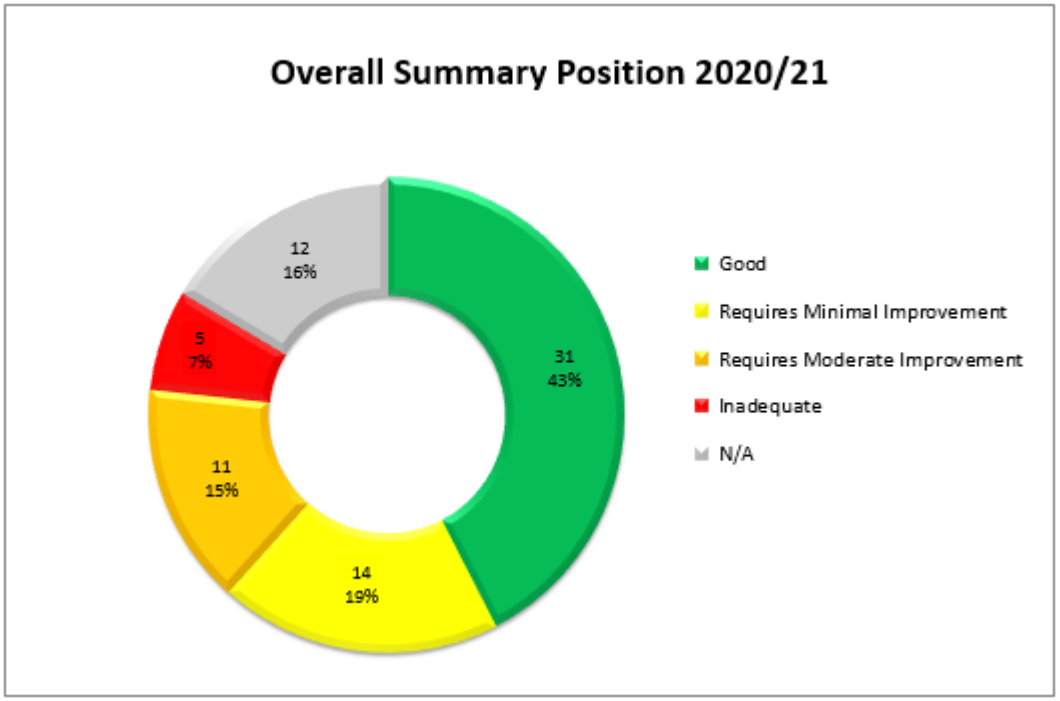
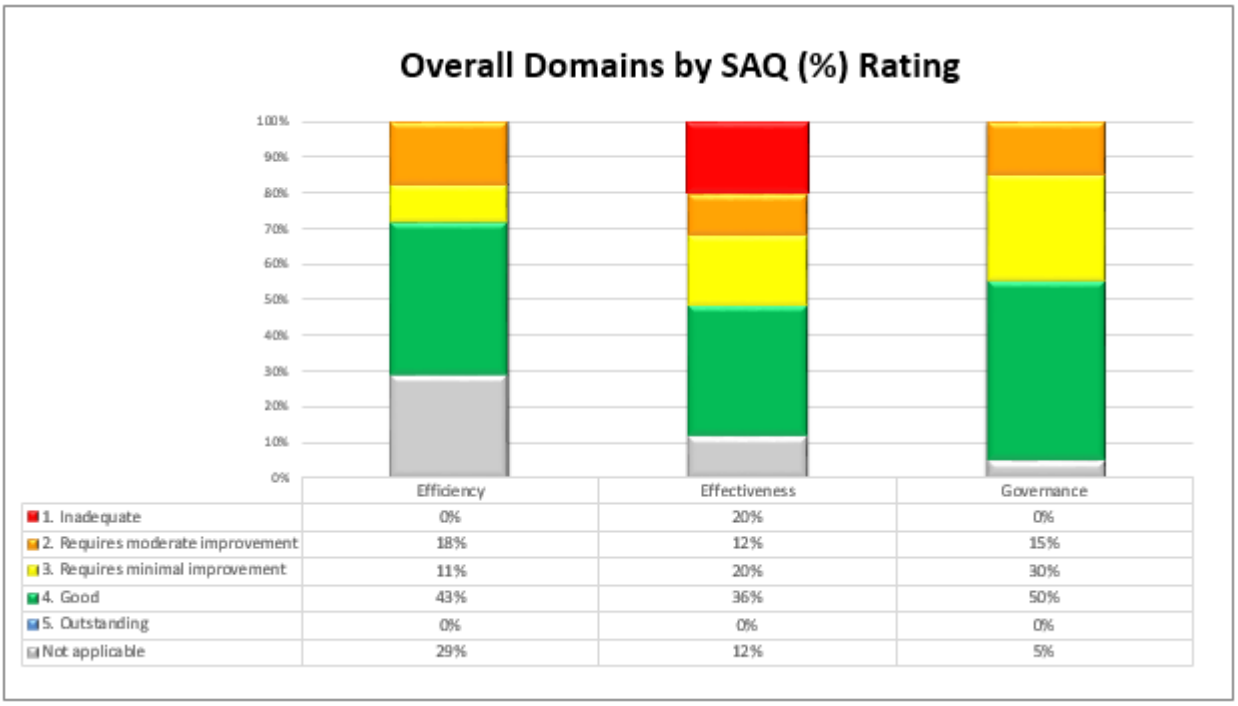


Figure 10: Overall Distribution of SAQ Ratings (%) for Efficiency, Effectiveness, Organisational Governance 2020/2021



	Efficiency	Effectiveness	Governance
1. Inadequate	0%	20%	0%
2. Requires moderate improvement	18%	12%	15%
3. Requires minimal improvement	11%	20%	30%
4. Good	43%	36%	50%
5. Outstanding	0%	0%	0%
Not applicable	29%	12%	5%

Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

Report Cover Page			
Meeting Title:	*Board of Directors*		
Meeting Date:	*June 2021*	**Agenda Reference:**	**E6**
Report Title:	**INTEGRATED QUALITY & PERFORMANCE REPORT (IQPR) / Performance Exception Report (January 2021)**		
Sponsor:	*Rebecca Joyce – Chief Operating Officer*		
Author:	*Julie Thornton – Head of Performance*		
Appendices:			

Executive Summary	
Purpose of report:	To provide assurance to the Board that the appropriate actions are being taken to support operational performance across the Trust in terms of recovery and moving towards business as usual.
Summary of key issues:	The Integrated Quality & Performance Report (IQPR) is split into three parts: 1. At A Glance Charts - showing performance against the set of indicators 2. Performance Exception Report - this analysis is provided by operational teams to outline performance against the three main areas of focus; elective, emergency and cancer performance. 3. Summary to show speciality level activity against % value of 2019/2020 in line with the Elective Recovery Fund Requirements. The report has now been refreshed in light of the 21/22 National Planning Guidance. Headlines from May 2021 report include: **Elective** • For 2021/2021, activity will be monitored against: - Performance against agreed Trust capacity plan - Performance against Elective Recovery Fund (ERF) - % value 2019/20 - Performance against % activity of 2019/20 – Accelerator Programme • **Elective Recovery Fund** – in May 2021 the Trust achieved 89% of the 2019/20 activity value against a target of 88% • **52 Week Breaches** – in May 2021 the Trust reported 1433 breaches due to Covid 19 delays, down from 1943 at the end of April. Regional benchmarking indicates that DBTH have 3.5% of the PTL waiting over 52 weeks, and a falling trend, which is benchmarked as "green" in the range across the region. • **RTT** - in May 2021 the Trust delivered 70.8% performance within 18 weeks, below the 92% standard. This is an improvement from last month and ahead of the most recent peer and national benchmarking position.

- **Diagnostics** – in May 2021 the Trust achieved 57.56% against a target of 99%. This is a reduction from last month and continues to be below the national and peer benchmark. There is a specific focus on recovering the Radiology position.

Emergency

- **Emergency Care Bundle –** The Trust are currently shadow monitoring the new standards and awaiting the performance thresholds to be issued from NHS England

- **4 Hour Access** – in May 2021 the Trust delivered 80.28% achievement against national target of 95%, although attendances increased by 996, giving the highest monthly attendance over the last 12 months on both Doncaster and Bassetlaw sites. For the month this is below the national benchmark and slightly below the peer benchmark. A wide ranging action plan is in place.

- **Ambulance Delays -** There are continued challenges related to COVID 19 pressures. This is similar to challenges in other North East and Yorkshire Trusts. A joint action plan for DBTH and YAS is in place and a set of agreed actions between EMAS and DBTH.

- **Length of Stay** for non-elective patients has decreased slightly in during May 2021. Focused work with partners is ongoing to improve complex discharge pathways.

- **Stroke –** for March 2021 reporting, all standards were delivered with the exception of direct admission within 4 hours to the Stroke Unit (58% against a standard of 75%).

Cancer

- **Faster Diagnosis Standard –** In April 2021 the Trust achieved 69.8% against the performance target of 75%

- **31 Day Standard – i**n April 2021 the Trust achieved 3 out of 3 nationally reported measures, exceeding peer and national benchmarks.

- **62 Day Standard -** in April 2021 the Trust achieved 0 out of 2 nationally reported measures.

- The Trust is **on track with its improvement trajectories** to reach the required reduction in over 62 day open pathways improvement on cancer pathways.

- **Open Pathways over 104 Days –** in April 2021 the number of open pathways decreased from 6 to 5, however the data is indicating this will increase to 8 then 7 for May and June 2021 reporting due to complex pathways.

Conclusions and Next Steps

For elective and cancer performance, the key next steps of the restoration strategy are:

- The progress since April should be noted – there has been a significant step up of activity, progress on the Accelerator activity, and improvement on a number of elective metrics.
- The ongoing focus on "getting the basics right" remains the right strategy

<table>
<tr><td></td><td colspan="5">

- There is a clear focus on recovering the radiology position and improving timely access for patients

The Trust is now bringing a further focus to emergency flow and winter planning with a focus on:

- Developing the bed and capacity plan for September onwards, devising the internal schemes and working with partners. This will focus on both additional capacity & improving systems and processes
- Noting and planning for the unpredictable context for emergency flow & emergency attendance for 21/22
- Working to improve key metrics such as ambulance handover and planning for the forthcoming Emergency Care Bundle standards and supporting monitoring arrangements
- Balancing elective recovery with improving resilience and capacity for emergency flow

</td></tr>
<tr><td></td><td colspan="5">The Board is asked to note and comment as appropriate on the attached.</td></tr>
<tr><td>Action Require:</td><td>Approval</td><td>Information</td><td>Discussion</td><td>Assurance
X</td><td>Review</td></tr>
<tr><td>Link to True North Objectives:</td><td>TN SA1:
To provide outstanding care for our patients

X</td><td>TN SA2:
Everybody knows their role in achieving the vision</td><td>TN SA3:
Feedback from staff and learners is in the top 10% in the UK</td><td colspan="2">TN SA4:
The Trust is in recurrent surplus to invest in improving patient care</td></tr>
<tr><td colspan="6">Implications</td></tr>
<tr><td colspan="2">Board assurance framework:</td><td colspan="4">No changes to BAF made – risks regarding elective restoration which this report reflects are outlined on the BAF</td></tr>
<tr><td colspan="2">Corporate risk register:</td><td colspan="4">Report regards Risks ID 6 and 2349 on the Risk Register - F&P 6 and F&P 8.
• Failure to achieve compliance with performance and delivery aspects of the SOF, CQC and other regulatory standards
• Failure to specifically achieve RTT 92% standard
Report outlines actions plan to make progress, no change to risks on CRR</td></tr>
<tr><td colspan="2">Regulation:</td><td colspan="4">Report links to national quality and access standards. Performance against the standards contributes to the CQC regulatory framework.</td></tr>
<tr><td colspan="2">Legal:</td><td colspan="4">Report outlines performance against standards, published annually by NHS England, some of which are outlined in the NHS Constitution.</td></tr>
<tr><td colspan="2">Resources:</td><td colspan="4">Impact on resources of delivering activity taken account of in Trust plans</td></tr>
<tr><td colspan="6">Assurance Route</td></tr>
<tr><td colspan="2">Previously considered by:</td><td colspan="4">Finance & Performance Committee (verbal update only – due to timing of meeting full report was not available)</td></tr>
<tr><td>Date:</td><td>17th May 2021</td><td>Decision:</td><td colspan="3">Implementation and future monitoring of elective restoration action plan.</td></tr>
<tr><td colspan="2">Next Steps:</td><td colspan="4">Continued monitoring of recovery & associated action plans at Finance & Performance Committee</td></tr>
<tr><td colspan="2">Previously circulated reports to supplement this paper:</td><td colspan="4"></td></tr>
</table>

Category	Indicator	Benchmarking Month Reported	Peer Benchmark	National Benchmark	Latest Month Reported	CURRENT MONTH			YEAR-TO-DATE			Trend Graph (Jun-19 - stated month) This is calculated based on rolling 24 month data with performance below expected control limits highlighted in red and above expected control limits in green
						Local Target	Actual	Variance	Local Target	Actual	Variance	
Performance (NHSI Compliance Framework -	A&E: Max wait four hours from arrival/admission/transfer/discharge (Type 1 benchmarking only)	May-21	81.8%	83.7%	May-21	85%	80.2%	-4.8%	85%	81.5%	-3.5%	
	ED Attendances (For Monitoring Only)				May-21	-	16848	-	-	32656	-	
4 Hour Access - Trust Boarding Times	Average Wait Time (from clinically ready to proceed to admission) - Medicine	-	-	-	May-21	<1 Hour	-	-	<1 Hour	-	-	
	Average Wait Time (from clinically ready to proceed to admission) - Surgery	-	-	-	May-21	<1 Hour	-	-	<1 Hour	-	-	
	Average Wait Time (from clinically ready to proceed to admission) - Gynaecology	-	-	-	May-21	<1 Hour	-	-	<1 Hour	-	-	
	Average Wait Time (from clinically ready to proceed to admission) - Paediatrics	-	-	-	May-21	<1 Hour	-	-	<1 Hour	-	-	
Performance (NHSI Compliance Framework - Elective Care)	Max time of 18 weeks from point of referral to treatment- incomplete pathway	Apr-21	61.0%	64.6%	May-21	TBC	70.8%	-	TBC	69.2%	-	
	RTT 52 Week Breaches to date	-	-	-	May-21	2004	1443	561	2004	1443	561	
	Waiting list size - 18 Weeks referral to treatment -Incomplete Pathways	-	-	-	May-21	-	37818	-	-	37818	-	
	% waiting less than 6 weeks from referral for a diagnostics test	Apr-21	77.3%	76.0%	May-21	TBC	57.6%	-	TBC	59.0%	-	
Performance (Cancer)	Maximum 2 week wait to see a specialist for all patients referred with suspected cancer symptoms	-	-	-	Apr-21	-	-	-	-	-	-	
	Maximum 2 week wait to see a specialist for breast symptoms, even if cancer not suspected	-	-	-	Apr-21	-	-	-	-	-	-	
	Day 28 Standard (patients received diagnosis or exclusion of cancer within 28 days)	-	-	-	Apr-21	-	-	-	-	-	-	
	Maximum 31 day wait from decision to treat to first definitive treatment for all cancers	-	-	-	Apr-21	-	90.9%	-	-	90.9%	-	
	Maximum 31 day wait for subsequent treatment - Surgery	-	-	-	Apr-21	-	100.0%	-	-	100.0%	-	
	Maximum 31 day wait for subsequent treatment - Drugs	-	-	-	Apr-21	-	100.0%	-	-	100.0%	-	
	Maximum 62 day wait for patients on 2ww pathway to first definitive treatment	-	-	-	Apr-21	-	84.4%	-	-	84.4%	-	
	Maximum 62 wait from referral from NHS cancer screening service to first definitive treatment	-	-	-	Apr-21	-	31.3%	-	-	31.3%	-	
	Cancer Waiting Times Open Suspected Cancer Pathways 63 - 104 Days - reduction of 10% month on month (trajectory at trust level - tracking only at specialty)	-	-	-	Apr-21	-	-	-	-	-	-	
	Cancer Waiting Times Open Suspected Cancer Pathways 104 Days +	-	-	-	Mar-21	-	11	-	-	196	-	
	Non Elective Activity - Discharges	-	-	-	May-21	-	4856	-	-	9718	-	
	TOTAL Activity (against plan - numbers)	-	-	-	Apr-21	37395	38356	961	37395	38356	961	
	Day Case Theatre Activity (against plan - numbers)	-	-	-	May-21	4513	3866	-647	7871	7683	-188	
	In Patient Elective Theatre Activity (against plan - numbers)	-	-	-	May-21	281	361	80	281	633	352	
	Endoscopy Activity (against plan - numbers)	-	-	-	May-21	1372	1078	-294	2788	2206	-582	
	Non-Theatre Elective Activity -excluding Endoscopy (against plan - numbers)	-	-	-	May-21	295	249	-46	785	516	-269	

Activity Against Plan	Elective Patient Activity - Independent Sector	-	-	-	May-21	0	44	44		74	-	
	Outpatient New Activity - face to face (Including Procedures against plan - numbers)	-	-	-	May-21	8371	8439	68	17364	16567	-797	
	Outpatient New Activity - telephone (against plan - numbers)	-	-	-	May-21	2476	2823	347	5083	6036	953	
	Outpatient New Activity - video (against plan - numbers)	-	-	-	May-21	98	42	-56	201	102	-99	
	Outpatient Follow Up Activity - face to face (Including Procedures against plan - numbers)	-	-	-	May-21	13747	16750	3003	28256	32857	4601	
	Outpatient Follow Up Activity - telephone (against plan - numbers)	-	-	-	May-21	6610	5611	-999	13597	11881	-1716	
	Outpatient Follow Up Activity - video (against plan - numbers)	-	-	-	May-21	458	130	-328	940	319	-621	
	Outpatient Procedures (For Monitoring Only)	-	-	-	May-21	-	5735	-	-	11460	-	
	Outpatient Activity - Independent Sector	-	-	-	May-21	0	213	213	0	391	391	
Activity Against Value (19/20) - Elective Recovery Fund National Submission	TOTAL Activity Value (%19/20)	-	-	-	May-21	88%	88.8%	0.8%	88.0%	85.2%	-2.8%	
	Day Case Theatre Activity Value (% 19/20)	-	-	-	May-21	88%	94.4%	6.4%	88.0%	93.1%	5.1%	
	In Patient Elective Theatre Activity Value (%19/20)	-	-	-	May-21	88%	84.5%	-3.5%	88%	74.6%	-13.4%	
	Outpatient New Activity Value (%19/20)	-	-	-	May-21	88%	87.3%	-0.7%	88%	84.8%	-3.2%	
	Outpatient Follow Up Activity Value (%19/20)	-	-	-	May-21	88%	87.6%	-0.4%	88%	86.4%	-1.6%	
Addressing Health Inequalities	TBC	-	-	-	-	-	-	-	-	-	-	
	TBC	-	-	-	-	-	-	-	-	-	-	
	TBC	-	-	-	-	-	-	-	-	-	-	
	TBC	-	-	-	-	-	-	-	-	-	-	
	TBC	-	-	-	-	-	-	-	-	-	-	
Performance Ambulance Handover Times	Ambulance Handovers Breaches -Number waited <= 15 Minutes	-	-	-	May-21	79%	56%	-23%	79%	55%	-24%	
	Ambulance Handovers Breaches -Number waited >15 & <30 Minutes	-	-	-	May-21	21%	29%	-8%	21%	29%	-8%	
	Ambulance Handovers Breaches-Number waited >30 Minutes	-	-	-	May-21	0%	15%	-15%	0%	16%	-16%	
Performance Stroke	Overall SSNAP Rating	-	-	-	Mar-21	B	B	-	B	B	-	
	Proportion of patients scanned within 1 hour of clock start (Trust)	-	-	-	Mar-21	48%	49%	1%	48%	52%	4%	
	Proportion directly admitted to a stroke unit within 4 hours of clock start	-	-	-	Mar-21	75%	58%	-17%	75%	55%	-20%	
	Percentage of all patients given thrombolysis	-	-	-	Mar-21	90%	100%	10%	90%	100%	10%	
	Percentage treated by a stroke skilled Early Supported Discharge team	-	-	-	Mar-21	24%	49%	25%	24%	74%	50%	
	Percentage discharged given a named person to contact after discharge	-	-	-	Mar-21	80%	65%	-15%	80%	77%	-3%	
	New to Follow Up Ratio (DCCG) (For Monitoring Only)	-	-	-	-	-	-	-	-	-	-	

Performance - Outpatients	New to Follow Up Ratio (BCCG) (For Monitoring Only)	-	-	-	-	-	-	-	-	-	-	
	New to Follow Up Ratio (TRUST) (For Monitoring Only)	-	-	-	May-21	-	1:1.99	-	-	1:1.98	-	
	Out Patients: DNA Rate (first appointment)	-	-	-	May-21	-	9.49%	-	-	10.01%	-	
	Out Patients: DNA Rate (Follow up appointment)	-	-	-	May-21	-	9.82%	-	-	9.80%	-	
	Out Patients: DNA Rate (Combined) (For Monitoring Only Target Set At Specialty Level)	-	-	-	May-21	-	9.71%	-	-	9.87%	-	
	Out Patients: Hospital Cancellation Rate (under 6 weeks)	-	-	-	May-21	-	11.44%	-	-	11.46%	-	
	Out Patients: Patient on the Day Cancellation Rate (For Monitoring Only)	-	-	-	May-21	-	-	-	-	-	-	
	Backlogs - To reflect Simple PTL Excluding Active Waiters (For Monitoring Only)	-	-	-	-	-	-	-	-	-	-	
	Typing Turnaround (Trust Contract)	-	-	-	May-21	7WD	48WD	41WD	7WD	49WD	42WD	
	Out Patient Clinic Utilisation - Booked 2 weeks Prior	-	-	-	May-21	95%	46.15%	-48.85%	95%	45.50%	-49.50%	
	Out Patient Clinic Utilisation (attended)	-	-	-	May-21	90%	84.69%	-5.31%	90%	83.54%	-6.46%	
	Registered Referrals not Appointed	-	-	-	May-21	0	5294	5294	0	5294	5294	
	Unreconcilled Appointments 14 days + E-Reconcillation	-	-	-	-	-	-	-	-	-	-	
	Unreconcilled Appointments 14 days + CAMIS	-	-	-	-	-	-	-	-	-	-	
	ERS Advice & Guidance Response Time	-	-	-	May-21	2WD	3WD	1WD	2WD	4WD	2WD	
	ERS Advice & Guidance Activity (Trust)	-	-	-	May-21	547	102	-445	547	61	-486	
	Number of Specialities offering PIFU (ENT / Cardiology / Dermatology) TRUST TAB ONLY	-	-	-	-	-	-	-	-	-	-	
	% of OP appointments delivered virtually (video or telephone)	-	-	-	May-21	25%	25.43%	0.43%	25%	27.02%	2.02%	
Performance - Theatres	Theatre Booking - 4 weeks prior -Lists Populated	-	-	-	May-21	50%	68.09%	18.09%	50%	67.31%	17.31%	
	Theatre Booking - 2 weeks prior -Lists Populated	-	-	-	May-21	75%	81.41%	6.41%	75%	80.56%	5.56%	
	Theatre Booking - 1 week prior -Lists Populated	-	-	-	May-21	95%	85.53%	-9.47%	95%	84.72%	-10.28%	
	Theatre Utilisation	-	-	-	May-21	87%	87.12%	0.12%	87%	86.24%	-0.76%	
	Number of Prioirity 2 Patients waiting 28 days + for surgery from date of listing/P2 Categorisation	-	-	-	May-21	-	193	-	-	193	-	
	% Cancelled Operations on the day (non-clinical reasons)	-	-	-	May-21	1%	0.52%	0.48%	1%	0.77%	0.23%	
	% Cancelled Operations on the day (clinical reasons) (For Monitoring Only)	-	-	-	May-21	-	-	-	-		-	
	Infection Control Hosptial Onset C.Diff (Medicine & Surgery Only)	-	-	-	May-21	2	7	-5	5	11	-9	
	Infection Control Community Onset C.Diff (Medicine & Surgery Only)	-	-	-	May-21	1	1	0	2	2	-1	
	Infection Control Combined Onset C.Diff (Medicine & Surgery Only)	-	-	-	May-21	3	8	-5	7	13	-10	
	MRSA Cases Reported	-	-	-	May-21	0	0	0	0	0	0	

Patients (National Requirements)	HSMR (rolling 12 Months - Combined)	-	-	-	May-21	100	110.68	-10.68	100	110.68	-10.68	
	HSMR : Non-Elective (rolling 12 Months)	-	-	-	May-21	100	110.29	-10.29	100	110.29	-10.29	
	HSMR : Elective (rolling 12 Months)	-	-	-	May-21	100	152.98	-52.98	100	152.98	-52.98	
	Never Events	-	-	-	May-21	0	0	0	0	0	0	
	Serious Incidents Reported in Month (For Monitoring Only)	-	-	-	May-21	-	3	-	-	4	-	
	SI Action Plans closed within 3 months of CCG closure of incident	-	-	-	May-21	100.00%	-	-	100%	-	-	
	All open incidents on Datix to be closed within 3 months of reporting (excluding patient experience)	-	-	-	May-21	100.00%	-	-	100%	-	-	
	Pressure Ulcers - Category 4	-	-	-	May-21	0	0	0	0	0	0	
	Pressure Ulcers - Category 3	-	-	-	May-21	4	3	1	9	7	2	
	Pressure Ulcers - Category 2 / UNS / DTI	-	-	-	May-21	61	68	-7	123	147	-24	
	Falls with Severe Harm / Lapse in Care / SI	-	-	-	May-21	-	0	-	-	0	-	
	Falls with Moderate or Severe Harm	-	-	-	May-21	1	3	-2	3	6	-3	
	Complaints Resolution Performance (% achieved closure in agreed timescales with complainant)	-	-	-	May-21	95.0%	50.0%	-45.00%	95.0%	50.0%	-45.00%	
	Complaints Upheld / Partially Upheld by Parliamentary Health Service Ombudsman	-	-	-	May-21	0	0	0	0	0	0	
	Claims CNST (patients)	-	-	-	May-21	-	7	-	-	7	-	
	Claims LTPS - staff	-	-	-	May-21	-	1	-	-	1	-	
	Friends & Family Response Rates (ED)	-	-	-	May-21	15%	0.02%	-15%	15%	0.05%	-15%	
	Friends & Family Response Rates (Inpatients)	-	-	-	May-21	30%	5.27%	-25%	30%	4.95%	-25%	
	% Reduction on LoS for patients remaining in hospital between 7-14 days compared to 2019-20	-	-	-	-	-	-	-	-	-	-	
	Mixed Sex Accommodation	-	-	-	May-21	0	0	0	0	0	0	
	Sepis Screening - % of appropriate patients screened	-	-	-	-	90%	-	-	90%	-	-	
	Sepsis Prescribing - Antibiotics within 1 Hour	-	-	-	-	90%	-	-	90%	-	-	
	Deaths Screened as part of Mortality Review Process	-	-	-	-	100%	-	-	100%	-	-	
	NICE Guidance Response Rate Compliance	-	-	-	May-21	95%	99%	4.44%	95%	99%	4.05%	
	NICE Guidance % Non & Partial Compliance (For Monitoring Only)	-	-	-	May-21	-	-	-	-	-	-	
	% Patients Asked for Smoking Status	-	-	-	-	50%	-	-	50%	-	-	
	Staff Flu Vaccinations (1.9.21 - 28.2.22)	-	-	-	-	-	-	-	-	-	-	
	Agenda for Change Appraisals (rolling 12 months)	-	-	-	May-21	90%	47%	-43.41%	90%	46%	-43.99%	
	Non-Medical Appraisals - in season (April - July)	-	-	-	May-21	-	9%	-	-	93%	-	

People	Sickness (rolling 12 months)	-	-	-	May-21	4%	6%	-2.17%	4%	6%	-2.10%	
	Job Planning (TBC)	-	-	-	May-21	TBC	-	-	TBC	-	-	
	SET Training	-	-	-	May-21	90%	87%	-2.97%	90%	87%	-3.46%	
	Vacancies	-	-	-	-	5%	-	-	5%	-	-	
	Turnover (rolling 12 months)	-	-	-	May-21	10%	1%	8.80%	10%	5%	4.74%	
	Casework - number of grievances opened in month	-	-	-	May-21	-	3	-	-	3	-	
	Casework - number of conduct cases opened in month	-	-	-	May-21	-	25	-	-	41	-	
	Number of Incorrect Payments (Trust Originated) (rolling 12 months)	-	-	-	May-21	-	90	-	-	114	-	
	Compliance with EWTD (on hold until 2021)	-	-	-	-	YES	-	-	YES	-	-	
	Time to Fill Vacancies (from TRAC authorisation - unconditional offer)	-	-	-	-	47WD	-	-	47WD	-	-	

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INTRODUCTION

This report provides a summary of the Trust's performance against the following national indicators:

1. Elective

a) Activity – Performance Against Trust Capacity Plan
b) Activity Value – Performance Against Elective Recovery Fund (ERF)
c) Priority 2 Elective Patients
d) 52 Weeks
e) Referral to Treatment Times
f) Diagnostic Performance
g) Cancelled Operations on the Day for Non Clinical Reasons
h) Cancelled Operations – Not Rebooked within 28 Days
i) Integrated action plan - elective

2. Emergency

a) Emergency Care Bundle Standards
b) 4 Hour Access
c) Ambulance Handover
d) Length of Stay & Super Stranded Patients
e) Stroke Performance – March 2021

3. Cancer Performance

a) Faster Diagnosis Standard
b) Performance against 31, 62 day standards
c) Cancer Performance - Specialty – April 2021
d) Cancer Performance Exceptions – 31/ 62 days
e) 104 Day Breaches

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1. ELECTIVE

A summary of performance against the standards is provided in section a) - f). A single integrated action plan for elective is provided at the end of this section.

a) Activity - Performance Against Trust Capacity Plan – with Comparison to 19/20 Activity Levels

The following table summarises performance against the Trust Capacity Plan.

		% Achievement Against Trust Capacity Plan						
Point of Delivery	**Trust Capacity Plan**	**April 2021**	**May 2021**	**June 2021**	**July 2021**	**August 2021**	**Sept 2021**	**% 19/20 Activity (May 2021)**
Outpatient New	10956	97.9%	103 %					78.2%
Outpatient F/U	20816	101.5%	108%					81.1%
Elective	576	104.7%	101%					77.7%
Day Case	4513	112.7%	85.7%					91.5%
CT	5726	117%	112%					110%
MRI	1381	102%	106%					86.8%
Non Obstetric Ultrasound	5830	96%	85%					71.1%
Endoscopy	1372	72%	73%					67.8%

*****Activity recorded at flex positon – achievement is subject to change up to 6 weeks after month end*

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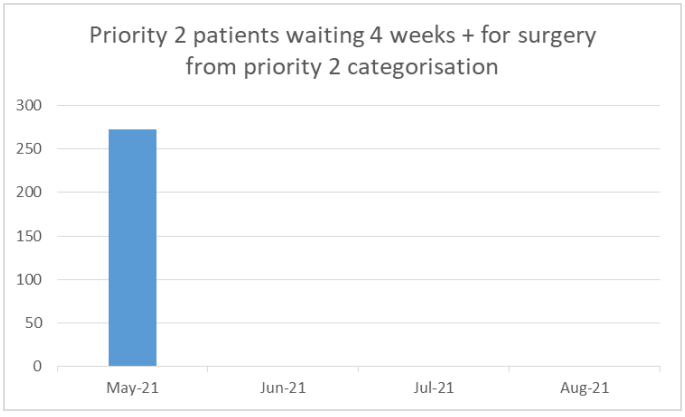
b) Activity Value – Performance Against Elective Recovery Fund (ERF)

The following table summarises performance against the Elective Recovery Fund - % activity value of 2019/20

	Elective Recovery Fund Target (% of 19/20 Activity Value)					
Point of Delivery	**April 2021**	**May 2021**	**June 2021**	**July 2021**	**August 2021**	**Sept 2021**
	77%	**88%**	**84%**	**89%**	**91%**	**85%**
Outpatient New	82.06%	87%				
Outpatient F/U	83.31%	88%				
Elective	65.09%	85%				
Day Case	88.88%	94%				
TRUST TOTAL	**80.4%**	**89%**				

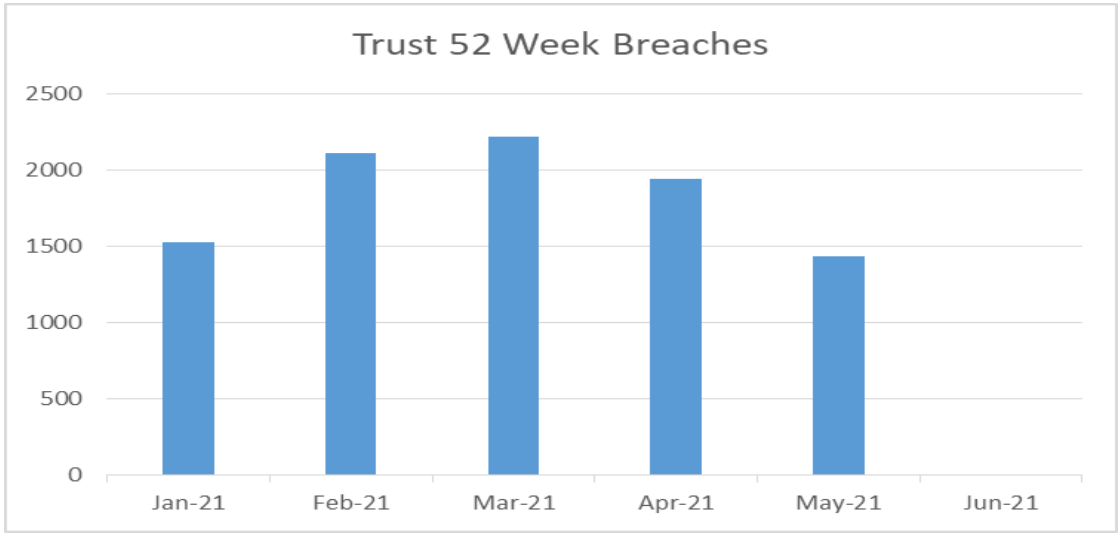
c) Priority 2 Patients – Waiting 4 Weeks + for Surgery (from P2 categorisation)

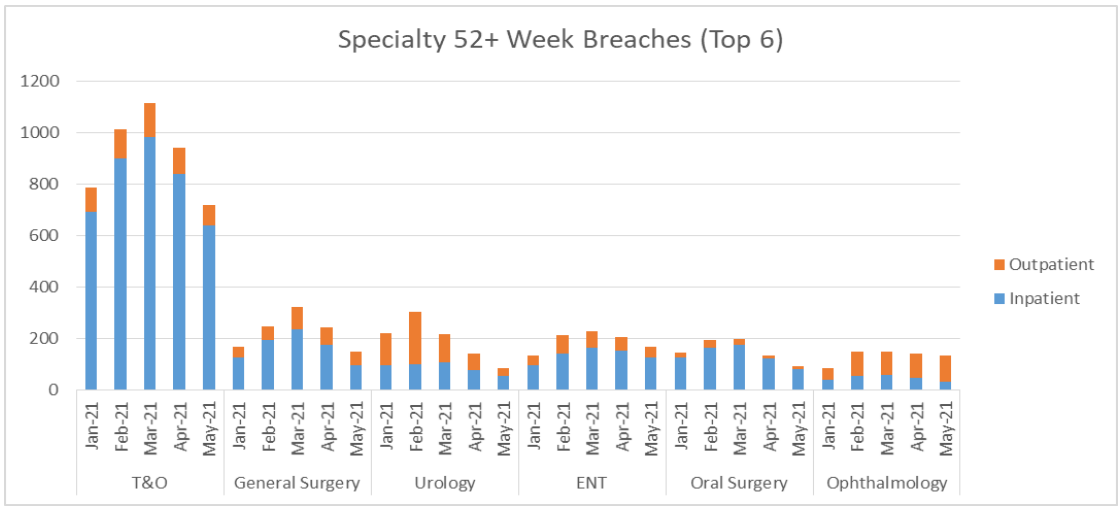
The following graph highlights the current Trust position for priority 2 patients waiting 4 weeks + for surgery from priority 2 categorisation. Reporting with this criteria only commenced for May 2021 so no historical data is available for comparison.



d) 52 Weeks

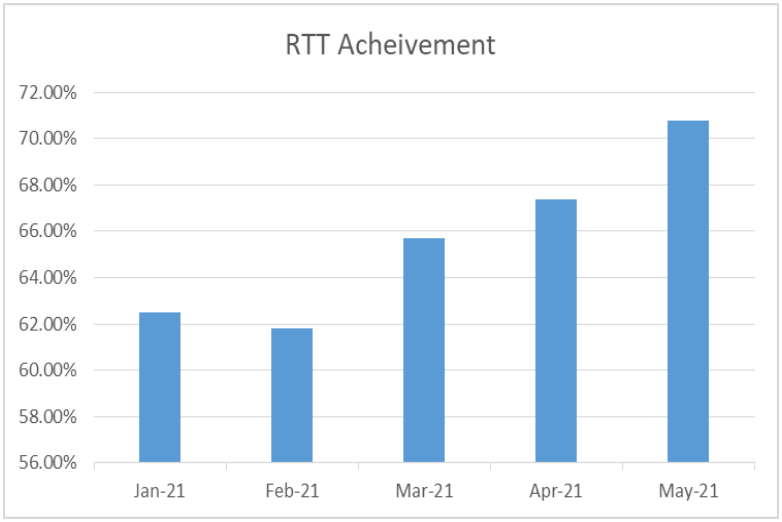
The following graphs highlight the current Trust and speciality 52 week breach position. May 2021 saw a continued reduction in breach numbers with a total of 1433 breaches reported. The Trust benefitted from the reduction of referrals during the first few months of the pandemic, however, this also reflects the focus of the scheduling teams on booking long waiting patients after clinical priorities.





e) RTT – Performance Against National Target – 92%

An improving position on RTT is shown month on month as the Trust recovers from the pandemic. Performance has improved since April 2021 with a 3.4% increase in achievement to 70.8%.



The table below summarises 18 weeks performance. It should be noted that a number of medical specialties continue to achieve the standard, which is excellent. A more challenging position exists in the surgical specialties which were more impacted by COVID.

The total waiting list size stands at **37818,** which is an increase of 2629 since last month, with a plan in development to improve this position.

Specialty	Waiting List	RTT Percentage	Longest Wait (weeks)
Breast Surgery	459	92.8 %	69
Cardiology	1454	96.4 %	88
Clinical Haematology	204	94.6 %	31
Dermatology	1393	98.3 %	38
Diabetic Medicine	341	94.4 %	58
ENT	4477	58.4 %	226
General Medicine	2032	86.9 %	62

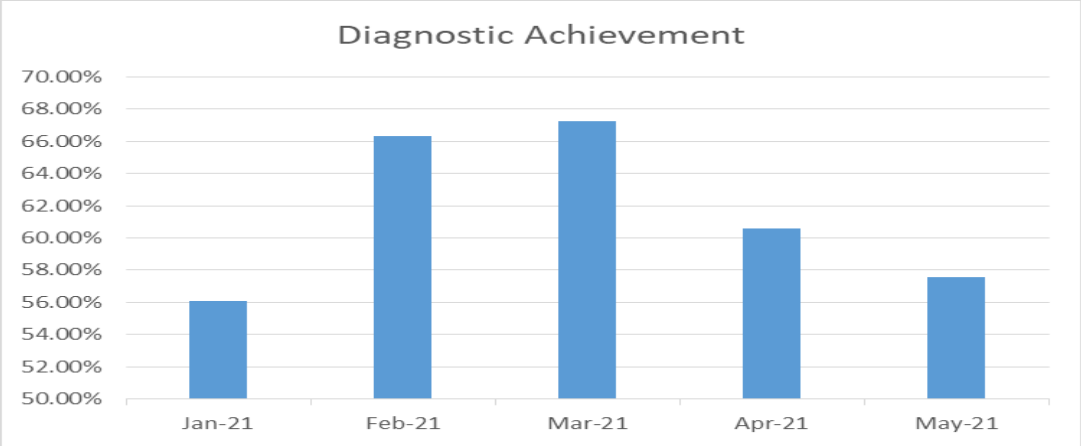
General Surgery	3595	65.6 %	113
Geriatric Medicine	189	83.6 %	47
Gynaecology	1923	83.3 %	102
Medical Ophthalmology	568	90.8 %	83
Nephrology	93	98.9 %	28
Ophthalmology	3881	68.0 %	102
Oral Surgery	2507	70.0 %	97
Orthodontics	62	83.9 %	33
Paediatric Cardiology	102	93.1 %	34
Paediatrics	499	95.6 %	33
Pain Management	495	90.5 %	68
Podiatry	239	68.6 %	78
Respiratory Medicine	886	94.9 %	68
Rheumatology	553	96.7 %	32
Trauma & Orthopaedics	8190	57.6 %	100
Upper GI Surgery	229	50.7 %	89
Urology	2630	55.2 %	90
Vascular Surgery	705	83.4 %	77
Grand Total	37818	70.8 %	N/A

A summary of breakdown by CCG and over the last 4 months is outlined below:

Incomplete Pathways	**May 2021**	**April 2021**	**March 2021**	**February 2021**
Total (Trust)	37818	35189	33018	32267
% under 18 Weeks (Trust)	70.8%	67.4%	65.7%	61.8%
Total (Doncaster CCG)	23139	21417	19973	19748
% under 18 Weeks (Doncaster CCG)	71.9%	68.3%	66.2%	61.9%
Total (Bassetlaw CCG)	8184	7655	7287	6962
% under 18 Weeks (Bassetlaw CCG)	70.9%	67.5%	66.9%	62.8%

f) Diagnostics – Performance Against National Target – 99%

Performance against the 6 week target has decreased compared to last month (57.56% compared to 60.57%). Additional activity is being organised to support the reduction of the backlog.



The total number of waiters has increased by 558 since last month with those over 6 weeks also increasing by 744. A challenging position is shown at modality level:

Exam Type	<6W	>=6W	Total	Performance	Longest Waits
MRI	1555	1274	2829	54.97%	49
CT	2153	1014	3167	67.98%	28
Non-Obstetric Ultrasound	4198	3928	8126	51.66%	40
DEXA	374	75	449	83.30%	45
Audiology	248	160	408	60.78%	68
Echo	248	1	249	99.60%	6
Nerve Conduction	181	162	343	52.77%	65
Sleep Study	8	0	8	100.00%	3
Urodynamic	39	16	55	70.91%	63
Colonoscopy	236	245	481	49.06%	29
Flexible Sigmoidoscopy	67	119	186	36.02%	34
Cystoscopy	356	62	418	85.17%	67
Gastroscopy	366	338	704	51.99%	26
Total	10029	7394	17423	57.56%	

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Performance for the Trust, NHS Doncaster and NHS Bassetlaw is outlined below:

	Waiters <6W	Waiters >=6W	Total	Performance
Trust	10029	7394	17423	57.56%
NHS Doncaster	6498	4722	11220	57.91%
NHS Bassetlaw	2675	2046	4721	56.66%

g) Cancelled Operations on the Day for Non Clinical Reasons

The table below summarises performance against the national standard of 1%, with a breakdown of reasons for cancellations.

CCG	Total Activity	No of Cancellations	% Achievement
Trust	4399	42	0.95%
Doncaster	2943	19	0.65%
Bassetlaw	982	19	1.93%
Other	474	4	0.8%

Issues driving performance and the related improvement plan are summarised below:

Issues Affecting Performance	No of Theatre Breaches	No of Non-Theatre Breaches	Improvement Plan
Missing Notes		4	
Insufficient Time/ Lack of Theatre Capacity (clinical reasons)	16	15	12 / 16 theatre cases the previous patient was more complex than initially planned via Bluespier timings 4 / 16 due to late start to the list – no common theme identified.
Equipment	2	3	1 x tear in theatre drapes. Third outside drape will be added to mitigate risk and instrument tins will be purchased awaiting feedback from HSDU. 1 x Planned operations on ENT list in excess of number of instrument trays, all options explored. Discussed with BM to avoid reoccurrence
Other Urgent Cases	1		Previous patient had emergency situation

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f) Cancelled Operations – Not Rebooked within 28 Days – Performance against National Target

In May 2021 there were 4 operations cancelled that were not rebooked within 28 days:

Speciality	TCI Date:	28 Day Breach Date:	New Date:	Cancellation Reason:	Breach Reason:	CCG:
Trauma & Orthopaedics	08/04/21	06/05/21	07/06/21	08/04/21 - equipment failure 28/04/21 flood	TCI 07/06/21	DCCG
Trauma & Orthopaedics	28/04/21	26/05/21	07/06/21	Flood	No theatre space until 07/06/21	DCCG
Trauma & Orthopaedics	08/04/21	26/05/21	07/06/21	Flood	08/04/21 equipment issue 28/04/20 flood 07/06/21 cancelled by anaesthetist	DCCG
Pain Management	20/04/21	18/05/21	15/06/21	20/04/2021 Equipment failure 17/05/2021 lack of theatre time	Cancellation day before breach date	Other

g) Elective Action Plan

A single action plan for elective is provided below:

Point of Delivery	Issues Affecting Performance	Improvement Plan
Outpatients	• Reduced capacity for all face to face activity due to COVID Safe Working	• Trust Accelerator Delivery Cell (ADC) formed inaugural meeting 03.06.2021, weekly meeting chaired by DCOO • Retained in House insourcing confirmed start dates agreed commencing through the month of June. ENT activity scheduled July / August • Insourcing Ophthalmology, Endoscopy, OMFS, (third party provider) confirmed target start date 21.06.2021 • T&O outsourcing contracts under negotiation with new provider Trent Cliff • Phase 2 programme of works to be driven through the ADC group
Elective/Day Case	• Reduced non-urgent elective activity due to reduced operating timetable • Challenge to maximise theatre capacity due to staffing	• As above
Diagnostics	• Reduction in 2ww but increase in urgent & routine MRI referrals • Reduction in 2ww/urgent and routine CT seen • Increase in 2ww USS, but reduction in urgent and routine referrals. 3.24WTE vacancies – priority given to obstetric ultrasound – reducing capacity for Non-obstetric. • Reduction in MSK US backlog with slight increase in referral for urgent patients.	• Service continues to proactively look for ways to optimise capacity and scheduling to help release more capacity. • 2ww and urgent patients have been booked onto all additional sessions this month to stop these cohorts from breaching • Additional sessions undertaken in May to increase capacity, which improved the backlog position for 2ww/urgent and routine USS and CT. • More additional sessions including routine scans planned in June to help with the backlog for routine.

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There is overall reduction plain film in referrals
Reduced capacity in NOUS waiting rooms due to COVID-19 Infection Control requirements

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<table>
<tr><th>Clinic type (2ww/Urgent/ Routine)</th><th>Modality</th><th>No. of additional sessions</th><th>No. of patients</th></tr>
<tr><td>Routine (Sonographer)</td><td>NOUS</td><td>9</td><td>129</td></tr>
<tr><td>Routine/urgent (Radiologist)</td><td>NOUS</td><td>11</td><td>168</td></tr>
<tr><td>Routine (Radiologist)</td><td>MSK</td><td>3</td><td>36</td></tr>
<tr><td>Urgent & 2WW Contrast</td><td>CT</td><td>8</td><td>90</td></tr>
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<td>Theatre Cancellations</td>
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See specific issues on specific patients

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Additional reporting for 2021/22 in the IQPR to show cancelled operations for clinical reasons – highlighting themes and opportunities for improvement, including utilisation of redeployed staff for pre-calling.

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<td>Looking Forward</td>
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Strengthened management team for Surgery & Cancer with additional General Manager & substantive Deputy Chief Operating Officer to start in June 2021
Monthly Performance and Access Board to continue to provide additional grip and control of service delivery of both core and accelerator activity.

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2. EMERGENCY

a) Emergency Care Bundle – New Standards

The Trust are currently shadow monitoring the new standards and awaiting the performance thresholds to be issued from NHS England

b) 4 Hour Access

Performance against the 4 hour target dipped slightly during May 2021, although attendances increased by 996, giving the highest monthly attendance over the last 12 months on Doncaster and Bassetlaw sites.

Hospital	% Achievement	Attendances	No of Breaches	% Streamed from FDASS
Doncaster	71.8%	10165	2867	18.69%
Bassetlaw	90.76%	4868	450	6.8%
Mexborough	100%	1784	0	0%
Trust	80.28%	16817	3317	13.27%

Issues driving performance and the related improvement plan are summarised below:

Issues Affecting Performance	Improvement Plan
• 4 hour performance reduced slightly due to continued increase in attendances • Increase in Ambulance arrivals and walk ins at peak periods • Main breach reasons continue to be doctor and bed waits • Boarding time in department increased due to bed pressures • Average time in department 181 minutes • Longer length of stay for COVID patients affecting discharges and flow impacting on bed waits • Reduced bed base impacting on bed waits	• Quality improvement work • New General Manager in post increasing capacity of senior leadership team • Flow work- right care, right place • Team development and leadership work progressing well • Early Senior Assessment working well at front door • Work to commence with ECIST/ICS to support the flow review work • Actions taken by primary care and CCGs to encourage primary care patients to attend GP practices and public communication campaigns that GPs open to business

• Improvement in streaming numbers to FCMS compared to April 2021 • Increased resus activity- 622 in May • Increase in overall attendances in reduced space due to social distancing	

c) Ambulance Handover

The following tables summarises performance against national standards. Whilst the national standards were not met, the Trust's performance is comparable to acute providers across North East and Yorkshire. The standards are:

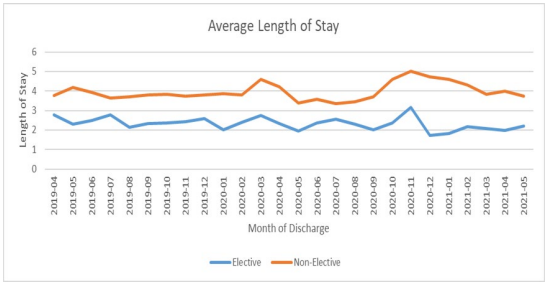
- Within 30 Minutes: 100%
- Less than 15 minutes: 78.4% (TBC for 2021/22)
- Between 15 – 30 minutes: 21.6% (TBC for 2021/22)

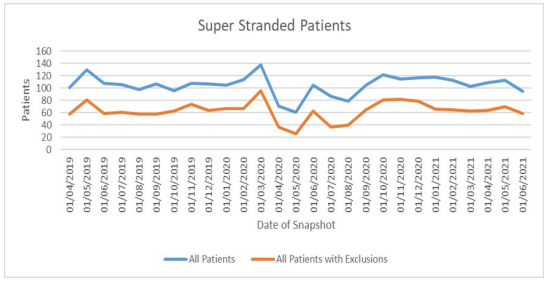
Month	Hospital	No of Arrivals	% less than 15 minutes	% between 15 & 30 minutes	% over 30 minutes	Longest Wait (hrs & minutes)
May 2021	**Doncaster**	2155	48.4%	31%	13.9%	3 hrs 47 mins
	Bassetlaw	824	38.2%	52%	9.5%	1 hrs 18 mins
	Trust	2979	45.6%	36.9%	7.4%	N/A

Issues driving performance and the related improvement plan is summarised below:

Issues Affecting Performance	Improvement Plan
• High levels of ambulances in the Doncaster area frequently disproportionate to the rest of Yorkshire • Exit block from ED causing challenges to flow of ambulances coming in and the receiving of handovers • Batching of ambulances • Increase in overall attendances and reduced space	• Action plan in place with YAS • ECIST / ICS support for improving handover process to be completed - awaiting start date • Direct pathways for YAS to Acute Medicine being implemented • Same Day Emergency Care full review – advanced stages to be discussed through Length of Stay work stream – will support emergency flow

d) Length of Stay & Super Stranded Patients





*The exclusions are as follows, based the data available on each snap shot date;

- Any patient who was at Montagu Hospital
- Any patient under the care of Rehabilitation
- Any patient aged under the age of 18
- Any patient on ward PARK, BARL, EPAU, ECL, ED WARD and D

Super Stranded Patients

Super stranded patients reported in May 2021 - 122 patients in total - 106 (DRI) 16 (BDGH), the majority of whom remain not medically fit for discharge. Patient numbers remain relatively consistent month on month with a slight increase this month.

Issues Affecting Performance	Improvement Plan
• Due to vaccinations, significantly fewer admissions from care homes and care home outbreaks resulting in improved flow / discharge for new and existing residents	• Negative swab required 48hrs prior to discharge for all care homes and assisted living residences - as internal capacity has increased, this has reduced delays • Designated COVID care home beds in Doncaster reduced to 4 beds - remains under review and escalation when necessary
• Neuro rehabilitation pathway - Magnolia Lodge unable/limited capacity to accept Category A patients resulting in complex, vulnerable patients being referred out of area. This significantly extends their length of stay Clinical staff time used to co-ordinate specialist placements	• Escalated through the System Surge and Operations Group, Partner Flow Meeting and with CCG colleagues • Doncaster CCG escalating
• Social care – limited capacity within the community for Short Term Enablement Programme (STEPs) and commissioned packages of care	• Escalated to senior social care colleagues

e) Stroke – Performance Against National Target – (Direct Admission within 4 hours) – 75%

All SSNAP KPIs compare favourably to the national average with DRI Stroke Unit 'B' rated on SNNAP the latest being received for October - December 2020. The remaining area of focus is timeliness of direct admission to the Stroke Unit with data for **March 2021** outlined below:

Direct Admission within 4 Hours	Bassetlaw CCG	Doncaster CCG	Barnsley CCG	Rotherham CCG	Other CCG	Total
Yes	7	26	0	6	3	**42**
No	6	21	0	1	2	**30**
Total	**13**	**47**	**0**	**7**	**5**	**72**
Performance	53.8%	53%		85.7%	60.0%	**58%**

Issues driving performance and the related improvement plan is summarised below:

Issues	Breaches	Improvement Plan Update
Stroke Unit Bed Availability	3	A Stroke Improvement Group has been established to review, update and work on the key priority areas across the pathway which fall under 4 Themes: • Treatment/ Diagnostics • Safer Care • Patient flow and Service Organisation • Research and Quality Improvement From mid-April Trainee Advanced Care Practitioner role is protected as supernumerary day and night. This will support ED reviews and reduce delays Staff sickness and bed capacity have contributed to delays in month, along with late diagnosis of patients who on initial triage were not through to be strokes.
Stroke Staff Availability	1	
ED Delay	14	
Delay in transfer of patients from ED to HASU	4	
Delay - transport BDGH to DRI	4	
Patient Presentation: secondary / late diagnosis of stroke	4	

Doncaster & Bassetlaw Teaching Hospitals NHS Foundation Trust
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3. CANCER

The following sections summarise cancer performance for April 2021 against 31 and 62 day standards

a) Faster Diagnosis Standard

The Trust achieved 69.8% for the above standard against the performance target of 75%

b) Cancer Performance (Trust) April 2021 – 31 and 62 day Standards

Standard	Target	Performance
31 Day Classic	96%	90.8%
31 Day Sub – Surgery	94%	100%
31 Day Sub – Drugs	98%	100%
62 Day – IPT Scenario Split	85%	76.8%
62 Day – Local Performance (local measure only)	-	83%
62 Day – Shared Performance only 50/50 Split (local measure only)	-	34.5%
62 Day Screening	90%	31.3%
62 Day Consultant Upgrades (local measure only)	85% (local)	84.4%

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c) Cancer Performance (Specialty) April 2021

	31 Day - Classic	31Day Sub - Surgery	31 Day Sub - Drugs	62 Day – Day 38 IPT split	62 Day Screening	62 Day Consultant Upgrades (no national standard)	Day 28 Faster Diagnosis Standard
Standard	**96%**	**94%**	**98%**	**85%**	**90%**	**85%** (local)	
Breast	93.3%	100%		80%	100%		76.5%
Gynaecology	100%			85.7%		100%	73.4%
Haematology	100%			40%		100%	25%
Head & Neck	100%			75%			62.4%
Lower GI	71.9%			47.6%	0%	80%	52.4%
Lung	100%			33.3%		66.7%	75%
Sarcoma				33.3%			
Skin	87.5%			91.7%		100%	83.7%
Upper GI	100%			100%		100%	77.1%
Prostate							71.4%
Urological	97.3%		100%	88.1%			73.4%
Performance	90.85%	100%	100%	76.8%	31.3%	84.4%	69.8%

Cancer performance by CCG is as follows:

	31 Day Classic	31Day Sub Surgery	31 Day Sub Drugs	62 Day Classic 50/50	62 Day Screening	62 Day Consultant Upgrades
Operational Standard	96%	94%	98%	85%	90%	85% (locally agreed)
Doncaster CCG	100%	100%		76.5%	38.5%	88.8%
Bassetlaw CCG	97.5%	100%	100%	77.7%	0%	50%

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d) Cancer Performance Exceptions (31/62 days) – April 2021

Tumour Group	Breached Standard 31 Day/62 Day	No of Breaches	Summary of Breach Issues
Lower GI	31 Day/62 Day	8	• 2 x Complex pathway • 1x COVID-19 delay • 1 x Admin delay • 1 x IPT received late in pathway • 1 x Patient choice • 1 x Medical reasons • 1 x Elective capacity
Breast	31 Day / 62 Day	5	• 2 x Outpatient capacity • 1 x Medical reasons • 2 x Complex diagnostic pathway
Gynaecology	62 Day	1	• 1 x Healthcare provider delay to diagnostics
Haematology	62 Day	6	• 1 x Complex diagnostic pathway • 1 x COVID-19 delay • 1 Capacity issues • 2 x Diagnostic delays • 1 x Patient choice
Lung	62 Day	3	2 x Complex pathway 1 x IPT received late in pathway
Head & Neck	62 Day	1	1 x Complex diagnostic pathway
Skin	62 Day	1	1 x Healthcare provider delay to diagnostics
Urology	62 Day	3	1 x IPT received late in pathway 2 x Diagnostic delays

e) 104 Day Breaches – April 2021

The table summarises the over 104 day waiters. The Trust continues to focus at patient level, looking to drive down pathways for every patient:

Cancer Waiting Times Open Suspected Cancer Pathways 104 Days +	Actual									Predicted 104 Day Open Suspected Cancer Pathway Breaches		
	Aug 20	Sept 20	Oct 20	Nov 20	Dec 20	Jan 21	Feb 21	Mar 21	April 21	May 21	June 21	July 21
	15	5	3	3	10	6	4	6	5	8*	7*	7*

*Due to complex pathways

Overall lessons to improve performance are summarised below:

Overarching Issues Affecting Performance	Summary of Trust Wide / Corporate Improvement Plan
• Improving position in Breast Services now achieving 14 day target • Continued Histopathology delays due to staffing levels and continued need to outsource for reporting impacting on 28 and 62 day Standards • 31 day & 62 day breaches – impact of 14 day patient self-isolation prior to surgical treatment • Continued radiology delays (see breach reasons above) • SY&B local intelligence reports indicate a surge in skin referrals above 2019/20 figures	• Additional capacity in Breast services continuing. • Internal and ICS meetings taking place to discuss support for diagnostic services across ICS footprint. Improvement mapping in plan from in- house QI team. • Review of self-isolation policy – investigation as to whether we can reduce as per ICS colleagues • Increased theatre capacity coming for all surgical groups • Additional Dermatology Locum Consultant offering additional capacity

Doncaster & Bassetlaw Teaching Hospitals NHS Foundation Trust
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Cancer Improvement Trajectories

Cancer 62 day pathways waiting 63 days or more after an urgent suspected cancer referral excluding non-site specific symptoms at the end of the reporting period	**April 2021**	**May 2021**	**June 2021**	**July 2021**	**August 2021**	**Sept 2021**
Trajectory	83	79	67	61	59	53
Actual	113	72				
Variance	30	7				

Total number of patients receiving first definitive treatment for cancer within a given period for all cancers	**April 2021**	**May 2021**	**June 2021**	**July 2021**	**August 2021**	**Sept 2021**
Trajectory	132	150	155	150	160	150
Actual	163					
Variance	30					

All patients urgently referred with suspected cancer by any source of referral excluding from a National Screening Programme who received a first outpatient appointment in the given month.	**April 2021**	**May 2021**	**June 2021**	**July 2021**	**August 2021**	**Sept 2021**
Trajectory	1450	1450	1401	1574	1434	1683
Actual	1490					
Variance	40					

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Report Cover Page					
Meeting Title:	**Trust Board of Directors**				
Meeting Date:	20 July 2021	**Agenda Reference:**	**G1**		
Report Title:	**Corporate Risk Register**				
Sponsor:	David Purdue, Chief Nurse / Deputy Chief Executive				
Author:	Fiona Dunn, Deputy Director Corporate Governance/Company Secretary				
Appendices:	CRR JUL 2021				
Executive Summary					
Purpose of report:	For assurance that the Trust risk management process is being followed; new risks identified and current risks reviewed and updated in a timely way.				
Summary of key issues:	Key changes to the CRR this period: • No new corporate risks added or escalated from Management Board • Currently there are 121 risk logged rated 15+ across the Trust and were tabled at the July Trust Executive Group (TEG) for review. • 13 of these risks are currently monitored via Corporate Risk register (CRR) Internal Audit Assurance • KPMG has undertaken Internal audit on 2 areas of the Risk Management system and Final report has been reviewed and recommendations being monitored via Audit & Risk Committee.. The two areas audited included: 1. Design of the Risk Management framework 2. Operating Effectiveness of the Risk Management framework Action required • Continuous review of existing risks and identification of new or altering risks through improving processes. • Ensure embedding of risk management process through refreshed training and education to ensure consistency of process. • Link to key strategic objectives indicated within the Board Assurance Framework.				
Recommendation:	The Committee is asked to note the Corporate Risk Register information and the progress from the previous report.				
Action Require:	~~Approval~~	Information	~~Discussion~~	Assurance	~~Review~~
Link to True North Objectives:	**TN SA1:** *To provide outstanding care for our patients*	**TN SA2:** *Everybody knows their role in achieving the vision*	**TN SA3:** *Feedback from staff and learners is in the top 10% in the UK*	**TN SA4:** *The Trust is in recurrent surplus to invest in improving patient care*	
Implications					

Board assurance framework:			The entire BAF has been reviewed alongside the CRR. The corresponding TN SA's have been linked to the corporate risks.
Corporate risk register:			This document
Regulation:			All NHSF trust are required to have a corporate risk register and systems in place to identify & manage risk effectively.
Legal:			Compliance with regulated activities and requirements in Health and Social Care Act 2008.
Resources:			Actions required are currently being delivered within existing trust Resources highlighted in individual risks
Assurance Route			
Previously considered by:			F&P , ARC, TEG Executive Team – (15+ risks)
Date:	TEG 12 July 2021	**Decision:**	Reviewed and updated
Next Steps:			Continuous review of individual risk by owners on DATIX risk management system
Previously circulated reports to supplement this paper:			None

Corporate Risk Register Summary June 2021

ID	Ref	Review date	Division / Corporate(s)	Speciality(ies)	Title	Description	Risk Owner	Exisiting Controls	Risk level (current)	Rating (current)	Risk level (Target)	Last Reviewed	Movement since last review
1517	Q&E9	31/08/2021	Clinical Specialist Services	Pharmacy (Outpatient), Pharmacy (inpatient)	**Availability and Supplies of Medicines**	There are extraordinary stresses on the medicine supply chain which are leading to unavailability of medicines in the hospital. This could have an impact on patient care, potentially delaying the delivery of treatment, non-optimisation of treatment and decrease in patient satisfaction. It could also increase the chance of error and harm occurring The issues is causing significant disruption and increased workload of the pharmacy procurement and logistics team which compounds the problem. Disruption of work by other professionals involved in supply and administration of medicines is possible as well. There a number of issues causing it: - Manufacturing Issues - Central rationing of supplies by CMU - Wholesaler and supply chain issues - Unpaid invoices - Knock on disruption of procurement and logistics teams sometimes delaying response Updated: 18/12/2020 The reason there has been no local action on review id that we have been explicitly instructed by NHS E & DoH not to take nay local action. There is an national mechanism for managing medicines shortages which has been used during the COVID-19 pandemic and will be used if required to manage any issues as a result of EUexit. Working with national and regional colleagues Esoop's team take any local actions required by the national scheme on a medicine by medicine basis - this general Datix is not the appropriate place to record these specific individual case actions	Barker, Andrew	There is an national mechanism for managing medicines shortages which has been used during the COVID-19 pandemic and will be used if required to manage any issues as a result of EUexit.	Extreme Risk	15	High Risk	Apr-21	⟺
2664	PEO3	01/07/2021	Clinical Specialist Services	Critical Care	**Staff shortage - Consultant Intensive Care**	Severe shortage of consultants in intensive care medicine (especially DRI site), caused by inability to recruit for past 6 years and two recent resignations from existing staff. Now high risk of burnout of remaining consultant staff with subsequent sick leave and possible further resignations. Negative impact on quality of patient care, team work on DCC and training of other staff, especially doctors.	Noble, Timothy / Jochen Seidel	Some support from general anaesthetists and external locums. Mutual from Sheffield commenced (covers approx. 5 shifts per week during the day -DRI site.). planned for 2 existing consultants to join rota following changes across site. Wider high impact recruitment planned alongside other action in the plan. CIG IT case has been agreed to improve attractiveness of the department.(RJ)	Extreme Risk	20	High Risk	May-21	⟺
2472	COVID1	30/08/2021	Directorate of Nursing, Midwifery and Allied Health Professionals	Not Applicable (Non-clinical Directorate)	**COVID-19**	World-wide pandemic of Coronavirus, which will infect the population of Doncaster and Bassetlaw (including staff) resulting in reduced staffing, increased workload due to COVID-19 and shortage of beds, ventilators. Now includes stabilisation and recovery plans etc	Purdue, David	17/5/21: Operational Update / Delivery of Elective Restoration Update (Presentation)given to F&P Committee on monthly basis. Covers risk areas of Theatre staffing, Be Plan, Risk to patients & Oversight & Governance. Mitigation via high level actions from COO led Performance & Access Board. High level actions from Performance and Access Board -Strengthening governance of "getting the basics right" (642, POA etc) -OP Utilisation – implementation of 1 m rule to increase throughout	Extreme Risk	25	High Risk	Jul-21	⟺
11	F&P1	13/08/2021	Directorate of Finance, Information and Procurement	Not Applicable (Non-clinical Directorate)	**Failure to achieve compliance with financial performance and achieve financial plan**	Failure to achieve compliance with financial performance and achieve financial plan leading to : (i) Adverse impact on Trust's financial position (ii) Adverse impact on operational performance (iii) Impact on reputation (iv) Regulatory action	Sargeant, Jonathan	13/5/21:New controls : Budget process linked to capacity planning; Additional Training Programmes for managers; Perf Assurance Framework; Close working with ICS and Provider DoF's	Extreme Risk	16	High Risk	May-21	⟺
7	F&P6	17/07/2021	Chief Operating Officer	Not Applicable (Non-clinical Directorate)	**Failure to achieve compliance with performance and delivery aspects of the SOF, CQC and other regulatory stanadrds**	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	Joyce, Rebecca	[10/03/2021] IQPR, Performance assurance framework goes to Sub committees, At divisional level = activity & performance meetings & wider governance framework. Accountability framework also in place at Organisational level. CQC regular engagement meetings & CQC action plan complete (Feb 21& agreed by CQC.) Performance also reported and discussed at ICS level and to NHSE/I etc via cancer alliance, weekly delivery meetings and performance delivery group.	Extreme Risk	16	High Risk	May-21	⟺
19	PEO1 (Q&E1)	31/08/2021	Directorate of People and Organisational Development	Not Applicable (Non-clinical Directorate)	**Failure to engage and communicate with staff and representatives in relation to immediate challenges and strategic development**	Failure to engage and communicate with staff and representatives in relation to immediate challenges and strategic development	Barnard, Karen	[12/02/2021] New people committee set up. People plan priorities being finalised for 2021/22. Improving staff survey performance focus on this via breakthrough objectives.	Extreme Risk	16	High Risk	Jul-21	⟺

Corporate Risk Register Summary June 2021

ID	Ref	Review date	Division / Corporate(s)	Speciality(ies)	Title	Description	Risk Owner	Exisiting Controls	Risk level (current)	Rating (current)	Risk level (Target)	Last Reviewed	Movement since last review
12	F&P4	29/10/2021	Estates and Facilities	Not Applicable (Non-clinical Directorate)	**Failure to ensure that estates infrastructure is adequately maintained and upgraded in line with current legislation**	Failure to ensure that estates infrastructure is adequately maintained and upgraded in line with current legislation, standards and guidance. Note: A number of different distinct risks are contained within this overarching entry. For further details please consult the E&F risk register. leading to (i) Breaches of regulatory compliance and enforcement (ii) Claims brought against the Trust (iii) Inability to provide safe services (iv) Negative impact on reputation (v) Reduced levels of business resilience (vi) Inefficient energy use (increased cost) (vii) Increased breakdowns leading to operational disruption (viii) Restriction to site development	Edmondson-Jones, Kirsty	[16/11/2020 16:51:07 Sean Alistair Tyler] - DBTH not included on list of 40 new hospitals, Board decision required on continuing developing case in preparation for bid for further 8 new hospitals mid decade.	Extreme Risk	20	High Risk	Apr-21	⟺
1410	F&P11	16/07/2021	Information Technology	Not Applicable (Non-clinical Directorate)	**Failure to protect against cyber attack**	Failure to protect against cyber attack - leading to: (i) Trust becoming non-operational (ii) Inability to provide clinical services (ii) Negative impact on reputation The top 3 DSP risk areas have been recognised as: (1) Insider threat (accidental or deliberate) (2) New / zero day vulnerability exploits (3) Failure to wholly implement patch management	Anderson, Ken	[17/05/2021 10:10:16 David Linacre] The server patching work has been subject to delays, with divisional system administration contacts not responding to requests from IT to arrange regular monthly maintenance windows. A decision was taken in April to enforce a recurring maintenance slot where no response had been received to multiple requests from IT. As a result, all supported systems should be patched up-to-date by end May. The backup software and hardware was installed to plan, but configuration and implementation has been delayed by other priorities in IT during January - March (final quarter / year end pressures). The work is now underway again and will be completed by end May. A small number of Windows 10 devices remain active on the network, with security concerns mitigated by a combination of ESU from Microsoft and network segmentation to restrict access to high-risk activities (eMail and web sites). The cyber-security dashboard is implemented and configuration is on-going, although valuable asset and vulnerability tracking information is already available. Work on security logging and retention is underway, with the initial systems expected to be integrated by end May. Network Access Control and Micro-segmentation have been delayed due to other work pressures, and delays on completed of the pre-requisite telephony system upgrade. New completion dates for these projects are under discussion at present.	Extreme Risk	15	Moderate Risk	May-21	⟺
16	PEO2 (F&P8)	31/08/2021	Directorate of People and Organisational Development	Not Applicable (Non-clinical Directorate)	**Inability to recruit right staff and ensure staff have the right skills to meet operational needs**	Inability to recruit right staff and have staff with right skills leading to: (i) Increase in temporary expenditure (ii) Inability to meet FYFV and Trust strategy (iii) Inability to provide viable services	Barnard, Karen	[12/02/2021] People Committee now in place to review vacancy data and obtain assurance re recruitment report and expenditure vs agency etc. International recruitment uptake where appropriate. Apprenticeship schemes in place. People committee reporting structures reviewed to ensure good governance,	Extreme Risk	16	High Risk	Jul-21	⟺
2426	F&P	30/07/2021	Information Technology	Not Applicable (Non-clinical Directorate)	**Multiple software systems end-of-support**	Installed software versions have gone past the date of supplier support and there has been insufficient internal resources to upgrade and dependencies with multiple software systems being incompatible with the supported software, have prevented these upgrades. This leads to vulnerabilities within our infrastructure. For example, unpatched systems are significantly more vulnerable to cyber attacks. A single compromised device threatens all devices. There is a further vulnerability the Trust faces where we cannot draw on the expertise of the supplier to fix faulty software in a timely manner or at all.	Linacre, David	Where possible support has been extended with supplier. Firewalls and antivirus software are in place. (linked with 2703)	Extreme Risk	15	High Risk	May-21	⟺
2147	F&P21	07/07/2021	Estates and Facilities	Not Applicable (Non-clinical Directorate)	**REF 29 - Edge Protection DRI**	Due to the lack of edge protection on flat roofs across the site at DRI there is an increased risk of falls from height, which could result in death or serious injury	Edmondson-Jones, Kirsty	[8/4821] Works carried out to install edge protection to various areas including OPD1 at DRI and MI Block at BDGH. Further review to be carried out for potential inclusion within 21/22.	Extreme Risk	15	Moderate Risk	Apr-21	⟺
1807	F&P20 / Q&E12	08/11/2021	Estates and Facilities	Not Applicable (Non-clinical Directorate)	**Risk of critical lift failure**	Risk of critical lift failure leading to: (a) Reduction in vertical transportation capacity in the affected area (b) Impact on clinical care delivery (c) General access and egress in the affected area	Edmondson-Jones, Kirsty	[08/04/2021] - Site wide Lift survey undertaken by independent lift consultant, lifts 3 and 7 in the EWB identified for upgrade and included within the FY21/22 Capital Plan.	Extreme Risk	20	High Risk	Jul-21	⟺
1412	F&P12	29/10/2021	Estates and Facilities	Not Applicable (Non-clinical Directorate)	**Risk of fire**	Failure to ensure that estates infrastructure is adequately maintained and upgraded in accordance with the Regulatory Reform (Fire Safety) Order 2005 and other current legislation standards and guidance. Note: a number of different distinct risks are conatained within this overarching entry. For further details please consult the EF risk register. leading to : (i) Breaches of regulatory compliance could result in Enforcement or Prohibition notices issued by the Fire and Rescue Services (ii) Claims brought against the Trust (iii) Inability to provide safe services (iv) Negative impact on reputation No change to risk rating	Edmondson-Jones, Kirsty	07/04/2021] SYFR wrote to CEO on 1st April to rescind both notices for EWB and W&C and replace with action plans to be complied with	Extreme Risk	15	High Risk	Apr-21	⟺

Trust Executive Group (TEG)

Terms of Reference

Name	Trust Executive Group ("the committee")
Purpose	The key operational decision-making meeting of the Trust, accountable to the Board of Directors for the operational delivery of the Trust's clinical and non-clinical services, for the delivery of organisational objectives and for ensuring quality of care within its delegated authority. The Trust Executive Group will consist of both a strategic planning session element together with an opportunity for divisional directors share key issues and improvements across divisions. To propose ideas for improvements for the benefit of patients and the Trust and have them formally considered.
Responsible to	Board of Directors
Delegated authority	The committee has the following delegated authority: • To approve new or replacement appointments to consultant posts. • To approve policies and operational procedures in line with the scheme of delegation.
Duties and work programme	• Organisational development and leadership, decision making and performance management. • Determining planning and investment priorities. • Overseeing the development of business plans. • Preparation for compliance visits to the Trust with reviews of action plans to address any identified requirements. • Setting appropriate frameworks, policies and procedures to support delivery of organisational objectives; and monitoring and reviewing the effectiveness of those frameworks, policies and procedures. • Monitoring and reviewing the quality outcomes of the Trust and agreeing action where necessary. • Advising on planning, service level agreements and change management initiatives. • Review of the Corporate Risk Register on a monthly basis, including consideration of possible additions to the register. • Sharing of key achievements and issues across divisional boundaries to improve outcomes. • Receiving monthly briefings on the activities of sub board

	committees, and from the Executive Team with regard to decisions taken at those weekly meetings.
Chair	Chief Executive (Deputy Chief Executive vice chair)
Membership	• Executive Directors • Divisional Directors • Director of Strategy &Transformation • Director of Estates & Facilities • Chief Information Officer
Substitution	A Divisional Director, if absent, may send a deputy who may be a Divisional Director of Nursing/ Deputy Divisional Director/Clinical Director/ Deputy Chief Operating Officer/ General Manager. Deputies will not hold a vote.
In attendance	• Medical Directors • Director of Nursing (Deputy Chief Nurse) • Company Secretary/Deputy Director Corporate Governance • Head of Communications & Engagement • Other senior staff will attend on a scheduled or ad hoc basis to provide advice and subject matter expertise as required, and in relation to the work plan of the committee.
Secretary	Trust Board Secretary (Corporate Governance Officer)
Quorum	Six (inc. at least two Executive Directors and two Divisional Directors)
Voting	Matters will generally be determined by the assent of the meeting and requirement for a vote will be in exceptional cases. In such cases, each member has one vote, with the chair of the meeting (the Chief Executive or Deputy Chief Executive) having the casting vote. Deputies will not hold a vote.
Decision making	The committee may make decisions and approve proposals both in and outside of meetings. Decisions may be made outside of Trust Executive Group by: • Email - proposals should be circulated by email to all members (or their deputies in case of absence), along with a deadline for response. Any objections to a proposal should be circulated prior to this deadline. Proposals shall be considered to be approved provided the majority of members do not communicate objections. • Executive Team Any decisions made outside of a Trust Executive Group shall be reported to the Trust Executive Group at the next meeting and recorded in the minutes of that meeting.

Attendance requirements	Committee members must attend at least 75% of meetings, and all members are expected to nominate deputies when they are unable to attend.
Frequency of meetings	Monthly.
Papers	Papers will be distributed at least 2 days in advance of the meeting.
Permanency	The committee is a permanent committee.
Reporting committees	• Local Negotiating Committee • Partnership Forum • Corporate Investment Committee • Senior Leadership Forum
Circulation of minutes	Members and responsible committee. Unless otherwise indicated, circulation by members to their management teams is expected.
Date approved by the committee:	12/7/2021
Date approved by Board of Directors:	To go to board
Review date:	

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Report Cover Page					
Meeting Title:	Trust Board				
Meeting Date:	20th July 2021	**Agenda Reference:**	G3		
Report Title:	Trust Annual Report 2020/21 including Annual Governance Statement, and Annual Accounts 2020/21				
Sponsor:	Jon Sargeant – Director of Finance				
Author:	Matthew Bancroft – Head of Financial Control				
Appendices:	Appendix A – Trust Annual Report 2020/21 including Annual Governance Statement and Account Accounts				

Report Summary					
Purpose of report:	To provide assurance that the Trust Annual Report and Annual Accounts has been submitted.				
Summary of key issues/positive highlights:	The Trust Annual Report 2020/21 including Annual Governance Statement, and Annual Accounts was presented at the Audit and Risk Committee on 9th June 2021. Following discussions at the Committee, the document was approved, with delegated authority from Trust Board, and submitted to NHS E/I in mid June.				
Recommendation:	The Board is asked to note the approval of the Annual Report and Annual Accounts by Audit and Risk Committee				
Action Required:	Approval	Information	Discussion	Assurance X	Review

Link to True North Objectives:	**TN SA1:**	**TN SA2:**	**TN SA3:**	**TN SA4:**
	To provide outstanding care for our patients	*Everybody knows their role in achieving the vision*	*Feedback from staff and learners is in the top 10% in the UK*	*The Trust is in recurrent surplus to invest in improving patient care*

Implications	
Board assurance framework:	N/A
Corporate risk register:	N/A
Regulation:	The documents are part of the financial governance framework within the Trust.
Legal:	N/A
Resources:	N/A

Assurance Route			
Previously considered by:	Audit and Risk Committee		
Date:	9/6/2021	**Decision:**	Approved, due to delegated authority from Trust Board.
Next Steps:	To be presented at Trust Board for ratification		

Previously circulated reports to supplement this paper:	N/A.

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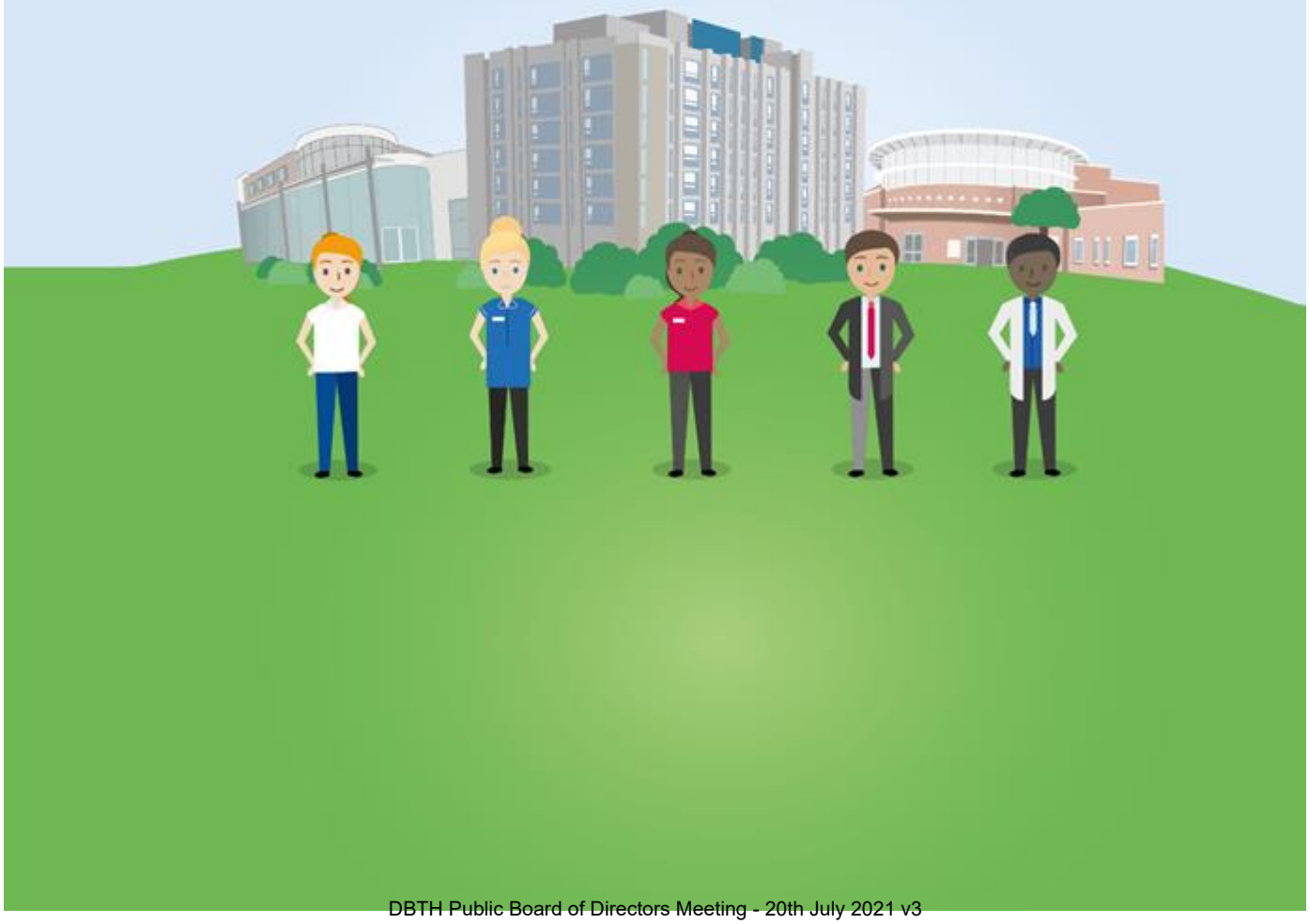
Annual Report and Accounts 2020/21



Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

Annual Report and Accounts 2020/21

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

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Performance Report

Chair and Chief Executive's statement

On 21 March 2021, we marked one year since we admitted and cared for our first COVID-19 positive patient. The 52 weeks from the first patients admission have probably been the most extraordinary year in the Trusts history.

Just 12 months ago, our organisation was preparing for a once-in-a-generation pandemic, uncertain as to what to expect and doing all we could to ensure we were able to weather the oncoming storm. Now, one year on, we are proud to reflect upon the compassion, dedication and fortitude shown by colleagues in the face of unprecedented challenge and great uncertainty.

Following the Prime Minister's announcement of a national lockdown on the evening of 23 March, we shared an open letter from the Trust to the people of Doncaster and Worksop, as well as with our colleagues. Despite the anxieties we all collectively felt at the time, the note stated that, once the pandemic was over, we would reflect upon what we have achieved together with a huge sense of pride. While the pandemic is not quite over at the time of writing, we believe this sentiment holds true today.

While we are not yet done with COVID-19, in the 365 days between that first patient and 31 March 2021, we have cared for over 3,269 people and safely discharged over 2,425 to continue their recovery. Colleagues have diligently cared for those suffering the worst effects of the disease and adapted to new ways of working as the country entered lockdown, never complaining or wishing to opt-out.

As a Trust, we saw peaks of activity in May, and again in November, with our hospitals being some of the busiest in the country for a brief period. For their efforts during this time, we would like to place on record our heartfelt thanks to everyone for both their individual and team efforts. In times of emergency, an organisation's true values become clear – and we believe that colleagues across the Trust have truly shown that 'We Care', pulling together in the most difficult of circumstances.

While we have so much to be proud of, like so many across the country we too have lost much-loved colleagues. We cherish the memories of our friends and co-workers, Kevin Smith, Dr Medhat Atalla and Lorraine Butterfield who passed away last year, following brief but extremely brave and determined battles with COVID-19.

Like so many families, words cannot account for the loss we feel, and their absence will be forever felt within our teams. It is our sincere hope that the memorial Rainbow Gardens (more information is available later in this report) we have created, funded generously by our local communities, will provide a lasting monument to those who have been lost.

During such a difficult year, we all wondered when the pandemic would end. However, we believe now more than ever before that there is light at the end of the tunnel. If infections continue to decline, as they are at the time of writing, we may be able to reclaim some normality as we move forwards in 2021/22 and beyond. Only time will tell but, for now, we remain cautiously optimistic.

We couldn't have achieved what we have without the support of those individuals who continued to supply and operate our ambulance, police and fire services, supermarkets and local shops, our streets and neighbourhood teams, all those who delivered the essential items we needed every day, educated our young people, and everyone in between. To every single person defined as a key, or essential worker, you should be proud of what you have achieved and you have our deep thanks and appreciation.

This report, like the one preceding it, will be slightly different from the norm. Within the following pages, we will highlight the collective efforts of colleagues throughout the past 12 months. We have detailed our response to COVID-19, as well as how we continued to care for those who needed routine treatment. Additionally, we have accounted for the money we received, and how we spent it, both in service of beating COVID-19 and to improve our hospital sites now and into the future.

In all, this document is an opportunity to reflect upon this most extraordinary year and, despite the challenges, we believe it is clear that our development as an organisation has been substantial – but in ways we could not have anticipated just 12 months ago.

Finally, we would like to thank staff, governors, members, volunteers, partner organisations, commissioners, regulators, and everyone else who has worked with us over the past year, as well as our local communities. Their positive support has been overwhelming and has contributed to what has been a successful year in many ways, albeit challenging in others.

This Annual Report sets out openly, honestly and in detail, how we performed in 2020/21, along with our plans for 2021/22. Finally, we can confirm this annual report was prepared on a 'group' basis within the Trust and thank colleagues for their efforts in collating this document.

Suzy Brain England OBE
Chair
25 June 2021

Richard Parker OBE
Chief Executive
25 June 2021

Who we are and what we do

As well as being an acute NHS Foundation Trust, hosting one of the busiest emergency services in the county, we are also a teaching hospital operating within the Yorkshire region, working closely with the University of Sheffield and Sheffield Hallam University. As a Trust, we also maintain strong links with Health Education England (HEE), our local Clinical Commissioning Groups in both Doncaster and Bassetlaw, as well as our system partners in South Yorkshire and Bassetlaw.

Doncaster and Bassetlaw Hospitals (pre-2017) was one of the first 10 NHS trusts in the country to be awarded 'Foundation Trust' status in 2004. This granted the organisation more freedom to act than a traditional NHS trust, although we are still closely regulated and must comply with the same strict quality standards as a non-foundation trust.

We are fully licensed by NHS Improvement and fully-registered (without conditions) by the Care Quality Commission (CQC) to provide the following regulated activities and healthcare services:

- Treatment of disease, disorder or injury
- Nursing care
- Surgical procedures
- Maternity and midwifery services
- Diagnostic and screening procedures
- Family planning
- Termination of pregnancies
- Transport services, triage and medical advice provided remotely
- Assessment or medical treatment for persons detained under the Mental Health Act 1983.

We provide the full-range of local hospital services, some community services (including family planning and audiology) and some specialist tertiary services including vascular surgery. We serve a population of more than 420,000 across South Yorkshire, North Nottinghamshire and the surrounding areas and run three hospitals and a smaller site at Retford:

- **Doncaster Royal Infirmary (DRI)**

  DRI is a large acute hospital with over 600 beds, a 24-hour Emergency Department (ED) and trauma unit status. In addition to the full range of district general hospital care, it also provides some specialist services. It has in-patient, day case and out-patient facilities.

- **Bassetlaw Hospital in Worksop (BH)**

  BH is an acute hospital with over 170 beds, a 24-hour Emergency Department (ED) and the full range of district general hospital services, including a breast care unit.

The site has in-patient, day case and out-patient facilities.

- **Montagu Hospital in Mexborough:**

  Montagu is a small, non-acute hospital with over 50 in-patient beds for people who need further rehabilitation before they can be discharged. There is a nurse-led Urgent Treatment Centre, open 9am to 9pm. It also has a day surgery unit, renal dialysis, a chronic pain management unit and a wide range of out-patient clinics. Montagu is the site of our Rehabilitation Centre, Clinical Simulation Centre and the base for the Abdominal Aortic Aneurysm screening programme.

Additionally, we are registered to provide out-patient and other health services at **Retford Hospital**, including clinical therapies and medical imaging. In early 2020 we vacated our Chequer Road Clinic premises which had become increasingly unfit for purpose. Moving our Audiology service less than two miles away to the Sandringham Road Centre, while Mammography and Children's Speech and Language Therapy transitioned to Devonshire House, less than a third of a mile away.

Our headquarters are at Doncaster Royal Infirmary:

Chief Executive's Office
Doncaster Royal Infirmary
Armthorpe Road
Doncaster
DN2 5LT
Tel: 01302 366666

Our strategy, vision, mission, values and objectives

Our Trust strategy for 2017 to 2022, ***Stronger Together,*** outlines our plans for the future, working with stakeholders and partners. In turn, this will help us to implement our plans and facilitate high quality services for the communities we serve in Doncaster, Bassetlaw and beyond.

The full strategy (refreshed in August 2019 and soon to be revised) can be found at:
https://www.dbth.nhs.uk/about-us/how-we-are-run/trust-strategy-2017-2022/

Vision: To be the safest trust in England, outstanding in all that we do.

Mission: As an Acute Teaching Hospitals Foundation Trust, and a leading partner in health and social care across South Yorkshire and Bassetlaw, we will work with our patients, partners and the public to maintain and improve the delivery of high quality integrated care.

Our values:

Guide us in everything that we do.

NHS
Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

We care

- **W** e always put the patient first.
- **E** veryone counts – we treat each other with courtesy, honesty, respect and dignity.
- **C** ommitted to quality and continuously improving patient experience.
- **A** lways caring and compassionate.
- **R** esponsible and accountable for our actions – taking pride in our work.
- **E** ncouraging and valuing our diverse staff and rewarding ability and innovation.

NHS
Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Our vision: To be the safest trust in England,

outstanding in all that we do.

Our strategic objectives which will help us get there:

Patients — Work with patients to continue to develop accessible, high quality and responsive services.

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.

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

Partners — We will increase partnership working to benefit people and communities.

Prevention — Support the development of enhanced community based services, prevention and self-care.

Qi — Working together using methods, tools, data measurement, curiosity and an open mindset to make improvements (Health Foundation).


NHS
Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust
Our vision
The ambition of the Trust
To be the safest trust in England, outstanding in all that we do.
True north
How we arrive at our vision
Objective one: To provide outstanding care and improve patient experience.
Objective two: Everybody knows their role in achieving the vision.
Objective three: Feedback from staff and learners in top 10% in UK.
Objective four: In recurrent surplus to invest in improving patient care.
Breakthrough
How we will move to deliver our True North in 2020/21.
Objective one: Achieve measurable improvements in our quality standards and patient experience.
Objective two: Achieve a 5% improvement in our staff having a meaningful appraisal linked to our vision.
Objective three: The Trust is within the top 25% for staff and learner feedback.
Objective four: Every team achieves their financial plan for the year.
We care
People
Performance
Patients
Partners
Prevention
Our Foundations

Overview of our activity and performance in 2020/21

When drafting our annual report in March 2020, we were anticipating to deliver a document which reflected upon a hugely successful 12 months for our Trust.

This was a year in which we had made huge strides both operationally and in terms of our performance, finally overcoming financial challenges which had come to light in 2016 and, together as a team, we were looking ahead to a brighter future filled with opportunity.

This was a 12 month period which saw the organisation achieve a Care Quality Commission (CQC) rating of 'Good' for the first time in four years, as well as registering our very best Staff Survey results and delivering a small surplus within our financial position. Unfortunately, this period also marked the arrival of COVID-19 into our lives, both personal and professional. As such, the report we delivered last year (as well as the one which we present to you in 2021) is very different to what we had anticipated.

Since March 2020, colleagues throughout our Trust have battled with COVID-19 – an illness which has not only significantly changed the way we work, but the physical flow of our hospital sites. It has meant a reorganisation of our priorities, a revision of our plans and strategies and a year of unprecedented challenge and upheaval.

It has been a year defined by great teamwork and togetherness, but also punctuated with great sadness. COVID-19 has affected everyone, and while many families will have an empty chair when able to come together again,, as an organisation we too have experienced loss with the passing of our beloved colleagues Kevin Smith, Dr Medhat Atalla and Lorraine Butterfield.

Words cannot account for the grief we feel and their absence will be felt forever within the Trust. However, we remember all three for the joy they brought to us, and the care, compassion and professionalism they embodied as members of Team DBTH.

In order to mark our respects and remember our colleagues in future years, a small 'in memory' section is available later in this report on page 33.

Despite the hugely challenging times we have found ourselves in, the Trust has much to be proud of, and particularly in the way that colleagues have dealt with COVID-19. Below is a summary of the number of patients we have cared for who were afflicted with this disease from 21 March 2020 (the date of the first related admission) until 31 March 2021.

Covid-19 data (as of 31 March 2021):

- Current Covid-19 patients: **20**
- Total Covid-19 patients in Intensive Care: **three**
- Total Covid-19 discharges: **2,377**
- Total number of patients who have died: **808**
- Total number of patients who have been admitted: **3,226** (DRI: 2,555 – BH: 559 – MH: 112)

Given the pace of events throughout the past 12 months, we have created a timeline to illustrate the changes, developments and milestones throughout the pandemic, as well as to give readers a greater understanding of the difficulties the Trust has faced.

As this report will make clear, a monumental amount of work has been undertaken from March 2020 to March 2021, making this annual report unlike any other we have produced.

Therefore we will not be focusing as heavily on traditionally reported operational performance (the interruption to services would make any data comparison largely irrelevant), but will instead summarise our activity throughout the past 12 months, the impact of COVID-19 and our next steps as an organisation.

Within the following pages, we have organised our commentary into the following themes and focuses which encompass our approach to the pandemic and the preceding 52 weeks:

- Safety, care and infection control
- Estates and facilities
- Procurement and personal protective equipment
- Communications and information sharing
- Colleague health and wellbeing
- Vaccination and testing
- Recovery and next steps

Through these sections, you will be able to view our overall activity as an organisation in terms of the numbers of patients cared for, broken down by inpatient, outpatient, and emergency attendances and babies born, as well as overall COVID-19 activity throughout 2020/21.

Finally this report will also contain notes upon our financial performance as well as a full and comprehensive Accountability Report as mandated, in addition to a concluding Quality Account. The latter will be slightly more abridged than usual, marking the final iteration of this particular document and evaluating the targets set in 2019/20 as the reporting expectations will change in the next financial year, as per the Annual Reporting Manual.

In all, 2020/21 has been unprecedented in the scale of challenge we have faced as an organisation. We hope you find the Annual Report for 2020/21 informative, laying out the actions we took and in what context, as well as highlighting the often heroic efforts of our healthcare professionals who make up Doncaster and Bassetlaw Teaching Hospitals.

Timeline of UK coronavirus lockdowns, March 2020 to March 2021

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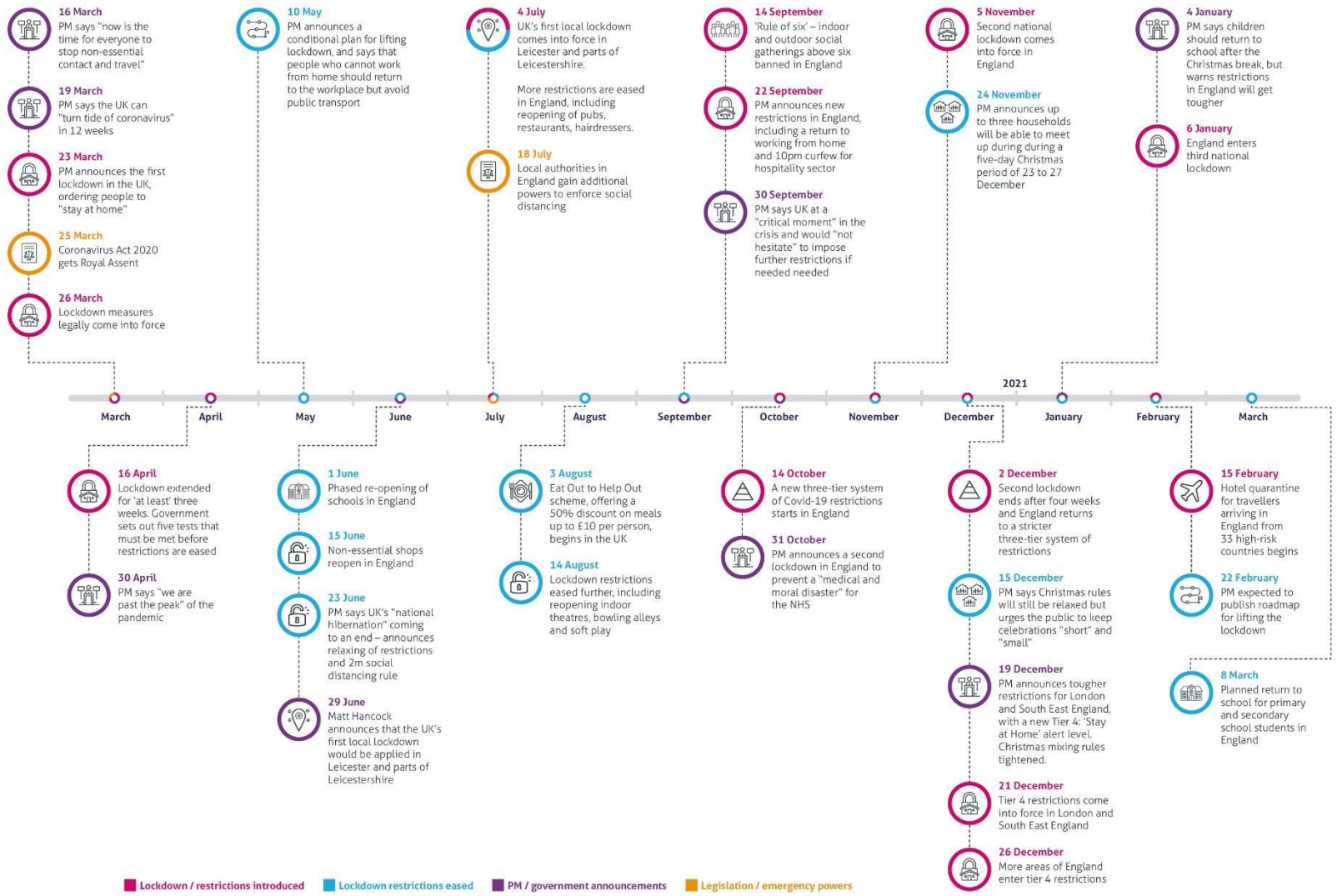


Source: Institute for Government analysis.

A timeline of the year at DBTH

In addition to the national timeline as created by the Institute for Government Analysis on the previous page, below is a calendar of notable events, achievements and milestones at the Trust through 2020 and 2021 – the list is not comprehensive by any means. This encompasses the entirety of the pandemic, as experienced locally.

March 2020

- **9 March:** With the emergence of COVID-19 and the accelerating challenegs across the world, this date marked the first formal meeting of all senior managers to understand the scale of the challenge ahead of the country, and the Trust. The date marks the start of our plans, preparations and measures against the illness.
- **13 March:** As the severity of the situation became apparent, and the vulnerabilities to certain age-groups known, we asked all volunteers over 70 and those with underlying conditions to stay home from this date.
- **17 March:** As COVID-19 began to proliferate throughout the UK, to protect patients and colleagues we restricted visitors to only essential circumstances.
- **19 March:** As per national guidance, we put a short-term pause on all face-to-face outpatient and elective procedures, and began stepping-up virtual arrangements for three months.
- **21 March:** The first patient with COVID-19 is admitted to Doncaster Royal Infirmary.
- **23 March:** To support colleagues and patients, we announce that parking is free on all sites until further notice.
- **23 March:** With much sadness, we confirm the first death related to COVID-19 at Doncaster Royal Infirmary.
- **24 March:** Due to the increase in cases and to reflect the national lockdown measures, all visiting is restricted.
- **24 March:** As the country enters lockdown measures, we introduced free catering and meals to all colleagues to support them while working.
- **25 March:** To assist with staffing, maternity services are consolidated and moved from Bassetlaw Hospital to Doncaster Royal Infirmary as an interim measure.
- **25 March:** With much sadness, we confirm the first death related to COVID-19 at Bassetlaw Hospital.
- **End of the month:** In total we admitted 21 patients with COVID-19 throughout March, and 14 are safely discharged.

April 2020

- **Beginning of April:** Essential works were undertaken on all sites to create separated corridors. We also moved some of our ward areas to maximise and enhance oxygen flow and some colleagues were redeployed to help in areas with increased activity.

Additionally, plans were made to be able to increase intensive care beds from 28 to 130.

- **3 April:** In order to enhance the safe continuation of service, our Dermatology department moved to Montagu Hospital.
- **7 April:** Our Outpatients entrance was moved to South Block to help with footfall, with hand hygiene stations fitted nearby.
- **10 April:** Polymerase Chain Reaction (PCR) was introduced in-house at the Trust, allowing for 100 COVID-19 tests to be undertaken daily. Our assay has been measured as having a sensitivity (chance of producing true negatives) of 96% and a specificity (chance of producing true positives) of 96%.
- **12 April:** With much sadness we shared the news that Kevin Smith, Plaster Technician, passed away following a brief but brave battle with COVID-19.
- **16 April:** Our Research and Development team organised the Trust's entry into medical trials looking at potential COVID-19 treatments.
- **17 April:** As a result of COVID-19 activity, all general recruitment paused, with pandemic related appointments taking precedent.
- **22 April:** With much sadness we shared the news that Dr Medhat Atalla, Consultant Physician and Geriatrician, passed away following a brief but brave battle with COVID-19.
- **27 April:** Our very first 'Rainbow Rooms' were introduced – dedicated spaces for colleagues to use when they need a break, to relax and recharge during difficult shifts.
- **End of the month:** In total, we admitted 324 patients with COVID-19 throughout April, and 163 were safely discharged.

May 2020

- **4 May:** In memory of Kevin Smith, Kevin's wife and Registered Nurse, Diane launched the 'Kev's Wheels appeal' to create a space for wheelchairs within the hospital. Within days over £15,000 was donated.
- **6 May:** A record of 27 patients were discharged on this day, the most in a single day.
- **5 May:** We launched the Doncaster and Bassetlaw Maternity Services Facebook page to assist and support mums and mums-to-be in the area. To-date, 4,300 people follow the page, and the platform has proved to be a huge success.
- **11 May:** This day marked the peak of the first wave locally, with 113 patients receiving care at the hospital.
- **12 May:** Following changes to all visiting, we made the decision to ease this slightly within our Neonatal services, allowing for both parents to visit at different times in the day.
- **13 May:** We marked the successful trial of video consultations within paediatrics, and began the process of rolling this out further, By the end of year, thousands of appointments are carried out in this manner.

- **18 May:** In order to support patients and their family, friends and loved ones to stay in touch, we introduced virtual visiting with the use of specific Trust devices.
- **Middle of May:** The number of inpatients with us began to slowly and consistently decline, reflecting the impact of Lockdown measures and signalling the beginning of the end of the first wave.
- **End of the month:** In total we admitted 263 patients with COVID-19 throughout May, and 162 were safely discharged.

June 2020

- **2 June:** As a result of a sustained decline in admissions related to COVID-19, on this day we eased visiting restrictions to allow individuals to support those receiving end of life care, those with learning disabilities, those with dementia, long-stay patients and maternity.
- **6 June:** As a result of national guidance, the wearing of face covers became mandatory, which also extended to hospital settings – albeit already largely followed.
- **12 June:** In order to pay our respects to those we have lost to COVID-19, we launched our Rainbow Garden appeal to create two memorial spaces at our Doncaster and Bassetlaw sites.
- **End of the month:** In total we admitted 92 patients with COVID-19 throughout June, and 99 were safely discharged.

July 2020

- **1 July:** The first £10,000 was raised for the Rainbow Gardens, and the project received the green-light to go ahead.
- **22 July:** We shared the news that one week has been achieved without an additional COVID-19 admission.
- **24 July:** We shared the news that one week has elapsed without any additional COVID-19 deaths at the Trust.
- **27 July:** Following a successful recruitment campaign, we shared the news that Maternity services will return to Bassetlaw Hospital in November.
- **End of the month:** In total we admitted 29 patients with COVID-19 throughout July, and 43 were safely discharged.

August 2020

- **Beginning of August:** As activity continues to decline, we started to develop plans to ensure a focus upon elective and non-urgent work, using the lull in COVID-19 infection to reduce waiting lists.
- **11 August:** We began an eight day sequence in which we did not admit any additional cases of COVID-19 in our hospitals.

- **19 August:** We began to work through non-urgent and elective work in chronological order, as per Trust plans and strategies.
- **End of the month:** In total we admitted eight patients with COVID-19 throughout August, and seven were safely discharged.

September 2020

- **7 September:** We registered the lowest number of COVID-19 inpatients staying with us since March, at just three.
- **11 September:** We safely discharged our 500th COVID-19 patient.
- **14 September:** We marked one month without registering an additional COVID-19 death
- **15 September:** Following successful fundraising efforts, work went underway on the Bassetlaw rainbow garden, finishing just 15 days later on 30 September.
- **End of the month:** In total we admitted 37 patients with COVID-19 throughout September, and 23 were safely discharged.

October 2020

- **10 October:** As per national guidance, the Trust adopted the usage of the NHS Test and Trace app in specific hospital areas.
- **12 October:** Patient numbers rose sharply to 50, signalling the beginning of a second wave locally.
- **14 October:** Visiting was restricted at Montagu Hospital as four patients contract COVID-19.
- **16 October:** Due to increasing patient admissions and a spiralling infection rate locally, all visiting was restricted again.
- **25 October:** Marked the largest rise of patients in one day throughout the pandemic for the Trust.
- **26 October:** Admission figures outstripped peak seen during the first wave.
- **End of the month:** In total we admitted 499 patients with COVID-19 throughout October and 221 were safely discharged.

November 2020

- **4 November:** Point of care testing arrived at the Trust, complementing existing PCR tests, meaning screening results are known within a few hours of swabbing.
- **5 November:** Second national lockdown was announced and enforced.
- **7 November:** With much sadness, we shared the news that Lorraine Butterfield, Registered Nurse, had passed away following a brief but brave battle with COVID-19.
- **16 November:** We marked the peak of the second wave with 244 inpatients testing positive for COVID-19.

- **Middle of November:** During this time we came under sustained pressure from COVID-19, more than at any time during the pandemic. All focus and efforts were placed upon getting through these challenging times.
- **25 November:** Regular COVID-19 screening was introduced into all clinical areas, with staff expected to undertake two weekly screening using lateral flow device kits.
- **End of the month:** In total, we admitted 575 patients with COVID-19 throughout November, and 409 were safely discharged.

December 2020

- **2 December:** Second national lockdown ends and country returns to tier-system.
- **24 December:** Our in-house vaccination programme got underway with vaccination clinics at Rutland House in Doncaster, and the Keepmoat Stadium initially.
- **End of the month:** In total we admitted 507 patients with COVID-19 throughout December, and 393 were safely discharged.

January 2021

- **Beginning of January:** Admission rates began to very slowly decline.
- **6 January:** Third national lockdown was announced and enforced.
- **End of the month:** In total we admitted 435 patients with COVID-19 throughout January, and 355 were safely discharged. Nationally, the NHS admits one third of all seen COVID-19 patients in this month.

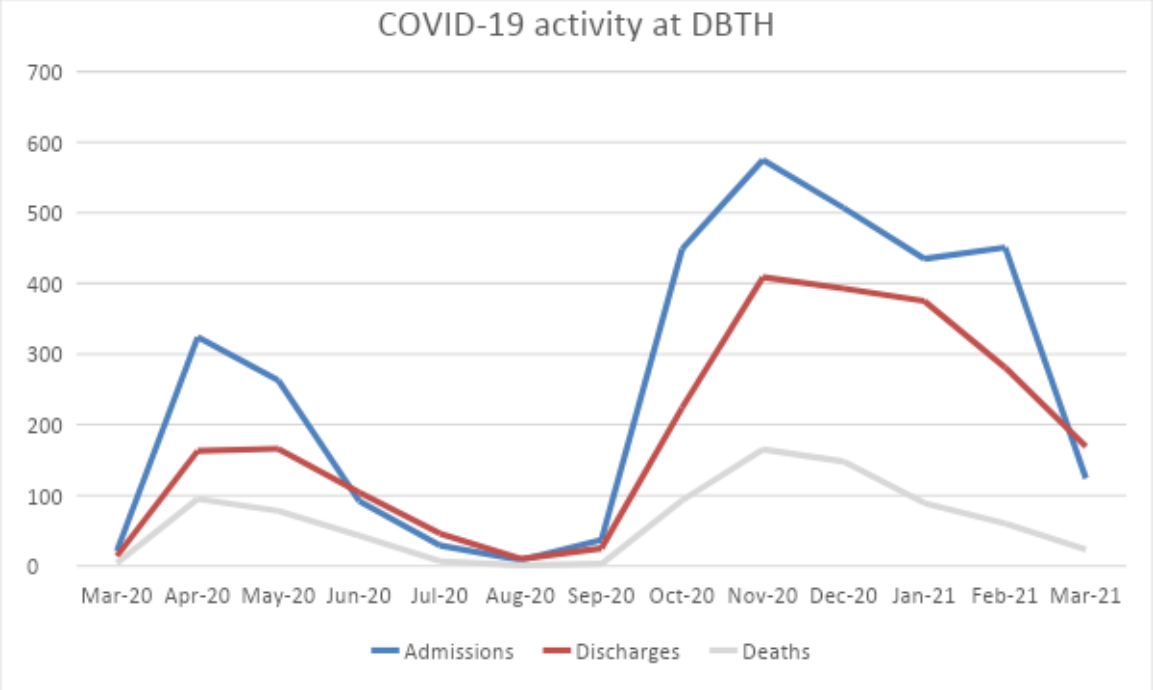
February 2021

- **8 February:** We safely discharged our 2,00th COVID-19 patient.
- **17 February:** We marked the admission of our 3,000th patient.
- **19 February:** Final in-house first dose COVID-19 vaccination clinic was held, with 6,764 colleagues receiving the jab.
- **End of the month:** In total we admitted 315 patients with COVID-19 throughout February, and 267 were safely discharged.

March 2021

- **11 March:** The 100,000th COVID-19 vaccine was administered in Doncaster.
- **12 March:** The Second dose vaccination programme began at the Trust, with an end point of 28 April.
- **21 March:** The Trust marked one year since the first COVID-19 patient was admitted.
- **23 March:** The Trust marked one year since the first COVID-19 patient passed away within our hospitals.
- **29 March:** Visiting restrictions were eased to allow for one named visitor per day, per patient, in most adult areas.

- **End of the month:** In total, we admitted 124 patients with COVID-19 throughout February, and 169 were safely discharged.



To highlight further work beyond the timetable above, throughout the following pages, we have organised our commentary into the following themes, which encompass our approach to the pandemic and the preceding 52 weeks:

A focus upon safety, care and infection control

When news of COVID-19 filtered through from China in late 2019, the broader NHS began to make plans for the potential implications of this new disease. For our part, our planning began in earnest in early March 2020, with senior teams mobilised to make significant changes when the scale of the challenge became apparent. What followed was a period of intensive change for our hospitals.

In the immediate aftermath of COVID-19 reaching the UK, we moved quickly as an organisation. Led by our Executive Team - as well as Director of Infection Prevention and Control, Dr Ken Agwuh - a number of physical changes were made to our sites, while daily 'Enhanced Operations' meetings were convened with senior colleagues across a range of specialities.

As such, the Trust implemented guidelines related to COVID-19, which were shared with all colleagues and regularly updated. This specified everything from treatment to the appropriate usage of PPE, and everything in between. Additionally, informed by predictive modeling of activity, we put in place plans to be able to increase our intensive care bed capacity from under 30, to just under 130 and consolidated several services to increase staffing resilience.

A system of testing was introduced early on (more detail on which can be seen below) with an in-house process developed within 20 days of the first confirmed positive at Doncaster Royal Infirmary. We believed that it was key to ensuring diagnosis was established early, with all admissions tested for COVID-19 upon arrival and specific pathways followed as the results became known. This system is still in place as of the time of writing this report.

Every patient with COVID-19 in our hospitals is, and has to be, cared for in a very specific way, no matter how the illness may be affecting them. This impacts on all manner of areas from what Personal Protective Equipment (PPE) colleagues must wear, to what treatments are used, which areas these individuals are transported through and what infection prevention and control procedures are in place.

In order to aid with the flow of patients - as well as improve our ability to deliver care in terms of increased activity - we moved our Respiratory wards from the top floor of the East Ward Block at Doncaster Royal Infirmary to the sixth floor, thereby enhancing piped oxygen pressures and flow, and consolidating relevant services together. Senior clinicians also kept abreast of any changes and incoming guidance in regards to the treatment of COVID-19, whilst we supported national research into the virus.

The above-mentioned reconfiguration impacted every single area of our hospital sites, as we moved into a system of ‘yellow’ and ‘blue’. The former is an environment with a higher risk of COVID-19 present, and therefore heightened PPE requirements and patient safety protocols. Ultimately, entire areas of our hospitals were designated in this way, with temporary walls erected throughout sites in order to better direct footfall - as well as ensuring those confirmed positive for COVID-19, or suspected, were segregated from the more vulnerable and negative - thereby minimising potential for cross-infection. This system is still in place at the time of writing this report.

Our teams also innovated, delivering new ways of delivering services in a COVID safe way. Our pathology team developed drive through phlebotomy and swabbing for urgent patients at the Keepmoat Stadium in Doncaster, helping to keep some of our most vulnerable patients safe. Similarly, our Cardio-respiratory team established a drive through cardiorespiratory tests.

We also worked closely with our independent sector partner, Ramsay Health, establishing a protected, safe environment for our cancer patients at Parkhill Hospital. Our outpatient services rapidly transferred many face-to-face services to telephone or video appointments. Technology helped establish rapid and efficient ways of working with system partners and colleagues across the Trust, this collaboration being so central to our response to the pandemic.

We also devised and put into operation a system for redeploying colleagues into areas experiencing workforce shortfalls, or those under increased strain. This service was setup early on during the pandemic and has been maintained ever since.

Given the infectious nature of COVID-19, it became clear that our measures of PPE needed to be enhanced, as did the availability of FFP3 masks for colleagues (filtering facepiece masks which protect against solid and liquid toxic aerosols). As such, we organised daily fit mask testing clinics, to ensure these pieces of equipment made an appropriate seal around colleagues' face when worn. In a short number of days, every member of staff working within a clinical setting and undertaking patient observations and related treatments were tested and given their own FFP3 respirator.

With increasing activity in March and into April, we took the decision to restrict all visiting. This also meant asking volunteers to stay at home, vulnerable colleagues to shield and the pausing of some elective and non-urgent appointments and procedures. Where possible, we continued some of this work, and in other cases we switched to virtual clinics, utilising secure platforms to keep in touch with patients. Still in operation today, the Trust intends to keep this new, digital way of working going forward, and it will form a crucial part of our strategy as we build towards a recovery.

The Trust experienced three waves of COVID-19, the first lasting from March to May, and the second from October to December and the third from January to March. While challenging, the initial surge in activity informed our approach later in the year, and helped us to refine, improve and enhance our policies and procedures, and whilst we came under far more strain during the winter, our collective experience meant that we were able to weather this particular storm.

The early foundations we put in place in response to COVID-19 have held firm throughout the past 12 months. Senior colleagues meet daily and weekly to update and escalate various matters, and our Executive Team remains in constant contact, revising and enhancing our response as necessary. In all, the successes we have experienced have been the result of constant vigilance, pouring over the detail and ensuring appropriate plans were in place to meet the challenges ahead of us. Plus, whenever things have not gone entirely as we would have liked, we have learnt from this, ensuring we improve going forward.

A focus upon estates and facilities

In addition to the changes outlined above, we made significant capital investments within our hospital throughout the year – both to combat COVID-19, as well as to enhance the Trust's infrastructure. Works included (note all costs are approximates):

- **Electrical Infrastructure**: Provision of a new electrical substation to replace an older facility and to provide new transformers and back-up generators for electrical resilience at Doncaster Royal Infirmary (£2.7m).
- **Fire precaution works:** Women's and Children's Hospital at Doncaster Royal Infirmary (£2,600,000), internal roads at Bassetlaw Hospital (£400k), Rehab 1 and 2 at Montagu Hospital (£200k), D Block at Doncaster Royal Infirmary (£100k).
- **Prevention of Legionella:** Removal of dead leg piping systems, installation of copper silver dosing, replacement of storage plate heat exchangers (£800k).

- **Works related to Care Quality Commissioning (CQC) recommendations**: Flooring upgrades and sanitary facilities (£350k).
- **Oxygen Resilience:** Installation of additional vacuum insulated evaporator and distribution pipework at Doncaster Royal Infirmary (£770k).
- **Roads and footpaths**: Improvements and repairs (£300k).
- **Medical gas improvements and investments:** Manifolds, pendants, Vacuum connections (£400k).
- **Roof Upgrades:** Minor Injuries Unit, theatres, resuscitation area, Ophthalmology (£800k)
- **Nurse on-call system**: Upgrades and replacement of obsolete equipment (£240k)
- **Emergency lighting:** Upgrades to main corridor areas (£350k)
- **Asbestos abatement:** Routine work across all hospital buildings (£400k)
- **Refrigeration:** Upgrade of chiller plant (£300k)
- **Generator upgrade:** Replacement of standby generator at Montagu Hospital (£150k).
- **Boilers:** Upgrade and replacement at Doncaster Royal Infirmary (£240k).
- **Lifts refurbishment:** Improvements to current lift system at Doncaster Royal Infirmary (£150k).
- **South Block Outpatients reconfiguration:** To aid with COVID-19 pathways and movements across site (£50k).
- **Emergency department flow and ventilation works:** Upgrades to patient entries, pathways and airflow within this area at Doncaster Royal Infirmary (£1,800,000).
- **Staff changing areas:** Refurbishments and enhancements at Doncaster Royal Infirmary theatres (£600k).
- **Endoscopy improvements:** Reconfiguration and ventilation for JAG accreditation (£220k).
- **Diagnostic improvements:** Replacement of existing CT scanner and provision of MRI at Bassetlaw Hospital (£200k).
- **Emergency Village:** Early design work at Bassetlaw Hospital (£250k).
- **ATC ward improvement:** Minor Reconfiguration at Bassetlaw Hospitals (£40k).
- **Doctors' mess:** Provision of new area at Doncaster Royal Infirmary (£150k).
- **Portacabins:** Additional office accommodation (£80k).

A focus upon procurement and personal protective equipment (PPE)

An early challenge experienced by the Trust, as well as providers across the country, was the availability of PPE. To date, we have used around three million items of equipment, from gloves to face coverings, and from early March 2020 have adhered to strict guidance to try and ensure the safety of colleagues.

Led by our Procurement service, the provision of PPE has been a priority throughout the past 12 months. The team regularly undertakes meticulous inventory management audits,

knowing the volume of equipment we have available, as well as sharing accurate and regular updates on how long this stock will last and when we can expect more. This real-time information ensured that, while challenging, we never ran out of PPE.

To support these endeavours, the role of 'PPE Champions' was devised and implemented across the Trust, supported by regular visits from the Infection Prevention and Control (IPC) team. With the data provided by Procurement, we were able to see where usage was most heavy, and whether additional training or support was required to ensure minimal wastage.

Furthermore, Procurement colleagues worked with the local community. This led to donations from local businesses and industry of relevant items, as well as enterprising individuals created appropriate equipment such as scrubs, gowns, masks and visors. As a Trust we owe a debt of gratitude to everyone who supported us in this endeavour.

A focus upon communications and information sharing

Given the significance of the events of the past 12 months, it became evident early on that communications, both internally and externally to the Trust, would be crucial. As such, we put a real emphasis on the sharing of information, ensuring that we were countering any false stories and that our communities and staff came along with us every step of the way as we fought against COVID-19.

To explain this process, we have split the following section into internal and external communications, as follows:

Internal communications:

As the reality of the pandemic became apparent, we created a 'Coronavirus Resource Centre' within the organisation's extranet. Updated daily, this webpage contains all the information colleagues need in regards to COVID-19, from how to access our swabbing service, to PPE guidance, clinical pathways and health and wellbeing support.

This information was shared via daily emails to all staff, as well as routine messaging via the organisation's private Facebook group, newsletters and other communications channels. These efforts have proved invaluable throughout the pandemic, with Communications colleagues being on-hand throughout the day to answer questions from members of staff, sharing relevant guidance and advice on a variety of topics.

The Chief Executive and Executive Team have also been very prominent on these communications channels, sharing their own updates, as well as messages of thanks throughout the 12-month period.

The need to share information was essential as the pandemic progressed, and while the Trust had established and embedded processes for this, one positive from COVID-19 has been the consolidation of communication techniques, with the vast majority of colleagues engaging with organisational news and updates on a daily basis, as well as sharing their own feedback, ultimately improving certain processes within our hospitals.

External communications:

With a number of announcements coming from the Trust throughout 2020 and 2021, we have worked closely with local journalists, as well as utilising our own platforms to share relevant messages with our local communities.

When lockdown came into effect - and our communities took to social media to keep in touch with friends, family and loved ones - we put particular emphasis on these platforms in order to keep local people up-to-date with our activities.

Within a ten-mile radius of Doncaster town centre, there are 320,000 registered and active users of Facebook between the ages of 13 and over 65. Within a ten-mile radius of Worksop town centre, there are 180,000 registered and active users of Facebook between the ages of 13 and over 65. This social network is therefore our main focus, as it is the one most used by our local communities.

On 1 March, our public Facebook page had 11,882 followers (people who are subscribed and receive our content on their news feed). This had taken around seven years to build up to and made us one of the highest followed in the area. By 16 April 2021, we were followed by 45,317 local people, an increase of 281%.

This significant growth means that we are now one of the most followed acute providers in the country, with our weekly reach averaging around 150,000 local users. In total, our social media messages have been seen around 20 million times between March 2020 and April 2021.

As a Trust, we have always made a concerted effort to make the most of Facebook and this activity follows a strategy which we implemented early on in the pandemic. This meant a daily schedule of posts (9am, 12pm and 9pm), with adhoc messages at certain points throughout. We also leave clear gaps of time between posts so as not to detract reach from each other. This continues at the time of writing this report.

Following this work, we have also shared numerous open letters from our Chief Executive, Richard Parker, which have been shared via Facebook and our local papers, while we have worked with our partners across Doncaster and Bassetlaw to share relevant messaging.

Throughout the pandemic, it was our intention to be open and transparent with our communities, detailing the challenges we have faced and why we are asking local people to make such sacrifices. Given the support and positive feedback we have received via our communications channels, this approach has been broadly successful.

We have also found that a constant stream of communication is able to cut through and counter the various forms of misinformation available. As such, we will continue to practice beyond COVID-19.

A focus upon colleague health and wellbeing

At DBTH the health and wellbeing of our colleagues has always been our top priority and never more so than in the last twelve months. There is no doubt that 2020 has been one of the most challenging years in the NHS' history, and colleagues have had to pull together each and every day. As such, it has been vital that we have done our best to keep our people safe, healthy and well – both physically and psychologically.

Led by the Health and Wellbeing team, with input from a range of other services, we offered a variety of avenues of support to our colleagues – with some of our initiatives listed below:

Free car parking and catering: As the challenges of the pandemic became evident, we made the decision to ease all parking restrictions on our hospitals sites, ahead of the same policy mandated by the Government. We also worked with the Council to lessen parking restrictions on nearby roads. Parking has always been a challenge for the Trust but, with fewer patients and visitors coming to site, we felt it was important that colleagues have appropriate access to our hospitals, leaving their vehicles safely and nearby.

In addition to parking, we also funded catering for all staff to ensure they were able to have access to an appropriate meal whilst on site and working. This took the form of meal bags, containing a sandwich, bag of crisps, drink and piece of fruit. The offer was also bolstered by donations of goodies and similar items from local well-wishers, as well as a month-long visit from Yellow Bus Catering (paid for by local company Mechanical FS) which provided a range of hot meals for all staff.

Risk Assessments: All areas, services and departments were required to undertake workplace risk assessments, as well as similar assessments for vulnerable colleagues. These allowed for changes to be made to enhance the safety of certain working environments, whilst also re-deploying those individuals who may be at an increased risk of COVID-19, or alternatively sending them home to shield.

Reiki practitioner: We have worked with Reiki Practitioner, Darren Fox, for a number of years. Proving a popular addition to the team, over 300 staff have accessed this service for free over the past 12 months. Given the challenges of the pandemic, additional clinics were laid on by the Trust and have been invaluable to colleagues looking for ways to relax, recharge or overcome stress.

The Talk, Listen, Care (TLC) service: This in-house service has made over 7,000 calls to absent staff in regards to stress, anxiety, depression, child care problems and COVID-19. This platform was created in order to check-in with colleagues to see what, if any, support was needed for those absent from work.

Mental health support: A range of counselling services and support lines were made available to colleagues, ensuring they had someone to speak to if they felt overwhelmed by the current situation, or simply needed to chat to someone.

Rainbow rooms: These spaces were created across all three sites giving staff a place to go for a well needed break and to recharge. The rooms were filled with tea and coffee and other comforting items. Many of these spaces still exist, and plans are being worked up to make similar areas a permanent fixture at the Trust.

Rainbow Memorial Gardens: This project was devised, with one garden situated at Doncaster Royal Infirmary and another at Bassetlaw Hospital, to remember those lost to COVID-19. With over £40,000 raised by the local community, the first of these gardens opened in September 2020 at Bassetlaw, whilst the Doncaster venue was later completed in April 2021. A garden is already in place at Montagu Hospital and a memorial to all those we have lost to Covid-19, including our three much missed colleagues, placed in each of the gardens.

Staff Physiotherapy Service: A well-established platform that supports people who experience musculoskeletal disorders affecting their muscles, tendons, ligaments, nerves and other soft tissues and joints. The common complaints are back, neck, shoulder and knee pain.

Comfort packs: A staff suggestion, these were created for patients being discharged who had no family support available to them. The packs included toiletries, tea and coffee and other essential items that patients may not have when returning from a hospital stay, particularly during lockdown.

Vivup, our Employee Assistance Provision: This service provides help 24/7, 365 days a year, giving our colleagues access to confidential impartial assistance. This includes counselling for issues such as anxiety and depression. There is also a Listening Line and a Bereavement Support Line set up to provide assistance on a wide range of matters like domestic abuse and financial wellbeing support.

Other items and schemes include:

- Our staff benefits scheme, enabling colleagues to purchase items - from home electronics to cars and gym memberships - through salary sacrifice.
- There are over 50 Health and Wellbeing Champions supporting the Health and Wellbeing Team by sharing information and signposting colleagues to different offers throughout the Trust.
- A Step Challenge was created to encourage our colleagues to get moving, this created much competition between departments and encouraged colleagues to look after their physical health when away from work.
- Free cycle events across our sites giving staff the opportunity to have their bikes serviced for free. As well as promoting the benefits of cycling to work, we also promoted our on-site facilities including shower facilities and secure bike shelters on all sites.
- Routine sharing of a list of free apps available for NHS staff, including Headspace and Sleepio.

- Finally, a Health and Wellbeing Calendar was created - with monthly campaigns running to offer staff access to advice and information on a variety of topics, including sleep, menopause, smoking and alcohol.

Our Trust Health and Wellbeing offer is continually expanding as colleagues share with us their needs and what would support them to better maintain their health and wellbeing. Many of these initiatives created during the months of COVID-19 will be retained, as per the wishes of colleagues.

A focus upon vaccination and testing

In March 2020, we recognised the importance of in-house screening and diagnosis of COVID-19. As such, we developed a system for achieving this in a relatively short time-frame, ordering the relevant equipment to do so.

From 21 March, we offered colleagues symptomatic of COVID-19 the ability to use a newly created drive-thru swabbing service based within the car park of the Old Ambulance Station (across the road from Doncaster Royal Infirmary). To access this, colleagues were asked to ring a dedicated 'Sickness Absence Line'. Following this, the individual would be given an appointment to safely visit the service and receive a swab, alongside household members if necessary. Afterwards samples were sent away to Sheffield Teaching Hospitals, until 9 April when they started to be screened within our own Pathology department. To-date, over 100,000 tests have been completed at the Trust, and the service remains in place (transitioned to Bassetlaw Hospital) at the time of writing this report.

Details on our testing process can be found at the bottom of this section.

In December, we also introduced a programme of regular testing for all clinical colleagues using lateral flow devices. In all, over 5,000 members of staff received a three-month supply of these kits, completing screening twice-weekly, with all results entered into a bespoke digital system. The intention of this process is to reduce asymptomatic carriage of COVID-19 into our hospitals via staff, and therefore reduce nosocomial spread of the illness amongst patients. This testing will continue for the foreseeable future.

Finally, in the same month we began our COVID-19 vaccination programme in partnership with NHS Doncaster Clinical Commissioning Group (CCG), NHS Bassetlaw CCG and primary care organisations within the area.

Moving to in-house clinics in early January 2021, 6,764 first dose vaccines were delivered in the Trust, accounting for the vast majority of colleagues. The second dose programme finished in late April 2021, with over 13,000 doses delivered in total.

Appendix - Testing for COVID-19 at DBTH:

Our Microbiology Team utilise cutting edge technology and techniques to provide an accurate and efficient laboratory identification of COVID-19 (SARS-CoV-2) in our patients

and staff. This information is used by Microbiology Consultants and other Clinicians to diagnose SARS-CoV-2 infection. Our method of choice is magnetic nucleic acid extraction from nose/throat swabs followed by highly specific Real-time PCR to identify the presence of SARS-CoV-2.

We are continuously looking for ways to refine and improve the standards of our service and outlined below is our current system. So far, the team has undertaken over 100,000 tests of SARS-CoV-2.

Sample Type:

- Our sample of choice is a Viral Swab (currently red or green topped) of the Nose and Throat.
- Our Viral swabs contain Viral Transport Media which contains a substance that sustains any viruses present and also antibiotics which will kill any bacteria present. Both of these additives help to keep the sample as pure as possible during transport before being processed and also help to remove the risk of contamination.
- This swab type means our assay is more sensitive or accurate for SARS-CoV-2 than using dry swabs or those in saline.

Sample Preparation:

- Our main SARS-CoV-2 testing is carried out in our Molecular suite, a room that has limited access via a locked door used only by trained staff wearing full PPE.
- All staff working in the Molecular suite are fully competent in the process and understand all safety considerations. Any staff member required to work with this level of Pathogen must be a Biomedical Scientist registered with the Health and Care Professions Council.
- Our testing system has been fully assessed by the Health and Safety Executive and approved as COVID secure.
- All sample processing for SARS-CoV-2 testing is initially carried out in a special safety cabinet that protects our Biomedical Scientists from any risk of infection from the samples. These cabinets also protect the sample from being contaminated by our staff.

Nucleic Acid Extraction

- The prepared samples are then loaded into one of our four Extraction instruments.
- These instruments use heat to break down the components of the samples, releasing Nucleic acid (genetic material) in the form of DNA and RNA.
- All viruses can be DNA or RNA based organisms and SARS-CoV-2 is an RNA virus.
- The instruments then use metal beads to bind to any RNA present and are held in place by magnets.
- The unwanted material is then washed away from the sample leaving the purified RNA known as an eluate.
- This eluate is then ready for PCR testing.

- We also add an internal control that must be detected in the final result to guarantee the sample has been extracted correctly.
- This method of magnetic extraction is more sensitive than other methods of extraction relying on heat alone.

Real Time PCR:

- We use Real time PCR (Polymerase Chain Reaction) to detect SARS-CoV-2 in our samples.
- PCR is a highly sensitive and specific method for detecting the DNA or RNA of any Virus or Bacterium.
- PCR kits or assays are uniquely designed to only look for a specific component of the target organism.
- Primers are used which will only bind to the desired target component. This makes the method highly specific as the gene our primers bind to is only found in SARS-CoV-2.
- We have tested the normal strains of Coronavirus and other "common cold" organisms, such as Rhinovirus, with this assay and not produced any false positives for SARS-CoV-2.
- The PCR method uses cycles of heating and cooling to help the primers bind to the SARS-CoV-2 gene if present. If present, the gene will be amplified and fluorescence will occur.
- This fluorescence is measured throughout the test to give a visual and quantitative result.
- Negative and positive Quality controls are run with every test and all results are checked before authorisation.
- Negative results are sent out by Senior BMS staff and positives telephoned by Consultant Microbiologists.

Our assay has been measured as having a sensitivity (chance of producing true negatives) of 96% and a specificity (chance of producing true positives) of 96%. The LOD (Limit of Detection) of our assay is 30 copies per ul, which means our assay can detect very small levels of the virus.

A focus upon recovery

The unfortunate fact is that COVID-19 will, in all probability, be a fact of life as we move forward beyond the pandemic. This will accordingly be factored into our plans and strategies as we look ahead to the future. In the short-term, we are developing and implementing plans to recover our performance and activity which has been affected by COVID-19, working through waiting lists in order of urgency as well as chronology – and this will be done as we keep a watching brief on levels of COVID-19 infection within our communities.

In the 2021/22 financial year, we will refresh our Trust strategy, resetting our objectives and factoring in much that we have learnt throughout the past 12 months. This will also be done within the context of a transitioning healthcare system within the region, and we will help

facilitate any changes, playing a key partnership role within the region and as part of the South Yorkshire and Bassetlaw Integrated Care System.

Throughout the pandemic, we have been evaluating our approach and it is our intention to, within reason, keep the things that have proven successful, whilst improving in those areas where we can do better. The next 12 months will be full of developments, changes and activity as we set our sights upon a sustainable recovery.

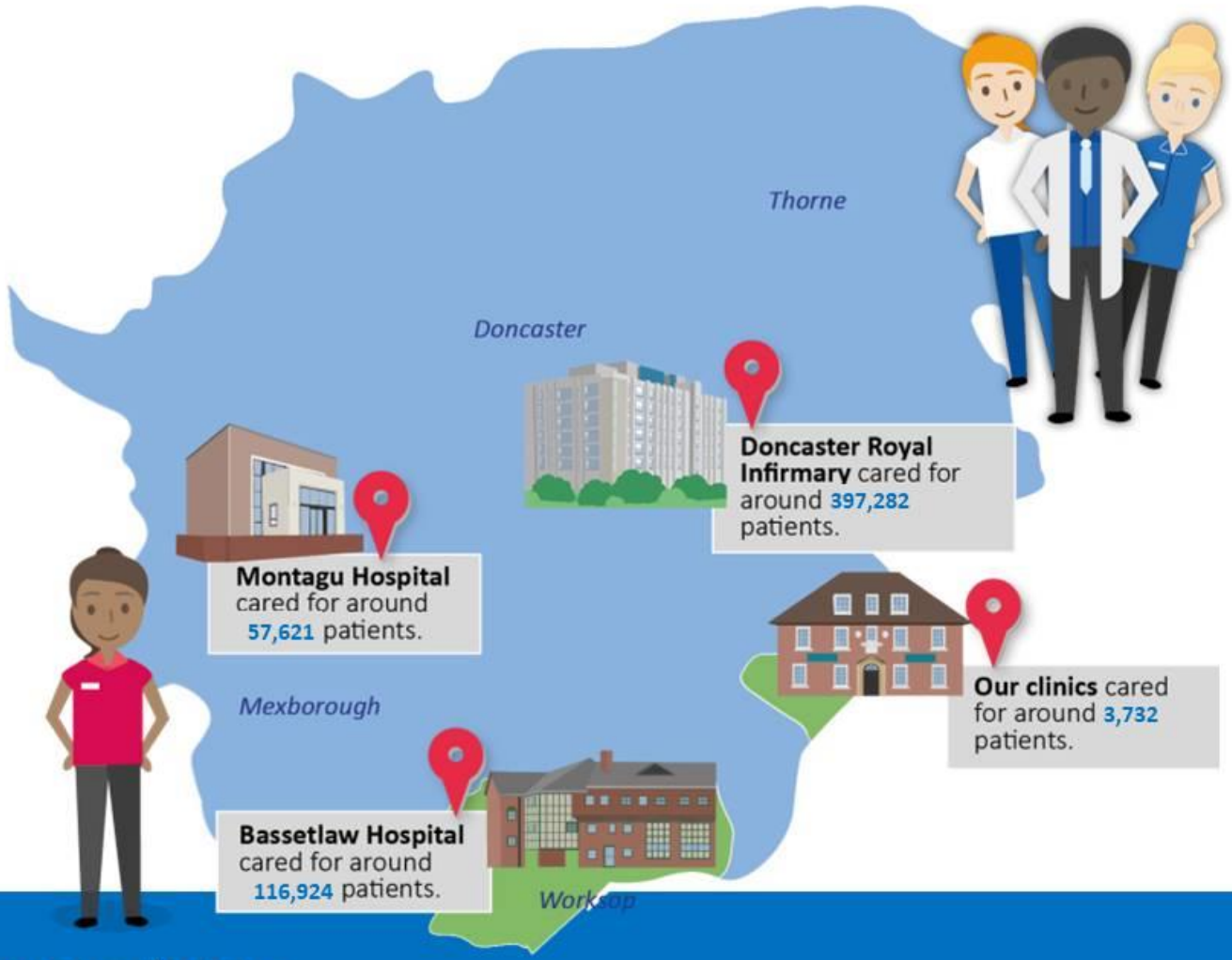
Our activity through 2020/2021

We cared for around **86,111** inpatients
[Last year 103,240]

We cared for approximately **337,950** outpatients
[Last year 425,561]

We cared for approximately **147,211** emergencies
[Last year 165,780]

We delivered approximately **4,287** babies
[Last year 4,730]



In loving memory

The past 12 months have been extraordinary in so many ways. While it is a sad fact that we will unfortunately lose colleagues throughout the course of an ordinary year (and memorialise them appropriately), Team DBTH lost three beloved members in a relatively short period of time due to COVID-19.

Our Chief Executive, Richard Parker OBE, shared the following words about their passing:

Kevin Smith, 23 April 1955 - 12 April 2020

Kevin Smith, a well-respected and hugely popular member of our team, sadly passed away following a brief, but courageous, battle with Covid-19 on Easter Sunday.

A Plaster Technician at Doncaster Royal Infirmary and a valued member of the team for over 35 years, Kev, as he was known to friends and colleagues, was renowned for his warm personality, diligence and compassion. He will be missed beyond all measure by everyone at the Trust.

I am incredibly thankful to colleagues who cared for Kevin, and for their tireless efforts during this time.

As an organisation, we share our collective thoughts, condolences and deepest sympathies with Kevin's wife, Diane, and their loved ones.

Dr Medhat Atalla, 3 January 1958 – 22 April 2020

Our colleague, Dr Medhat Atalla, passed away following treatment for Covid-19 at Doncaster Royal Infirmary.

Dr Atalla became a full-time member of our Trust in 2014, when he was appointed as a Consultant Geriatrician on our Gresley Unit. We were fortunate to have worked with him for many years prior to this, since his arrival in the United Kingdom in the early 2000s, where he cared for many elderly patients in hospitals throughout the North of England.

A hugely popular and respected colleague, Dr Atalla was a very special human being who practised medicine across three continents throughout his career, affecting the lives of so many in such a positive way. He was a truly gentle gentleman and he will be hugely missed by us all.

We would also like to take a moment to thank colleagues who cared for Medhat during his illness, and who did all they could to care for and support him as he bravely battled Covid-19.

As a Trust, we share our deepest sympathies with Dr Atalla's brother and sister, and loved ones in Egypt.

Lorraine Butterfield, 6 January 1957 – 11 November 2020

We are so deeply saddened to note the unexpected passing of our much-loved colleague, Lorraine Butterfield.

A Registered Nurse of many years' experience, Lorraine was a familiar face within our Emergency Department at Doncaster Royal Infirmary, and made such a huge difference to the countless patients she cared for since joining our Trust in 2004.

Colleagues who worked closely with Lorraine describe her as a hugely warm, kind and joyous person, who always had a smile for everyone she came across, as well as an ever-extended helping hand for those in need.

To Lorraine's family we will share our collective thoughts, condolences and sympathies. Lorraine touched so many lives both in her native South Africa, as well as within Doncaster, the town which she made her home. She will be missed desperately.

Financial performance

NHS Improvement has directed that Foundation Trusts' financial statements should meet the accounting requirements of the NHS Foundation Trust Annual Reporting Manual (FT ARM), as agreed with HM Treasury.

Our financial statements have been prepared in accordance with the 2020/21 FT ARM and follow International Financial Reporting Standards (IFRS) and HM Treasury's Financial Reporting Manual to the extent to which they are meaningful and appropriate to NHS foundation trusts. Accounting policies are applied consistently in dealing with items considered material in relation to the accounts.

This is the second year that the accounts of the Trust's charitable funds and the Wholly Owned Subsidiary, have been consolidated with the accounts of the Foundation Trust, to produce 'group' accounts (in-line with the guidance above). The comments below refer to the financial performance of the Foundation Trust, with a separate annual report for each of the Charity and Wholly Owned Subsidiary being published at a later date.

2020/21 in review

As a result of the focus on treating Covid-19 in the year, the financial performance of the Trust has reflected, and been affected by the challenges of the pandemic.

Clinical income for the Trust increased by £25.8m in the year, as the Trust received additional income of £18.3m to support the treatment of Covid-19 patients.

The overall surplus for the Trust was £2.7m, as a result of the extra income as detailed above, alongside cost control due to lower elective activity.

A summary of our financial performance (set out in more detail in the annual accounts) is as follows:

Working capital

Cash balances for the Trust held at 31 March 2021 were £50.9m.

Loan Repayments

The Trust received £71m of PDC Dividend Equity from the Department of Health and Social Care in 2020/21, and this was used to repay all revenue loans that were outstanding as at 1 April 2020.

Public Dividend Capital (PDC) dividend

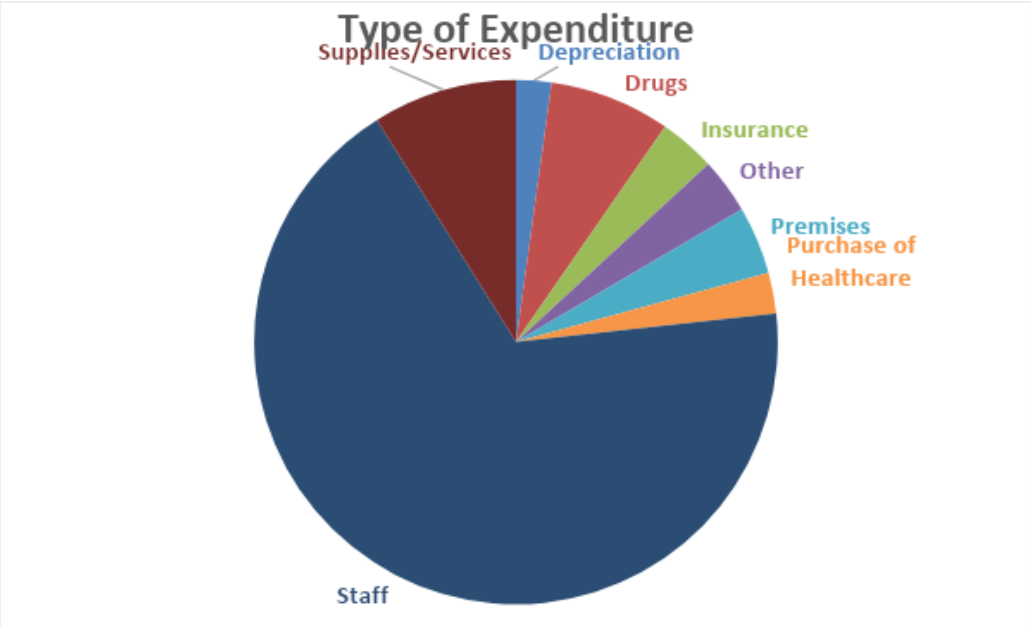
A charge of 3.5% of average relevant net assets is payable to the Department of Health as a PDC dividend, reflecting the forecast cost of the capital we used. A dividend of £4.7m was payable during 2020/21.

Income

We received a total of £469m income in 2020/21, which is growth of £34m from the previous year. The contracting arrangements for 2020/21 changed, compared to previous years, meaning the vast majority of clinical income came under "Block" arrangements and as such, not linked to activity. Such arrangements are due to be wound down by 30 September 2021.

Revenue expenditure

During the year, the Foundation Trust had operating expenses of £458m. As in previous years, the vast majority of our expenditure is on pay budgets (staffing) at £306.1m, with nursing and medical staffing continuing to be our biggest areas of expenditure.



Capital expenditure

Expenditure on larger items with a life of more than one year - typically buildings and equipment - was £36.6m, of which £2m was funded by the Department of Health and Social Care, providing medical equipment to assist with the treatment of patients with Covid-19. The areas of capital expenditure can be summarised as:

- Property Maintenance - £20.3m including Electrical Works, Fire Protection Works and Emergency Department Works
- Medical Equipment - £10m including Covid-19 treatment medical equipment, MRI at Bassetlaw and CT Scanner at Bassetlaw
- IT Software - £4m including Electronic Patient Records project.

Principal risks, opportunities and uncertainties and factors affecting future performance

The principal risks against achievement of the Trust's strategic objectives are as highlighted below:

- **Ongoing COVID-19 challenges and recovery plans**

Like all providers across the country, COVID-19 has significantly impacted the Trust, and work will have to take place to bring performance and activity back into line. Our focus in the coming financial year is to recover our position as much as possible, working with our regional partners in order to do so.

- **Delivering our financial plan, cost reduction programme and Efficiency and Effectiveness Plans (EEP)**

Whilst the Trust has undergone an extensive and detailed budget setting process, the organisation has a number of risks which may affect the delivery of this budget.

There is also a variance between the Trust's financial plan and what commissioners feel they are able to pay. Whilst there are plans across the health community aimed at reducing demand for acute services, demand predictions for demographic growth not included in contracts by commissioners may result in an adverse variance in the financial performance of the Trust.

- **Ensuring that appropriate estates infrastructure is in place to deliver services and an inability to meet the Trust's need for capital investment**

A significant proportion of the Trust's estate dates back to the 1960s and requires significant investment to ensure that we are able to meet our legal requirements and maintain a safe environment in which to care for our patients. External reports have highlighted necessary remedial action to ensure the buildings are compliant with existing regulations and additional surveys have brought the main issues into corporate focus.

The Grenfell Tower tragedy increased the emphasis on ensuring public buildings are meeting changed evacuation strategies in-line with fire safety regulations, with additional requirements put in place over and above the significant investment the Trust was already making in respect of fire safety compliance.

In 2020/21 the Trust Estate Capital Programme was based upon maintaining and improving the safety of the buildings and environments, and in doing so, supporting patient safety. A number of property improvement areas are to be considered in 2021/22. Nevertheless, the availability of capital funds to support improvements remains an ongoing challenge.

- **Availability of workforce and addressing the effects of agency caps**

Like many trusts nationwide this year, we have faced staffing challenges. In order to address these issues, we are looking at new and innovative programmes to fill these workforce gaps, using our teaching hospital status to aid our recruitment processes. We continue to strive to improve the use of locums and our bank workforce, utilising our temporary workforce in a cost-effective and efficient way.

A key challenge for 2020/21 was to recruit, retain and develop sufficient nursing and other clinical staff to ensure safe staffing levels. We are using both national and local evidence to define evidence-based staffing levels for an increasingly wide range of staff.

The governance structures are in place to support the active reduction of our agency spending, in line with the identified price caps and to minimise our reliance on agency and locums. This active management approach to our workforce has already achieved improvements in the relative use of agency nurses.

- **Opportunities in 2021/22**

I. Following the creation of the Education and Research directorate and related appointments, we will anticipate an increase in the amount of research undertaken at the Trust.
II. We will further implement digital solutions to support innovative and effective ways of working, not only in patient settings but also in support functions. Some of this work has been expedited following the outbreak of Covid-19.
III. We will make best use of our multiple sites to provide access and flexibility within our services
IV. We will continue strong partnership-working with our established Integrated Care System (ICS), in order to support improvements to services for regional populations.

Going Concern

The Department of Health requires NHS Foundation Trusts to decide the going concern status on an annual basis, the 'Going Concern' principle being the assumption that the entity will remain in business for the foreseeable future.

The Trust's annual report and accounts have been prepared on a going concern basis. Non-trading entities in the public sector are assumed to be going concerns where the continued provision of a service in the future is anticipated, as evidenced by inclusion of financial provision for that service in published documents.

After making enquiries, the directors have a reasonable expectation that the Trust has adequate resources to continue in operational existence for the foreseeable future. This is based on:

- Continuing support from local commissioners
- The Trust will end the year with £50.9 million cash in the bank
- The Trust has delivered a surplus in 2020/21
- There are no licence conditions in place on the Trust from its regulatory body
- The Trust has received a Good rating from the CQC for use of resources during 2019/20.

All planning assumptions that the Trust operates under imply that this will be forthcoming. As a result of this, the financial statements do not contain the adjustments that would result if the Trust was unable to continue as a going concern.

Richard Parker OBE
Chief Executive
25 June 2021

Accountability Report

Directors Report

Composition of the Board

During 2020/21, the following persons were members of the Board of Directors:

Name	Position	Term of office	Term of office from	Attendance at Board meetings
Suzy Brain England OBE	Chair of the Board	5 years	1.1 2017	11 of 11
Neil Rhodes	Non-executive Director (Deputy Chair of the Board)	5 years	1.4.2017	10 of 11
Sheena McDonnell	Non-Executive Director	3 Year	1.7.2018	11 of 11
Pat Drake	Non-Executive Director (Senior Independent Director)	3 Year	1.4.2018	11 of 11
Kath Smart	Non-Executive Director	3 Year	1.4.2018	11 of 11
Mark Bailey	Non-Executive Director	2 Year	1.2.2020	11 of 11
Richard Parker	Chief Executive			11 of 11
Karen Barnard	Director of People and Organisational Development			11 of 11
David Purdue	Chief Nurse and Deputy Chief Executive			11 of 11
Jon Sargeant	Director of Finance			11 of 11
Rebecca Joyce	Chief Operating Officer			11 of 11
Dr Tim Noble	Medical Director (from 01.04.20)			10 of 11

All Non-Executive Directors are considered to be independent, meeting the criteria for independence as laid out in *NHS Improvement's Code of Governance*.

Non-Executive Directors are appointed and removed by the Council of Governors, while Executive Directors are appointed and removed by the Nominations and Remuneration Committee of the Board of Directors.

The Chair of the Board's other main commitment is as Chair of Keep Britain Tidy. In 2017/18, she was co-opted as a member of the Board of Doncaster Chamber of Commerce, and more recently became the Lead Examiner for Chartered Directors for the Institute of Directors

Balance of the Board

Non-Executive Directors are appointed to bring particular skills to the Board, ensuring the balance, completeness and appropriateness of the Board membership.

The Board of Directors considers the balance and breadth of skills and experience of its members to be appropriate to the requirements of the Trust.

Brief details of all Directors who served during 2020/21 are as follows:

Chair

Suzy Brain England OBE C.Dir is an experienced board chair, non-executive director, consultant, mentor and counsellor. Suzy is currently the Chair and Trustee of Keep Britain Tidy, a member of the Institute of Directors' Accreditation and Standards Committee, and founder of Cloud Talking mentoring services. Suzy has a wealth of experience in chairing and serving on boards in a variety of sectors, including: health; housing; enterprise; and finance. She was awarded an OBE for 'public service', in particular for her work as Chair of the Department of Work and Pensions Decision Making Standards Committee. Suzy began her career as a journalist and was CEO of the Earth Centre in South Yorkshire.

Non-Executive Directors

Neil Rhodes was born and brought up in Barnsley and now lives in the north of Lincolnshire. His particular areas of interest in the NHS are the quality of patient care and the importance of the patient perspective in designing services that give real value for money. Neil is the Deputy Chair of the Trust; and the Chair of the Finance and Performance Committee, in which he is responsible for the scrutiny of those areas on behalf of the wider board. His professional background was in policing where, as a chief constable, he was responsible for the running of a large public sector organisation, with complex finances and a clear public service ethos. Neil has extensive experience in the delivery of large programmes of work, including the management of organisational change, provision of core computer systems and the outsourcing of services. His interests outside of the Trust include non-executive membership of the national Youth Justice Board since 2013 and both personnel and organisational development work as a consultant.

Patricia Drake is a former nurse with a wide-range of experience in both acute and community care. Since retiring from the Health Service, Pat has served a number of organisations and charities as a Non-Executive Director, whilst serving as Deputy Chair of Yorkshire Ambulance Service. She has also worked as a Non-Executive Director at Locala Community Partnerships, Justice of the Peace and as Governor of a further education college. A passionate advocate for the delivery of high-quality patient care, Pat is focused upon ensuring that patients and the public have a significant voice within the NHS. Pat has taken on the role of Clinical Non-Executive, a position the Trust established following the Francis Report into failings at Mid Staffordshire NHS Foundation Trust.

Sheena McDonnell specialises in leadership and organisational development, as well as governance and transformation. She has extensive experience in both the public and charitable sectors and has held senior roles in housing for the past twenty five years. This includes several years with the Audit Commission, giving her a strong understanding of regulatory and governance requirements. Sheena is now an independent consultant and coach, focused on delivering effective leadership within organisations and individuals. She has

a keen interest in the quality of patient care and the views of patients and communities. Sheena also holds a non-executive role on the board of a leisure trust, encouraging people to be more active more often.

Kath Smart a Doncaster resident, has an extensive background in the public sector, working within the NHS for over a decade as a commissioner in Doncaster, Wakefield and Hull, where she covered a variety of roles: from risk management to governance and external inspections. As a Chartered Institute of Public Finance and Accountancy (CIPFA) qualified accountant, Kath has most recently worked with Rotherham, Doncaster and South Humber NHS Foundation Trust (RDaSH) as a Non-Executive Director, as well as Chair of the organisation's Audit Committee and social enterprise, Flourish Enterprises. Kath also has other Audit Committee-related roles with Doncaster Council and Acis Group (local housing provider), whilst undertaking financial work for Foresters Friendly Society and mental health act work for RDaSH.

Mark Bailey commenced as Non-Executive Director in the Trust in February 2020. Mark, a former Group Director for Customers and Services at Rolls-Royce plc, has an extensive background in the private sector, having spent over 30 years with the world-renowned engineering company. Initially trained as an engineer, Mark has extensive experience operating at senior leadership and board level environments, while nurturing a specialist interest in strategic development, business growth and customer service transformation. He has also led the introduction of innovative digital solutions throughout his career, something which is a particular focus for the Trust as it looks to further modernise how clinicians use technology to support patient care.

Executive Directors

Richard Parker OBE was appointed Chief Executive in January 2017. Richard's previous role was Director of Nursing, Midwifery & Quality. Richard began his career as a student nurse, qualifying in 1985. Richard was appointed Deputy Chief Nurse at Sheffield Teaching Hospitals in 2005, Deputy Chief Operating Officer in 2010 and then Chief Operating Officer in 2013. He held that position until joining us in October 2013. Richard has a special interest in ensuring that nurse staffing levels are safe, appropriate and that they provide high-quality patient care. He gained an MBA (Health and Social Services) in 1997 from Leeds University and the Nuffield Institute for Health and his dissertation was on acuity, patient dependency and safe staffing levels. In 2018, Richard was awarded an OBE in the Queen's New Year Honours for his service in health and social care.

Karen Barnard joined the Trust from Sheffield Teaching Hospitals where she was Deputy Director of HR and Organisational Development. Before that she worked at Mid Yorkshire Hospitals as Deputy Director of HR and has experience working for various NHS organisations across Northern Lincolnshire.

David Purdue qualified as a registered general nurse from Nottingham University in 1990 and specialised in cardiac nursing in Nottingham, where he set up a number of cardiac nurse-led services. This particular innovation won him an award from the National Modernisation

Agency. After four years working on the implementation of the National Service Framework for coronary heart disease, and then improving access to heart services in the East Midlands, David returned to hospital life in 2004 as clinical nurse manager for cardiothoracics at City Hospital in Nottingham. He joined the Trust in October 2008 as Divisional Nurse Manager for Medicine. David was Associate Director of Performance from 2010. He was Acting Chief Operating Officer from June 2013 until his substantive appointment to the role in July 2013. In 2018, David was appointed Deputy Chief Executive, and he became Chief Nurse in September 2019.

Jon Sargeant joined the Trust as Director of Finance in November 2016. Previously Director of Finance at Burton Hospitals NHS Foundation Trust, Jon has over 25 years of experience, working exclusively in the health service. Starting as a Financial Trainee at Heartlands Hospital in 1989, Jon held a number of board level posts, most notably as Director of Finance at Epsom and St Helier University Hospitals, leading a number of reconfiguration projects at the London-based Trust, before moving to Burton Hospitals in 2013.

Rebecca Joyce joined the Trust on 3 June 2019 as Chief Operating Officer. A graduate from the University of Cambridge, Rebecca joined the Trust from Sheffield where she held the post of Accountable Care Partnership Director since 2017, working across the NHS, Council and Voluntary Sector to develop a more integrated, prevention orientated care system. With almost 20 years' experience within the Health Service, Rebecca's career began in 2000 when she joined the NHS Graduate Management Training Scheme, working in acute and primary care roles across North West London, alongside working for a Not-For-Profit Health Network in Tanzania on the coordination of HIV and AIDs services. Following that, she worked within senior hospital operational roles at Imperial NHS Foundation Trust and Ealing Hospital. In 2007, Rebecca moved to Sheffield Teaching Hospitals to take up the role of Operations Director for Specialised Cancer, Medicine and Rehabilitation. Rebecca then transitioned into more transformational and strategic roles, moving into the role of Service Improvement Director for Sheffield Teaching Hospitals in 2014. Rebecca joined DBTH in June 2019.

Dr Tim Noble qualified from St Bartholomew's Hospital Medical School in London in 1989, having been born and raised in York. After five years of medical training, he practised in a number of hospitals in the south of England. In 1995, Dr Noble returned to the North of England and completed a research project at Sheffield Teaching Hospitals, qualifying as a specialist in respiratory medicine in 2002. A move to Barnsley Hospital followed in 2003, before he went on to start his career at DBTH in 2006 as a Consultant Respiratory Physician. From 2010 to 2017, the Doncaster resident oversaw the hospitals' respiratory medicine service, as well as undertaking two Clinical Director posts, before becoming Deputy Medical Director in 2017. Dr Tim Noble was appointed Medical Director of Doncaster and Bassetlaw Teaching Hospitals in 2020.

Registers of interests

All Directors and Governors are required to declare their interests, including company directorships, upon taking up appointment and (as appropriate) at Council of Governors and Board of Directors meetings in order to keep the register up to date.

The Trust can specifically confirm that there are no material conflicts of interest in the Council of Governors or Board of Directors. The Register of Directors' Interests and the Register of Governors' Interests are available on request from the Foundation Trust Office at Doncaster Royal Infirmary.

Cost allocation and charging

The Trust complied with the cost allocation and charging guidance issued by HM Treasury.

Donations

The Trust made no donations to political parties or other political organisations in 2020/21 and no charitable donations in 2020/21.

Payments Practice Code

The Trust has adopted the Public Sector Payment Policy, which requires the payment of non-NHS trade creditors in accordance with the CBI prompt payment code and government accounting rules. The target is to pay these creditors within 30 days of receipt of goods or a valid invoice (whichever is the later), unless other payment terms have been agreed with the supplier. In 2019/20 the Trust has been in receipt of cash support from the Department of Health and therefore the Trust's cash flow is proactively managed with the aim of paying outstanding invoices within the Public Sector Payment Policy 30 day target.

Non NHS	Number	Value '£000
Total bills paid in the year	87,006	£224,678
Total bills paid within target	85,277	£218,019
Percentage of total bills paid within target	**98%**	**97%**

NHS	Number	Value '£000
Total bills paid in the year	2,865	£18,312
Total bills paid within target	2,693	£18,312
Percentage of total bills paid within target	**94%**	**100%**

Quality Governance

During 2019/20 the Trust underwent a Use of Resource inspection which informed the overall CQC inspection, the inspection assessed the Trust on 5 principals: effective, caring, responsive, well-led and safe. The Trust received an overall rating of 'Good', improving on the previous years' rating of 'Requires Improvement'. As part of the Use of Resources inspection the Trust was complimented for the way that all areas were focused on, not just patient safety but also value for money.

The Board of Directors monitors a series of quality measures and objectives on a monthly basis, reported as part of the Business Intelligence Report and Nursing Workforce report. Risks to the quality of care are managed and monitored through robust risk management and assurance processes, which are outlined in our Annual Governance Statement. The committees of the Board, particularly the Quality and Effectiveness Committee, play a key role in quality governance, receiving reports and using internal audit to test the processes and quality controls in place. This enables rigorous challenge and action to be taken to develop services to enable improvement.

The Board gives regular consideration to ensuring service quality in all aspects of its work, including changes to services and cost improvement plans. The Board proactively works to identify and mitigate potential risks to quality. More information on the arrangements to govern service quality can be found in the Annual Governance Statement. There are no material inconsistencies to report between the Annual Governance Statement, annual/quarterly board statements, the Board Assurance Framework, Annual Report and CQC reports.

We aim to work with patients and the public to improve our services, including the collection of feedback through the Friends and Family Test comments, patient surveys and involvement in service changes. We also work in partnership with Healthwatch Doncaster and Healthwatch Nottinghamshire and the Trust's public Governors, to promote patient and public engagement. We have actively been supported by Healthwatch and local Learning Disability patients in undertaking the Patient Led Assessment of the Care Environment (PLACE) this year. Their contribution is very helpful and important in our endeavours to make improvements for patients.

Income disclosures

The directors confirm that, as required by the Health and Social Care Act 2012, the income that the Trust has received from the provision of goods and services for the purposes of the health service in England is greater than its income from the provision of goods and services for any other purposes. The Trust has processes in place to ensure that this statutory requirement will be met in future years, and has amended its constitution to reflect the Council of Governors' role in providing oversight of this.

In addition to the above, the directors confirm that the provision of goods and services for any other purposes has not materially impacted on our provision of goods and services for the purposes of the health service in England.

Remunerations Report

Annual Statement on Remuneration

The Nomination and Remuneration Committee) aims to set executive remuneration at an appropriate level to ensure good value for money while enabling the Trust to attract and retain high quality executives.

During 2020/21 the Trust continued to build on the benchmarking work undertaken in previous years, comparing executive's remuneration to that of market trends and neighbouring Trusts. Adjustments have been made to the remuneration packages of all executives, thus ensuring the Trust's objective to attract and retain high quality executives.

Suzy Brain England OBE
Chair of the Board
25 June 2021

Remuneration policy– Executive Directors

It is the policy of the Nominations and Remuneration Committee of the Board of Directors to consider all reviews and proposals regarding executive remuneration on their own merits. This means that the recruitment market will be taken into account when seeking to appoint new directors. It also means that salaries will be set to ensure that the Trust is able to recruit and retain individuals with the required competencies and skills to support delivery of the Trust's strategy.

Executive directors do not have any performance related components within their remuneration, and do not receive a bonus.

The committee does not routinely apply annual inflationary uplifts or increases, and only applies uplifts of any kind where it is advised by NHSE/I or where this is thought to be justified by the context.

The primary aim of the Remuneration Committee is to ensure that executive remuneration is set at an appropriate level to ensure good value for money while enabling the Trust to attract and retain high quality executives.

The committee considers the pay and conditions of other employees when setting the remuneration policy, but does not actively consult with employees. The committee also considers the remuneration information published annually by NHS Providers when making decisions regarding appropriate remuneration levels. All work is taken in respect to the Equality Analysis policy which the Trust holds.

Three Executive Directors earn more than £150,000, and the Nominations and Remuneration Committee – Board of Directors has given detailed consideration to the context of this salary and the performance of the individuals in order to satisfy itself that this remuneration is reasonable.

Remuneration policy – senior managers

As at 31 March 2021, three senior managers other than the Executive Directors are not remunerated according to Agenda for Change Terms and Conditions of service.

As part of the appraisal process, the remuneration of these managers may reduce or increase on the basis of performance, including delivery of personal objectives and CIP targets. The starting salary for these managers is generally market-based, within the pay strategy set by the Trust. With the exception of remuneration, all other Agenda for Change terms and conditions, including those relating to payment for loss of office, are applied to these managers.

The committee considers the pay and conditions of other employees when setting the remuneration policy, but does not actively consult with employees. The committee also considers the remuneration information published annually by NHS Providers when making

decisions regarding appropriate remuneration levels. All work is taken in respect to the Equality Analysis policy which the Trust holds.

All other managers are remunerated in accordance with Agenda for Change terms and conditions of service. Approval to pay remuneration outside of Agenda for Change terms and conditions may only be granted by the Director or Deputy Director of People and Organisational Development.

For managers who are paid according to Agenda for Change terms and conditions, the Trust is under an obligation to pay increments and uplifts in accordance with national pay agreements. The Trust does not propose to introduce any new obligation which could give rise to, or impact on, remuneration payments or payments for loss of office.

The Trust intends to maintain this remuneration policy for 2021/22.

Remuneration policy – Other employees

Other than the senior managers and Executive directors referred to above, all employees are paid according to either the Agenda for Change or Medical and Dental Terms and Conditions of service.

Early Termination Liability

Depending on the circumstances of the early termination the Trust would, if the termination were due to redundancy, apply redundancy terms under Section 16 of the Agenda for Change Terms and Conditions of Service or consider severance settlements in accordance with HSG94 (18) and HSG95 (25).

Future Policy Table

Salary/Fees		**Taxable Benefits**	**Annual Performance Related Bonus**	**Long Term Related Bonus**	**Pension Related Benefits**
Support for the short and long-term strategic objectives of the Foundation Trust	Ensure the recruitment/retention of directors of sufficient calibre to deliver the Trust's objectives	None disclosed	N/A	N/A	Ensure the recruitment/retention of directors of sufficien calibre to deliver the Trust's objectives
How the component Operates	Paid monthly	None disclosed	N/A	N/A	Contributions paid by both employee and employer, except for any employee who has opted out of the scheme
Maximum	As set out in the	None	N/A	N/A	Contributions are

payment	Remuneration table. Salaries are determined by the Trust's Remuneration committee	disclosed			made in accordance with the NHS Pension Scheme
Framework used to assess performance	Trust appraisal system	None disclosed	N/A	N/A	N/A
Performance Measures	Based on individual objectives agreed with line manager	None disclosed	N/A	N/A	N/A
Performance period	Concurrent with the financial year	None disclosed	N/A	N/A	N/A
Amount paid for minimum level of performance and any further levels of performance	No performance related payment arrangements	None disclosed	N/A	None paid	N/A
Explanation of whether there are any provisions for recovery of sums paid to directors, or provisions for withholding payments	Any sums paid in error may be recovered. In addition there is provision for recovery of payments in relation to Mutually Agreed Resignation Scheme (MARS) payments where individuals are subsequently employed in the NHS	None disclosed	Any sums paid in error may be recovered	None paid	N/A

Annual Report on Remuneration

Nominations and Remuneration Committee of the Board of Directors

The Nominations and Remuneration Committee of the Board of Directors is responsible for the appointment and remuneration of Executive Directors.

The membership of the committee in 2020-21 consisted of the Chair and Non-executive Directors. The Chief Executive, the Director of People and Organisational Development (both of whom withdraw if their remuneration or appointment is considered) and the Trust Company Secretary attend by invitation in order to assist and advise the committee. The committee was convened on three occasions during the year to discuss appointments and the remuneration of Executive Directors.

Name	Role	Attendance
Suzy Brain England OBE	Chair of the Board	3 of 3
Neil Rhodes	Non-executive Director (Deputy Chair of the Board)	3 of 3
Sheena McDonnell	Non-Executive Director	3 of 3
Kath Smart	Non-Executive Director	3 of 3
Pat Drake	Non-Executive Director (Senior Independent Director)	3 of 3
Mark Bailey	Non-Executive Director	3 of 3

Fair pay comparison

Reporting bodies are required to disclose the relationship between the remuneration of the highest-paid director in their organisation and the median remuneration of the organisation's workforce.

The banded remuneration of the highest paid director in the financial year 2020/21 was £195k-£200k (2019/20: £190k-£195k). This was 7.14 times (2019/20: 7.21 times) the median remuneration of the workforce, which is £27,677 (2019/20: £26,553). Total remuneration includes salary, non-consolidated performance-related pay, benefits-in-kind, but not severance payments. It does not include employers' pension contributions and the cash equivalent transfer value of pensions.

Expenses

	2019/20			**2020/21**		
	No. in office	**No. receiving expenses**	**Expenses paid (£)**	No. in office	No. receiving expenses	Expenses Paid (£)
Non-executive directors	6	5	£10,372	6	6	£3,478.05
Executive directors	6	3	£3,011	6	0	£0.00
Governors	39	8	£3,718	39	0	£0.00

Senior Managers Service Contracts

All directors have a notice period of six months; this does not affect the right of the Trust to terminate the contract without notice by reason of the conduct of the Executive Director. All other employees have notice periods between one and three months depending on the seniority of the role.

Name	Position	Date of contract (date commenced in post as senior manager)	Unexpired term as at 31st March 2021

Suzy Brain England OBE	Chair of the Board	1.1.2017	One year and nine months
Sheena McDonnell	Non-executive Director	1.7.2018	One year three months extension (COVID-19)
Pat Drake	Non-executive Director (Senior Independent Director)	1.4.2018	One year extension (COVID-19)
Kath Smart	Non-executive Director	1.4.2018	One year extension (COVID-19)
Neil Rhodes	Non-executive Director	1.4.2017	Two years
Mark Bailey	Non-executive Director	1.2.2020	One year ten months
Richard Parker OBE	Chief Executive	14.10.2013	N/A
Karen Barnard	Director of People and Organisational Development	2.5.2016	N/A
David Purdue	Chief Nurse (and Deputy Chief Executive)	10.7.2013	N/A
Jon Sargeant	Director of Finance	2.10.2016	N/A
Dr Tim Noble	Medical Director	1.4.2020	N/A
Rebecca Joyce	Chief Operating Officer	3.6.2019	N/A

Name and Title	2019/20							2020/21						
	Salary and fees (bands of £5000)	**Taxable benefits** Rounded to the nearest £100	**Annual Performance related bonus** (bands of £5000)	**Long Term Performance related bonus** (bands of £2500)	**Pension Related benefit** (bands of £2500)	**Other Remuneration** (bands of £5000)	**Total** (bands of £5000)	**Salary and fees** (bands of £5000)	**Taxable benefits** Rounded to the nearest £100	**Annual Performance related bonus** (bands of £5000)	**Long Term Performance related bonus** (bands of £2500)	**Pension Related benefit** (bands of £2500)	**Other Remuneration** (bands of £5000)	**Total** (bands of £5000)
Suzy Brain England OBE – Chair of the Board	50-55						50-55	50-55						50-55
Neil Rhodes Non-executive Director	10-15						10-15	15-20						15-20
Mark Bailey Non-executive Director	0-5						0-5	10-15						10-15
Kathryn Smart Non-executive Director	5-10						5-10	15-20						15-20
Sheena McDonnell Non-executive Director	10-15						10-15	10-15						10-15
Patricia Drake Non-executive Director	10-15						10-15	15-20						15-20
Dr Tim Noble Medical Director	-				-		-	165–170				50-52.5		215-220
David Purdue Chief Nurse and Deputy Chief Executive	130-135				12.-15		145-50	135-140				22.5-25		160-165
Richard Parker OBE - Chief Executive	190-195						190-195	195-200				-		195-200
Jon Sargeant – Director of Finance	135-140				7.5-10		145-150	145-150				40-42.5		185-190

Karen Barnard – Director of People and Organisational Development	110-115				7.5-10		115-120	115-120				25-27.5		140-145
Rebecca Joyce – Chief Operating Officer	100-105				70-72.5		170-175	125-130				42.5-45		165-170

The remuneration report table above has been prepared in-line with 2020/21 ARM for Foundation Trusts. The basis of calculation for pension related benefits shows the pension accrued in year multiplied by a factor of 20. This has resulted in large pension related benefits being shown in the remuneration report table above.

The basis of calculation for pension related benefits is in line with section 7.69 of the ARM, and follows the 'HMRC method' which is derived from the Finance Act 2004 and modified by Statutory Instrument 2013/1981. The calculation required is:
Pension benefit increase = ((20 x PE) + LSE) - ((20 x PB) + LSB))

PE is the annual rate of pension that would be payable to the director, if they became entitled to it at the end of the financial year.
PB is the annual rate of pension, adjusted for inflation, that would be payable to the director if they became entitled to it at the beginning of the financial year. LSE is the amount of lump sum that would be payable to the director if they became entitled to it at the end of the financial year.
LSB is the amount of lump sum, adjusted for inflation, that would be payable to the director if they became entitled to it at the beginning of the financial year.

Pension benefits

Salary and pension entitlements of senior managers. * denotes colleague who has left the pension scheme.

	Real increase/ (decrease) in Pension age (Bands of £2500) £000k	Real increase/(decrease) in pension related lump sum at pension age (Bands of £2500) £000k	Total accrued pension at pension age at 31 March 2021 (Bands of £5000) £000k	Lump sum at pension age related to accrued pension at 31 March 2021 (Bands of £5000) £000k	Cash Equivalent Transfer Value at 1 April 2020 £000k	Real increase in Cash Equivalent Transfer Value £000k	Cash Equivalent Transfer value at 31 March 2021 £000k	Employers contribution to stakeholder pension £000k
Richard Parker OBE Chief Executive*	0	0	0	0	0	0	0	0
David Purdue Chief Nurse and Deputy Chief Executive	0 - 2.5	0	50 - 55	115 - 120	947	31	1,010	0
Dr Tim Noble Medical Director	2.5 – 5	0 – 2.5	60 – 65	135 – 140	1,119	59	1,214	0
Jon Sargeant Director of Finance	2.5 – 5	0 – 2.5	45 – 50	105 – 110	915	49	996	0
Karen Barnard Director of People and Organisational Development	0 - 2.5	5 – 7.5	50 – 55	150 – 155	1,144	56	1,234	0
Rebecca Joyce Chief Operating Officer	2.5 – 5	0 – 2.5	30 – 35	60 – 65	445	26	496	0

* Figures were not provided by the NHS Business Services Authority for members that have left the NHS Pension Scheme. Therefore, the Trust has not included any values for this in the table above.

Cash Equivalent Transfer Value (CETV)

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

Real increase in CETV

This reflects the increase in CETV effectively funded by the employer. It takes account of the increase in accrued pension due to inflation, contributions paid by the employee (including the value of any benefits transferred from another pension scheme or arrangement) and uses common market valuation factors for the start and end of the period. On 1 October 2008, there was a change in the factors used to calculate CETVs as a result of the Occupational Pension Scheme (Transfer Value Amendment) regulations. These placed responsibility for the calculation method for CETVs (following actuarial advice) on Scheme Managers or Trustees. Further regulations from the Department for Work and Pensions to determine CETV from Public Sector Pension Schemes came into force on 13 October 2008. In his budget of 22 June 2010 the Chancellor announced that the uprating (annual increase) of public sector pensions would change from the Retail Prices Index (RPI) to the Consumer Prices Index (CPI) with the change expected from April 2011. As a result the Government Actuaries Department undertook a review of all transfers factors. The new CETV factors have been used in the above calculations and are lower than the previous factors we used. As a result the value of the CETVs for some members has fallen since 31 March 2010.

Richard Parker OBE
Chief Executive
25 June 2021

Governance Report

Responsibility for preparing this annual report and ensuring its accuracy sits with the Board of Directors. The principal responsibilities and decisions of the Board of Directors and Council of Governors are as shown below. The process for resolution of conflict between the Board of Directors and Council of Governors is detailed in the Trust Constitution.

The respective roles of the Board of Directors and Council of Governors are as follows:

Board of Directors	Council of Governors
● Operational management ● Strategic development ● Capital development ● Business planning ● Financial, quality and service performance ● Trust-wide policies ● Risk assurance and governance ● Strategic direction of the Trust (taking account of the views of the Council of Governors).	● Hold the Non-executive Directors to account for the performance of the Board of Directors. ● Appoint and determine the remuneration of the chairman and Non-executive Directors ● Appoint the external auditors ● Promote membership, and governorship, of the Trust ● Establish links and communicate with members and stakeholders ● Seek the views and represent the interests of members and stakeholders ● Approve significant transactions, mergers, acquisitions, separations, dissolutions, and increases in non-NHS income of over 5%.

Board of Directors

Although the Board remains accountable for all its functions, it delegates to management the implementation of Trust policies, plans and procedures and receives sufficient information to enable it to monitor performance.

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

Performance evaluation of directors

The Chair conducts the performance appraisals of the Chief Executive and Non-Executive Directors. The Senior Independent Director conducted the performance appraisal of the Chair in 2020/21. The Council of Governors receives the objectives of the Chair and Non-executive Directors, and governors and directors feed into the appraisal process by providing commentary regarding the performance of the Chair and Non-executive Directors.

The performance review of Executive Directors is carried out by the Chief Executive, with input from the Chair, from Non-executive Directors and Governors.

Performance evaluation of the Board and its committees

The Board and its committees conduct regular self-assessments of their performance. In 2020/21, the Board committed to a review of its risk management and board assurance framework. This review resulted in a 'significant assurance with minor opportunities for improvement' rating. However, the Board is reviewing the risk management processes to bring a stronger focus on strategic and operational risks in 2021/22

Audit and Risk Committee

The Audit Committee's role is to provide the Board of Directors with a means of independent and objective review of internal controls and risk management arrangements relating to:

- Financial systems
- The financial information used by the Trust
- Controls and assurance systems
- Risk management arrangements
- Compliance with law, guidance and codes of conduct
- Counter fraud activity

The Committee has a Board-approved Terms of reference, reviewed on a regular basis. It has four members – all Non-executive Directors, including the Chair of the Committee. One member (the chair) has recent and relevant financial experience and is a qualified accountant. The committee maintains a formal work plan and action log to ensure that areas of concern are followed up and addressed by the Trust. The Committee reviews the effectiveness of both the internal auditors and the external auditors on an annual basis and tenders the contracts in line with its Standing Orders.

Name	**Role**	**Meeting attendance**
Kath Smart – Chair	Non-executive Director	5 of 5
Sheena McDonnell	Non-executive Director	4 of 5
Neil Rhodes	Non-executive Director	5 of 5
Mark Bailey	Non-executive Director	5 of 5

The Trust has a tendered contract for an internal audit function, provided by KPMG, who attend all meetings of the Audit and Risk Committee, in order to report on progress against the annual audit plan and present summary reports of all internal audits conducted. Internal audit's main functions are to provide independent assurance that an organisation's risk management, governance and internal control processes are operating effectively by:

- Reviewing the Trust's internal control system.

- Undertaking investigations into particular aspects of the Trust's operations
- Examining relevant financial and operating information
- Reviewing compliance by the Trust with particular laws or regulations
- Identifying, assessing and recommending controls to mitigate significant risks to the Trust.

The Trust employs Ernst and Young (EY) as its external auditing firm, who were appointed in 2016 following a competitive tender process. Their extended contract runs until September 2021. External auditors review the accuracy of the Annual Accounts and present significant or material matters to the Audit Committee. For 2020/21, the Trust paid audit fees to the external auditor of £92k, £11k for the Wholly Owned Subsidiary audit and £7k for the Charitable Funds Statutory Audit.

Our staff

We can only realise our vision to be outstanding in all that we do through the enthusiasm, innovation, hard work, engagement, values and behaviours of our staff. It is absolutely crucial that we recruit and retain the right people, support their health and wellbeing, enable them to develop the highest level of knowledge and skill, and support them in doing their jobs. We believe that DBTH is an organisation with great people that provide great care, each and every day.

Keeping staff informed and engaged

We engage with our staff in a range of ways, from formal consultation with Staff Side union representatives, through to collective agreements and open feedback forums regarding planned changes.

Our monthly Staff Brief keeps team members informed about important news and developments, including the Trust's performance and how staff can contribute towards improvement. This follows the monthly Board of Directors' meeting, which takes place a few days earlier and ensures information is cascaded quickly throughout the organisation. Due to COVID-19, all sessions are purely virtual, filmed and shared via digital platforms.

The weekly DBTH Buzz staff newsletter - which communicates key information, celebrates individual and team achievements and draws attention to the various roles within the organisation - enjoys a healthy following. It has an average of around 4,000 readers each week.

In 2017 we introduced a staff Facebook 'group' and since then this has grown to over 5,600 members by March 2021, with an active community. This network is administered by the Communications Team and is only open to members of the Trust. This has been followed up by a variety of departments, divisions and service-specific groups, each of which have been very successful in their own right.

Following this success on social media, the Communications Team continues to share daily tweets and Facebook posts on the Trust's public profiles.

The Trust also has an extranet, named the Hive, which is accessed daily by colleagues, with an average of around 112,113 page views per month.

A further update related to COVID-19 communications can be found in the performance section of this report.

Reward and recognition

We have an awards scheme called DBTH Stars (Staff Awards and Recognition Scheme), which enables any employee to nominate colleagues whom they believe deserve recognition for the work they do. A panel of staff and managers review the nominations and select the winning 'Star' for each month of the year. The winner receives gift vouchers, a certificate and is nominated for the Trust's annual award ceremony.

In 2021, the award ceremony was postponed as a result of COVID-19. As such, we organised alternative schemes to recognise colleagues for their efforts and also worked with the Doncaster Chamber. On that note, the latter dedicated a section of their annual business awards (held virtually) to the local NHS.

In this category the following people were nominated for awards, with around 1,500 members of staff from the Trust casting votes to select the winners (*denote the winners):

The compassionate care award:

- Dr Ken Agwuh, Director of Infection Prevention and Control *
- Toni Peet, Lung Nurse Specialist
- Miriam Boyack, Infection Prevention and Control Pandemic Matron
- Lisa Robins, Health Visitor
- Claire Fry, Nursery Nurse

The unsung hero award:

- Michael Leng, Head Biomedical Scientist in Microbiology
- Richard Somerset, Head of Procurement
- Adam Tingle, Senior Communications and Engagement Manager *
- Emma Dickinson, Health Promotion Practitioner and Single Point of Contact Lead Practitioner
- Jackie Bone, Community Nurse

Outstanding contribution award:

- Respiratory Wards, Department of Critical Care and Intensive Care Unit multi-disciplinary team
- Assessment Units multi-disciplinary team
- Pathology
- Emergency Departments
- Team DBTH *

A further 'Thank You' event will take place in September 2021 at the Yorkshire Wildlife Park, a rearrangement of the initial date set for September 2020. All colleagues have been given one free ticket, with a discount on a further two with family and friends encouraged to attend.

Health and Wellbeing

A comprehensive description of all Health and Wellbeing services is outlined within the performance report section of this report.

Education and training

As part of our promise to colleagues to '*Develop Belong Thrive Here'* and our formal recognition as a Teaching Hospital, we remain committed to the training and education of our staff. We aim to ensure that our workforce is reflective of our local patient needs, enabling safe and excellent care for our patients. This year has been exceptional in the way we have delivered on this promise by adapting and responding to the COVID-19-pandemic, not only in our planning of education provision but also in the direct upskilling of our staff to meet the changing clinical need. On a related note, we have also deployed our education clinical staff to deliver direct patient care and been flexible around the clinical offer for individuals on educational programmes requiring clinical competence in practice.

Our Training and Education Department supports and governs this by providing a wide range of educational opportunities, including Statutory and Essential Training (SET), Role Specific Training (ReST), the wider up-skilling of staff (to complement the introduction of new roles) and supporting on-going Professional Development. Educational Leads collaborate with the Division and corporate service leaders to ensure that the Training and Education Department are commissioning and delivering education that is aligned to the business need. As a Trust we have successfully secured funding from Health Education England (HEE) to support our staff in the areas outlined above. We have also worked closely with the Local Workforce Action Board to help shape and support the key regional priorities: South Yorkshire Region Excellence Centre (SYREC); Advanced Practice Faculty, and the Allied Health Professional; Healthcare Scientist; and Primary Care Workforce hubs.

With the opportunity afforded by the apprenticeship levy, we have and continue to expand our educational offer across all workforce areas - from entry level to Postgraduate study. The Apprenticeship Operational Group, provides oversight, direction and support for all apprenticeships, enabling us to work with the Divisions and Corporate areas to maximise the use of apprenticeships. DBTH has been the first Trust to utilise the apprenticeship levy transfer ability to support training in Primary Care as part of our Doncaster Place Plan.

Although we suspended physical work experience placements (in partnership with our Further Education Institutes and local schools), we remain committed to delivering virtual workshops and opportunities for local learners, so they can explore the variety of roles employed across DBTH, gaining an understanding of the entry criteria and progression routes. We remain a strong partner with our local schools and colleges to ensure learners are work ready.

We have continued to deliver training for pre-registration students from a number of Higher Education Institutes (HEIs). This is an important part of core business for DBTH. We are pleased to have achieved a reputation for providing quality education, which is confirmed by student evaluation feedback. Ensuring this continues to improve and assuring the Board of appropriate governance remains a key priority. We continue to lead regionally and nationally with our multi professional approach and are often approached by other provider organisations to share our experiences.

The nationally recognised Montagu Clinical Simulation Centre continues to deliver high quality regional training to Yorkshire and the Humber as well as supporting research activity. It consistently delivers on contract (Health Education England) and the feedback from attendees remains positive.

Research

Over the last year, our research activity has predominantly and rightly focused on COVID-19 studies, which has directly helped grow the national evidence-base to develop treatment of the disease. DBTH has successfully engaged and delivered on a number of national COVID-19 studies, including the recovery trial (supporting the national target of consenting 10% of inpatients with COVID-19 to participate in the study), the ISARIC WHO study, the Canine COVID-19 study and The SIREN study.

The engagement of our patients, staff and the wider public with our research activity has significantly increased during the last year, which we want to build on for 2021/22. We have developed a communication and engagement strategy to help maintain the profile and benefits of being involved in research activity for all.

Alongside actual delivery of studies, we have also started to develop partnerships with our academic institutions (University of Sheffield and Sheffield Hallam University) and local place based organisations (Doncaster Council, RDaSH, CCG) as well as our wider partners across the SYB ICS, with the intention of progressing research activity outside the hospital setting. An example of this is the local vaccine hubs, for which we are working closely with RDaSH and Barnsley. It is our ambition that during 2021 we will progress our clinical academic activity, developing clearer career pathways and growing capacity and capability across all professional staff groups.

Health and safety

The following report covers all aspects of Health and Safety (H&S) Management at Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust (for the reporting period 2020-2021) through the development and implementation of appropriate systems and processes to effectively manage H&S issues. This includes creating a no-blame culture to reduce H&S incidents and proactively identifying risks, via the delivery of an environment that is safe and secure for patients, staff and visitors and by encouraging staff to report H&S related incidents via the Trust electronic Datix reporting system.

The Trust H&S Committee continues to meet bi-monthly, delivering a formal bi-annual report to the Audit and Risk Committee (ARC) and enabling the Chair to escalate areas of concern to the Board via the Chair's assurance report.

In addition the Director of Estates & Facilities (E&F) provides a Trust annual declaration of compliance performance against the Department of Health (DOH) NHS Premises Assurance Model (NHS PAM), which is now mandatory for the safety and patient experience elements of the annual assurance return to NHSE/I, and is aligned to the Care Quality Commission (CQC) Key Lines of Enquiry (KLOE).

Throughout the reporting year there has been an increase in the number of H&S related incidents likely to result in injury (97) believed to be due to the increase in patient numbers and working with COVID-19 patients. There has also been an increase in the number of falls (163), which correlates with the overall reporting period for the Trust, again believed to be due to the increase in patient numbers and COVID-19.

The location of falls incidents is primarily within the Care of Older Persons, Rehabilitation and Emergency department/wards, where patients are acutely unwell. These are recognised as areas of high likelihood of falls and risk assessments are completed. All identified fall areas are notified to the Falls Prevention Committee (FPC) with actions taken to review incidents and train staff within the areas if falls management deficiencies are found.

Following completion of the externally accredited H&S Responsible Persons training for Senior Managers (Band 8 and above) in December 2019, training was temporarily put on hold due to the COVID-19 Pandemic. As a direct consequence of COVID-19, the current service provider has closed down its training facility, prompting the Trust to enter into discussions about moving to another provider and commencing further role out of the training package for 2021/2022.

Regular review and update of the Trust's electronic COSHH system Alcumus Sypol is undertaken, with no current outstanding actions. Divisional clinical COSHH management leads identified have now completed system user training sessions. COSHH guidance folders are now in place at all ward nurse stations and sluice rooms throughout the Trust with a comprehensive COSHH information and guidance area located on the Trust Hive.

The lone worker device system Reliance risk assessed user group has increased to approximately 180 new devices holders. Following the COVID-19 Pandemic the introduction of the new device reporting portal system from Reliance was placed on hold due to staff

reduction, but is now fully operational. The lone worker identified champions for each division/department have received training on the portal and will now produce monthly user reports from the end of March 2021, to provide assurance that the Trust Policy, Processes and Procedures for lone working are being complied with for assurance and audit purposes.

Following postponement of the fire improvement Capital programme on the 19th March 2020, again due to the COVID-19 Pandemic, the programme of works was reviewed and re-programmed in consultation with clinical Divisions to ensure works did not impact on any wards or access/circulation areas. This led to a reduction in the scope of works undertaken within the reporting period. Capital fire improvement works completed FY 2020/21 are listed in Table 1:

Table 1: Capital Fire improvement work complete FY 2020/21

Site	Block	Project
DRI	DRI 09	Level 1 Lift circulation lobby and stairwell
DRI	DRI 09	Level 6 Lift circulation lobby and stairwell
DRI	DRI 09	Level 5 Administration offices
DRI	DRI 09	Level 3 On all overnight staff accommodation compartmentation improvement
MMH	MMH 02	Level 2 Fire compartmentation improvement
BDGH	BDGH 43/44	Level 3 Phase 3 main hospital street compartmentation improvement
BDGH	BDGH 43/44	Level 4 Phase 4 main hospital street compartmentation improvement

Finally a Working Safely Group was initiated in May 2020 following Government COVID-19 secure workplace guidance, with the Director of P&OD taking the lead role as Senior Responsible Officer (SRO) for the group. The group includes a multi-disciplinary membership, both clinical and non-clinical, with a focus on compliance with all related COVID-19 Guidance documentation to ensure the provision of a safe and secure working environment for staff, patients, visitors and contractors whilst on Trust premises.

Throughout the reporting period the multi-disciplinary team have worked collaboratively on a number of COVID-19 related H&S work streams including: provision of PPE and face fit testing; staff personal risk assessments and safe working environment risk assessments as guidance and circumstances change.

Workforce statistics as at 31 March 2021

(excl. bank and locum)	Headcount (Perm)	FTE	Headcount (Other)
Total staff employed as at 31 March 2021	**6,221**	**5,175.37**	**505**
Clinical Support	1,444	1,194.59	32
Other Healthcare Professionals	703	616.94	21
Medical and Dental	304	287.92	315
Nursing and Midwifery	1,829	1,563.77	46
Non Clinical (Admin & Clerical and Estates & Ancillary)	1,941	1,512.15	91

Sickness

	2020/21 Actual	2020/21 Target	Benchmarking data
Staff Sickness Absence Rate	5.69%	3.50%	2019/20 the rate was 5.06%
			In 2018/19 the regional average was 4.51%

Staff Cost

	Total £000	Permanently employed total £000	Other total £000
Salaries and wages	**232,301**	**222,661**	**9,640**
Social security costs	**21,833**	**21,833**	**-**
Apprenticeship Levy	**1,074**	**1,074**	
Pension cost – defined contribution plans employer's contributions to NHS Pensions	**25,390**	**25,390**	**-**

Pension cost – defined contribution plans employer's contributions to NHS Pensions paid by NHS England on provider's behalf	**11,133**	**11,133**	**-**
Pension cost - other	**116**	**116**	**-**
Temporary staff – external bank	**9,295**	**-**	**9,295**
Temporary staff – agency/contract staff	**9,346**	**-**	**9,346**
Total Staff costs	**310,488**	**282,207**	**28,281**

Equality and diversity

We have a richly diverse workforce (see our related statistics below), with staff from across the globe working alongside those born in South Yorkshire and Bassetlaw. Respect for each other's unique skills, experience and strengths is an integral element in effective team-working and our Fair Treatment for All Policy sets out the standards we expect. This includes equality of opportunity for job applicants, where we anonymise applications before shortlisting. We are now recognised as Level 2 on the Disability Confident Scheme (replacing the Disability Two Ticks framework), focused on retention as well as recruitment. To support this work we have policies and guidelines in place to encourage recruitment of people with disabilities. We also make reasonable adjustments to enable us to retain staff that become ill, or develop disabilities, with further support available from our Occupational Health Team.

Details of our equality priorities and some of the actions we take can be found on the Equality and Diversity page of the Trust website www.DBTH.nhs.uk, where we also publish information to comply with our obligations under the Equality Act.

In late 2020, the Trust employed Equality, Diversity and Inclusion Officer, Qurban Hussain to lead this particular agenda within the Trust.

As a Trust, we reflected our commitment to equality, diversity and inclusion (EDI) as part of our 'WE CARE' values as stated below:

- **W**e always put the patient first.
- **E**veryone counts – we treat each other with courtesy, honesty, respect and dignity.
- **C**ommitted to quality and continuously improving patient experience.
- **A**lways caring and compassionate.
- **R**esponsible and accountable for our actions – taking pride in our work.
- **E**ncouraging and valuing our diverse staff and rewarding ability and innovation.

While this work is being further developed with Qurban's expertise, we continue to host an Equality, Diversity and Inclusion Network, as well as an LGBTQIA Forum which has been recently established by colleagues.

Within our internal communications we make all best efforts to highlight cultural events, as well as awareness days, using these as opportunities to share learning, lectures and other items of engagement for colleagues, should they wish to get involved.

The Trust traditionally has had a presence at the local PRIDE events within the town, however due to COVID-19-19 this has not been possible.

Furthermore, as the challenges of COVID-19 reached the Trust, we introduced specific workplace risk assessments for colleagues defined as Black, Asian and Minority Ethnic. This was to ensure their safety whilst at work, and all were encouraged, although not mandatory, to complete a self-assessment form to flag any health concerns that may make them more vulnerable to COVID-19.

Also, during the COVID-19 vaccination programme, those observing Ramadan were given the option to receive the second dose slightly earlier, before the fast began, to alleviate any concerns they had about taking this during their holy month.

Like so many organisations, we understand there is more to be done in regards to the EDI agenda, and we will continue to develop and improve in the coming years as we further embed this within our Trust.

Equality Information as at 31 March 2021 – Executive and Senior Directors

Gender (Directors Only)	Headcount	Headcount %
Female	3	33.33%
Male	6	66.67%

Senior managers

Gender	Headcount	Headcount %
Female	156	68.72%
Male	71	31.28%

Equality Information as at 31 December 2020

Gender	Headcount	FTE	Headcount %
Female	5,534	4550.48	82.30%
Male	1,190	1103.58	17.70%

Age	Headcount	FTE	Headcount %
16 - 20	40	35.29	0.59%
21 - 25	453	427.75	6.74%
26 - 30	748	661.17	11.12%
31 - 35	820	698.92	12.20%
36 - 40	791	666.82	11.76%
41 - 45	646	554.50	9.61%
46 - 50	839	734.02	12.48%
51 - 55	896	768.18	13.33%
56 - 60	836	646.93	12.43%
61 - 65	521	371.35	7.75%
66 - 70	108	73.57	1.61%
71 & above	26	15.57	0.39%

Ethnicity	Headcount	FTE	Headcount %
Any Other	75	70.65	0.01%
Asian	351	330.80	0.05%
Black	151	136.14	0.02%
Chinese	23	21.72	0.00%
Mixed	66	57.43	0.01%
White	5,924	4923.18	0.88%
Not Disclosed	134	114.15	0.02%

Disability	Headcount	FTE	Headcount %
No	5,547	4670.08	82.50%
Not Declared	141	116.08	2.10%
Prefer Not To Answer	6	4.21	0.01%
Unspecified	833	700.90	12.04%
Yes	197	162.80	2.90%

Sexual Orientation	**Headcount**	**FTE**	**Headcount %**
Bisexual	42	39.21	0.62%
Gay or Lesbian	61	59.45	0.91%
Heterosexual or Straight	3,673	3138.07	54.63%
Not Disclosed	2,371	1926.63	35.26%

Our Trust values, set out in the strategic direction, embeds our desire to eliminate all forms of discrimination, promote equality of opportunity, value diversity and foster good relations. We are firmly committed to fair and equitable treatment for all and, by truly valuing the diversity everyone brings, we hope to create the best possible services for our patients and working environment for our staff.

Our Fair Treatment for All Policy explicitly sets out our expectations of all staff that we will not tolerate any form of discrimination, victimisation, harassment, bullying or unfair treatment on the grounds of a person's age, disability, gender re-assignment, marriage and civil partnership, pregnancy and maternity, race including nationality and ethnic origin, religion or belief, gender or sexual orientation.

Gender Pay Gap

The Trust uses the national job evaluation framework for Agenda for Change staff to determine appropriate pay bandings. This provides a clear process of paying employees equally for the same or equivalent work. Each grade has a set of pay points for annual progression. The longer period of time that someone has been in a grade, the higher their salary is likely to be, irrespective of their gender.

It should be noted that gender pay gap reporting is different from equal pay which deals with the pay differences between men and women who carry out the same jobs, similar jobs or work of equal value. It is prohibited under UK law to pay people unequally because they are a man or a woman. The gender pay gap shows the differences in the average pay between men and women and the regulations require both median and mean figures to be reported. The median shows the mid-point salary of any sample, calculated through sorting the hourly rates from lowest to highest and calculating the middle value. The mean is the overall average of the sample and therefore the overall figure can be influenced by any extremely high or low hourly rates of pay.

It is therefore possible to have genuine pay equality but still have a significant gender pay gap.

Gender	Avg. Hourly Rate	Median Hourly Rate		Quartile	Female	Male	Female %	Male %
Male	22.8791	17.2181		1	1360.00	212.00	86.51	13.49
Female	14.5924	12.6261		2	1368.00	207.00	86.86	13.14
Difference	8.2867	4.5920		3	1392.00	183.00	88.38	11.62
Pay Gap %	36.2197	26.6694		4	1057.00	517.00	67.15	32.85
Mar-20								
Gender	Avg. Hourly Rate	Median Hourly Rate		Quartile	Female	Male	Female %	Male %
Male	23.4124	18.1892		1	1398.00	206.00	87.16	12.84
Female	14.9564	12.7690		2	1384.00	220.00	86.28	13.72
Difference	8.4560	5.4202		3	1422.00	182.00	88.65	11.35
Pay Gap %	36.1177	29.7992		4	1059.00	546.00	65.98	34.02
19/20 comparison								
Gender	Avg. Hourly Rate	Median Hourly Rate		Quartile	Female	Male	Female %	Male %
Male	0.5333	0.9711		1	38.00	-6.00	0.64	-0.64
Female	0.3640	0.1428		2	16.00	13.00	-0.57	0.57
Difference	0.1693	0.8283		3	30.00	-1.00	0.27	-0.27
Pay Gap %	-0.1020	3.1298		4	2.00	29.00	-1.17	1.17

Organisation's Structure and Principal Activities

As well as being an acute foundation trust with one of the busiest emergency services in the country, we are a Teaching Hospital, supported by Sheffield University and Sheffield Hallam University and have strong links with the Yorkshire and Humber Deanery.

We are fully licensed by NHS Improvement and are fully registered (i.e. without conditions) by the Care Quality Commission (CQC) to provide the following regulated activities and healthcare services:

- Treatment of disease, disorder or injury
- Nursing care

- Surgical procedures
- Maternity and midwifery services
- Diagnostic and screening procedures
- Family planning
- Termination of pregnancies
- Transport services, triage and medical advice provided remotely
- Assessment or medical treatment for persons detained under the Mental Health Act 1983.

We serve a population of more than 420,000 across south Yorkshire, north Nottinghamshire and the surrounding areas and we run three hospitals: Doncaster Royal Infirmary, Bassetlaw Hospital and Montagu Hospital, as well as outpatient services at Retford Hospital and our external clinics.

Our Supply Chains

Our supply chains include the sourcing of all products and services necessary for the provision of high quality care to our service users.

Slavery and Human Trafficking Statement 2020/21

Slavery and human trafficking remains a hidden blight on society. We all have a responsibility to be alert to the risks in our business and in the wider supply chain. Employees are expected to report concerns and management are expected to act upon them.

Our Policies on Slavery and Human Trafficking

We are committed to ensuring that there is no modern slavery or human trafficking in our supply chains or in any part of our business.

Due Diligence Processes for Slavery and Human Trafficking

We expect that our supply chains have suitable anti-slavery and human trafficking policies and processes. Most of our purchases are against existing supply contracts or frameworks which have been negotiated under the NHS Standard Terms and Conditions of Contract which have the requirement for suppliers to have in place suitable anti-slavery and human trafficking policies and processes.

We expect each element in the supply chain to, at least, adopt 'one-up' due diligence on the next link in the chain as it is not always possible for us (and every other participant in the chain) to have a direct relationship with all links in the supply chain.

Our standard ITT documentation includes a question asking whether suppliers are compliant with section 54 (transparency in supply chains etc.) of the Modern Slavery Act 2015. If they are, they are required to provide evidence. If they are not, they are required to provide an

explanation as to why not. In addition, our standard contract contains the following provisions:

The Supplier warrants and undertakes that it will:

I. comply with all relevant Law and Guidance and shall use Good Industry Practice to ensure that there is no slavery or human trafficking in its supply chains; and

II. Notify the authority immediately if it becomes aware of any actual or suspected incidents of slavery or human trafficking in its supply chains;

III. At all times conduct its business in a manner that is consistent with any anti-slavery policy of the authority and shall provide to the Authority any reports or other information that the Authority may request as evidence of the Supplier's compliance with this Clause 10.1.29 and/or as may be requested or otherwise required by the Authority in accordance with its anti-slavery policy.

Supplier Adherence to Our Values

We have zero tolerance to slavery and human trafficking. We expect all those in our supply chain and contractors to comply with our values. The Trust will not support or deal with any business knowingly involved in slavery or human trafficking.

Training

Senior members of staff within our Procurement Team are duly qualified as Fellows of the Chartered Institute of Procurement and Supply and have passed the Ethical Procurement and Supply Final Test.

This statement is made pursuant to section 54 (1) of the Modern Slavery Act 2015 and constitutes the Trust's slavery and human trafficking statement for the current financial year.

Trade Union Facility Time

Number of employees who were relevant union officials during the relevant period	***Full-time equivalent employee number (Trust Total)***
28	22.4

Percentage of time	***Number of employees***
0%	21
1-50%	7
51-99%	0
100%	0

Provide the total cost of facility time	£16,556.38
Provide the total pay bill	£282,207,000
Provide the percentage of the total pay bill spent on facility time calculated as: (total cost of facility time / total pay bill x100)	0.00586675

Time spent on paid union activities as a percentage of total facility time hours calculated as: (total hours spent on paid trade union activities by relevant union officials during the relevant period / total paid facility time hours x100)	96.69

NOTE: As a result of COVID-19 and in agreement with the, National Social Partnership Forum the amount of union time was reduced this year as the health system responded to the challenges of pandemic.

National Staff Survey in summary

NHS
Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Summary

Response rates

6,339 Invited to complete the survey..

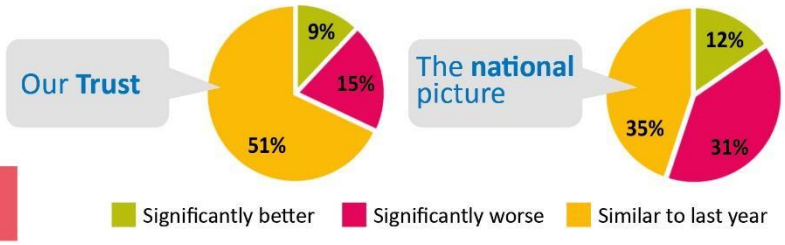
50% Completed the survey (3,157).

49% Average response rate for similar organisations.

Notable feedback

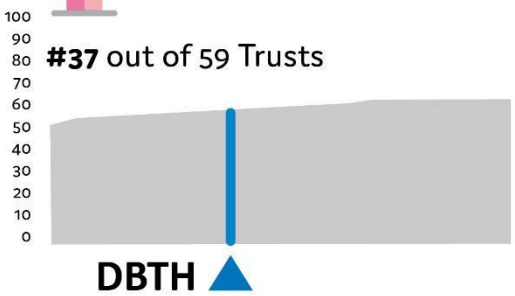
- **91%** Feel trusted to do their job.
- **80%** Believe care of patients is the Trust's top priority.
- **76%** Immediate manager supportive in a pesonal crisis.
- **71%** Are often enthusiastic about the job they do.

Compared to last year, responses were:

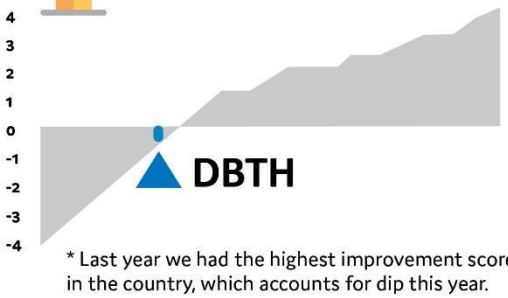


Comparison

Overall score



Most improved scores



* Last year we had the highest improvement score in the country, which accounts for dip this year.

Above data is benchmarked against Picker data of cohort of 59 trusts across the country.

Top and bottom scores

Top 5 scores (compared to average)

52% Don't work any additional unpaid hours per week for this organisation, over and above contracted hours

89% Organisation acts fairly: career progression

96% Not experienced discrimination from patients/service users, their relatives or other members of the public

95% Not experienced discrimination from manager/team leader or other colleagues

90% Not experienced harassment, bullying or abuse from managers

Bottom 5 scores (compared to average)

45% Team members often meet to discuss the team's effectiveness

56% Staff given feedback about changes made in response to reported errors/near misses/ incidents

69% Disability: organisation made adequate adjustment(s) to enable me to carry out work

50% Satisfied with opportunities for flexible working patterns

53% Often/always look forward to going to work

Most improved and least improved

Most improved from last survey

50% In last three months, have not come to work when not feeling well enough to perform duties

80% Care of patients/service users is organisation's top priority

31% Organisation definitely takes positive action on health and well-being

71% If friend/relative needed treatment would be happy with standard of care provided by organisation

31% Enough staff at organisation to do my job properly

Least improved from last survey

45% Team members often meet to discuss the team's effectiveness

54% In last 12 months, have not felt unwell due to work related stress

53% Often/always look forward to going to work

71% Often/always enthusiastic about my job

35% Satisfied with level of pay

The following data is benchmarked against Picker data of cohort of 59 trusts across the country.

Your job

	2016	2017	2018	2019	This year Average	This year Organisation
Q2a. Often/always look forward to going to work	53%	52%	53%	59%	58%	53%
Q2b. Often/always enthusiastic about my job	72%	70%	71%	75%	73%	71%
Q2c. Time often/always passes quickly when I am working.	75%	73%	73%	77%	76%	74%
Q3a. Always know what work responsibilities are.	87%	86%	87%	89%	86%	87%
Q3b. Feel trusted to do my job.	91%	91%	91%	92%	91%	91%
Q3c. Able to do my job to a standard I am pleased with.	78%	77%	78%	79%	80%	79%
Q4a. Opportunities to show initiative frequently in my role.	68%	68%	67%	69%	71%	69%
Q4b. Able to make suggestions to improve the work of my team/dept.	69%	71%	69%	72%	72%	70%
Q4c. Involved in deciding changes that affect work.	44%	48%	46%	49%	49%	46%
Q4d. Able to make improvements happen in my area of work.	47%	49%	48%	53%	54%	50%
Q4e. Able to meet conflicting demands on my time at work	43%	43%	45%	47%	49%	48%
Q4f. Have adequate materials, supplies and equipment to do my work	53%	50%	51%	55%	59%	57%
Q4g. Enough staff at organisation to do my job properly	26%	28%	28%	30%	38%	33%
Q4h. Team members have a set of shared objectives	67%	68%	69%	72%	71%	69%
Q4i. Team members often meet to discuss the team's effectiveness	47%	52%	49%	53%	56%	45%
Q4j. I receive the respect I deserve from my colleagues at work	N/A	N/A	68%	71%	70%	68%
Q5a. Satisfied with recognition for good work	44%	45%	50%	55%	56%	53%
Q5b. Satisfied with support from immediate manager	61%	62%	64%	69%	69%	67%
Q5c. Satisfied with support from colleagues	79%	80%	79%	82%	80%	80%
Q5d. Satisfied with amount of responsibility given	70%	70%	70%	75%	74%	72%
Q5e. Satisfied with opportunities to use skills	67%	67%	68%	71%	72%	70%
Q5f. Satisfied with extent organisation values my work	37%	39%	43%	49%	48%	46%

Your job

	2016	2017	2018	2019	This year Average	This year Organisation
Q5g. Satisfied with level of pay	33%	28%	35%	38%	36%	35%
Q5h. Satisfied with opportunities for flexible working patterns	45%	47%	48%	50%	55%	50%
Q6a. I have realistic time pressures	N/A	N/A	21%	24%	24%	25%
Q6b. I have a choice in deciding how to do my work	N/A	N/A	52%	52%	53%	53%
Q6c. Relationships at work are unstrained	N/A	N/A	41%	45%	45%	44%
Q7a. Satisfied with quality of care I give to patients/service users	79%	78%	77%	81%	82%	79%
Q7b. Feel my role makes a difference to patients/service users	88%	88%	88%	89%	90%	88%
Q7c. Able to provide the care I aspire to	64%	64%	64%	69%	70%	66%

Your managers

	2016	2017	2018	2019	Organisation type Average	Organisation type Organisation
Q8a. My immediate manager encourages me at work	-	-	63%	68%	69%	67%
Q8b. Immediate manager can be counted on to help with difficult tasks	66%	66%	66%	70%	70%	70%
Q8c. Immediate manager gives clear feedback on my work	54%	54%	56%	61%	61%	59%
Q8d. Immediate manager asks for my opinion before making decisions that affect my work	48%	50%	48%	52%	54%	51%
Q8e. Immediate manager supportive in personal crisis	70%	70%	71%	74%	74%	76%
Q8f. Immediate manager takes a positive interest in my health & well-being	60%	61%	61%	65%	68%	68%
Q8g. Immediate manager values my work	65%	65%	65%	70%	71%	68%
Q9a. I know who senior managers are	81%	83%	80%	83%	83%	86%
Q9b. Communication between senior management and staff is effective	34%	38%	36%	42%	43%	43%
Q9c. Senior managers try to involve staff in important decisions	28%	31%	29%	35%	35%	33%
Q9d. Senior managers act on staff feedback	27%	31%	29%	35%	34%	33%

This data is benchmarked against Picker data of cohort of 59 trusts across the country.

Your health, wellbeing and safety

	2016	2017	2018	2019	This year Average	This year Organisation
Q10b. Don't work any additional paid hours per week for this organisation, over and above contracted hours	65%	67%	65%	62%	65%	64%
Q10c. Don't work any additional unpaid hours per week for this organisation, over and above contracted hours	46%	48%	50%	51%	46%	52%
Q11a. Organisation definitely takes positive action on health and well-being	26%	29%	25%	27%	32%	31%
Q11b. In last 12 months, have not experienced musculoskeletal (MSK) problems as a result of work activities	73%	70%	68%	71%	71%	72%
Q11c. Not felt unwell due to work related stress in last 12 months	61%	59%	59%	61%	56%	54%
Q11d. In last 3 months, have not come to work when not feeling well enough to perform duties	39%	39%	39%	39%	52%	50%
Q11e. Not felt pressure from manager to come to work when not feeling well enough	66%	68%	69%	74%	73%	72%
Q11f. Not felt pressure from colleagues to come to work when not feeling well enough	78%	79%	78%	80%	77%	78%
Q11g. Not put myself under pressure to come to work when not feeling well enough	7%	6%	6%	7%	8%	6%
Q12a. Not experienced physical violence from patients/service users, their relatives or other members of the public	82%	81%	83%	84%	85%	85%
Q12b. Not experienced physical violence from managers	99%	99%	100%	100%	99%	99%
Q12c. Not experienced physical violence from other colleagues	98%	98%	99%	99%	98%	99%
Q12d. Last experience of physical violence reported	67%	63%	62%	63%	68%	64%
Q13a. Not experienced harassment, bullying or abuse from patients/service users, their relatives or members of the public	73%	74%	73%	74%	74%	75%
Q13b. Not experienced harassment, bullying or abuse from managers	87%	87%	89%	90%	87%	90%
Q13c. Not experienced harassment, bullying or abuse from other colleagues	83%	84%	83%	85%	80%	83%
Q13d. Last experience of harassment/ bullying/abuse reported	42%	42%	42%	47%	46%	44%
Q14. Organisation acts fairly: career progression	84%	82%	85%	90%	84%	89%
Q15a. Not experienced discrimination from patients/service users, their relatives or other members of the public	96%	96%	95%	96%	93%	96%

Your health, wellbeing and safety

	2016	2017	2018	2019	This year Average	This year Organisation
Q15b. Not experienced discrimination from manager/team leader or other colleagues	94%	93%	94%	95%	91%	95%
Q16a. Organisation encourages reporting of errors/near misses/incidents	49%	52%	55%	60%	60%	61%
Q16b. Organisation encourages reporting of errors/near misses/incidents	86%	86%	86%	88%	88%	87%
Q16c. Organisation takes action to ensure errors/near misses/incidents are not re-peated	64%	65%	66%	70%	73%	72%
Q16d. Staff given feedback about changes made in response to reported errors/near misses/incidents	50%	51%	53%	57%	63%	56%
Q17a. Know how to report unsafe clinical practice	94%	94%	92%	93%	95%	93%
Q17b. Would feel secure raising concerns about unsafe clinical practice	67%	69%	68%	72%	72%	72%
Q17c. Would feel confident that organisation would address concerns about unsafe clinical practice	54%	56%	55%	61%	60%	60%

This data is benchmarked against Picker data of cohort of 59 trusts across the country.

Your organisation

	2016	2017	2018	2019	Organisation type: Average	Organisation type: Organisation
Q18a. Care of patients/service users is organisaiton's top priority	69%	71%	72%	76%	80%	80%
Q18b. Organisation acts on concerns raised by patients/service users	67%	69%	69%	72%	74%	74%
Q18c. Would recommend organisation as place to work	48%	51%	54%	61%	66%	65%
Q18d. If friend/relative needed treatment would be happy with standard of care provided by organisation	59%	62%	63%	68%	73%	71%
Q18e. I feel safe in my work	N/A	N/A	N/A	N/A	80%	77%
Q18f. I feel safe to speak up about anything that concerns me in this organisation	N/A	N/A	N/A	N/A	65%	67%
Q19a. I don't often think about leaving this organisation	N/A	N/A	43%	48%	48%	48%
Q19b. I am unlikely to look for a job at a new organisation in the next 12 months	N/A	N/A	54%	58%	55%	58%
Q19c. I am not planning on leaving this organisation.	N/A	N/A	57%	63%	61%	64%

This data is benchmarked against Picker data of cohort of 59 trusts across the country.

Countering fraud, bribery and corruption

Fraud is estimated to cost the NHS over a billion pounds a year that could have been spent on patient care, so everyone has a duty to help prevent it. NHS fraud may be committed by staff, patients and suppliers of goods/services to the NHS and with the onset of Covid-19 there was a potential for external fraud threats to increase.

We have an in-house collaborative counter fraud arrangement with four other local NHS trusts, which allows us to have a Local Counter Fraud Specialist (LCFS) permanently on site, supported by a small team of counter fraud specialists dedicated to combating fraud within both community and secondary care settings.

To ensure we have the right culture and that our staff are able to recognise and report fraud, we require all employees to receive fraud awareness training as part of our Statutory and Essential Training (SET) program; the compliance level for 2020/21 was at 98%.

The NHS Counter Fraud Authority (NHSCFA) provides the national framework through which NHS trusts seek to minimise losses through fraud. The Trust follows the guidance contained in the NHS Provider Standards and ensures our contractual obligations with our local Clinical Commissioning Groups are adhered to.

The Director of Finance is nominated to lead counter fraud work and is supported by the Trust's LCFS. During 2020 the role of Counter Fraud Champions was introduced across all NHS organisations, with a view to further strengthening the counter fraud profile by supporting LCFSs in the work which they already do. A Counter Fraud Champion was duly nominated at the Trust.

The Trust has a robust Counter Fraud, Bribery and Corruption Policy and Response Plan which provides a framework for responding to suspicions of fraud and provides advice and information on various aspects of fraud investigations. The Trust also has a Standards of Business Conduct Policy which sets out the expectations we have of all our staff where probity is concerned. The policy also contains a statement from the Chief Executive in relation to ensuring that our organisation is free from bribery and corruption. There are references to counter fraud measures and reporting processes in various other Trust policies and procedures. 2020/21 has also seen closer collaboration between the LCFS with our Freedom to Speak Up Guardian and integration of our whistleblowing procedures.

In addition to continuing to raise awareness of fraud against the NHS throughout the year, in November 2020 we also held a Fraud Awareness Month and the Trust was an official supporter of International Fraud Awareness Week in the same month. Those efforts were however amplified as a result of intelligence received relating to emerging Covid-19 threats in the early part of 2020. As a result the LCFS revisited both the annual work plan and the Trust's local Fraud Risk Assessment, in order to reflect where certain types of fraud were increasing in, or likely to increase in, risk. Based on this, fraud awareness work was substantially increased generally across the Trust, and also targeted at specific areas of heightened risk.

We have a well-publicised system in place for staff to raise concerns if they identify or suspect fraud. They can do this via our LCFS, the Director of Finance or via the NHS Fraud and Corruption reporting line (0800 028 40 60 or online at https://cfa.nhs.uk/reportfraud). Patients and visitors can also refer suspicions of NHS fraud to the Trust via the same channels.

Expenditure on consultancy

The Trust incurred consultancy expenditure of £572k (2019/20: £614k).

Staff Exit packages for 2020/21

Exit package cost band	Number of compulsory redundancies	Number of other departures agreed	Total value of exit packages
<£10,000			
£10,001 - £25,000			
£25,001 - £50,000		1	£48,000
£50,001 - £100,000			
£100,001+			
Total number of exit packages by type		1	£48,000

	Agreement Number	Total value of Agreement
Voluntary redundancies including early retirement contractual costs		
Mutually agreed resignations (MARS) contractual costs		
Early retirements in the efficiency of the service contractual costs		
Contractual payments in lieu of notice		
Exit payments requiring HMT approval	1	£48,000
Total	0	£0.00

High paid and off pay-roll arrangements

For all off-payroll engagements as of 31 March 2021, for more than £245 per day and that last for longer than six months:

No. of existing engagements as of 31 March 2021	0
Of which:	
Number that have existed for less than one year at the time of reporting	0
Number that have existed for between one and two years at the time of reporting	0
Number that have existed for between two and three years at the time of reporting	0
Number that have existed for between three and four years at the time of reporting	0
Number that have existed for four or more years at the time of reporting	0

The Trust undertakes a risk based assessment on new and existing off-payroll engagements, to seek assurance that each individual is paying the right amount of tax.

For all new off-payroll engagements, or those that reached six months in duration, between 1 April 2020 and 31 March 2021, for more than £245 per day and that last for longer than six months:

Number of new engagements, or those that reached six months in duration, between 1 April 2020 and 31 March 2021	0
Of which:	
Number assessed as within the scope of IR35	0
Number assessed as not within the scope of IR35	0
The number that were engaged directly (via PSC contracted to trust) and are on the trust's payroll	0
The number that were reassessed for consistency/ assurance purposes during the year	0
The number that saw a change to IR35 status following the consistency review	0

For any off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, between 1 April 2020 and 31 March 2021

Number of off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, during the financial year.	0
Number of individuals that have been deemed 'board members and/or senior officials with significant financial responsibility' during the financial year. This figure must include both off-payroll and on-payroll engagements.	15

Finance and Performance Committee

The remit of the committee is to provide assurance on the systems of control and governance specifically in relation to operational performance, workforce and financial planning and reporting.

Name	Role	Meeting attendance
Neil Rhodes – Chair	Non-executive Director	9 of 9
Karen Barnard	Director of People and Organisational Development	6 of 6
Rebecca Joyce	Chief Operating Officer	8 of 9
Jon Sargeant	Director of Finance	9 of 9
Pat Drake	Non-executive Director	9 of 9
Kath Smart	Non-executive Director	8 of 9

In the year the Committee has, on behalf of the Board:

- Provided assurance on:
  - Current financial and operational performance
  - Workforce performance (responsibility moved to the People Committee in November 2020)
  - Financial forecasts, budgets and plans in the light of trends and operational expectations
  - Plans and processes for the implementation of Effectiveness and Efficiency Improvement plans
  - Any specific risks in the Board Assurance Framework relevant to the committee.
- Reviewed and developed strategy in relation to clinical site development, estates and facilities, IT and information and finance
- Undertaken deep dives into key service areas, effectiveness and efficiency plans and areas of performance.

Quality and Effectiveness Committee

The Quality and Effectiveness Committee was established in June 2017, replacing the Clinical Governance Oversight Committee. The remit of the committee is to provide assurance on the systems of control and governance, specifically in relation to clinical quality and governance and organisational effectiveness.

Name	Role	Meeting attendance
Pat Drake – Chair	Non-executive Director	5 of 5
Sheena McDonnell	Non-executive Director	4 of 5
Mark Bailey	Non-executive Director	5 of 5
Karen Barnard	Director of People and Organisational Development	3 of 3
David Purdue	Chief Nurse and Deputy Chief Executive	5 of 5
Dr Tim Noble	Medical Director	5 of 5

In the year the Committee has, on behalf of the Board:

- Provided assurance on:
  - The effectiveness of clinical governance, clinical risk management and clinical control
  - Compliance with Care Quality Commission standards
  - Adverse clinical incidents, complaints and litigation and examples of good practice and learning
  - Patient experience in terms of care, comments, compliments and complaints
  - Workforce matters including workforce planning, staff engagement, training, education and development, staff wellbeing, equality and diversity, employee relations and HR and OD systems and processes (responsibility moved to the People Committee in November 2020).
- Reviewed and developed strategy in relation to clinical site development, patient experience and person centred care, clinical governance, research and development, quality improvement and innovation, people and workforce development and communications and engagement
- Undertaken strategic discussions and deep dives into quality, governance and workforce related issues
- Carried out interrogations of key risks on the Trust's corporate risk register and board assurance framework
- Ensured that the Trust has reliable, up-to-date information about what it is like being a patient experiencing care administered by the Trust

People Committee

The People Committee was established in November 2020, as a committee of the Board of Directors. Its remit is to provide assurance on the systems of control and governance specifically in relation to people matters and specifically, but not limited to, the delivery of the People Plan.

Name	Role	Meeting Attendance
Sheena McDonnell	Non-executive Director (Chair)	4 of 4
Kath Smart	Non-executive Director	3 of 4
Pat Drake	Non-executive Director	3 of 4
Mark Bailey	Non-executive Director	4 of 4
Karen Barnard	Director of People and Organisational Development	4 of 4
David Purdue	Chief Nurse and Deputy Chief Executive	4 of 4
Dr Tim Noble	Medical Director	4 of 4

In the year the Committee has, on behalf of the Board:

- Reviewed workforce matters including workforce planning, staff engagement, training, education and development, staff wellbeing, equality and diversity, employee relations and HR and OD systems and processes
- Reviewed the NHS People Plan and developed a strategy to deliver the plan locally
- Reviewed the staff survey results and developed an action plan based on the results
- Scrutinised the leadership offer to ensure it was fit for purpose
- Reviewed Freedom to Speak Up information

Council of Governors

During 2020/21 the Council of Governors met on five occasions. Council of Governors meetings are held in public. The composition of the Council of Governors, including attendance at Council of Governors meetings is shown below

Name	Constituency / Partner Organisation	Meeting attendance
Ann-Louise Bailey	Public – Doncaster	2 of 4
Beverley Marshall	Public – Doncaster	5 of 5
Dave Harcombe	Public – Doncaster (ended 23 June 2020)	1 of 1
David Cuckson	Public – Rest of England & Wales (ended 22 June 2020)	1 of 1
David Goodhead	Public – Doncaster (from 01 April 2019)	5 of 5

David Northwood	Public – Doncaster	5 of 5
Dennis Atkin	Public – Doncaster (from 21 September 2020)	3 of 3
Doug Wright	Public – Doncaster (ended 18 June 2020)	0 of 0
Geoffrey Johnson	Public – Doncaster	4 of 5
Hazel Brand	Public – Bassetlaw (Lead Governor)	5 of 5
Jackie Hammerton	Public – Rest of England & Wales (from 21 September 2020)	2 of 3
Linda Espey	Public – Doncaster	5 of 5
Lynne Logan	Public – Doncaster	4 of 4
Lynne Schuller	Public – Bassetlaw (from 21 September 2020)	3 of 3
Maria Jackson-James	Public – Rest of England & Wales (from 21 September 2020)	1 of 3
Mark Bright	Public – Doncaster	4 of 4
Mary Spencer	Public – Bassetlaw (from 21 September 2020)	3 of 3
Michael Addenbrooke	Public – Doncaster	4 of 5
Pauline Riley	Public – Doncaster (from 21 September 2020)	3 of 3
Peter Abell	Public – Bassetlaw	4 of 4
Philip Beavers	Public – Doncaster	5 of 5
Sheila Walsh	Public – Bassetlaw (ended 22 June 2020)	0 of 1
Steven Marsh	Public – Bassetlaw	4 of 5
Steven Wells	Public – Bassetlaw (ended 20 May 2020)	0 of 1
Susan McCreadie	Public – Doncaster	2 of 5
Dr Vivek Panikkar	Staff – Medical and Dental	4 of 5
Duncan Carratt	Staff – Non-Clinical	4 of 4
Karl Bower	Staff – Other Healthcare Professionals (ended 22 June 2020)	0 of 2
Kay Brown	Staff – Non-Clinical	3 of 5
Lorraine Robinson	Staff – Nurses and Midwives (ended 22 June 2020)	0 of 1
Sally Munro	Staff – Nurses and Midwives (from 21 September 2020)	1 of 3
Sophie Gilhooly	Staff – Other Healthcare (from 21 September 2020)	2 of 3
Mandy Tyrrell	Staff – Nurses and Midwives	1 of 5
Ainsley MacDonnell	Partner – Nottinghamshire County Council	2 of 5
Alexis Johnson	Partner – Doncaster Deaf Trust	3 of 5
Anthony Fitzgerald	Partner – Doncaster CCG	2 of 5
Clive Tattley	Partner – Bassetlaw Community and Voluntary Services	5 of 5
Jackie Hammerton	Partner – Sheffield Hallam University (ended 6 September 2020)	2 of 2

Jo Posnett	Partner – Sheffield Hallam University (from 21 September 2020)	2 of 3
Kathryn Dixon	Partner – Doncaster College (ended 6 August 2020)	2 of 4
Phil Holmes	Partner – Doncaster Council (from 21 September 2020)	0 of 3
Prof Robert Coleman	Partner – Sheffield University (ended 30 November 2020)	2 of 4
Rupert Suckling	Partner – Doncaster Council (ended 27 July 2020)	0 of 2
Susan Shaw	Partner – Bassetlaw District Council	5 of 5
Tina Harrison	Partner – Doncaster College and University Centre (from 21 September 2020)	2 of 3
Victoria McGregor-Riley	Partner – Bassetlaw CCG	3 of 5
Wendy Baird	Partner – University of Sheffield (from 1 February 2021)	0 of 1

Our public and staff governors are elected by the members of their constituencies, while our partner governors are appointed by the partner organisations named in our constitution.

In addition to the Chair of the Board, all directors attend Council of Governors meetings to listen to governors' views and to brief and advise governors on the business of the Trust.

Director	**Role**	**Council of Governors meeting attendance**
Suzy Brain England OBE	Chair of the Board	4 of 5
Neil Rhodes	Non-executive Director	5 of 5
Sheena McDonnell	Non-executive Director	5 of 5
Kath Smart	Non-executive Director	5 of 5
Pat Drake	Non-executive Director and Senior Independent Director	5 of 5
Mark Bailey	Non-executive Director	4 of 5
Richard Parker	Chief Executive	5 of 5
Karen Barnard	Director of People and Organisational Development	3 of 5
David Purdue	Chief Nurse and Deputy Chief Executive	1 of 5
Jon Sargeant	Director of Finance	4 of 5
Dr Tim Noble	Medical Director (from 1 April 2021)	3 of 5
Rebecca Joyce	Chief Operating Officer	2 of 5

Nomination and Remuneration Committee of the Council of Governors

Non-executive Directors, including the Chair, are appointed for a term of office of up to three years, and may be removed by the Council of Governors. The Council of Governors delegates the recruitment and selection of candidates to its Nomination and Remuneration Committee.

During 2020/21, the Nomination and Remuneration Committee of the Council of Governors was convened to discuss the recruitment of Non-executive Directors, objective setting and performance evaluation for the Chair and Non-executives and remuneration of Chair and Non-executives. The committee recommended the following appointments, all of which were approved by the Council of Governors:

- Pat Drake, whose term of office as Non-executive Director was due to end on 31 March 2021, was extended for one calendar year, to provide continuity and stability required for an effective Board.
- Kath Smart, whose term of office as Non-executive Director was due to end on 31 March 2021, was extended for one calendar year, to provide continuity and stability required for an effective Board.
- Sheena McDonnell, whose term of office as Non-executive Director was due to end on 30 June 2021, was extended for one calendar year, to provide continuity and stability required for an effective Board.

The committee was convened on two occasions during the year.

The membership of the Nominations and Remuneration Committee during the year consisted of:

Name	Role	Attendance
Suzy Brain England OBE	Chair of the Board	1 of 2
Phil Beavers	Public Governor, Doncaster	2 of 2
Hazel Brand	Lead Governor / Public Governor, Bassetlaw	2 of 2
David Cuckson	Public Governor, Rest of England & Wales (until 22 June 2020)	0 of 1
Clive Tattley	Partner Governor	2 of 2
Vivek Pannikar	Staff Governor	2 of 2
Kay Brown	Staff Governor	2 of 2
Lynne Logan	Public Governor, Doncaster (until 22 June 2020)	1 of 1
Steve Marsh	Public Governor, Bassetlaw	2 of 2
Jackie Hammerton	Partner Governor (until 6 September 2020)	0 of 1
Jackie Hammerton	Public Governor, Rest of England & Wales (from 1 December 2020)	1 of 1
Victoria McGregor-Riley	Partner Governor, Bassetlaw CCG (from 1 December 2020)	0 of 1

Governor elections and terms of office

Governors serve for a three year term of office and are eligible to stand for re-election or re-appointment at the end of that period. There is a maximum of three terms.

Membership

The trust has two categories of members:

- Public members - people who live within the areas covered by either of the three public constituencies:
    - Bassetlaw District
    - Doncaster Metropolitan Borough
    - Rest of England and Wales.

- Staff members - Trust staff automatically become members unless they decide to 'opt-out'. There are four staff classes:
    - Medical and Dental
    - Nurses and Midwives
    - Other healthcare professionals
    - Non-clinical.

As of 31 March 2021, there were 14,969 members overall. An analysis of our current membership body is provided below:

	Number of members at 31st March 2021
Public Constituency	8,907
Doncaster	5,171
Bassetlaw	2,625
Rest of England and Wales	1,111
Staff Constituency	6,062
Nurses and Midwives	1,731
Non-clinical	1,877
Other healthcare professionals	2,000
Medical and Dental	454
Total	**14,969**

The Trust's current membership strategy is to improve the quality and quantity of member engagement with a focus on underrepresented groups rather than increasing the overall membership numbers.

The Trust did not hold a member event during 2020/21 due to the circumstances around the COVID-19 pandemic. However the Trust held a virtual Annual Members' Meeting in September.

We ordinarily work to engage with our members, and support Governors to seek the views of members, in a number of ways, including:

- Continuing to communicate directly with individual members and keeping them informed regarding governors activities via the member magazine, Foundations for Health
- Inviting feedback from members through the Trust Board Office
- Holding member events on the topics that our members are interested in, and seeking their feedback on the services discussed
- Governor attendance at local community events, targeting events at schools and colleges in order to recruit and engage with young people
- Continuing to regularly inform the membership of the Trust's plans and activities through the member magazine, Foundations for Health
- Working to ensure contested Governor Elections and improved member participation in the election process
- Holding 'meet the governor' events at each of our main hospital sites

Members who wish to contact directors or Governors may do so via the Foundation Trust Office on dbth.TrustBoardOffice@nhs.net or 01302 644158, or by post to: Trust Company Secretary, Doncaster Royal Infirmary, Armthorpe Road, Doncaster, DN2 5LT.

Steps that Board members have taken to understand the views of governors and members

Executive and Non-executive Directors attend Council of Governors meetings to offer their knowledge on their areas of expertise and to listen to the views of Governors. Other steps that directors have taken to understand the views of Governors and members are:

- Attendance at governors' regular briefing.
- Attendance at Council of Governors' committee meetings
- Giving governors opportunities to raise queries and concerns directly with directors
- Regular meetings and briefings between the Council of Governors, Chief Executive and Chair of the Board
- Accessibility of the Chair of the Board, Trust Company Secretary, Senior Independent Director, and Trust Board Office
- Nominated governor observers are invited to observe or sit on committees with directors, including the Finance and Performance Committee, Audit and Risk Committee, Quality and Effectiveness Committee, People Committee, Charitable Funds Committee
- Governor sponsorship of wards
- Non-Executive Directors buddy arrangements for Governors
- Consultation sessions with governors regarding the development of Trust forward plans and issues

- Governor views are sought as part of the process for appraising the performance of the Chair of the Board and Non-executive Directors
- Sharing information, such as Board minutes, reports and briefing papers and Foundations for Health, the members' magazine.

NHS Foundation Trust Code of Governance

Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust has applied the principles of the NHS Foundation Trust Code of Governance on a 'comply or explain basis'. The NHS Foundation Trust Code of Governance, most recently revised in July 2014, is based on the principles of the UK Corporate Governance Code issued in 2012.

For the year ending 31 March 2021, the Board considers that it was fully compliant with the provisions of the NHS Foundation Trust Code of Governance.

The Board of Directors is committed to high standards of corporate governance, understanding the importance of transparency and accountability and the impact of Board effectiveness on organisational performance. The Trust carries out an ongoing programme of work to ensure that its governance procedures are in line with the principles of the Code, including:

- Supporting governors to appoint Non-executive Directors and external auditors with appropriate skills and experience
- Ensuring a tailored and in-depth induction programme for any new Chair, Non-executive Directors and Governors
- Facilitating an external review of the Trust's governance arrangements
- Working with governors in briefings and enabling governors to attend meetings of the committees of the Board, to improve the ways in which governors engage with and hold Non-executive Directors to account for the performance of the Board
- Ongoing review of compliance with the Code of Governance by the Council of Governors and Board of Directors when making decisions which impact on governance arrangements.

For details on the disclosures required by the Code of Governance, see below:

Ref.	Requirement	Disclosure
A.1.1	This statement should also describe how any disagreements between the council of governors and the board of directors will be resolved. The annual report should include this schedule of matters or a summary statement of how the board of directors and the council of governors operate, including a summary of the types of decisions to be taken by each of the boards and which are delegated to the executive management of the board of directors.	See Governance Report (p. 55).
A.1.2	The annual report should identify the chairperson, the deputy chairperson (where there is one), the chief	See Accountability Report (p.39);

	executive, the senior independent director (see A.4.1) and the chairperson and members of the nominations, audit and remuneration committees. It should also set out the number of meetings of the board and those committees and individual attendance by directors.	Remuneration Report (p.44); and Audit Committee section (p.55).
A.5.3	The annual report should identify the members of the council of governors, including a description of the constituency or organisation that they represent, whether they were elected or appointed, and the duration of their appointments. The annual report should also identify the nominated lead governor.	See Council of Governors section (p. 85).
B.1.1	The board of directors should identify in the annual report each non-executive director it considers to be independent, with reasons where necessary.	See Accountability Report (p.39).
B.1.4	The board of directors should include in its annual report a description of each director's skills, expertise and experience. Alongside this, in the annual report, the board should make a clear statement about its own balance, completeness and appropriateness to the requirements of the NHS foundation trust.	See Accountability Report (p.39).
B.2.10	A separate section of the annual report should describe the work of the nominations committee(s), including the process it has used in relation to board appointments.	See Remuneration Report (p.44); and Council of Governors section (p.85).
B.3.1	A chairperson's other significant commitments should be disclosed to the council of governors before appointment and included in the annual report. Changes to such commitments should be reported to the council of governors as they arise, and included in the next annual report.	See Accountability Report (p.39).
B.5.6	Governors should canvass the opinion of the trust's members and the public, and for appointed governors the body they represent, on the NHS foundation trust's forward plan, including its objectives, priorities and strategy, and their views should be communicated to the board of directors. The annual report should contain a statement as to how this requirement has been undertaken and satisfied.	See membership section (p.88).
B.6.1	The board of directors should state in the annual report how performance evaluation of the board, its committees, and its directors, including the chairperson, has been conducted.	See Governance Report (p.55).
B.6.2	Where an external facilitator is used for reviews of governance, they should be identified and a statement made as to whether they have any other connection with the trust.	See Governance Report (p.55).
C.1.1	The directors should explain in the annual report their responsibility for preparing the annual report and accounts,	See Governance Report (p.55);

	and state that they consider the annual report and accounts, taken as a whole, are fair, balanced and understandable and provide the information necessary for patients, regulators and other stakeholders to assess the NHS foundation trust's performance, business model and strategy. There should be a statement by the external auditor about their reporting responsibilities. Directors should also explain their approach to quality governance in the Annual Governance Statement (within the annual report).	And Auditor's report.
C.2.1	The annual report should contain a statement that the board has conducted a review of the effectiveness of its system of internal controls.	See the Annual Governance Statement (p.97).
C.2.2	A trust should disclose in the annual report: (a) if it has an internal audit function, how the function is structured and what role it performs; or (b) if it does not have an internal audit function, that fact and the processes it employs for evaluating and continually improving the effectiveness of its risk management and internal control processes.	See Audit Committee section (p.55).
C.3.5	If the council of governors does not accept the audit committee's recommendation on the appointment, reappointment or removal of an external auditor, the board of directors should include in the annual report a statement from the audit committee explaining the recommendation and should set out reasons why the council of governors has taken a different position.	n/a.
C.3.9	A separate section of the annual report should describe the work of the audit committee in discharging its responsibilities. The report should include: ● the significant issues that the committee considered in relation to financial statements, operations and compliance, and how these issues were addressed; ● an explanation of how it has assessed the effectiveness of the external audit process and the approach taken to the appointment or re-appointment of the external auditor, the value of external audit services and information on the length of tenure of the current audit firm and when a tender was last conducted; and ● if the external auditor provides non-audit services, the value of the non-audit services provided and an explanation of how auditor objectivity and independence are safeguarded.	See Audit Committee section (p.55).
D.1.3	Where an NHS Foundation Trust releases an Executive Director, for example to serve as a Non-executive Director elsewhere, the remuneration disclosures of the annual	n/a.

	report should include a statement of whether or not the director will retain such earnings.	
E.1.5	The board of directors should state in the annual report the steps they have taken to ensure that the members of the board, and in particular the non-executive directors, develop an understanding of the views of governors and members about the NHS foundation trust, for example through attendance at meetings of the council of governors, direct face-to-face contact, surveys of members' opinions and consultations.	See membership section (p.88).
E.1.6	The board of directors should monitor how representative the NHS foundation trust's membership is and the level and effectiveness of member engagement and report on this in the annual report.	See membership section (p. 88).
E.1.4	Contact procedures for members who wish to communicate with Governors and/or Directors should be made clearly available to members on the NHS foundation trust's website and in the annual report.	See membership section (p.88).

NHS Oversight Framework

NHS England and NHS Improvement's NHS Oversight Framework provides the framework for overseeing providers and identifying potential support needs. The framework looks at five themes:

- Quality of care
- Finance and use of resources
- Operational performance
- Strategic change
- Leadership and improvement capability (well-led).

Based on information from these themes, providers are segmented from 1 to 4, where '4' reflects providers receiving the most support, and '1' reflects providers with maximum autonomy. A foundation trust will only be in segments 3 or 4 where it has been found to be in breach or suspected breach of its licence.

Segmentation

The Trust ended the year in segment **2** (Targeted Support).

This segmentation information is the Trust's position as at 31 March 2021. Current segmentation information for NHS trusts and foundation trusts is published on the NHS Improvement website.

Statement of Accounting Officer's responsibilities

The NHS Act 2006 states that the Chief Executive is the Accounting Officer of the NHS Foundation Trust. The relevant responsibilities of the Accounting Officer, including their responsibility for the propriety and regularity of public finances for which they are answerable, and for the keeping of proper accounts, are set out in the NHS Foundation Trust Accounting Officer Memorandum issued by NHS Improvement and England.

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

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

- Observe the Accounts Direction issued by NHS Improvement, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis
- Make judgements and estimates on a reasonable basis
- State whether applicable accounting standards as set out in the NHS Foundation Trust Annual Reporting Manual have been followed, and disclose and explain any material departures in the financial statements
- Ensure that the use of public funds complies with the relevant legislation, delegated authorities and guidance
- Confirm that the annual report and accounts, taken as a whole, is fair, balanced and understandable and provides the information necessary for patients, regulators and stakeholders to assess the NHS foundation trust's performance, business model and strategy and
- Prepare the financial statements on a going concern basis and disclose any material uncertainties over going concern.

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

As far as I am aware, there is no relevant audit information of which the Foundation Trust's auditors are unaware, and I have taken all the steps that I ought to have taken to make myself aware of any relevant audit information and to establish that the entity's auditors are aware of that information.

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

Richard Parker OBE
Chief Executive (acting in his capacity as Accounting Officer)
25 June 2021

Annual governance statement

Scope of responsibility

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

The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place in Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust for the year ended 31 March 2021 and up to the date of approval of the annual report and accounts.

Capacity to handle risk

The Chief Executive has overall accountability and responsibility for risk management, while the Executive Directors are responsible for those risks which are relevant to their areas of responsibility. In particular, the Chief Nurse is responsible for risk to the safety and quality of patient care, and the Director of Finance is responsible for financial risk. The allocation of risks to individual directors is outlined in both the Board Assurance Framework and Corporate Risk Register. The Trust Company Secretary, on behalf of the Chief Executive, is responsible for the Board Assurance Framework and Corporate Risk Register.

Risk policies are reviewed annually, in light of current best practice advice, to assess whether changes are required.

Divisional Directors and Directorate Managers are responsible for the risk registers for their departments. In addition, management of risk is a fundamental duty of all employees whatever their grade, role or status. The Trust uses the DatixWeb© integrated risk management system, and an associated training programme has been undertaken with staff at all levels, including Divisional management teams, to ensure that they are aware of current good practice in relation to risk management. Local risk management training needs are discussed with the risk management department and tailored accordingly, and the Trust Board Office may be contacted to provide guidance to staff on application of the relevant policies.

The risk and control framework

The Board assures itself of the validity of its corporate governance statement through reviews of its governance processes which are routinely undertaken by internal audit. In the financial year 2020/21 a review was undertaken of the risk management and board assurance framework, which resulted in a significant assurance with minor opportunities for improvement rating. Nevertheless, the board is currently reviewing its risk management processes to bring a stronger focus on strategic and operational risks in 2021/22.

Other assurance comes from; NHS Improvement/England's well led framework, committee effectiveness reviews, Board and committee inspection of key performance metrics, consideration of the board assurance framework and corporate risk register, reviews of key governance documents such as the constitution, standing financial instructions and standing orders and involvement in a range of processes geared towards maintaining focus on quality such as ward walkabouts and quality impact assessments.

Governors assurance is given to the Board through public board meetings, active questioning of Directors and governor observation/opinions.

The Board is responsible for determining the organisation's risk appetite, ensuring that robust systems of internal control and management are in place and that risks to the achievement of organisational objectives are being appropriately managed. During 2020/21 this responsibility has been supported through the assurance committees of the Board:

- Audit and Risk Committee – responsible for non-clinical risk, including financial governance, information governance, health and safety, counter fraud, law and corporate governance
- Quality and Effectiveness Committee – responsible for clinical risk, including clinical and quality governance, patient safety and experience.
- People Committee (from December 2020) - responsible for reviewing systems of control and governance specifically in relation to people matters.
- Finance and Performance Committee – responsible for undertaking monthly scrutiny of financial reporting and progress against effectiveness and efficiency plans.

- Charitable Funds Committee – responsible for undertaking scrutiny of the Trust's charitable fundraising efforts.

The primary role of these committees in respect of risk management is to review the assurance framework on at least a quarterly basis, and to satisfy the Board of Directors that there are satisfactory review arrangements in place for the Trust's internal control and risk management systems. The Board receives a quarterly report highlighting control and assurance as well as any proposed changes to the assurance framework.

In addition to the above, the committees receive assurance regarding compliance with Care Quality Commission (CQC) registration and information governance requirements. Data quality forms part of the internal audit annual work plan. Risks to data security are managed and controlled through application of the Information Governance Policy and assessment of compliance with the requirements in the Data Security and Protection Toolkit, previously known as the Information Governance Toolkit.

The Management Board is responsible for monitoring and reviewing the Corporate Risk Register, which is linked with the assurance framework, on a monthly basis. Each Division and Department is responsible for maintaining its own risk register, which is a standing agenda item on the Divisional governance team meeting. Any risk identified as 'extreme' is escalated to the Management Board for consideration regarding action required.

To mitigate the risk of Efficiency and Effectiveness savings programmes adversely impacting on quality of care, all plans are reviewed and signed off by the Medical Director and Chief Nurse approved.

The principal risks to compliance with licence condition FT4 are:

- Risks to the provision of accurate, comprehensive, timely and up to date financial information to support board decision-making and oversight
- Risk of failure to maintain sound financial governance and control processes
- Failure to maintain fit for purpose board assurance and governance processes.

The Trust undertakes a variety of work in order to mitigate corporate governance risks, including regular audits and reviews of governance processes each year including reviews of its constitution and standing orders and of the reporting lines between Board, committees and other decision-making bodies. Significant risks to achievement of governance standards are included within the assurance framework and corporate risk register, and therefore reviewed in line with the processes outlined above.

The Trust has ended 2020/21 in full compliance with the code of governance.

The Business Intelligence Report and Finance and Performance report are the key methods through which operational performance data is reported to the Board for oversight and assurance purposes. These reports are kept under continuous review and their formats are amended regularly in order to ensure they meet the needs of the board and support rigorous oversight and decision making.

The most significant risks/challenges currently facing the Trust are:

- Inability to recruit right staff and have staff with right skills
- Uncertainty around the immediate financial regime in a post COVID-19 environment
- Failure to achieve effectiveness and efficiency savings to address the Trust's underlying deficit
- Failure to ensure that estates infrastructure is adequately maintained and upgraded in line with current legislation, standards and guidance.
- Inability to meet Trust's needs for capital investment

This list is not exhaustive and more details can be found in the Corporate Risk Register, where mitigating actions and outcomes are detailed. These risks will be managed through the governance and assurance processes outlined above. Outcomes will be assessed through the Trust's management reporting systems.

The Trust has an effective structure in place for public stakeholder involvement, predominantly through the Council of Governors. The Trust's assurance framework has been informed by partnership working and a variety of external contacts, including:

- Collaborative working between governors and directors. The Council of Governors reviews updates from executive directors on performance, quality, and finance and associated risks at its quarterly meetings and through regular briefings
- Consistent engagement with commissioners through contract review meetings and other contacts, and in relation to key shared risks
- Governor observers in attendance at the Finance and Performance Committee, Audit and Risk Committee, People Committee and Quality and Effectiveness Committee.

Public stakeholders are involved in managing risks through involvement in patient safety review group and patient experience committee as well as a range of patient safety campaigns such as Sharing How We Care, patient experience films and other initiatives.

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

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

Control measures are in place to ensure that all the organisation's obligations under equality, diversity and human rights legislation are complied with. - The Foundation Trust has published on its website an up-to-date register of interests, including gifts and hospitality, for

decision-making staff (as defined by the trust with reference to the guidance) within the past twelve months as required by the Managing Conflicts of Interest in the NHS23 guidance

In response to the NHS's ambitious objective to become the world's first 'net zero' national health service, with a target to achieve net zero carbon emissions by 2040 and an 80% reduction by 2028 to 2032, the Trust is currently developing its 'Green Plan'. Part of this process includes a revision of the way in which carbon emissions are calculated and reported. This work is ongoing and our results for 2020/21 will be available later this year following the finalisation of the annual reporting scope and the publication of our board approved Green Plan.

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

The following policies and processes are in place to ensure that resources are used economically, efficiently and effectively:

- Scheme of Delegation and Reservation of Powers to the Board
- Standing Financial Instructions and Standing Orders
- Competitive processes used for procuring non-staff expenditure items
- Use of materials management and other best practice approaches to hold appropriate stock levels and minimise wastage
- Cost improvement plans and effectiveness and efficiency work-streams, managed by the Finance directorate and designed to not impinge on effective delivery of quality patient care
- Grip and control work, including tight controls on vacancy management, non-permanent staffing and recruitment.

The Board gains assurance regarding financial and budgetary management from a monthly finance report. The Audit and Risk Committee receives reports regarding losses and compensations and waiver of standing orders, among others, while the Finance and Performance Committee receives monthly detailed reports on progress in delivering effectiveness and efficiency plans. Risks to the Trust's financial objectives are subject to regular review and monitoring in the same way as other risks.

A range of internal and external audits that provide further assurance on economy, efficiency and effectiveness have been conducted during the year and reported to the Audit and Risk Committee.

The Head of Internal Audit is required to provide an annual opinion in accordance with Public Sector Internal Audit Standards, based upon and limited to the work performed, on the overall adequacy and effectiveness of the Trust's risk management, control and governance processes (i.e. the system of internal control). This is achieved through a risk-based programme of work, agreed with Management and approved by the Audit and Risk Committee, which can provide assurance, subject to the inherent limitations described below. The opinion covers the period 1 April 2020 to 31 March 2021 inclusive, and is based

on the 12 audits that were completed in this period, with one deferred to 2021/22 due to the impact of COVID-19.

For the period 1 April 2020 to 31 March 2021 Internal Audit was able to provide a 'significant assurance with minor improvement opportunities' opinion to reflect that there is generally a sound system of internal control which is designed to meet the Trust's objectives and that controls are being consistently applied in all the areas reviewed.

Recommendations are being addressed in each case and reported to the Audit and Risk Committee on a quarterly basis.

The Trust was subject to a use of resources review by NHSI in September 2019, taken over two days the review informed the Trust's overall CQC assessment. This review rated the Trust 'Good' for use of resources and complemented the Trust in the way all areas of the Trust were focused on not just patient safety but value for money.

The Trust reacted quickly to the COVID-19 pandemic and instigated an incident based control process that encompassed faster decision making and revised SFI's, in March 2020 and continued into the first months of the financial year.

The annual external audit review by EY, as stated in their ISA 260 report, provides an unqualified opinion on the Trust's financial statements.

Information governance

There have been no serious incidents relating to information governance in 2020/21, this includes data loss or confidentiality breach.

Additionally, information governance requirements are reviewed by various committees with data quality forming part of the internal audit annual work plan.

CQC Review

The Board has taken assurance from the CQC inspection outcome. Unannounced and announced inspections by the CQC took place across Trust sites in September and October 2019 and the Trust received an overall rating of 'Good', improving on the previous years' rating of 'Requires Improvement'.

Overall, the CQC rated effective, caring, responsive and well-led as good, and safe as requires improvement. In rating the Trust, the CQC took into account the current ratings of the services not inspected. Well-led for the senior leadership of the trust was also rated as good.

The inspection report identified some areas for improvement and a programme of work is in place to address these. Progress against this programme is reported to the Trust's board in-line with the governance and control processes outlined above.

Review of effectiveness

As Accounting Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, clinical audit and executive managers and clinical leads within the NHS Foundation Trust who have responsibility for the development and maintenance of the internal control framework. I have drawn on performance information available to me.

My review is also informed by comments made by the external auditors in their management letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Board, the Audit and Risk, Finance and Performance, People Committee and Quality and Effectiveness Committees and plans to address any weaknesses and ensure continuous improvement of the system are in place.

A number of the ways in which the Board and I have received assurance regarding the effectiveness of the Board's system of controls have been outlined above.

This year has seen a stable leadership team continuing its efforts to reduce our retained financial deficit whilst continuing to improve standards of care. Building on our teaching hospital status gained in January 2017, we have continued to demonstrate improvement and innovation, building an excellent new Quality Improvement and Innovation Team and supporting specific projects developed by our own clinicians.

We have reviewed our strategy and strategic objectives and continue to have an active role in the developing accountable care partnerships at Place in Doncaster and Bassetlaw and the developing Integrated Care System for South Yorkshire and Bassetlaw (ICS). We continue to monitor our Board governance structures and the arrangements for financial governance including effectiveness and efficiency plans and for quality and effectiveness.

We recognise that our organisation would not exist without its fantastic staff and we have worked hard throughout the year to engage with them on a number of issues including the strategic direction, and wider local health system changes.

Overall, the Trust has seen an improving position on all NHS Constitution Standards due to the recovery/improvement plans implemented throughout 2019/20, with some specific remaining challenges. COVID-19 had a major impact on performance from mid-March onwards and until recovery plans have been agreed, performance levels will remain uncertain for 2021/2022.

Conclusion

Following my review, my opinion is that Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust has a sound system of internal control that supports the achievement of its policies, aims and objectives. No significant internal control issues have been identified.

Richard Parker OBE
Chief Executive
25 June 2021

Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

Auditor's Annual Report

Year ended 31 March 2021

02 July 2021

Building a better working world

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Section 1

Executive Summary

Executive Summary: Key conclusions from our 2020/21 audit

Area of work	Conclusion
Opinion on the Trust's:	
Financial statements	Unqualified – the financial statements give a true and fair view of the financial position of the Trust as at 31 March 2021 and of its expenditure and income for the year then ended. We issued our auditor's report on 25 June 2021.
Parts of the remuneration report and staff report subject to audit	Qualified - The Remuneration Report, did not disclose the Total Accrued Pension at Pension Age, Lump Sum at Pension Age or the Cash Equivalent Transfer Values at Pension Age as at 1 April 2020 and 31 March 2021 for all senior managers. Figures were not provided by the NHS Business Services Authority for members that had left the NHS Pension Scheme. Therefore, the Trust could not disclose all of the required information.
Consistency of the annual report and other information published with the financial statements	Financial information in the Annual report and published with the financial statements was consistent with the audited accounts.

Area of work	Conclusion
Reports by exception:	
Value for money (VFM)	We had no matters to report by exception on the Trust's VFM arrangements. We have included our VFM commentary in Section 04.
Consistency of the annual governance statement	We were satisfied that the annual governance statement was consistent with our understanding of the Trust.
Referrals to the Secretary of State	We made no referrals.
Public interest report and other auditor powers	We had no reason to use our auditor powers.

Area of work	Conclusion
Reporting to the Trust on its consolidation schedules	We concluded that the Trust's consolidation schedules agreed, within a £300,000 tolerance, to the audited financial statements.
Reporting to the National Audit Office (NAO) in line with group instructions	The NAO did not include the Trust in its sample of Department of Health component bodies requiring extended procedures.. We had no matters to report to the NAO.

Executive Summary: Key conclusions from our 2020/21 audit

As a result of the work we carried out we have also:

Outcomes	Conclusion
Issued a report to those charged with governance of the Trust communicating significant findings resulting from our audit.	We issued an Audit Results Report to the 09 June 2021 Audit and Risk Committee. A final updated Audit Results Report was circulated to management on 24 June 2021.
Issued a certificate that we have completed the audit in accordance with the requirements of the Local Audit and Accountability Act 2014 and the National Audit Office's 2020 Code of Audit Practice.	We issued our certificate on 02 July 2021

Fees

We carried out our audit of the Trust's financial statements in line with the Audit Planning Report where we set out an expected fee of £76,000.

We would like to take this opportunity to thank the Trust's staff for their assistance during the course of our work.

Hassan Rohimun

Associate Partner
For and on behalf of Ernst & Young LLP

Section 2

Purpose and responsibilities

Purpose and responsibilities

This report summarises our audit work on the 2020/21 financial statements.

Purpose

The purpose of the auditor's annual report is to bring together all of the auditor's work over the year. A core element of the report is the commentary on VFM arrangements, which aims to draw to the attention of the Trust or the wider public relevant issues, recommendations arising from the audit and follow-up of recommendations issued previously, along with the auditor's view as to whether they have been implemented satisfactorily.

Responsibilities of the appointed auditor

We have undertaken our 2020/21 audit work in accordance with the Audit Planning Report that we presented on 25 April 2021. We have complied with the NAO's 2020 Code of Audit Practice, International Standards on Auditing (UK), and other guidance issued by the NAO.

As auditors we are responsible for:

Expressing an opinion on:

- The 2020/21 financial statements;
- The parts of the remuneration and staff report to be audited;
- The consistency of other information published with the financial statements, including the annual report; and
- Whether the consolidation schedules are consistent with the Trust's financial statements for the relevant reporting period.

Reporting by exception:

- If the governance statement does not comply with relevant guidance or is not consistent with our understanding of the Trust;
- To the Secretary of State for Health and Social Care if we have concerns about the legality of transactions of decisions taken by the Trust;
- If we identify a significant weakness in the Trust's arrangements in place to secure economy, efficiency and effectiveness in its use of resources;
- Any significant matters that are in the public interest; and
- Any significant issues or outstanding matters arising from our work which are relevant to the NAO as group auditor.

Responsibilities of the Trust

The Trust is responsible for preparing and publishing its financial statements, annual report and governance statement. It is also responsible for putting in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources.

Section 3

Financial Statement Audit

Financial Statement Audit

We have issued an unqualified audit opinion on the Trust's 2020/21 financial statements.

Key issues

The Annual Report and Accounts is an important tool for the Trust to show how it has used public money and how it can demonstrate its financial management and financial health.

On 25 June 2021, we issued an unqualified opinion on the financial statements. We reported our detailed findings to the 09 June 2021 Audit and Risk Committee and issued an updated Audit Results Report to management on 24 June 2021. We outline below the key issues identified as part of our audit, reported against the significant risks and other areas of audit focus we included in our Audit Planning Report.

Significant risk	Work undertaken and conclusion
Misstatements due to fraud or error An ever present risk that management is in a unique position to commit fraud because of its ability to manipulate accounting records directly or indirectly, and prepare fraudulent financial statements by overriding controls that otherwise appear to be operating effectively.	• We carried out procedures for identifying fraud risks during the planning stages, inquired with management about risks of fraud and the controls put in place to address those risks, gained an understanding of the oversight given by those charged with governance of management's processes over fraud. • We considered the effectiveness of management's controls designed to address the risk of fraud, and assessed the nature of any significant unusual transactions identified. • We considered the nature and existence of significant unusual transactions during the year, and performed review and testing as required. • We tested items relating to revenue and expenditure recognition in order to identify indicators of management override of controls e.g. management bias in key accounting estimates and judgements in the financial statements. • We performed risk based testing of journals from the accounting period identified from application of specified audit risk criteria. Our testing of journal entries found no errors. We did not identify any: • material weaknesses in controls or evidence of management override; • instances of material inappropriate judgements being applied which would indicate manipulation in accounting records or fraudulent financial reporting; or • other transactions during our audit which appeared unusual or outside the Trust's normal course of business.

Financial Statement Audit (cont'd)

Significant risk	Work undertaken and conclusion
Risk of fraud in revenue and expenditure recognition We presume that there is a risk that revenue and expenditure may be misstated due to improper recognition or manipulation. We considered that this risk could be increased by the Trust's financial position resulting in a risk that the financial statements could be manipulated to ensure that an agreed financial target was achieved. We have assessed that the risk is prevalent predominantly in: • Completeness and valuation of accruals. • Completeness and valuation of provisions. • Existence and valuation of manual debtors and creditors, and accrued income and expenditure, and specifically in regards to the timing of significant one off income transactions in and around the year end.	• We reconciled income for the period 1 April 2020 to 30 September 2020 to the amounts notified by NHSE/I and bank statements and performed a risk-based review of journal entries made around the changeover point between financial frameworks at the end of September 2020. We then reconciled income for the period 1 October 2020 to 31 March 2021 to the amounts notified by the Integrated Care System and bank statements. • We reviewed the intra-NHS agreement of balances outputs to investigate significant variances between parties to gain assurance that the transactions and balances recorded by the Trust are not materially misstated. • We tested a sample of property, plant and equipment additions to confirm that capitalisation is consistent with the reporting framework and reviewed a sample of transactions recorded in the ledger and payments made from the bank account post year end to confirm that the associated expenditure has been recorded in the correct period. • We considered the completeness of provisions in the financial statements based on our understanding of the Trust. Our testing included the valuation of management judgements for provisions and accruals. We had no errors to report from our completed testing on expenditure and creditors. We therefore concluded that our testing did not identify any: • material misstatements due to revenue and expenditure recognition; or • material issues or unusual transactions which indicate any improper misreporting of the Trust's financial position

Financial Statement Audit (cont'd)

In addition to the significant risks above, we also concluded on the following areas of audit focus.

Other area of audit focus	Conclusion
Going concern assessment and disclosures The Trust is required to carry out an assessment of its ability to continue as a going concern for the foreseeable future, being at least 12 months after the date of the approved financial statements. There is a risk that the Trust's financial statements do not adequately disclose the assessment made, the assumptions used and the relevant risks and challenges that have impacted the going concern period.	Management set out their going concern assumptions in a paper to the Board. This assessment was supported by a cash flow forecast to the end of June 2022. The cash flow forecasting was based on two different scenarios post-September: • The first considered the same arrangements as applies to the first half of the 2021/22 year continuing to apply post September. • The second considered a downside position with a reduction in income post September. Under both of these models, the Trust projects a cash position at the end of June 2022 which will require no additional short-term financial support. We concluded that there is no material uncertainty that exists regarding the going concern status of the Trust.

Other area of audit focus	Conclusion
Valuation of land and buildings Land and buildings are the most significant assets on the Trust's Statement of Financial Position. The valuation of land and buildings is complex and is subject to a number of assumptions and judgements. A small movement in these assumptions can have a material impact on the financial statements.	We were satisfied that the classification of assets reported in the financial statements were appropriate and that these were not materially misstated. We did not identify any material misstatements in the application of the valuers indexation report to the financial statements. We identified errors in the accounting application of valuation transactions which led to adjustments being performed by management to correct errors outlined on page 11 in relation to understatement of impairment in the Statement of Comprehensive Income. Overall we were satisfied that the valuation of land and buildings was not materially misstated.

Financial Statement Audit (cont'd)

Audit differences

We identified a small number of misstatements in disclosures which management corrected, these related to: the audit fee disclosure note; remuneration report; maturity analysis of financial liabilities; and the accounting policy in relation to inventory.

During the course of our audit we highlighted the following misstatements greater than £0.3m which were corrected by management:

- £5.9m understatement of impairment charge and an opposite £1.1m reversal of impairment. These corrections also resulted in an increase to the Revaluation Reserve of £5.4m and £0.4m increase to the Net Book Value (NBV) of Land and Buildings.
- £0.8m reduction to prepayments and accruals for a 2021/22 invoice that was incorrectly included in both balances in the 31 March 2021 Statement of Financial Position

Our application of materiality

When establishing our overall audit strategy, we determined a magnitude of uncorrected misstatements that we judged would be material for the financial statements as a whole.

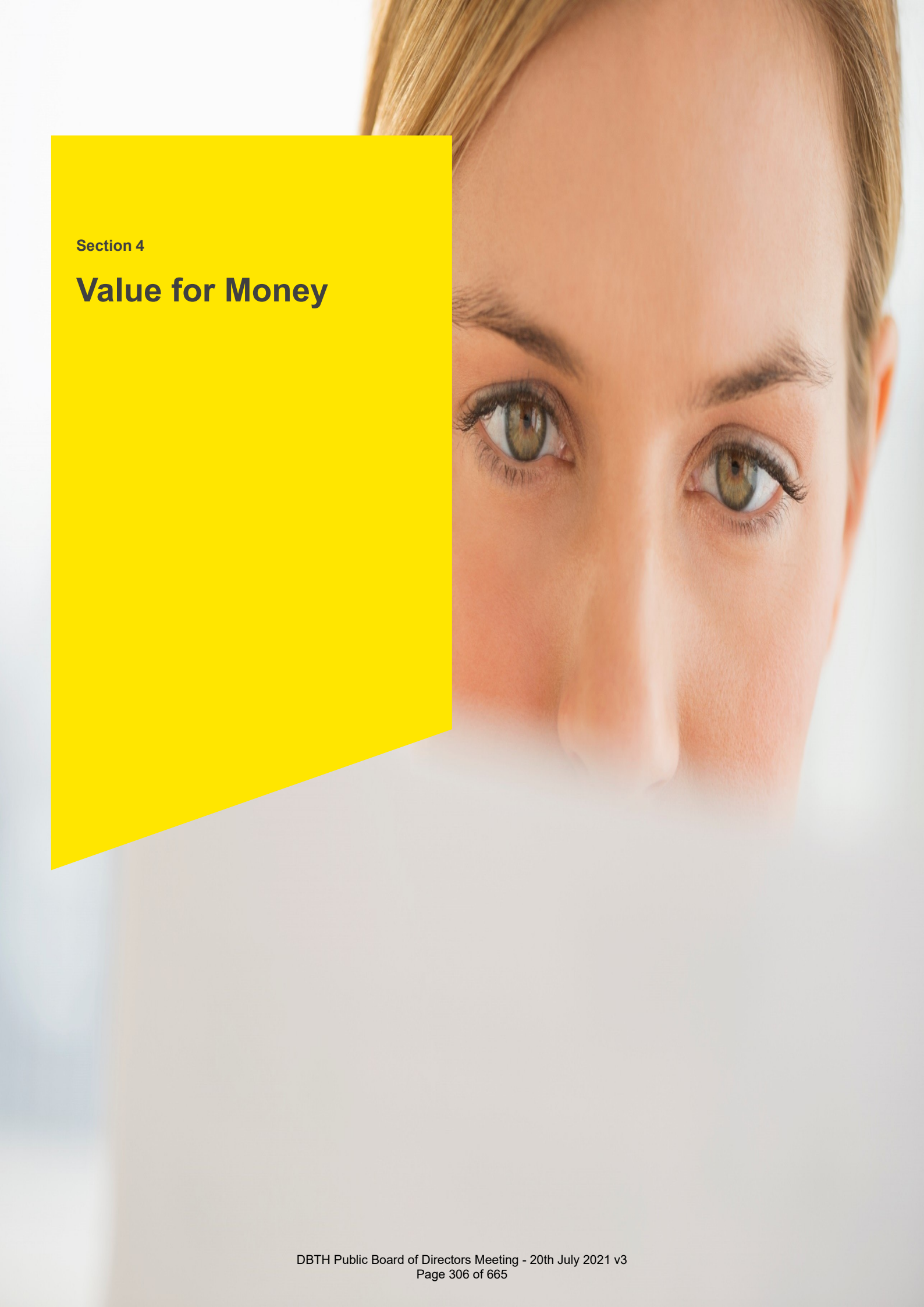
Item	Thresholds applied
Planning materiality	We determined planning materiality to be £6.61m as 2% of gross revenue expenditure reported in the accounts. We consider gross revenue expenditure to be one of the principal considerations for stakeholders in assessing the financial performance of the Trust.
Reporting threshold	We agreed with the Audit and Risk Committee that we would report to the Committee all audit differences in excess of £0.3m.

We also identified the following areas where misstatement at a level lower than our overall materiality level might influence the reader. For these areas we developed an audit strategy specific to these areas. The areas identified and audit strategy applied include:

- Remuneration disclosures: We audited all disclosures and undertook procedures to confirm material completeness
- Related party transactions. We audited all disclosures and undertook procedures to confirm material completeness

Section 4

Value for Money



Value for Money

We did not identify any risks of significant weaknesses in the Trust's VFM arrangements for 2020/21.

Scope and risks

We have complied with the NAO's 2020 Code and the NAO's Auditor Guidance Notes in respect of VFM. We presented our VFM risk assessment to the 09 June 2021 Audit and Risk Committee meeting which was based on a combination of our cumulative audit knowledge and experience, our review of Trust board and committee reports, meetings with the Director of Finance and evaluation of associated documentation through our regular engagement with Trust management and the finance team.

We reported that we had not identified any risks of significant weaknesses in the Trust's VFM arrangements for 2020/21.

We had no matters to report by exception in the audit report.

Reporting

We completed our planned VFM arrangements work in May and June 2021 and did not identify any significant weaknesses in the Trust's VFM arrangements. As a result, we had no matters to report by exception in the audit report on the financial statements.

Our VFM commentary highlights relevant issues for the Trust and the wider public.

VFM Commentary

In accordance with the NAO's 2020 Code, we are required to report a commentary against three specified reporting criteria:

- Financial sustainability
  How the Trust plans and manages its resources to ensure it can continue to deliver its services;
- Governance
  How the Trust ensures that it makes informed decisions and properly manages its risks; and
- Improving economy, efficiency and effectiveness:
  How the Trust uses information about its costs and performance to improve the way it manages and delivers its services.

Introduction and context

The commentary below aims to provide a clear narrative that explains our judgements in relation to our findings and any associated local context.

For 2020/21 the Trust has operated within a NHS Financial Framework that has taken into account the significant impact that the Covid-19 pandemic has had on the NHS as a whole as well as on individual providers and commissioners. In addition, the Trust has progressed its partnership working with the local Integrated Care System, which has included shared financial targets.

We have reflected these national and local contexts in our VFM commentary.

Financial sustainability

The Trust has had the arrangements we would expect to see to enable it to plan and manage its resources to ensure that it can continue to deliver its services.

The Trust's arrangements for 2020/21 were in the context of changes to the NHS financial framework as part of the coronavirus pandemic response. Transaction flows were simplified in the NHS and the Trust and its commissioners moved onto block contract payments at the start of 2020/21. In the second half of the year, a revised financial framework built on these arrangements but with a greater focus on local 'system' partnerships of NHS bodies. The Trust derived most of its income from these system arrangements.

How the body ensures that it identifies all the significant financial pressures that are relevant to its short and medium-term plans and builds these into them

The Trust recognise financial sustainability and the pressures it is facing as a risk within the risk register. The risk register includes actions to mitigate the risk to manage the short and medium-term impact on the Trust's service delivery. These are managed through formal monthly internal reporting on financial pressures, performance against plans and the Trust's liquidity position as well as external reporting to NHSI on the Trusts progress against plans. The risk register is considered frequently by the executive team and is a regular item for Board consideration and that it is subject to review by the Audit and Risk Committee.

How the body plans to bridge its funding gaps and identifies achievable savings

In recent years the Trust has a track record of achieving savings requirements and agreed control totals. However for 2020-21 savings requirements (CIP) were removed as part of national transitional arrangements in response to the pandemic. The Trust have set a £2.8m CIP target for achievement in the first half (H1) of the forthcoming financial year. There exist arrangements to develop mitigating plans in cases where programmes fall behind schedule; management conduct fortnightly performance meetings to monitor plans and progress.

The Trust prepared an operational plan for 2020/21 prior to the national changes in response to the pandemic, and have submitted an operational plan for 2021/22. The Trust formally reports revenue and capital position against their plan to the Finance and Performance Committee on a monthly basis. The Trust reported a strong cash position of £50.9million as at 31 March 2021.

Financial sustainability (continued)

How the body plans finances to support the sustainable delivery of services in accordance with strategic and statutory priorities

The Trust has a vision and a long-term strategic plan which articulates how it will deliver its statutory responsibilities.

The Trust translates this into an annual operating plan including the financial plans for enabling sustainable delivery of services. This forms the basis of monthly Trust Board reporting.

The national planning process has been temporarily suspended in response to the pandemic. Prior to this suspension, the Trust had prepared and submitted financial plans and savings targets to meet the agreed control total. In line with other NHS bodies, the certainty of the future funding arrangements are yet to be concluded. While we have not identified any risks to continuing service delivery, detailed medium term financial planning necessarily includes a number of assumptions.

The Trust has had the arrangements we would expect to see to enable it to plan and manage its resources to ensure that it can continue to deliver its services.

How the body ensures that its financial plan is consistent with other plans such as workforce, capital, investment, and other operational planning which may include working with other local public bodies as part of a wider system

The Trust reports to each Board meeting on key performance areas including Quality and Effectiveness; People and Organisational Development; and Finance and Performance. The Trust's financial plans include reporting on these "True North" strategic areas as part of its mechanisms for monitoring the achievement of targets for each of the key performance areas. Monthly reporting on the financial position to the Finance and Performance Committee links financial risks to strategic risks.

How the body identifies and manages risks to financial resilience, e.g. unplanned changes in demand, including challenge of the assumptions underlying its plans.

The Trust management have maintained appropriate risk management and governance processes throughout the year. The Finance and Performance Committee review a monthly performance report which is then presented to the Board. The report includes actual year to date financial outturn performance as well as the expected/projected outturn position for the financial year. The report also highlights risks to achieving the planned outturn position, any changes to the original plan and how the Trust plans to address new risks.

During the 2020/21 financial year the Department of Health and Social Care made changes to the financial framework for all trusts as part of their response to Covid-19. Further changes are expected for the 2021/22 financial year. The Trust recognises Failure to achieve compliance with financial performance and achieve financial plan within its risk register demonstrating how the Trust identifies significant financial pressures and builds them into their short term and medium-term plans.

The Trust has had the arrangements we would expect to see to enable to make informed decisions and properly manage its risks.

Governance

The Trust's governance arrangements for 2020/21 have taken into account NHSE/I's 28 March 2020 guidance entitled "Reducing the burden and releasing capacity at NHS providers and commissioners to manage the COVID-19 pandemic.'

How the body monitors and assesses risk and how the body gains assurance over the effective operation of internal controls, including arrangements to prevent and detect fraud

The Trust's Board Assurance Framework (BAF) is refreshed annually to match its strategic aims and align to strategic priorities and risks. The BAF outlines the actions being undertaken by the Trust to provide assurance that risks are being mitigated to an acceptable level, and is reviewed and updated by the senior management team. The Board of Directors have responsibility for oversight of the BAF.

The Board committee calendar ensures up-to-date information is provided to meetings for scrutiny and assurance. The Trust has a Risk Identification and Management Policy in place and the Board Assurance Framework and Corporate Risk Register provide the framework through which high-level risks are considered. The Board and committees receive and review the BAF and Risk Register on a frequent basis.

The Board of Directors monitors a series of quality measures and objectives on a monthly basis. Risks to the quality of care are managed and monitored through robust risk management and assurance processes. The committees of the Board, particularly the Quality and Effectiveness Committee and the People Committee, play a key role in quality governance, receiving reports and using internal audit to test the processes and quality controls in place. This enables rigorous challenge and action to be taken to develop services to enable improvement. The Board gives regular consideration to ensuring service quality in all aspects of its work, including changes to services and cost improvement plans. The Board proactively works to identify and mitigate potential risks to quality.

The Trust has a sound and embedded control environment in place. Relevant policies and procedures are in place and used in practice. We identified no issues of concern from the work we have completed.

The Trust has appropriate fraud prevention policies in place. The annual programme of counter fraud work agreed by the Audit and Risk Committee includes fraud prevention. and the committee received reports from the counter fraud specialist throughout the year.

The Trust has had the arrangements we would expect to see to enable to make informed decisions and properly manage its risks.

Governance (continued)

How the body approaches and carries out its annual budget setting process

The Trust has a track record of submitting planning, key data and final financial information to NHSI in line with agreed timetables. The external national planning process has been suspended with a national approach in response to the pandemic.

The Trust's internal budgeting and budget monitoring process has continued throughout the year and reported through Finance and Performance committee monthly.

The Trust develops its financial plan and budget using dual processes:

- Top down: where the Trust quantifies the core financial gap to assess its affordability envelope and inform the scale of the efficiency expectation for forthcoming year. This is developed through the application of national and local planning assumptions, as well as known commitments.
- Bottom up: where the Trust develops a granular level of activity, income, expenditure, workforce, capacity and efficiency planning.

There remains uncertainty over the final income allocations for the second half of 2021-22 and beyond due to the current national and local arrangements, but the Trust have applied a number of policies and processes to ensure resources are used economically, efficiently and effectively in 2020-21.

How the body ensures effective processes and systems are in place to ensure budgetary control; to communicate relevant, accurate and timely management information (including non-financial information where appropriate); supports its statutory financial reporting requirements; and ensures corrective action is taken where needed.

The Trust has the appropriate arrangements in place to set, approve and monitor budgets. The Trust's internal budgeting and budget monitoring process has continued throughout the year, reviewed by management and subsequently reported through the Finance and Performance Committee monthly.

Reporting to the Board also includes the full range of non-financial management information on all the Trust's key performance areas.

Budget meetings with budget holders were maintained throughout 2020-21 and formed the basis for reviewing variances from the 2020-21 base.

Throughout 2020-21 monthly reporting on pay and non-pay cost variance analysis, as well as reporting against capital programme progress, has been the source of executive oversight to enable budget monitoring and therefore assess the sustainability of future financial plans.

Governance (continued)

How the body ensures it makes properly informed decisions, supported by appropriate evidence and allowing for challenge and transparency. This includes arrangements for effective challenge from those charged with governance/audit committee.

The effective operation of the Board, supported with regular, clear and relevant information, is the Trust's key tool for ensuring that it makes properly informed decisions. Published Board papers are presented with header sheets that provide consideration of the key elements of the Trust strategic aims the report relates to, demonstrating the Board is informed of the relevant areas in making decisions. These executive summaries also draw out the implications in terms of legislation, regulation and resources. The minutes evidence the challenge made by non-executive members and the transparency in decision making.

In response to NHSE/I's 28 March 2020 guidance entitled "Reducing the burden and releasing capacity at NHS providers and commissioners to manage the COVID-19 pandemic.' the Trust introduced Gold & Silver Command pandemic management structure amongst other measures to ensure speedy approval of urgently required decisions.

The Audit and Risk Committee is comprised of appropriately skilled and experienced members, it has clear terms of reference which emphasises the Committee's role in providing effective challenge and has an annual work plan to help ensure that it focuses on the relevant aspects of governance, internal control and financial reporting.

How the body monitors and ensures appropriate standards, such as meeting legislative/regulatory requirements and standards in terms of officer or member behaviour (such as gifts and hospitality or declarations/conflicts of interests).

The Trust has appropriate Governance structures in place to assure itself that appropriate standards and regulations are met. Declarations of interest are a standing item in all board and Audit and Risk Committee meetings.

The Audit and Risk Committee, oversee an annual programme of work that is part of a suite of actions the Trust has in place to monitor adherence to clinical and care related standards and requirements.

The Trust has policies and procedures in place to ensure that staff operate in accordance with relevant legislative and regulatory requirements. These policies and procedures are reviewed and revised regularly.

Safety and quality is monitored by the Quality and Effectiveness Committee, which holds quarterly learning sessions on patient safety.

Improving economy, efficiency and effectiveness

How financial and performance information has been used to assess performance to identify areas for improvement.

The Trust report and monitor financial and non financial performance information through internal governance frameworks. The Board and Audit and Risk Committee oversee financial performance with formal monthly reporting on outturns and financial performance at Finance and Performance Committee monthly meetings.

The Board receives reports on performance in its key areas, which include Quality and Effectiveness; People and Organisational Development; and Finance and Performance. The reports clearly outline performance against planned targets and outcomes. Depending on the performance area, a Board committee will have oversight of the actions being identified and taken to address areas where performance is below plan. Each committee has a process in place for monitoring agreed actions and these are then included in subsequent Board reports.

The Trust has had the arrangements we would expect to see to enable it to use information about its costs and performance to improve the way it manages and delivers services.

How the body evaluates the services it provides to assess performance and identify areas for improvement

The integrated performance report identifies the key performance indicators for key service areas. These are monitored on a regular basis by the Board and Finance and Performance committee and where appropriate for areas performing below target requirements action is taken to address. Safety and quality is monitored by the Quality and Effectiveness Committee, which holds quarterly learning sessions on patient safety.

Trust has an array of ways of measuring its own performance across all aspects of its operations. It brings these together in the form of monthly reporting to the Board against national and local indicators. Where performance is below plan these reports highlight the action being taken to seek the required improvement.

The Trust is also subject to inspection by the Care Quality Commission, and is rated ‘Good’ overall and in all areas in the latest published report. The latest full CQC inspection was published in February 2020.

The Trust publishes an annual Quality Report outlining its performance against a wide range of quality measures. Prior to the pandemic the Quality Report was published as part of the Annual Report and elements were subject to audit. This requirement has been removed for 2019-20 and 2020-21 and the report is published separately.

Improving economy, efficiency and effectiveness (continued)

How the body ensures it delivers its role within significant partnerships, engages with stakeholders it has identified, monitors performance against expectations, and ensures action is taken where necessary to improve;

The Trust reports internally on system working and working with commissioners. The Trust reports it has maintained good and supportive relationships with lead commissioners and on the strengthened collaboration and mutual aid between providers and commissioners as part of reporting to Audit and Risk Committee the preparation for production of the 20-21 annual report.

The Trust has an established Finance and Performance Committee which provides oversight of its active partnership role within the local Integrated Care System. The same Committee also receives regular reports from Service Leads on other partnership working and engagement with stakeholders including local CCGs and local authorities. The Committee has a remit to request that Service Leads take action where significant partnerships are not delivering the performance or outcomes that the Trust expects. The Board has a duty to work in partnership with service users, carers, local health organisations, local government authorities and others to provide safe, effective, accessible, and well governed services for patients

How the body ensures that commissioning and procuring services is done in accordance with relevant legislation, professional standards and internal policies, and how the body assesses whether it is realising the expected benefits.

The Trust faces further challenge and change beyond 2021 which will form part of our 2021/22 VFM arrangements work.

Doncaster & Bassetlaw Teaching Hospitals NHS Foundation Trust is an acute provider and the majority of its services are commissioned by local CCGs and some specialist services by NHS England. The Trust monitors outcomes through its governance framework, reporting internally to board and committees and externally via the Annual Governance Report.

For procurement, the Trust uses national contracts or agreements wherever possible, primarily through NHS Supply Chain, the Crown Commercial Service and NHS Commercial Alliance. Where it is not possible to use a national agreement, contracts are advertised in the public domain via the government portal Contracts Finder. The Audit and Risk Committee review cases where single tender waivers have been performed and assess the conditions around such incidences.

Forward look

Looking forward to 2021 and beyond, the Trust is working as part of the local Integrated Care System (ICS) and planning budgets and forecasts for the 2021-22 year on the latest available information and assumptions for arrangements for the second half of 2021-22 and future years. As these arrangements have not yet been formalised the Trust will need to revisit and maintain the Medium Term Financial Plan and monitor savings requirements and achievement as part of securing financial sustainability in the longer term.

Section 5

Other Reporting Issues

Other Reporting Issues

Department of Health and Social Care / NHSI England Group Instructions

We are only required to report to the NAO on an exception basis if there were significant issues or outstanding matters arising from our work. There were no such issues.

Governance Statement

We are required to consider the completeness of disclosures in the Trust's governance statement, identify any inconsistencies with the other information of which we are aware from our work, and consider whether it complies with relevant guidance.

We completed this work and did not identify any areas of concern

Report in the Public Interest

We have a duty under the Local Audit and Accountability Act 2014 to consider whether, in the public interest, to report on any matter that comes to our attention in the course of the audit in order for it to be considered by the Trust or brought to the attention of the public.

We did not identify any issues which required us to issue a report in the public interest.

Other powers and duties

We identified no issues during our audit that required us to use our additional powers under the Local Audit and Accountability Act 2014.

Other Reporting Issues (cont'd)

Control Themes and Observations

As part of our work, we obtained an understanding of internal control sufficient to plan our audit and determine the nature, timing and extent of testing performed. Although our audit was not designed to express an opinion on the effectiveness of internal control, we are required to communicate to you significant deficiencies in internal control identified during our audit.

We have adopted a fully substantive approach and have therefore not tested the operation of controls.

The matters reported are shown below and are limited to those deficiencies that we identified during the audit and that we concluded are of sufficient importance to merit being reported.

Description	Impact
The trust experienced issues with the RAM fixed asset register in Quarter 4, that prevented valuation transactions being inputted. The Fixed Asset Register (FAR) is a vital subledger operating a key role in the financial reporting system which should maintain a robust and detailed chronology of events for each asset. The reporting functionality of the FAR is therefore equally vital to the provision of sufficient management information.	Issues with the fixed asset register should be identified and rectified as soon as possible to prevent any compound impact of further delays to information being entered into the system.
The result of the system issues impacting the FAR was increased manual intervention to perform valuation transactions and create working papers. The working papers that were provided, took much longer as a result and contained errors outlined leading to adjustments being necessary.	Where it is clear that there have been issues and workpapers have been delayed requiring more manual input, there should be increased Quality Assurance procedures performed on the workpapers. Where issues are known in advance, this should be flagged to the audit team to enable a better understanding and more warning.

Other Reporting Issues (cont'd)

Description	Impact
Within our work in testing the starters and leavers process, we have been provided with contracts for starters which were not signed and/or retained to demonstrate that contracts were signed in a timely manner, at the start of individual's contracts. A contract demonstrates the commitment of both parties to their side of an agreement. Retention of this evidences both sides' commitment to the contract. Although the Trust does not feel potentially exposed with respect to employment law it is best practice to retain evidence that employees understand contractual specifics.	A control should be implemented within appropriate timescales following an employee's start date, to ensure contracts are signed and retained.
Our testing in this area we sampled an accrual for an invoice that had been previously paid. This arose where the invoice was raised against two purchase order numbers, but only matched against one in the system. The error identified was individually insignificant (£9k), but due to the nature of the error identified, we could not gain assurance that this error would be prevented in other circumstances. As such we performed the extrapolation which was below our materiality level.	The trust should investigate the cause of this error and implement appropriate mitigating controls.

Follow-up of Prior Year Recommendations

Description	20/21 Update
We identified that provisions were made against bodies within the DHSC group. Although the total allowance raised is trivial (£100k) the DHSC Group Accounting Manual states "DHSC group bodies should not normally recognise stage-3 impairments (objective evidence of impairment) for receivables due from other DHSC group bodies, as such amounts are not expected to be irrecoverable. If in doubt as to whether it is correct to recognise either an expected (stages 1 and 2) or an incurred (stage 3) loss allowance against a body, DHSC group bodies should consult their national body or DHSC Finance." Management have not consulted with DHSC finance before making the allowance.	The Trust continues to provide in line with previous practice, against DHSC bodies. The total amount of provision made is less that £20k.
We experienced difficulties in obtaining requested information to support testing of starters and leavers. We were not provided with three pieces of evidence. Poor record and document retention can leave the Trust exposed in disputes and also presents a risk that the Trust may not comply with General Data Protection Regulation (GDPR) or the Data Protection Act.	As noted in our recommendations we have raised a finding relating to the retention of signed employment contracts.

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Ernst & Young LLP

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Ernst & Young LLP, 1 More London Place, London, SE1 2AF.

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INDEPENDENT AUDITOR'S REPORT TO THE COUNCIL OF GOVERNORS OF DONCASTER AND BASSETLAW TEACHING HOSPITALS NHS FOUNDATION TRUST

Issue of audit opinion on the financial statements

In our audit report for the year ended 31 March 2021 issued on 25 June 2021 we reported that, in our opinion, the financial statements:

- gave a true and fair view of the financial position of Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust as at 31 March 2021 and of its income and expenditure for the year then ended;
- gave a true and fair view of the financial position of the Group as at 31 March 2021 and of its expenditure and income for the year then ended; and
- had been prepared properly in accordance with the Department for Health and Social Care's Group Accounting Manual 2020/21 and the directions under paragraphs 24 and 25 of Schedule 7 of the National Health Service Act 2006 (as amended by the Health and Social Care Act 2012).

Certificate

In our report dated 25 June 2021, we explained that we could not formally conclude the audit on that date until we had completed our procedures on the Foundation Trust's value for money arrangements for the year ended 31 March 2021. We have now completed our procedures and no matters have come to our attention that would have resulted in a different opinion on the financial statements or additional exception reporting on significant weaknesses in the Foundation Trust's value for money arrangements.

We certify that we have completed the audit of the accounts of Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust in accordance with the requirements of Chapter 5 of Part 2 of the National Health Service Act 2006 and the Code of Audit Practice issued by the National Audit Office on behalf of the Comptroller and Auditor General.

Hassan Rohimun
For and on behalf of Ernst & Young LLP
Manchester
02 July 2021

Doncaster & Bassetlaw Teaching Hospitals NHS Foundation Trust

Annual accounts for the year ended 31 March 2021

Foreword to the accounts

Doncaster & Bassetlaw Teaching Hospitals NHS Foundation Trust

These accounts, for the year ended 31 March 2021, have been prepared by Doncaster & Bassetlaw Teaching Hospitals NHS Foundation Trust in accordance with paragraphs 24 & 25 of Schedule 7 within the National Health Service Act 2006.

Signed ……

Date **25 June 2021**

Statement of Comprehensive Income

		Group		Trust	
		2020/21	2019/20	2020/21	2019/20
	Note	£000	£000	£000	£000
Operating income from patient care activities	3	404,601	379,103	404,601	378,852
Other operating income	4	57,902	55,419	64,301	55,464
Operating expenses	7	(457,245)	(430,268)	(463,271)	(429,149)
Operating surplus/(deficit) from continuing operations		**5,258**	**4,254**	**5,631**	**5,167**
Finance income	12	278	550	11	272
Finance expenses	13	(336)	(1,507)	(336)	(1,507)
PDC dividends payable		(4,720)	(2,924)	(4,720)	(2,924)
Net finance costs		**(4,778)**	**(3,881)**	**(5,045)**	**(4,159)**
Other gains / (losses)	14	1,438	(600)	111	-
Corporation tax expense		(33)	-	-	-
Surplus / (deficit) for the year		**1,885**	**(227)**	**697**	**1,008**
Other comprehensive income					
Will not be reclassified to income and expenditure:					
Net Impairments	8	2,409	(3,116)	2,409	(3,116)
Revaluations		88	340	88	340
Total comprehensive income / (expense) for the period		**4,382**	**(3,003)**	**3,194**	**(1,768)**
Surplus/ (deficit) for the period attributable to:					
Doncaster & Bassetlaw Teaching Hospitals NHS Foundation Trust		1,885	(227)	697	1,008
TOTAL		**1,885**	**(227)**	**697**	**1,008**
Total comprehensive income/ (expense) for the period attributable to:					
Doncaster & Bassetlaw Teaching Hospitals NHS Foundation Trust		4,382	(3,003)	3,194	(1,768)
TOTAL		**4,382**	**(3,003)**	**3,194**	**(1,768)**

Adjusted Financial Performance

Surplus/ (deficit) for the period for Trust:	697	1,008
Surplus/ (deficit) for the period for Wholly Owned Subsidiary:	140	(1)
Surplus/ (deficit) for the period for non-charity aspects of the Group	837	1,007
Add back all I&E impairments/(reversals)	4,902	135
Remove capital donations/grants I&E impact	(1,615)	(348)
Remove impact of prior year PSF post accounts reallocation	-	(744)
Adjusted financial performance surplus/(deficit) including PSF, FRF, MRET and Top-Up	4,124	50

Statement of Financial Position

		Group		Trust	
		2021	2020	2021	2020
	Note	£000	£000	£000	£000
Non-current assets					
Intangible assets	17	9,370	6,394	9,370	6,394
Property, plant and equipment	18	225,459	204,149	225,459	204,149
Other investments / financial assets	22	8,741	7,303	550	550
Receivables	25	1,511	2,619	1,511	2,619
Total non-current assets		**245,081**	**220,465**	**236,890**	**213,712**
Current assets					
Inventories	24	7,022	6,637	6,501	5,835
Receivables	25	15,090	22,635	16,549	24,993
Non-current assets held for sale and assets in disposal groups	27	-	343	-	343
Cash and cash equivalents	28	52,085	32,079	50,947	30,823
Total current assets		**74,197**	**61,694**	**73,997**	**61,994**
Current liabilities					
Trade and other payables	29	(66,661)	(51,467)	(67,447)	(53,003)
Borrowings	31	(2,112)	(73,295)	(2,112)	(73,295)
Provisions	34	(637)	(603)	(637)	(603)
Other liabilities	30	(1,383)	(2,503)	(1,383)	(2,503)
Total current liabilities		**(70,793)**	**(127,868)**	**(71,579)**	**(129,404)**
Total assets less current liabilities		**248,485**	**154,291**	**239,308**	**146,302**
Non-Current liabilities					
Borrowings	31	(12,618)	(14,675)	(12,618)	(14,675)
Provisions	34	(2,170)	(1,982)	(2,170)	(1,982)
Total non-current liabilities		**(14,788)**	**(16,657)**	**(14,788)**	**(16,657)**
Total assets employed		**233,697**	**137,634**	**224,520**	**129,645**
Financed by					
Public dividend capital		228,869	137,188	228,869	137,188
Revaluation reserve		44,945	42,454	44,945	42,454
Income and expenditure reserve		(49,294)	(49,997)	(49,294)	(49,997)
Charitable fund reserves	44	9,038	7,990	-	-
Doncaster & Bassetlaw Healthcare Services Ltd	45	139	(1)	-	-
Total taxpayers' equity		**233,697**	**137,634**	**224,520**	**129,645**

The notes on pages 7 to 49 form part of these accounts.

Signed .....

Date **25 June 2021**

Statement of Changes in Equity for the year ended 31 March 2021

Group	Public dividend capital	Revaluation reserve	Income and expenditure reserve	Charitable fund reserves	DBHS Limited	Total
	£000	£000	£000	£000	£000	£000
Taxpayers' and others' equity at 1 April 2020	**137,188**	**42,454**	**(49,997)**	**7,990**	**(1)**	**137,634**
Surplus/(deficit) for the year	-	-	697	1,048	140	**1,885**
Net Impairments	-	2,497	-	-	-	**2,497**
Transfer to retained earnings on disposal of assets	-	(6)	6	-	-	**-**
Public dividend capital received	91,681	-	-	-	-	**91,681**
Taxpayers' and others' equity at 31 March 2021	**228,869**	**44,945**	**(49,294)**	**9,038**	**139**	**233,697**

Statement of Changes in Equity for the year ended 31 March 2020

Group	Public dividend capital	Revaluation reserve	Income and expenditure reserve	Charitable fund reserves	DBHS Limited	Total
	£000	£000	£000	£000	£000	£000
Taxpayers' and others' equity at 1 April 2019	132,019	45,327	(51,005)	9,224	-	**135,565**
Surplus/(deficit) for the year	-	-	492	(718)	(1)	**(227)**
Net Impairments	-	(3,213)	-	-	-	**(3,213)**
Revaluations - property, plant and equipment	-	340	-	-	-	**340**
Other reserve movements - charitable fund consolidation adjustment	-	-	516	(516)	-	**-**
Public dividend capital received	5,169	-	-	-	-	**5,169**
Taxpayers' and others' equity at 31 March 2020	**137,188**	**42,454**	**(49,997)**	**7,990**	**(1)**	**137,634**

Statement of Changes in Equity for the year ended 31 March 2021

Trust	Public dividend capital	Revaluation reserve	Income and expenditure	Total
	£000	£000	£000	£000
Taxpayers' and others' equity at 1 April 2020	**137,188**	**42,454**	**(49,997)**	**129,645**
Surplus/(deficit) for the year	-	-	697	**697**
Transfer to retained earnings on disposal of assets		(6)	6	**-**
Net Impairments		2,497	-	**2,497**
Public dividend capital received	91,681	-	-	**91,681**
Taxpayers' and others' equity at 31 March 2021	**228,869**	**44,945**	**(49,294)**	**224,520**

Statement of Changes in Equity for the year ended 31 March 2020

Trust	Public dividend capital	Revaluation reserve	Income and expenditure	Total
	£000	£000	£000	£000
Taxpayers' and others' equity at 1 April 2019	**132,019**	**45,327**	**(51,005)**	**126,341**
Surplus/(deficit) for the year	-	-	492	**492**
Other reserve movements - charitable fund consolidation adjustment	-	-	516	**516**
Net Impairments	-	(2,873)	-	**(2,873)**
Public dividend capital received	5,169	-	-	**5,169**
Taxpayers' and others' equity at 31 March 2020	**137,188**	**42,454**	**(49,997)**	**129,645**

Information on reserves

Revaluation reserve
Increases in asset values arising from revaluations are recognised in the revaluation reserve, except where, and to the extent that, they reverse impairments previously recognised in operating expenses, in which case they are recognised in operating income. Subsequent downward movements in asset valuations are charged to the revaluation reserve to the extent that a previous gain was recognised unless the downward movement represents a clear consumption of economic benefit or a reduction in service potential. If this is the case, a charge is made to the Statement of Comprehensive Income.

Income and expenditure reserve
The balance of this reserve is the accumulated surpluses and deficits of the Trust.

Charitable funds reserve
This reserve comprises the ring-fenced funds held by the NHS charitable funds consolidated within these financial statements. These reserves are classified as restricted or unrestricted.

DBHS Ltd reserve
This reserve comprises the ring-fenced funds held by Doncaster & Bassetlaw Healthcare Services Limited ("DBHS Ltd") which is a wholly owned subsidiary.

Statement of Cash Flows

		Group		Trust	
		2020/21	2019/20	2020/21	2019/20
	Note	£000	£000	£000	£000
Cash flows from operating activities					
Operating surplus / (deficit)		5,258	4,254	5,631	5,167
Non-cash income and expense:					
Depreciation and amortisation	7.1	9,828	8,490	9,828	8,490
Net impairments	8	4,902	135	4,902	135
Income recognised in respect of capital donations	4	(2,038)	-	(2,038)	(516)
(Increase) / decrease in receivables and other assets		8,651	12,721	9,552	10,417
(Increase) / decrease in inventories		(385)	(1,127)	(666)	(325)
Increase / (decrease) in payables and other liabilities		14,038	2,949	11,933	4,406
Increase / (decrease) in provisions		233	(352)	233	(352)
Movements in charitable fund working capital		6	21	-	-
Other movements in operating cash flows		156	150	-	-
Net cash flows from / (used in) operating activities		**40,649**	**27,241**	**39,375**	**27,422**
Cash flows from investing activities					
Interest received		11	272	11	272
Purchase of investments - Doncaster & Bassetlaw Healthcare Services Limited		-	-	-	(550)
Purchase of intangible assets		(3,956)	(297)	(3,956)	(297)
Purchase of non-current assets and investment property		(30,526)	(9,445)	(29,134)	(9,445)
Sales of non-current assets and investment property		454	-	454	-
		(34,017)	**(9,470)**	**(32,625)**	**(10,020)**
Cash flows from financing activities					
Public dividend capital received		91,681	5,169	91,681	5,169
Movement on loans from DHSC		(73,025)	(6,962)	(73,025)	(6,962)
Interest on loans		(562)	(1,516)	(562)	(1,516)
PDC dividend (paid) / refunded		(4,720)	(3,010)	(4,720)	(3,010)
Net cash flows from / (used in) financing activities		**13,374**	**(6,319)**	**13,374**	**(6,319)**
Increase / (decrease) in cash and cash equivalents		**20,006**	**11,452**	**20,124**	**11,083**
Cash and cash equivalents at 1 April - brought forward		**32,079**	**20,627**	**30,823**	**19,740**
Cash and cash equivalents at 31 March	28	**52,085**	**32,079**	**50,947**	**30,823**

Notes to the Accounts

Note 1 Accounting policies and other information

Note 1.1 Basis of preparation
NHS Improvement, in exercising the statutory functions conferred on Monitor, has directed that the financial statements of the Trust shall meet the accounting requirements of the Department of Health and Social Care Group Accounting Manual (GAM), which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the GAM 2020/21 issued by the Department of Health and Social Care. The accounting policies contained in the GAM follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the GAM permits a choice of accounting policy, the accounting policy that is judged to be most appropriate to the particular circumstances of the Trust for the purpose of giving a true and fair view has been selected. The particular policies adopted are described below. These have been applied consistently in dealing with items considered material in relation to the accounts.

Note 1.1.1 Accounting convention
These accounts have been prepared under the historical cost convention modified to account for the revaluation of property, plant and equipment, intangible assets, inventories and certain financial assets and financial liabilities.

Note 1.2 Going concern
These accounts have been prepared on a going concern basis, in accordance with the definition as set out in section 4 of the DHSC Group Accounting Manual (GAM) which outlines the interpretation of IAS1 'Presentation of Financial Statements' as "the anticipated continuation of the provision of a service in the future, as evidenced by the inclusion of financial provision for that service in published documents".

The Directors of the Trust have considered whether there are any local or national policy decisions that are likely to affect the continued funding and provision of services by the Trust and no circumstances were identified causing the Directors to doubt the continued provision of NHS services.

The Directors have a reasonable expectation that the Trust has adequate resources to continue in operational existence for the foreseeable future. This is based on:
• Continuing support from local commissioners, as shown within the South Yorkshire & Bassetlaw Integrated Care System (ICS) 5 Year Plan
• The Trust has ended the year with £50.9m cash in the bank
• The Trust has delivered a surplus in both 2019/20 and 2020/21
• There are no licence conditions in place on the Trust from its regulatory body.
• The Trust has received a Good rating from the CQC for use of resources during 2019/20.
• Additional costs due to the pandemic were supported on an actual cost reimbursement basis for the first half the year and on an advance block payment basis for the second half of the year.

The Trust has also performed a range of cash flow forecasts up to June 2022. Whilst the forecasts have a number of variables, all show that the Trust has a positive cash balance throughout. For the first half of 21/22 national funding arrangements have been confirmed, with the cashflow based on the plan submitted to the ICS and NHSE&I. For the second half of the year a range of options has been modelled including the current arrangements extending into the second half of the year or a return to pre COVID financial arrangements, with both options showing the Trust has a positive cash balance to June 2022.

In April 2020, the Department of Health and Social Care (DHSC) and NHS England and NHS Improvement (NHSE&I) announced reforms to the NHS cash regime for the 2020/21 financial year. During 2020/21 existing DHSC interim revenue loans as at 31 March 2020 were extinguished and replaced with the issue of Public Dividend Capital (PDC) to allow their repayment. The Trust received PDC of £71.1m to repay these loans which had accumulated from prior year deficits and thereby increased the total net assets by £71.1m, strengthening the value of the balance sheet and meaning the Trust is no longer required to generate surpluses to service this historic debt.

As a result of this, the financial statements do not contain the adjustments that would result if the Trust was unable to continue as a going concern.

Note 1.3 Consolidation

NHS Charitable Funds

The Trust is the corporate trustee to Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust charitable fund. The Trust has assessed its relationship to the charitable fund and determined it to be a subsidiary because the trust is exposed to, or has rights to, variable returns and other benefits for itself, patients and staff from its involvement with the charitable fund and has the ability to affect those returns and other benefits through its power over the fund.

The charitable fund's statutory accounts are prepared to 31 March in accordance with the UK Charities Statement of Recommended Practice (SORP) which is based on UK Financial Reporting Standard (FRS) 102. On consolidation, necessary adjustments are made to the charity's assets, liabilities and transactions to:

• recognise and measure them in accordance with the Trust's accounting policies and

• eliminate intra-group transactions, balances, gains and losses.

Other subsidiaries

Subsidiary entities are those over which the Trust is exposed to, or has rights to, variable returns from its involvement with the entity and has the ability to affect those returns through its power over the entity. The income, expenses, assets, liabilities, equity and reserves of subsidiaries are consolidated in full into the appropriate financial statement lines. The capital and reserves attributable to minority interests are included as a separate item in the Statement of Financial Position.

The amounts consolidated are drawn from the published financial statements of the subsidiaries for the year except where a subsidiary's financial year end is before 1 January or after 1 July in which case the actual amounts for each month of the Trust's financial year are obtained from the subsidiary and consolidated.

Where subsidiaries' accounting policies are not aligned with those of the Trust (including where they report under UK FRS 102) then amounts are adjusted during consolidation where the differences are material. Inter-entity balances, transactions and gains/losses are eliminated in full on consolidation.

Subsidiaries which are classified as held for sale are measured at the lower of their carrying amount and fair value less costs to sell.

The Foundation Trust has an investment of £550k of Share Capital in a Wholly Owned Subsidiary, Doncaster & Bassetlaw Healthcare Services Ltd ("DBHS Ltd"). DBHS Ltd operates at an arms length basis, currently providing Out-patient pharmacy dispensary services at the Doncaster Royal Infirmary site. The summarised financial statements can be seen in Note 45.

Note 1.4.1 Revenue from contracts with customers

Where income is derived from contracts with customers, it is accounted for under IFRS 15. The GAM expands the definition of a contract to include legislation and regulations which enables an entity to receive cash or another financial asset that is not classified as a tax by the Office of National Statistics (ONS).

Revenue in respect of goods/services provided is recognised when (or as) performance obligations are satisfied by transferring promised goods/services to the customer and is measured at the amount of the transaction price allocated to those performance obligations. At the year end, the Trust accrues income relating to performance obligations satisfied in that year. Where the Trust's entitlement to consideration for those goods or services is unconditional a contract receivable will be recognised. Where entitlement to consideration is conditional on a further factor other than the passage of time, a contract asset will be recognised. Where consideration received or receivable relates to a performance obligation that is to be satisfied in a future period, the income is deferred and recognised as a contract liability.

Revenue from NHS contracts

The accounting policies for revenue recognition and the application of IFRS 15 are consistently applied. The contracting arrangements in the NHS changed between 2019/20 and 2020/21 affecting the application of the accounting policy under IFRS 15. This difference in application is explained below.

2020/21

The main source of income for the Trust is contracts with commissioners for health care services. In 2020/21, the majority of the trust's income from NHS commissioners was in the form of block contract arrangements. During the first half of the year the trust received block funding from its commissioners. For the second half of the year, block contract arrangements were agreed at a Integrated Care System/Sustainability and Transformation Partnership level. The related performance obligation is the delivery of healthcare and related services during the period, with the trust's entitlement to consideration not varying based on the levels of activity performed.

The Trust has received additional income outside of the block and system envelopes to reimburse specific costs incurred and other income top-ups to support the delivery of services. Reimbursement and top-up income is accounted for as variable consideration.

Note 1.4.1 Revenue from contracts with customers (cont.)

Comparative period (2019/20)

In the comparative period (2019/20), the trust's contracts with NHS commissioners included those where the trust's entitlement to income varied according to services delivered. A performance obligation relating to delivery of a spell of health care was generally satisfied over time as healthcare was received and consumed simultaneously by the customer as the Trust performed it. The customer in such a contract was the commissioner, but the customer benefited as services were provided to their patient. Even where a contract could be broken down into separate performance obligations, healthcare generally aligned with paragraph 22(b) of the Standard entailing a delivery of a series of goods or services that were substantially the same and had a similar pattern of transfer. At the year end, the Trust accrued income relating to activity delivered in that year, where a patient care spell was incomplete. This accrual was disclosed as a contract receivable as entitlement to payment for work completed was usually only dependent on the passage of time.

In 2019/20, the Provider Sustainability Fund and Financial Recovery Fund enabled providers to earn income linked to the achievement of financial controls and performance targets. Income earned from the funds is accounted for as variable consideration.

Revenue from research contracts

Where research contracts fall under IFRS 15, revenue is recognised as and when performance obligations are satisfied. For some contracts, it is assessed that the revenue project constitutes one performance obligation over the course of the multi-year contract. In these cases it is assessed that the Trust's interim performance does not create an asset with alternative use for the Trust, and the Trust has an enforceable right to payment for the performance completed to date. It is therefore considered that the performance obligation is satisfied over time, and the Trust recognises revenue each year over the course of the contract. Some research income alternatively falls within the provisions of IAS 20 for government grants.

NHS injury cost recovery scheme

The Trust receives income under the NHS injury cost recovery scheme, designed to reclaim the cost of treating injured individuals to whom personal injury compensation has subsequently been paid, for instance by an insurer. The Trust recognises the income when performance obligations are satisfied. In practical terms this means that treatment has been given, it receives notification from the Department of Work and Pension's Compensation Recovery Unit, has completed the NHS2 form and confirmed there are no discrepancies with the treatment. The income is measured at the agreed tariff for the treatments provided to the injured individual, less an allowance for unsuccessful compensation claims and doubtful debts in line with IFRS 9 requirements of measuring expected credit losses over the lifetime of the asset.

Note 1.4.2 Revenue grants and other contributions to expenditure

Government grants are grants from government bodies other than income from commissioners or trusts for the provision of services. Where a grant is used to fund revenue expenditure it is taken to the Statement of Comprehensive Income to match that expenditure.

The value of the benefit received when accessing funds from the the Government's apprenticeship service is recognised as income at the point of receipt of the training service. Where these funds are paid directly to an accredited training provider from the Trust's Digital Apprenticeship Service (DAS) account held by the Department for Education, the corresponding notional expense is also recognised at the point of recognition for the benefit.

Note 1.4.3 Other income

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

Note 1.5 Expenditure on employee benefits

Short-term employee benefits

Salaries, wages and employment-related payments, including social security costs and payments arising from the apprenticeship levy, are recognised in the period in which the service is received from employees, including non-consolidated performance pay earned but not yet paid. The cost of leave earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry forward leave into the following period.

Note 1.5 Expenditure on employee benefits (cont.)

Pension costs

NHS Pension Scheme

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Both schemes are unfunded, defined benefit schemes that cover NHS employer, general practices and other bodies, allowed under the direction of Secretary of State for Health and Social Care in England and Wales. The scheme is not designed in a way that would enable employers to identify their share of the underlying scheme assets and liabilities. Therefore, the scheme is accounted for as though it is a defined contribution scheme: the cost to the trust is taken as equal to the employer's pension contributions payable to the scheme for the accounting period. The contributions are charged to operating expenses as they become due.

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

Note 1.6 Expenditure on other goods and services

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

Note 1.7 Property, plant and equipment

Note 1.7.1 Recognition

Property, plant and equipment is capitalised where:
• it is held for use in delivering services or for administrative purposes
• it is probable that future economic benefits will flow to, or service potential be provided to, the Trust
• it is expected to be used for more than one financial year
• the cost of the item can be measured reliably
• the item has cost of at least £5,000, or
• collectively, a number of items have a cost of at least £5,000 and individually have cost of more than £250, where the assets are functionally interdependent, had broadly simultaneous purchase dates, are anticipated to have similar disposal dates and are under single managerial control.

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

Note 1.7.2 Measurement

All property, plant and equipment is measured initially at cost, representing the cost directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management. Assets that are held for their service potential and are in use are measured subsequently at their current value in existing use. Assets that were most recently held for their service potential but are surplus with no plan to bring them back into use are surplus are measured at fair value where there are no restrictions preventing access to the market at the reporting date.

Revaluations of property, plant and equipment are performed with sufficient regularity to ensure that carrying values are not materially different from those that would be determined at the end of the reporting period. Current values in existing use are determined as follows:
• Land and non-specialised buildings – market value for existing use
• Specialised buildings – depreciated replacement cost on a modern equivalent asset basis.

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees and, where capitalised in accordance with IAS 23, borrowing costs. Assets are revalued and depreciation commences when they are brought into use.

IT equipment, transport equipment, furniture and fittings, and plant and machinery that are held for operational use are valued at depreciated historic cost where these assets have short useful economic lives or low values or both, as this is not considered to be materially different from current value in existing use.

An increase arising on revaluation is taken to the revaluation reserve except when it reverses an impairment for the same asset previously recognised in expenditure, in which case it is credited to expenditure to the extent of the decrease previously charged there. A revaluation decrease that does not result from a loss of economic value or service potential is recognised as an impairment charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset, and thereafter to expenditure. Gains and losses recognised in the revaluation reserve are reported as other comprehensive income in the Statement of Comprehensive Income.

Note 1.7.3 Subsequent expenditure

Subsequent expenditure relating to an item of property, plant and equipment is recognised as an increase in the carrying amount of the asset when it is probable that additional future economic benefits or service potential deriving from the cost incurred to replace a component of such item will flow to the enterprise and the cost of the item can be determined reliably. Where a component of an asset is replaced, the cost of the replacement is capitalised if it meets the criteria for recognition above. The carrying amount of the part replaced is de-recognised. Other expenditure that does not generate additional future economic benefits or service potential, such as repairs and maintenance is charged to the Statement of Comprehensive Income in the period in which it is incurred.

Depreciation

Items of property, plant and equipment are depreciated over their remaining useful lives in a manner consistent with the consumption of economic or service delivery benefits. Freehold land is considered to have an infinite life and is not depreciated.

Property, plant and equipment which has been reclassified as 'held for sale' cease to be depreciated upon the reclassification.

Revaluation gains and losses

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

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

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

Impairments

In accordance with the GAM, impairments that arise from a clear consumption of economic benefits or of service potential in the asset are charged to operating expenses. A compensating transfer is made from the revaluation reserve to the income and expenditure reserve of an amount equal to the lower of (i) the impairment charged to operating expenses; and (ii) the balance in the revaluation reserve attributable to that asset before the impairment.

An impairment that arises from a clear consumption of economic benefit or of service potential is reversed when, and to the extent that, the circumstances that gave rise to the loss is reversed. Reversals are recognised in operating expenditure to the extent that the asset is restored to the carrying amount it would have had if the impairment had never been recognised. Any remaining reversal is recognised in the revaluation reserve. Where, at the time of the original impairment, a transfer was made from the revaluation reserve to the income and expenditure reserve, an amount is transferred back to the revaluation reserve when the impairment reversal is recognised.

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

Note 1.7.4 De-recognition

Assets intended for disposal are reclassified as 'held for sale' once the criteria in IFRS 5 are met. The sale must be highly probable and the asset available for immediate sale in its present condition.

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

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

Note 1.7.5 Donated and grant funded assets

Donated and grant funded property, plant and equipment assets are capitalised at their fair value on receipt. The donation/grant is credited to income at the same time, unless the donor has imposed a condition that the future economic benefits embodied in the grant are to be consumed in a manner specified by the donor, in which case, the donation/grant is deferred within liabilities and is carried forward to future financial years to the extent that the condition has not yet been met.

The donated and grant funded assets are subsequently accounted for in the same manner as other items of property, plant and equipment.

In 2020/21, this includes assets donated to the trust by the Department of Health and Social Care as part of the response to the coronavirus pandemic. As defined in the GAM, the trust applies the principle of donated asset accounting to assets that the trust controls and is obtaining economic benefits from at the year end.

Note 1.7.6 Useful lives of property, plant and equipment

Useful lives reflect the total life of an asset and not the remaining life of an asset. The range of useful lives are shown in the table below:

	Min life Years	**Max life Years**
Land	Not depreciated	
Buildings, excluding dwellings	9	58
Dwellings	18	40
Plant & machinery	7	18
Transport equipment	7	10
Information technology	5	14
Furniture & fittings	8	18

Finance-leased assets (including land) are depreciated over the shorter of the useful life or the lease term, unless the Trust expects to acquire the asset at the end of the lease term in which case the assets are depreciated in the same manner as owned assets above.

Note 1.8 Intangible assets

Note 1.8.1 Recognition

Intangible assets are non-monetary assets without physical substance which are capable of being sold separately from the rest of the Trust's business or which arise from contractual or other legal rights. They are recognised only where it is probable that future economic benefits will flow to, or service potential be provided to, the Trust and where the cost of the asset can be measured reliably.

Internally generated intangible assets

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

Expenditure on research is not capitalised. Expenditure on development is capitalised when it meets the requirements set out in IAS 38.

Software

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

Note 1.8.2 Measurement
Intangible assets are recognised initially at cost, comprising all directly attributable costs needed to create, produce and prepare the asset to the point that it is capable of operating in the manner intended by management.

Subsequently intangible assets are measured at current value in existing use. Where no active market exists, intangible assets are valued at the lower of depreciated replacement cost and the value in use where the asset is income generating. Revaluations gains and losses and impairments are treated in the same manner as for property, plant and equipment. An intangible asset which is surplus with no plan to bring it back into use is valued at fair value where there are no restrictions on sale at the reporting date and where they do not meet the definitions of investment properties or assets held for sale.

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

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

Note 1.8.3 Useful economic life of intangible assets

Useful lives reflect the total life of an asset and not the remaining life of an asset. The range of useful lives are shown in the table below:

	Min life Years	**Max life Years**
All intangible assets	1	7

Note 1.9 Inventories

Some inventories are valued at the lower of cost and net realisable value, using the first-in first-out cost formula, and some are valued at Weighted Average Cost.

In 2020/21, the Trust received inventories including personal protective equipment from the Department of Health and Social Care at nil cost. In line with the GAM and applying the principles of the IFRS Conceptual Framework, the Trust has accounted for the receipt of these inventories at a deemed cost, reflecting the best available approximation of an imputed market value for the transaction based on the cost of acquisition by the Department.

Note 1.10 Cash and cash equivalents

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in 3 months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value.

In the Statement of Cash Flows, cash and cash equivalents are shown net of bank overdrafts that are repayable on demand and that form an integral part of the Trust’s cash management. Cash, bank and overdraft balances are recorded at current values.

Note 1.11 Financial assets and financial liabilities

Note 1.11.1 Recognition

Financial assets and financial liabilities arise where the Trust is party to the contractual provisions of a financial instrument, and as a result has a legal right to receive or a legal obligation to pay cash or another financial instrument. The GAM expands the definition of a contract to include legislation and regulations which give rise to arrangements that in all other respects would be a financial instrument and do not give rise to transactions classified as a tax by ONS.

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

Note 1.11.2 Classification and measurement

Financial assets and financial liabilities are initially measured at fair value plus or minus directly attributable transaction costs except where the asset or liability is not measured at fair value through income and expenditure. Fair value is taken as the transaction price, or otherwise determined by reference to quoted market prices or valuation techniques.

Financial assets/liabilities are classified into the following categories: financial assets/liabilities at amortised cost, financial assets/liabilities at fair value through other comprehensive income, and financial assets/liabilities at fair value through profit and loss. The classification is determined by the cash flow and business model characteristics of the financial assets/liabilities, as set out in IFRS 9, and is determined at the time of initial recognition.

Financial assets and financial liabilities at amortised cost

Financial assets/liabilities measured at amortised cost are those held within a business model whose objective is to hold financial assets/liabilities in order to collect contractual cash flows and where the cash flows are solely payments of principal and interest. This includes most trade receivables, loans receivable, and other simple debt instruments.

After initial recognition, these financial assets and financial liabilities are measured at amortised cost using the effective interest method less any impairment (for financial assets). The effective interest rate is the rate that exactly discounts estimated future cash payments or receipts through the expected life of the financial asset or financial liability to the gross carrying amount of a financial asset or to the amortised cost of a financial liability.

Financial assets/liabilities measured at fair value through other comprehensive income

met by both collecting contractual cash flows and selling financial assets and where the cash flows are solely payments of principal and interest. Movements in the fair value of financial assets in this category are recognised as gains or losses in other comprehensive income except for impairment losses. On derecognition, cumulative gains and losses previously recognised in other comprehensive income are reclassified from equity to income and expenditure, except where the Trust elected to measure an equity instrument in this category on initial recognition. [Describe any financial

The Trust does not currently have any such financial assets/liabilities.

Financial assets and financial liabilities at fair value trough income and expenditure

Financial assets/liabilities measured at fair value through profit or loss are those that are not otherwise measured at amortised cost or fair value through other comprehensive income. This includes derivatives and financial assets/liabilities acquired principally for the purpose of selling in the short term.

The Trust does not currently have any such financial assets/liabilities.

Note 1.11.2 Classification and measurement (cont.)

Impairment of financial assets

For all financial assets measured at amortised cost or at fair value through other comprehensive income (except equity instruments designated at fair value through other comprehensive income), lease receivables and contract assets, the Trust recognises a loss allowance representing expected credit losses on the financial instrument.

The Trust adopts the simplified approach to impairment, in accordance with IFRS 9, and measures the loss allowance for trade receivables, contract assets and lease receivables at an amount equal to lifetime expected credit losses. For other financial assets, the loss allowance is measured at an amount equal to lifetime expected credit losses if the credit risk on the financial instrument has increased significantly since initial recognition (stage 2), and otherwise at an amount equal to 12-month expected credit losses (stage 1).

HM Treasury has ruled that central government bodies may not recognise stage 1 or stage 2 impairments against other government departments, their executive agencies, the Bank of England, Exchequer Funds, and Exchequer Funds' assets where repayment is ensured by primary legislation. The Trust therefore does not recognise loss allowances for stage 1 or stage 2 impairments against these bodies. Additionally, the Department of Health and Social Care provides a guarantee of last resort against the debts of its arm's length bodies and NHS bodies (excluding NHS charities), and the Trust does not recognise loss allowances for stage 1 or stage 2 impairments against these bodies.

For financial assets that have become credit impaired since initial recognition (stage 3), expected losses are charged to operating expenditure within the Statement of Comprehensive Income and reduce the net carrying value of the financial asset in the Statement of Financial Position.

Note 1.11.3 Derecognition

Financial assets are de-recognised when the contractual rights to receive cash flows from the assets have expired or the Trust has transferred substantially all the risks and rewards of ownership.

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

Note 1.11.4 Other financial liabilities

After initial recognition, all other financial liabilities are measured at amortised cost using the effective interest method. The effective interest rate is the rate that exactly discounts estimated future cash payments through the life of the asset, to the amortised cost of the financial liability. In the case of DHSC loans that would be the nominal rate charged on the loan.

Note 1.12 Leases

Leases are classified as finance leases when substantially all the risks and rewards of ownership are transferred to the lessee. All other leases are classified as operating leases.

Note 1.12.1 The Trust as lessee

Finance leases

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

The asset and liability are recognised at the commencement of the lease. Thereafter the asset is accounted for an item of property plant and equipment.

The annual rental charge is split between the repayment of the liability and a finance cost so as to achieve a constant rate of finance over the life of the lease. The annual finance cost is charged to Finance Costs in the Statement of Comprehensive Income. The lease liability, is de-recognised when the liability is discharged, cancelled or expires.

Operating leases

Operating lease payments are recognised as an expense on a straight-line basis over the lease term. Lease incentives are recognised initially in other liabilities on the statement of financial position and subsequently as a reduction of rentals on a straight-line basis over the lease term.

Contingent rentals are recognised as an expense in the period in which they are incurred.

Leases of land and buildings

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

Note 1.12.2 The Trust as lessor

Finance leases

Amounts due from lessees under finance leases are recorded as receivables at the amount of the Trust's net investment in the leases. Finance lease income is allocated to accounting periods to reflect a constant periodic rate of return on the Trust's net investment outstanding in respect of the leases.

Operating leases

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

Note 1.13 Provisions

Provisions are recognised when the Trust has a present legal or constructive obligation as a result of uncertain timing or amount; for which it is probable that there will be a future outflow of cash or other resources; and a reliable estimate can be made of the amount.. The amount recognised as a provision is the best estimate of the expenditure required to settle the obligation at the end of the reporting period, taking into account the risks and uncertainties. Where a provision is measured using the cash flows estimated to settle the obligation, its carrying amount is the present value of those cash flows using HM Treasury's discount rates.

Early retirement provisions and injury benefit provisions both use the HM Treasury's pension discount rate of minus 0.95% in real terms.

Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using HM Treasury's discount rates effective for 31 March 2021:

		Nominal rate
Short-term	Up to 5 years	Minus 0.02%
Medium-term	After 5 years up to 10 years	0.18%
Long-term	Exceeding 10 years	1.99%

HM Treasury provides discount rates for general provisions on a nominal rate basis. Expected future cash flows are therefore adjusted for the impact of inflation before discounting using nominal rates. The following inflation rates are set by HM Treasury, effective 31 March 2020:

	Inflation rate
Year 1	1.20%
Year 2	1.60%
Into perpetuity	2.00%

Clinical negligence costs
NHS Resolution operates a risk pooling scheme under which the Trust pays an annual contribution to NHS Resolution, which, in return, settles all clinical negligence claims. Although NHS Resolution is administratively responsible for all clinical negligence cases, the legal liability remains with the Trust. The total value of clinical negligence provisions carried by NHS Resolution on behalf of the Trust is disclosed at note 34.2 but is not recognised.

Non-clinical risk pooling
The Trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the Trust pays an annual contribution to NHS Resolution and in return receives assistance with the costs of claims arising. The annual membership contributions, and any "excesses" payable in respect of particular claims are charged to operating expenses when the liability arises.

Note 1.14 Contingencies

Contingent assets (that is, assets arising from past events whose existence will only be confirmed by one or more future events not wholly within the entity's control) are not recognised as assets, but are disclosed in note 35 where an inflow of economic benefits is probable.

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

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

Note 1.15 Public dividend capital (PDC) and PDC Dividend

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

The Secretary of State can issue new PDC to, and require repayments of PDC from, the Trust. PDC is recorded at the value received.

A charge, reflecting the cost of capital utilised by the Trust, is payable as public dividend capital dividend. The charge is calculated at the rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the Trust during the financial year. Relevant net assets are calculated as the value of all assets less the value of all liabilities, with certain additions and deductions as defined in the PDC dividend policy issued by the Department of Health and Social Care. This policy is available at https://www.gov.uk/government/publications/guidance-on-financing-available-to-nhs-trusts-and-foundation-trusts .

In accordance with the requirements laid down by the Department of Health and Social Care (as the issuer of PDC), the dividend for the year is calculated on the actual average relevant net assets as set out in the “pre-audit” version of the annual accounts. The dividend calculated is not revised should any adjustment to net assets occur as a result the audit of the annual accounts.

Note 1.16 Value added tax

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

Note 1.17 Foreign exchange

The Trust's functional currency and presentational currency is pounds sterling, and figures are presented in thousands of pounds unless expressly stated otherwise. Transactions denominated in a foreign currency are translated into sterling at the spot exchange rate on the date of the transaction.

At the end of the reporting period, monetary items denominated in foreign currencies are retranslated at the spot exchange rate on 31 March.

Exchange gains and losses on monetary items (arising on settlement of the transaction or on retranslation at the Statement of Financial Position date) are recognised in the Statement of Comprehensive Income in the period in which they arise.

The Trust performs all its transactions in Sterling.

Note 1.18 Corporation tax

As the Trust operated a Wholly Owned Subsidiary in 2020/21, this entity is liable to Corporation Tax regulations. At present, the subsidiary does not have significant assets, and as such, deferred tax is not applicable. As such, the subsidiary is liable to Corporation Tax in line with existing rates.

Note 1.19 Third party assets

Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the Trust has no beneficial interest in them. The Trust has no such assets.

Note 1.20 Losses and special payments

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled.

Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis, including losses which would have been made good through insurance cover had the Trust not been bearing its own risks.

Note 1.21 Gifts

Gifts are items that are voluntarily donated, with no preconditions and without the expectation of any return. Gifts include all transactions economically equivalent to free and unremunerated transfers, such as the loan of an asset for its expected useful life, and the sale or lease of assets at below market value. Details an be found in Note 41.

Note 1.22 Critical judgements in applying accounting policies

In the application of the Trust's accounting policies, management is required to make various judgements, estimates and assumptions. These are regularly reviewed.

Income estimates

In measuring income for the year, management have taken account of all available information. Income estimates that have been made have been based on actual information related to the financial year.

Injury compensation scheme income is also included to the extent that it is estimated it will be received in future years. It is recorded in the current year as this is the year in which it was earned. However as cash is not received until future periods, when the claims have been settled, an estimation must be made as to the collectability.

Expense accruals

In estimating expenses that have not yet been charged for, management have made a realistic assessment based on costs actually incurred in the year to date, with a view to ensuring that no material items have been omitted. This is done utilising data extracted from the Trust's accounts payable system, allied with professional judgement of the Trust's expenditure profile. The Trust is also required to account for the cost of annual leave carried forward, which is based on a statistically sound sample of staff.

Impairment of trade receivables

In accordance with the stated policy on impairment of financial assets, management have assessed the impairment of receivables based on professional judgement and the type of debts typically held by the Trust.

Provisions

In accordance with the stated policy on provisions, management have used best estimates of the expenditure required to settle the obligations concerned, applying HM Treasury's discount rate as stated in the case of provisions for injury benefit claims and early retirements. The level of this provision is also based on information provided by the Government Actuaries Department. Other provisions that may arise are employee related claims and legal claims, which are based on information received from the Trust's insurers and internally generated information.

Valuation of property, plant and equipment

Specialised property has been valued at depreciated replacement cost on a modern equivalent asset basis in line with Royal Institute of Chartered Surveyors standards. Land has been valued having regard to the cost of purchasing notional replacement sites in the same locality as the existing sites. The application of valuation methodologies and external indices are covered in the accounting policies at note 1.7.

Asset lives applied to property, plant and equipment are provided by the Trust's externally appointed and professionally qualified valuers.

Note 1.22.1 Sources of estimation uncertainty

There are no key assumptions concerning the future, or other key sources of estimation uncertainty at the end of the reporting period, that have a significant risk of causing a material adjustment to the carrying amounts of assets and liabilities within the next financial year.

The main area of estimation uncertainty within the Trust is the carrying value of the property portfolio and the assumptions used in the determination of fair value at the Statement of Financial Position date. However, the Trust commissioned a property revaluation exercise as at 31 December 2020, which significantly reduces the risk of material misstatement.

Note 1.23 Early adoption of standards, amendments and interpretations

No new accounting standards or revisions to existing standards have been early adopted in 2020/21.

Note 1.24 Standards, amendments and interpretations in issue but not yet effective or adopted

The DHSC GAM does not require the following IFRS Standards and Interpretations to be applied in 2020-21. These Standards are still subject to HM Treasury FReM adoption, with IFRS 16 being for implementation in 2022-23, and the government implementation date for IFRS 17 still subject to HM Treasury consideration.

IFRS 16 Leases

IFRS 16 Leases will replace IAS 17 Leases, IFRIC 4 Determining whether an arrangement contains a lease and other interpretations and is applicable in the public sector for periods beginning 1 April 2021. The standard provides a single accounting model for lessees, recognising a right of use asset and obligation in the statement of financial position for most leases: some leases are exempt through application of practical expedients explained below. For those recognised in the statement of financial position the standard also requires the remeasurement of lease liabilities in specific circumstances after the commencement of the lease term. For lessors, the distinction between operating and finance leases will remain and the accounting will be largely unchanged

IFRS 16 changes the definition of a lease compared to IAS 17 and IFRIC 4. The trust will apply this definition to new leases only and will grandfather its assessments made under the old standards of whether existing contracts contain a lease.

On transition to IFRS 16 on 1 April 2022, the trust will apply the standard retrospectively with the cumulative effect of initially applying the standard recognised in the income and expenditure reserve at that date. For existing operating leases with a remaining lease term of more than 12 months and an underlying asset value of at least £5,000, a lease liability will be recognised equal to the value of remaining lease payments discounted on transition at the trust's incremental borrowing rate. The trust's incremental borrowing rate will be a rate defined by HM Treasury. Currently this rate is 0.91% but this may change between now and adoption of the standard. The related right of use asset will be measured equal to the lease liability adjusted for any prepaid or accrued lease payments. No adjustments will be made on 1 April 2022 for existing finance leases.

For leases commencing in 2022/23, the trust will not recognise a right of use asset or lease liability for short term leases (less than or equal to 12 months) or for leases of low value assets (less than £5,000). Right of use assets will be subsequently measured on a basis consistent with owned assets and depreciated over the length of the lease term.

IFRS 14 Regulatory Deferral Accounts

Applies to first time adopters of IFRS after 1 January 2016. Therefore, not applicable to DHSC group bodies.

IFRS 17 Insurance Contracts

Application required for accounting periods beginning on or after 1 January 2021. Standard is not yet adopted by the FReM which is expected to be from April 2023: early adoption is not permitted.

Note 1.25 Impact of Covid-19

Whilst Covid-19 has had a significant impact on the operational performance of the Trust, there have been significant impacts on the financial performance as well. The Trust has received block income from Commissioners in year, which has improved cash flow certainty, and the Trust has received equipment, both capital and revenue, donated by the Department of Health and Social Care. Also, due to operational pressures, staff have carried forward more annual leave days at 31st March 2021, meaning that the Trust has had an increase in its annual leave accrual.

	2020/21
Income	18,258
Non Pay	(17,182)
Pay	(14,339)
	(13,263)
Capital assets donated by DHSC	2,020
Donated income as a result of donated capital assets, not included above and not included in adjusted performance	2,020

Note 2 Operating Segments

The Trust Board, as the chief operating decision maker as defined by IFRS 8, consider that all of the Trust's activities fall under the single segment of 'Provision of Healthcare'. They consider that this is consistent with the core principle of IFRS 8 which is to enable users of the financial statements to evaluate the nature and financial effects of business activities and economic environments. No further segmental analysis is therefore required.

Note 3 Operating income from patient care activities (Group)

All income from patient care activities relates to contract income recognised in line with accounting policy 1.4.1

Note 3.1 Income from patient care activities (by nature)	**2020/21 £000**	**2019/20 £000 restated**
Acute services		
Block contract / system envelope income	363,363	341,705
High cost drugs income from commissioners (excluding pass-through costs)	19,461	20,785
Other NHS clinical income	258	55
Community services		
Income from other sources (e.g. local authorities)	3,578	3,483
All services		
Private patient income	740	2,393
Additional pension contribution central funding	11,133	10,431
Other clinical income	6,068	251
Total income from activities	**404,601**	**379,103**

As part of the coronavirus pandemic response, transaction flows were simplified in the NHS with providers and their commissioners moving onto block contract arrangements at the start of 2020/21. In the second half of the year, a revised financial framework built on these arrangements but with a greater focus on system partnership with providers deriving most of their income from system envelopes. Comparatives in the note are presented to be comparable with the current year activity. This does not reflect the contracting and payment mechanisms in place during the prior year.

Note 3.2 Income from patient care activities (by source)

Income from patient care activities received from:	**2020/21 £000**	**2019/20 £000**
NHS England	44,419	40,655
Clinical commissioning groups	354,681	329,573
NHS Foundation Trusts	6	1
Department of Health and Social Care	-	-
NHS other	-	41
Local authorities	3,578	3,483
Non-NHS: private patients	183	2,393
Non-NHS: overseas patients (chargeable to patient)	557	559
Injury cost recovery scheme	1,046	1,778
Non NHS: other	131	620
Total income from activities	**404,601**	**379,103**
Of which:		
Related to continuing operations	404,601	379,103
Related to discontinued operations	-	-

Note 3.2 Income from patient care activities (by source) cont,

Income by Clinical Commissioning Group	2020/21	2019/20
South Yorkshire and Bassetlaw Integrated Care System (ICS)	**£000**	**£000**
Doncaster CCG	240,599	219,045
Bassetlaw CCG	77,271	74,775
Rotherham CCG	10,108	9,965
Barnsley CCG	5,470	5,114
Sheffield CCG	1,237	1,934
Non South Yorkshire and Bassetlaw ICS CCGs	19,996	18,740
	354,681	**329,573**

Note 3.3 Overseas visitors (relating to patients charged directly by the provider)

	2020/21	2019/20
	£000	**£000**
Income recognised this year	557	559
Cash payments received in-year	72	82
Amounts added to provision for impairment of receivables	448	315
Amounts written off in-year	191	141

Note 4 Other operating income (Group)

	2020/21	2019/20
	£000	**£000**
Other operating income from contracts with customers:		
Research and development (contract)	632	661
Education and training (including notional apprenticeship levy income)	14,214	11,901
Non-patient care services to other bodies	23,062	23,218
Provider sustainability / sustainability and transformation fund income (PSF / STF)	-	16,466
Reimbursement and top-up income	12,292	-
Other contract income	404	2,008
Other non-contract operating income:		
Rental revenue from operating leases	232	694
Donations/grants of physical assets (non-cash) - received from other bodies	20	-
Donated equipment from DHSC for COVID response (non-cash)	2,018	-
Contributions to expenditure - receipt of equipment donated from DHSC for COVID response below capitalisation threshold	104	-
Contributions to expenditure - consumables (inventory) donated from DHSC group bodies for COVID response	4,448	-
Charitable fund incoming resources	476	471
Total other operating income	**57,902**	**55,419**
Of which:		
Related to continuing operations	57,902	55,419
Related to discontinued operations	-	-

Non-patient care services to other bodies includes activities such as Lead Unit staff recharges to other NHS organisations.

Note 5.1 Additional information on contract revenue (IFRS 15) recognised in the period

	2020/21	2019/20
	£000	£000
Revenue recognised in the reporting period that was included in within contract liabilities at the previous period end	-	2,178
Revenue recognised from performance obligations satisfied (or partially satisfied) in previous periods	-	-

Note 5.2 Transaction price allocated to remaining performance obligations

	31 March 2021	31 March 2020
	£000	£000
Revenue from existing contracts allocated to remaining performance obligations is expected to be recognised:	**-**	**-**

The Trust has exercised the practical expedients permitted by IFRS 15 paragraph 121 in preparing this disclosure. Revenue from (i) contracts with an expected duration of one year or less and (ii) contracts where the Trust recognises revenue directly corresponding to work done to date is not disclosed.

As a result of the changing financial framework during 2020/21, the Trust does not have any Partially Completed spells revenue within Receivables, nor Maternity Pathway revenue within Liabilities as at 31st March 2021. As at 31st March 2021, the Trust does not have contract liabilities or remaining performance obligations.

Note 5.3 Income from activities arising from commissioner requested services

Under the terms of its provider licence, the Trust is required to analyse the level of income from activities that has arisen from commissioner requested and non-commissioner requested services. Commissioner requested services are defined in the provider licence and are services that commissioners believe would need to be protected in the event of provider failure. This information is provided in the table below:

	2020/21	2019/20
	£000	£000
Income from services designated as commissioner requested services	404,601	379,103
Income from services not designated as commissioner requested services	57,902	55,419
Total	**462,503**	**434,522**

For the Trust, commissioner requested services are all patient care activities.

Note 5.4 Profits and losses on disposal of property, plant and equipment

The Trust has not disposed of any land or buildings relating to services designated as commissioner requested services. Equipment that has been disposed of, has been disposed during the normal course of business.

Note 6 Fees and charges (Group)

The Group does not have any material fees or charges in either 2020/21 or 2019/20.

Note 7.1 Operating expenses (Group)

	2020/21	2019/20
	£000	£000
Purchase of healthcare from NHS and DHSC bodies	5,459	5,378
Purchase of healthcare from non-NHS and non-DHSC bodies	5,867	10,407
Staff and executive directors costs	306,109	286,551
Remuneration of non-executive directors	135	118
Supplies and services - clinical (excluding drugs costs)	27,986	31,895
Supplies and services – clinical: utilisation of consumables donated from DHSC group bodies for COVID response	4,448	-
Supplies and services - general	7,686	6,073
Supplies and services - general: notional cost of equipment donated from DHSC for COVID response below capitalisation threshold	104	-
Drug costs (drugs inventory consumed and purchase of non-inventory drugs)	33,724	37,796
Consultancy costs	567	614
Establishment	2,555	2,520
Premises	18,901	16,032
Transport (including patient travel)	1,137	1,516
Depreciation on property, plant and equipment	8,848	7,648
Amortisation on intangible assets	980	842
Net impairments	4,902	135
Movement in credit loss allowance: contract receivables / contract assets	1,911	779
Increase/(decrease) in other provisions	363	(97)
Change in provisions discount rate(s)	(60)	101
Audit fees payable to the external auditor		
audit services- statutory audit	98	98
other auditor remuneration (external auditor only)	11	11
Internal audit costs	100	92
Clinical negligence	15,448	14,672
Legal fees	212	357
Insurance	282	282
Research and development	391	356
Education and training	5,777	3,333
Rentals under operating leases	1,428	1,169
Car parking & security	849	720
Losses, ex gratia & special payments	5	3
Other NHS charitable fund resources expended	1,022	867
Total	**457,245**	**430,268**
Of which:		
Related to continuing operations	457,245	430,268
Related to discontinued operations	-	-

Note 7.2 Other auditor remuneration (Group)

	2020/21	2019/20
	£000	£000
Other auditor remuneration paid to the external auditor:		
1. Audit of accounts of any associate of the Trust	11	11
2. Audit-related assurance services	-	-
3. Taxation compliance services	-	-
4. All taxation advisory services not falling within item 3 above	-	-
5. Internal audit services	-	-
6. All assurance services not falling within items 1 to 5	-	-
7. Corporate finance transaction services not falling within items 1 to 6 above	-	-
8. Other non-audit services not falling within items 2 to 7 above	-	-
Total	**11**	**11**

Note 7.3 Limitation on auditor's liability (Group)

The limitation on auditor's liability for external audit work is £2,000k (2019/20: £2,000k).

Note 8 Impairment of assets (Group)

	2020/21	2019/20
	£000	£000
Net impairments charged to operating surplus / deficit resulting from:		
Changes in market price	4,902	135
Total net impairments charged to operating surplus / deficit	**4,902**	**135**
Impairments (and reversals) of property, plant and equipment charged to the revaluation reserve	(2,409)	3,116
Total net impairments	**2,493**	**3,251**

The impairment in 2019/20 arose due to a revaluation exercise on certain buildings under the modern equivalent asset basis.

Note 9 Employee benefits (Group)

	2020/21	2019/20
	Total	Total
	£000	£000
Salaries and wages	232,301	211,246
Social security costs	21,833	21,252
Apprenticeship levy	1,074	1,030
Employer's contributions to NHS pensions	25,390	23,866
Pension cost - employer contributions paid by NHSE on provider's behalf (6.3%)	11,133	10,431
Pension cost - other	116	117
Temporary staff (including agency)	18,641	21,375
Total gross staff costs	**310,488**	**289,317**
Recoveries in respect of seconded staff	-	-
Total staff costs	**310,488**	**289,317**
Of which		
Costs capitalised as part of assets	546	354
Disclosed within:		
Staff and executive directors costs	306,109	286,551
Research and development	391	356
Education and training	3,442	2,056
	309,942	**288,963**

Note 9.1 Retirements due to ill-health (Group)

During 2020/21 there were 6 early retirements from the Trust agreed on the grounds of ill-health (3 in the year ended 31 March 2020). The estimated additional pension liabilities of these ill-health retirements is £272k (£156k in 2019/20). The cost of these ill-health retirements will be borne by the NHS Business Services Authority - Pensions Division.

There are no director long term incentive schemes, other pension benefits, guarantees or advances.

Note 10 Pension costs

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Details of the benefits payable and rules of the Schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State for Health and Social Care in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that “the period between formal valuations shall be four years, with approximate assessments in intervening years”. An outline of these follows:

a) Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary’s Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2021, is based on valuation data as 31 March 2020, updated to 31 March 2021 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the report of the scheme actuary, which forms part of the annual NHS Pension Scheme Accounts. These accounts can be viewed on the NHS Pensions website and are published annually. Copies can also be obtained from The Stationery Office.

b) Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the schemes (taking into account recent demographic experience), and to recommend contribution rates payable by employees and employers.

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2016. The results of this valuation set the employer contribution rate payable from April 2019 to 20.6% of pensionable pay. The 2016 funding valuation was also expected to test the cost of the Scheme relative to the employer cost cap that was set following the 2012 valuation. In January 2019, the Government announced a pause to the cost control element of the 2016 valuations, due to the uncertainty around member benefits caused by the discrimination ruling relating to the McCloud case.

The Government subsequently announced in July 2020 that the pause had been lifted, and so the cost control element of the 2016 valuations could be completed. The Government has set out that the costs of remedy of the discrimination will be included in this process. HMT valuation directions will set out the technical detail of how the costs of remedy will be included in the valuation process. The Government has also confirmed that the Government Actuary is reviewing the cost control mechanism (as was originally announced in 2018). The review will assess whether the cost control mechanism is working in line with original government objectives and reported to Government in April 2021. The findings of this review will not impact the 2016 valuations, with the aim for any changes to the cost cap mechanism to be made in time for the completion of the 2020 actuarial valuations.

c) Alternative pension schemes

As a result of "automatic enrolment", the Trust has taken steps to ensure those members of staff who are not eligible for the NHS Pension Scheme, are enrolled into a pension scheme. The Trust treats such pension arrangements as a defined contribution pension and as such, no actuarial assumptions are required to measure the obligation or the expense and there is not possibility of any actuarial gain or loss.

Note 11 Operating leases (Group)

Note 11.1 Doncaster & Bassetlaw Teaching Hospitals NHS Foundation Trust as a lessor

This note discloses income generated in operating lease agreements where Doncaster & Bassetlaw Teaching Hospitals NHS Foundation Trust is the lessor.

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

	2020/21	2019/20
	£000	£000
Operating lease revenue		
Minimum lease receipts	232	694
Contingent rent	-	-
Other	-	-
Total	**232**	**694**

	31 March 2021	31 March 2020
	£000	£000
Future minimum lease receipts due:		
- not later than one year;	232	312
- later than one year and not later than five years;	-	886
- later than five years.	-	-
Total	**232**	**1,198**

Note 11.2 Doncaster & Bassetlaw Teaching Hospitals NHS Foundation Trust as a lessee

This note discloses costs and commitments incurred in operating lease arrangements where Doncaster & Bassetlaw Teaching Hospitals NHS Foundation Trust is the lessee.

	2020/21	2019/20
	£000	£000
Operating lease expense		
Minimum lease payments	1,428	1,169
Total	**1,428**	**1,169**

	31 March 2021	31 March 2020
	£000	£000
Future minimum lease payments due:		
- not later than one year;	601	1,151
- later than one year and not later than five years;	137	240
- later than five years.	-	-
Total	**738**	**1,391**
Future minimum sublease payments to be received	-	-

Note 12 Finance income (Group)

Finance income represents interest received on assets and investments in the period.

	2020/21	2019/20
	£000	£000
Interest on bank accounts	11	272
NHS charitable fund investment income	267	278
Total finance income	**278**	**550**

Note 13.1 Finance expenditure (Group)

Finance expenditure represents interest and other charges involved in the borrowing of money.

	2020/21	2019/20
	£000	£000
Interest expense:		
Loans from the Department of Health and Social Care	347	1,501
Total interest expense	**347**	**1,501**
Unwinding of discount on provisions	(11)	6
Total finance costs	**336**	**1,507**

Note 13.2 The late payment of commercial debts (interest) Act 1998 / Public Contract Regulations 2015 (Group)

	2020/21	2019/20
	£000	£000
Total liability accruing in year under this legislation as a result of late payments	-	-
Amounts included within interest payable arising from claims made under this legislation	-	-
	-	**-**

Note 14 Other gains / (losses) (Group)

	2020/21	2019/20
	£000	£000
Gains on disposal of assets	111	-
Losses on disposal of assets	-	-
Gains / (losses) on disposal of charitable fund assets	-	-
Gains / (losses) on charitable fund investment revaluations	1,327	(600)
Total gains / (losses) on disposal of assets	**1,438**	**(600)**
Total other gains / (losses)	**1,438**	**(600)**

Note 15 Trust income statement and statement of comprehensive income

In accordance with Section 408 of the Companies Act 2006, the Trust is exempt from the requirement to present its own income statement and statement of comprehensive income. The Trust's surplus/(deficit) for the period was £697k (2019/20: £1,008k). The Trust's total comprehensive income/(expense) for the period was £3,194k (2019/20: (£1,767k)).

Note 16 Discontinued operations (Group)

The Trust does not have any operations that are classified as discontinued in the year ended 31st March 2021.

Note 17.1 Intangible assets - 2020/21

Group and Trust	Software licences	Other (purchased)	Total
	£000	£000	£000
Valuation / gross cost at 1 April 2020 - brought forward	**15,092**	**27**	**15,119**
Additions	3,956	-	**3,956**
Valuation / gross cost at 31 March 2021	**19,048**	**27**	**19,075**
Amortisation at 1 April 2020 - brought forward	**8,725**	**-**	**8,725**
Provided during the year	980	-	**980**
Amortisation at 31 March 2021	**9,705**	**-**	**9,705**
Net book value at 31 March 2021	**9,343**	**27**	**9,370**
Net book value at 1 April 2020	**6,367**	**27**	**6,394**

Note 17.2 Intangible assets - 2019/20

Group and Trust	Software licences	Other (purchased)	Total
	£000	£000	£000
Valuation / gross cost at 1 April 2019	**14,795**	**27**	**14,822**
Additions	297	-	**297**
Valuation / gross cost at 31 March 2020	**15,092**	**27**	**15,119**
Amortisation at 1 April 2019	**7,883**	**-**	**7,883**
Provided during the year	842	-	**842**
Amortisation at 31 March 2020	**8,725**	**-**	**8,725**
Net book value at 31 March 2020	**6,367**	**27**	**6,394**
Net book value at 1 April 2019	**6,912**	**27**	**6,939**

Note 18.1 Property, plant and equipment - 2020/21

Group and Trust	Land	Buildings excluding dwellings	Dwellings	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Valuation/gross cost at 1 April 2020 - brought forward	**8,510**	**182,240**	**3,448**	**58,919**	**440**	**26,828**	**6,598**	**286,983**
Additions	-	19,934	383	8,054	-	2,021	133	**30,525**
Additions - donations of physical assets (non-cash)	-	-	-	20	-	-	-	**20**
Additions - equipment donated from DHSC for COVID response (non-cash)	-	-	-	2,018	-	-	-	**2,018**
Impact of revaluations/impairments	-	(12,094)	(493)	-	-	-	-	**(12,587)**
Reclassifications	-	159	(159)	-	-	-	-	**-**
Valuation/gross cost at 31 March 2021	**8,510**	**190,239**	**3,179**	**69,011**	**440**	**28,849**	**6,731**	**306,959**
Accumulated depreciation at 1 April 2020 - brought forward	**-**	**5,873**	**384**	**46,403**	**332**	**23,929**	**5,913**	**82,834**
Provided during the year	-	5,291	107	2,485	-	754	211	**8,848**
Impact of revaluations/impairments	-	(9,719)	(463)	-	-	-	-	**(10,182)**
Accumulated depreciation at 31 March 2021	**-**	**1,445**	**28**	**48,888**	**332**	**24,683**	**6,124**	**81,500**
Net book value at 31 March 2021	**8,510**	**188,794**	**3,151**	**20,123**	**108**	**4,166**	**607**	**225,459**
Net book value at 1 April 2020	**8,510**	**176,367**	**3,064**	**12,516**	**108**	**2,899**	**685**	**204,149**

Note 18.2 Property, plant and equipment - 2019/20

Group and Trust	Land	Buildings excluding dwellings	Dwellings	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Valuation / gross cost at 1 April 2019	**8,170**	**174,031**	**3,240**	**55,201**	**415**	**24,676**	**6,507**	**272,240**
Additions	-	11,668	-	3,718	25	2,152	91	**17,654**
Impairments charged to operating expenses	-	(135)	-	-	-	-	-	**(135)**
Impairments charged to revaluation reserve	-	(3,227)	-	-	-	-	-	**(3,227)**
Reversal of impairments credited to the revaluation reserve	-	(97)	208	-	-	-	-	**111**
Revaluations	340	-	-	-	-	-	-	**340**
Valuation/gross cost at 31 March 2020	**8,510**	**182,240**	**3,448**	**58,919**	**440**	**26,828**	**6,598**	**286,983**
Accumulated depreciation at 1 April 2019	**-**	**980**	**276**	**44,784**	**332**	**23,138**	**5,676**	**75,186**
Provided during the year	-	4,893	108	1,619	-	791	237	**7,648**
Accumulated depreciation at 31 March 2020	**-**	**5,873**	**384**	**46,403**	**332**	**23,929**	**5,913**	**82,834**
Net book value at 31 March 2020	**8,510**	**176,367**	**3,064**	**12,516**	**108**	**2,899**	**685**	**204,149**
Net book value at 1 April 2019	**8,170**	**173,051**	**2,964**	**10,417**	**83**	**1,538**	**831**	**197,054**

Note 18.3 Property, plant and equipment financing - 2020/21

Group and Trust	Land	Buildings excluding dwellings	Dwellings	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2021								
Owned - purchased	8,510	188,794	3,151	16,787	108	4,151	607	**222,108**
Owned - equipment donated from DHSC and NHS England for Covid response	-	-	-	1,834	-	-	-	**1,834**
Owned - donated/granted	-	-	-	1,502	-	15	-	**1,517**
NBV total at 31 March 2021	**8,510**	**188,794**	**3,151**	**20,123**	**108**	**4,166**	**607**	**225,459**

Note 18.4 Property, plant and equipment financing - 2019/20 - restated

Group and Trust	Land	Buildings excluding dwellings	Dwellings	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2020								
Owned - purchased	8,510	175,776	3,064	11,398	108	2,876	685	**202,417**
Owned - donated/granted	-	591	-	1,118	-	23	-	**1,732**
NBV total at 31 March 2020	**8,510**	**176,367**	**3,064**	**12,516**	**108**	**2,899**	**685**	**204,149**

Note 19 Donations of property, plant and equipment

Doncaster & Bassetlaw Teaching Hospitals Foundation Trust has received donated assets totalling £2,038k. £2,018k was from Department of Health and Social Care, and related to assets associated to the treatment of patients who had contracted Covid-19.

Note 20 Revaluations of property, plant and equipment

All land and buildings are revalued using professional valuations in accordance with IAS 16 to ensure that property is stated at fair value. The default frequency of these valuations is currently every five years, in accordance with the FT ARM. However, interim valuations are also carried out as deemed appropriate by the Trust. Valuations are performed by professionally qualified valuers in accordance with the Royal Institute of Chartered Surveyors (RICS) Appraisals and Valuation Manual. The Trust commissioned a full valuation of its land and buildings as at 31 March 2020, which was undertaken by Cushman & Wakefield.

In 2019/20 and 2020/21, the Trust undertook a revaluation based on a Modern Equivalent Asset basis on its land and buildings.

Note 21 Investment Property

The Foundation Trust does not hold any Land, Buildings or Dwellings on an Investment only basis.

Note 22 Other investments / financial assets (non-current)

	Group		Trust	
	2020/21	2019/20	2020/21	2019/20
	£000	£000	£000	£000
Carrying value at 1 April - brought forward	**7,303**	**8,388**	**550**	
Acquisitions in year	1,427	6,608	-	550
Movement in fair value through income and expenditure	1,327	(600)	-	-
Disposals	(1,316)	(7,093)	-	-
Carrying value at 31 March	**8,741**	**7,303**	**550**	**550**

The Group investments relate to investments made by Doncaster & Bassetlaw Teaching Hospitals Charitable Funds as part of a diverse investment portfolio. During 2019/20, the level of acquisitions and disposals was high as a result of a new investment manager being engaged.

Note 22.1 Other investments / financial assets (current)

The Foundation Trust does not hold either other investments or financial assets (current).

Note 23 Disclosure of interests in other entities

The Trust does not hold any interests in unconsolidated subsidiaries, joint ventures, associates or unconsolidated structured entities.

Note 24 Inventories

	Group		Trust	
	31 March 2021 £000	31 March 2020 £000	31 March 2021 £000	31 March 2020 £000
Drugs	2,758	3,049	2,237	2,247
Consumables	4,249	3,565	4,249	3,565
Energy	15	23	15	23
Total inventories	**7,022**	**6,637**	**6,501**	**5,835**

Inventories recognised in expenses for the year were £46,834k (2019/20: £52,123k). Write-down of inventories recognised as expenses for the year were £0k (2019/20: £0k).

Note 25.1 Receivables

	Group		Trust	
	31 March 2021	31 March 2020	31 March 2021	31 March 2020
	£000	£000	£000	£000
Current				
Contract receivables	11,584	20,965	13,528	23,325
Allowance for impaired contract receivables / assets	(1,945)	(1,620)	(1,945)	(1,620)
Prepayments (non-PFI)	2,945	2,054	2,945	2,054
PDC dividend receivable	4	4	4	4
VAT receivable	2,502	1,230	2,017	1,230
Other receivables	-	-	-	-
NHS charitable funds: trade and other receivables	-	2	-	-
Total current receivables	**15,090**	**22,635**	**16,549**	**24,993**
Non-current				
Contract receivables	3,042	3,349	3,042	3,349
Allowance for impaired contract receivables / assets	(1,531)	(730)	(1,531)	(730)
Total non-current receivables	**1,511**	**2,619**	**1,511**	**2,619**
Of which receivable from NHS and DHSC group bodies:				
Current	7,273	15,613	7,273	15,613
Non-current	-	-	-	-

The fall in overall receivables is as a result of the change in Financial Framework that the NHS has been working under during 2020/21. In 2020/21, income from Clinical Commissioning Groups has been received as part of a monthly block, which reduces the amount owed at period end. Also, at March 2020, the Trust was owed Quarter 4 Performance and Sustainability Funding, which was not part of the 2020/21 Financial Framework.

Note 25.2 Allowances for credit losses - 2020/21

	Group		Trust	
	Contract receivables and contract assets	All other receivables	Contract receivables and contract assets	All other receivables
	£000	£000	£000	£000
Allowances as at 1 Apr 2020 - brought forward	**2,350**	**-**	**2,350**	**-**
New allowances arising	1,911	-	1,911	-
Utilisation of allowances	(785)	-	(785)	-
Allowances as at 31 Mar 2021	**3,476**	**-**	**3,476**	**-**

	Group		Trust	
	Contract receivables and contract assets	All other receivables	Contract receivables and contract assets	All other receivables
	£000	£000	£000	£000
Allowances as at 1 Apr 2019 - brought forward	**1,842**	**-**	**1,842**	**-**
New allowances arising	779	-	779	-
Utilisation of allowances (write offs)	(271)	-	(271)	
Allowances as at 31 Mar 2020	**2,350**	**-**	**2,350**	**-**

Note 26 Other assets

The Trust does not have any receivables classified as other assets.

Note 27 Non-current assets held for sale and assets in disposal groups

	Group		Trust	
	2020/21	2019/20	2020/21	2019/20
	£000	£000	£000	£000
NBV of non-current assets for sale and assets in disposal groups at 1 April	**343**	**343**	**343**	**343**
Disposals made in year	(343)	-	(343)	-
NBV of non-current assets for sale and assets in disposal groups at 31 March	**-**	**343**	**-**	**343**

The Trust sold a building (Chequer Road) in 2020/21, which was designated as being Held for Sale at 31st March 2020.

Note 27.1 Liabilities in disposal groups

The Trust does not have any liabilities in disposal groups.

Note 28 Cash and cash equivalents movements

Cash and cash equivalents comprise cash at bank, in hand and cash equivalents. Cash equivalents are readily convertible investments of known value which are subject to an insignificant risk of change in value.

	Group		Trust	
	2020/21	2019/20	2020/21	2019/20
	£000	£000	£000	£000
At 1 April	**32,079**	**20,627**	**30,823**	**19,740**
Net change in year	20,006	11,452	20,124	11,083
At 31 March	**52,085**	**32,079**	**50,947**	**30,823**
Broken down into:				
Cash at commercial banks and in hand	444	1,442	34	541
Cash with the Government Banking Service	51,641	30,637	50,913	30,282
Total cash and cash equivalents as in SoFP and SOCF	**52,085**	**32,079**	**50,947**	**30,823**

Doncaster & Bassetlaw Teaching Hospitals NHS Foundation Trust held cash and cash equivalents which relate to monies held by the Trust on behalf of patients or other parties. This has been excluded from the cash and cash equivalents figure reported in the accounts.

Note 29 Trade and other payables

	Group		Trust	
	31 March 2021	31 March 2020	31 March 2021	31 March 2020
	£000	£000 (restated)	£000	£000 (restated)
Current				
Trade payables	9,255	6,463	10,092	5,928
Capital payables	10,373	10,374	10,373	10,374
Accruals	32,320	23,914	32,320	25,999
Annual leave accrual	5,119	1,156	5,119	1,156
Social security costs	5,809	5,237	5,809	5,237
Other taxes payable	33	-	-	-
Other payables	3,734	4,309	3,734	4,309
NHS charitable funds: trade and other payables	18	14	-	-
Total current trade and other payables	**66,661**	**51,467**	**67,447**	**53,003**
Of which payables from NHS and DHSC group bodies:				
Current	5,280	6,427	5,280	6,427
Non-current	-	-	-	-

The increase in annual leave accrual is as a result of staff being unable to take annual leave due to the pressures during the Covid-19 response.

Note 29.1 Early retirements in NHS payables above

The payables note above includes amounts in relation to early retirements as set out below:

	31 March 2021	31 March 2021	31 March 2020	31 March 2020
	£000	Number	£000	Number
- to buy out the liability for early retirements over 5 years	-		-	
- number of cases involved		-		-

Note 30 Other liabilities

	Group		Trust	
	31 March 2021	31 March 2020	31 March 2021	31 March 2020
	£000	£000	£000	£000
Current				
Deferred income: contract liabilities	1,383	2,503	1,383	2,503
Total other current liabilities	**1,383**	**2,503**	**1,383**	**2,503**
Deferred income: contract liabilities	-	-	-	-
Total other non-current liabilities	**-**	**-**	**-**	**-**

Note 31 Borrowings

	Group		Trust	
	31 March 2021	31 March 2020	31 March 2021	31 March 2020
	£000	£000	£000	£000
Current				
Loans from DHSC	2,112	73,295	2,112	73,295
Total current borrowings	**2,112**	**73,295**	**2,112**	**73,295**
Non-current				
Loans from DHSC	12,618	14,675	12,618	14,675
Total non-current borrowings	**12,618**	**14,675**	**12,618**	**14,675**

On 2 April 2020, the Department of Health and Social Care (DHSC) and NHS England and NHS Improvement announced reforms to the NHS cash regime for the 2020/21 financial year. During 2020/21, DHSC interim revenue and capital loans as at 31 March 2020 were extinguished and replaced with the issue of Public Dividend Capital (PDC) to allow the repayment. The affected loans totalling £71.1m were classified as current liabilities within the 2019/20 financial statements. The repayment of these loans were be funded through the issue of PDC.

Note 31.1 Reconciliation of liabilities arising from financing activities

Group and Trust	Loans from DHSC	Other loans	Finance leases	Total
	£000	£000	£000	£000
Carrying value at 1 April 2020	**87,970**	**-**	**-**	**87,970**
Cash movements:				
Financing cash flows - payments and receipts of principal	(73,025)	-	-	**(73,025)**
Financing cash flows - payments of interest	(562)	-	-	**(562)**
Non-cash movements:				**-**
Application of effective interest rate	347	-	-	**347**
Carrying value at 31 March 2021	**14,730**	**-**	**-**	**14,730**

Note 32 Other financial liabilities

Neither the Group or Trust has any other financial liabilities.

Note 33 Finance leases

Note 33.1 Doncaster & Bassetlaw Teaching Hospitals NHS Foundation Trust as a lessor

The Trust does not have any finance lease receivables as a lessor.

Note 33.2 Doncaster & Bassetlaw Teaching Hospitals NHS Foundation Trust as a lessee

The Trust does not have any finance lease receivables as a lessee. Certain items of equipment and machinery are leased via operating leases which are disclosed within note 11.

Note 34.1 Provisions for liabilities and charges analysis - Group and Trust

Group & Trust	Pensions: early departure costs	Pensions: injury benefits*	Legal claims	Redundancy	Other	Total
	£000	£000	£000	£000	£000	£000
At 1 April 2020	**1,171**	**1,086**	**222**	**106**	**-**	**2,585**
Change in the discount rate	(39)	(21)	-	-	-	**(60)**
Arising during the year	158	234	111	-	238	**741**
Utilised during the year	(83)	(104)	(82)	-	-	**(269)**
Reversed unused	-	-	(73)	(106)	-	**(179)**
Unwinding of discount	(6)	(5)	-	-	-	**(11)**
At 31 March 2021	**1,201**	**1,190**	**178**	**-**	**238**	**2,807**
Expected timing of cash flows:						
- not later than one year;	84	137	178	-	238	**637**
- later than one year and not later than five years;	343	559	-	-	-	**902**
- later than five years.	774	494	-	-	-	**1,268**
Total	**1,201**	**1,190**	**178**	**-**	**238**	**2,807**

The provision for legal claims is in respect of employer's liability and public liability cases made against the Trust. This figure is based on information provided by the NHS Resolution which at present represents the Trust's best assessment of the likely future costs associated with processing the claims. The eventual settlement costs and legal expenses may be higher or lower than that provided.

Pensions: early departure costs (2020/21: £1,200k, 2019/20: £1,171k) and Pensions: injury benefits (2020/21: £1,191k, 2019/20: £1,088K) are calculated based on information provided by the NHS Business Services Authority - Pensions Division. There are uncertainties surrounding these provisions as the amounts incorporate assumptions made concerning the life expectancy of the individuals.

"Other" relates to dilapidation provisions for buildings that the Trust leases.

Note 34.2 Clinical negligence liabilities

At 31 March 2021, £231,942k was included in provisions of NHS Resolution in respect of clinical negligence liabilities of Doncaster & Bassetlaw Teaching Hospitals NHS Foundation Trust (31 March 2020: £226,992k).

Note 35 Contingent assets and liabilities

	Group		Trust	
	31 March 2021	31 March 2020	31 March 2021	31 March 2020
	£000	£000	£000	£000
Value of contingent liabilities				
Employment Tribunal and other employee based litigation	-	22	-	22
NHS Resolution legal claims	92	107	92	107
Gross value of contingent liabilities	**92**	**129**	**92**	**129**
Amounts recoverable against liabilities	-	-	-	-
Net value of contingent liabilities	**92**	**129**	**92**	**129**
Net value of contingent assets	**-**	**-**	**-**	**-**

The contingent liabilities relate to personal litigation claims above the amount included in provisions up to the maximum excess amount for which the Trust is liable.

Note 36 Contractual capital commitments

	Group		Trust	
	31 March 2021	31 March 2020	31 March 2021	31 March 2020
	£000	£000	£000	£000
Property, plant and equipment	989	2,163	989	2,163
Intangible assets	-	554	-	554
Total	**989**	**2,717**	**989**	**2,717**

Note 37 Other financial commitments

The group / Trust does not have any commitments to make payments under non-cancellable contracts.

Note 38 Defined benefit pension schemes

The Trust does not operate any material defined pension schemes other than the statutory NHS Pension Scheme.

Note 39 Financial instruments

Note 39.1 Financial risk management

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

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

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

Currency risk

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

Credit risk

Credit risk is the risk of financial loss to the Trust if a customer or counterparty to a financial instrument fails to meet its contractual obligations, and arises principally from the Trust's trade receivables. As the majority of the Trust's income comes from contracts with other public sector bodies, the Trust has low exposure to credit risk.

The carrying amount of financial assets represents the maximum credit exposure. Therefore the maximum exposure to credit risk at the reporting date for the Group was £71,341k (2019/20: £61,348k), being the total of the carrying amount of financial assets.

With regard to the credit quality of financial assets and impairment losses, the movement in the allowance for impairment in respect of trade receivables during the year is disclosed in note 25.2.

Interest rate risk

All of the Trust's financial liabilities carry nil or fixed rates of interest. In addition, the only element of the Trust's financial assets that is currently subject to a variable rate is cash held in the Foundation Trust's main bank accounts and in a short term deposit account. The Trust is therefore not exposed to significant risk of fluctuations in interest rates.

The Trust's operating costs are incurred under contracts with Clinical Commissioning Groups and other NHS or Government bodies, which are financed from resources voted annually by Parliament. The Trust funds its capital expenditure from cash reserves or loans. All major capital expenditure is supported by detailed financial assessment including the assessment of cash flow requirements and impact on liquidity and any funding is within the Trust's prudential borrowing limit, as set by NHS Improvement. The Trust is not, therefore, exposed to significant liquidity risks.

Note 39.2 Carrying values of financial assets

Group	Held at amortised cost	Held at fair value through I&E	Held at fair value through OCI	Total book value
Carrying values of financial assets as at 31 March 2021 under IFRS 9	**£000**	**£000**	**£000**	**£000**
Trade and other receivables excluding non financial assets	11,150	-	-	**11,150**
Cash and cash equivalents	51,675	-	-	**51,675**
Consolidated NHS Charitable fund financial assets	-	9,151	-	**9,151**
Total at 31 March 2021	**62,825**	**9,151**	**-**	**71,976**

The only Group financial assets held at fair value through the I&E are the Investments held within the NHS Charitable Fund. These have been valued in a consistent manner throughout.

Trust	Held at amortised cost	Held at fair value through I&E	Held at fair value through OCI	Total book value
Carrying values of financial assets as at 31 March 2021 under IFRS 9	**£000**	**£000**	**£000**	**£000**
Trade and other receivables excluding non financial assets	12,609	-	-	**12,609**
Cash and cash equivalents	50,947	-	-	**50,947**
Total at 31 March 2021	**63,556**	**-**	**-**	**63,556**

Note 39.2 Carrying values of financial liabilities

IFRS 9 Financial Instruments is applied restrospectively from 1 April 2018 without restatement of comparatives. As such, comparative disclosures have been prepared under IAS 39 and the measurement categories differ to those in the current year analyses.

Group	Held at amortised cost	Held at fair value through I&E	Total book value
	£000	£000	£000
Carrying values of financial liabilities as at 31 March 2021 under IFRS 9			
Loans from the Department of Health and Social Care	14,730	-	**14,730**
Trade and other payables excluding non financial liabilities	63,608	-	**63,608**
Consolidated NHS charitable fund financial liabilities	18	-	**18**
Total at 31 March 2021	**78,356**	**-**	**78,356**

Group	Held at amortised cost	Held at fair value through I&E	Total book value
	£000	£000	£000
Carrying values of financial liabilities as at 31 March 2020 under IFRS 9			
Loans from the Department of Health and Social Care	87,970	-	**87,970**
Trade and other payables excluding non financial liabilities	48,801	-	**48,801**
Consolidated NHS charitable fund financial liabilities	14	-	**14**
Total at 31 March 2020	**136,785**	**-**	**136,785**

Note 39.3 Fair values of financial assets and liabilities

The book value (carrying value) of receivables is a reasonable approximation of the fair value of the asset.

The book value (carrying value) of payables is a reasonable approximation of the fair value of the asset.

Note 39.4 Maturity of financial liabilities

	Group		Trust	
	31 March 2021	31 March 2020	31 March 2021	31 March 2020
	£000	£000 (restated)	£000	£000 (restated)
In one year or less	63,568	120,129	63,568	120,129
In more than one year but not more than five years	5,650	7,124	5,650	7,124
In more than five years	9,141	9,533	9,141	9,533
Total	**78,359**	**136,786**	**78,359**	**136,786**

This table replaces the previous maturity analysis for financial liabilities. Previously this analysis has been performed on book values. However IFRS 7 (para B11D) requires this analysis to be based on undiscounted future contractual cash flow (ie gross liabilities including finance charges).

Note 40 Losses and special payments

Group and Trust	2020/21		2019/20	
	number of cases	value of cases	number of cases	value of cases
	Number	£000	Number	£000
Total losses - bad debts	**182**	**238**	**253**	**157**
Special payments				
Compensation under court order or legally binding arbitration award	17	55	19	81
Ex-gratia payments	10	5	7	3
Total special payments	**27**	**60**	**26**	**84**
Total losses and special payments	**209**	**298**	**279**	**241**

There were no individual cases in excess of £300k.

Note 41 Gifts

In 2020/21, the Charity committed expenditure to recognise the efforts of all staff during the year. This included purchasing tickets for staff to visit the Yorkshire Wildlife Park, as well as a small gift voucher, as a token of appreciation. No gifts were made by either the Trust, or subsidiary company in year.

In 2019/20, neither the Trust or Group made gifts during the year.

Note 42 Related parties

The total value of receivables and payables balances held with related parties as at 31 March is:

	2021 Receivables £000	2020 Receivables £000
Department of Health and Social Care	-	-
Other NHS bodies	7,269	15,610
Other bodies (including WGA bodies)	2,502	1,230
	9,771	**16,840**

	31 March 2021 Payables £000	31 March 2020 Payables £000
Other NHS bodies	5,281	6,406
Other bodies (including WGA bodies)	9,280	5,270
	14,561	**11,676**

The Department of Health and Social Care ("the Department") is regarded as a related party. During the year, the Trust has had a significant number of material transactions with the Department, and with other entities for which the Department is regarded as the parent Department. These entities include NHS England, Clinical Commissioning Groups, NHS Foundation Trusts, NHS Trusts, NHS Resolution, the NHS Business Services Authority and the NHS Purchasing and Supply Agency.

"Other bodies (including WGA bodies)" includes local authories, HM Revenue & Customs and NHS Pension Scheme.

In addition, the Trust has had a number of material transactions with other Government Departments and other central and local Government bodies. Most of these transactions have been with HM Revenue and Customs (including National Insurance Fund), NHS Pension Scheme and Doncaster Metropolitan Borough Council.

Note 43 Events after Balance Sheet Date

There are no events after the Balance Sheet date

Note 44 NHS Charitable Fund

The Foundation Trust is the Corporate Trustee of the Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust Charitable Fund (registered charity number 1057917). The object is for funds to be used “for any purpose or purposes relating to the National Health Service wholly or mainly for the service provided by Doncaster and Bassetlaw Hospitals NHS Foundation Trust”.

Summary statement of financial activities

	2020/21	2019/20
	Total Funds	
	£000	£000
Incoming resources	476	471
Resources expended	(1,022)	(1,383)
Net outgoing resources	**(546)**	**(912)**
Investment Income	267	278
Gains on revaluation and disposal of investment assets	1,327	(600)
Net movement in funds	**1,048**	**(1,234)**
Fund balances at 1 April	7,990	9,224
Fund balances at 31 March	**9,038**	**7,990**

	2020/21	2019/20
	Total Funds	
	£000	£000
Investment assets	8,741	7,303
Current assets	-	2
Cash	410	901
Current liabilities	(113)	(216)
Total net assets	**9,038**	**7,990**

	2021	2020
	£000	£000
Unrestricted income funds	2,635	2,210
Other restricted income funds	6,403	5,780
	9,038	**7,990**

Unrestricted income funds are accumulated income funds that are expendable at the discretion of the Trustees in furtherance of the charity's objects. Unrestricted funds may be earmarked or designated for specific future purposes which reduces the amount that is readily available to the charity.

Restricted funds may be accumulated income funds which are expendable at the Trustee's discretion only in furtherance of the specified conditions of the donor and the objects of the charity. They may also be capital funds (e.g. endowments) where the assets are required to be invested, or retained for use rather than expended.

Note 45 Doncaster & Bassetlaw Healthcare Services Ltd

The Foundation Trust has a Wholly Owned Subsidiary, Doncaster & Bassetlaw Healthcare Services Ltd ("DBHS Ltd"). DBHS Ltd operates at an arms length basis, currently providing Out-patient pharmacy dispensary services at the Doncaster Royal Infirmary site. The summarised financial statements can be seen below:

Summary statement of financial activities

	2020/21	2019/20
	£000	£000
Incoming resources	7,525	3,677
Resources expended	(7,385)	(3,678)
Net outgoing resources	**140**	**(1)**

	2020/21	2019/20
	£000	£000
Current assets	1,844	2,494
Cash	728	355
Current liabilities	(1,883)	(2,300)
Total net assets	**689**	**549**
Share Capital	550	550
Income & Expenditure reserve	139	(1)
Total net assets	**689**	**549**

NHS

Doncaster and Bassetlaw Teaching Hospitals

NHS Foundation Trust

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Report Cover Page					
Meeting Title:	Trust Board				
Meeting Date:	20th July 2021	**Agenda Reference:**	**G4**		
Report Title:	Update to Standing Financial Instructions, Standing Orders and Delegation of Powers				
Sponsor:	Jon Sargeant – Director of Finance				
Author:	Matthew Bancroft – Head of Financial Control				
Appendices:	Appendix A – Standing Orders Appendix B – Standing Financial Instructions Appendix C – Delegation of Powers				
Report Summary					
Purpose of report:	To update the relevant documents in line with current/best practice and changes				
Summary of key issues/positive highlights:	The documents have been reviewed, with the following minor adjustments being made: • Updating the references to the new NHS Improvement/NHS England structure • Updating names of various job titles and Committees • Clarified the Procurement processes, particularly around tender portals • Removal of Covid-19 Business Continuity arrangements				
Recommendation:	The Board is asked approve the documents.				
Action Required:	Approval X	Information	Discussion	Assurance	Review
Link to True North Objectives:	**TN SA1:** *To provide outstanding care for our patients*	**TN SA2: X** *Everybody knows their role in achieving the vision*	**TN SA3:** *Feedback from staff and learners is in the top 10% in the UK*	**TN SA4:** *The Trust is in recurrent surplus to invest in improving patient care*	

Implications	
Board assurance framework:	N/A
Corporate risk register:	N/A
Regulation:	The documents are part of the financial governance framework within the Trust.
Legal:	N/A
Resources:	N/A

Assurance Route			
Previously considered by:	Risk & Audit Committee		
Date: 15/7/2021		**Decision:**	Recommend approval at Board
Next Steps:	Documents require Board approval		

Previously circulated reports to supplement this paper:	N/A.

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Standing Orders
Board of Directors
July 2021

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:	July 2021
Approved by (Committee/Group):	Board of Directors
Date of approval:	
Date issued:	
Next review date:	July 2022
Target audience:	Trust-wide

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 11	July 2021	• Removal of appendix 1 – Temporary COVID19 Business continuity Terms of Reference for Trust Board and Committee meetings. • Addition of People Committee • Change of Director of Nursing to "Chief Nurse" • Updated references to Monitor, NHS improvement and NHS England. • Updated Procurement references to tender portals and EU tender regulations.	Matthew Bancroft
Version 10	July 2020	• Update of legislation references to include any subsequent updates relating to the UK's exit from EU. • Removal of all references and detail pertaining to the use of 'Approved Lists' in relation to Works tenders. • Removed references to Prudential Borrowing Limits. • Updated limits with relation to Charitable Funds expenditure. • Includes Appendix 1. Temporary COVID19 Business Continuity Terms of Reference Trust Board, Board Committee and Governor Meetings – Emergency powers section 6.2	Matthew Bancroft

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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 England/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 England/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 England/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 England"	means the body corporate known as NHS England.

"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 England/NHS Improvement. Accountability for non-charitable funds held on trust is only to NHS England/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 Executive Medical Director
- the Chief Nurse

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 England/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 Risk & 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 England/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 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 England/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 England/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 England/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 England/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) People Committee

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 NHSE (2019) `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) or any subsequent public procurement legislation following the UKs exit from the European Union 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 £50,000, procurement team review all spend over 25k, local tenders £50,000 to EU Threshold

11.8 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.

11.9 **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.

11.10 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.

11.11 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

11.12 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.

11.13 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.

11.14 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).

11.15 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.

11.16 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.

11.17 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.

11.18 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.

11.19 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.

11.20 Tendering procedures are set out in the Annex.

11.21 Quotations should be in writing 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. All quotations for goods and services valued between £25,000 and £50,000 quotations should be undertaken by the Procurement Department.

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

11.23 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.

11.24 **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.

11.25 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).

11.26 **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.

11.27 **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, their subsequent replacements in UK law 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.

11.28 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.

11.29 **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.

11.30 **Healthcare Services Contracts**

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

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

11.32 **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.

11.33 **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 eachother 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 Company 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 England/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 should be procured under an EU Public Procurement compliant process

4 APPROVED FIRMS

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

(i) Invitations to tender shall be via compliant procurement routes in conjunction with the procurement team.

(ii) Suppliers that are successful in winning contracts 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) All Contractors shall conform with the requirements of the Health and Safety at Work Act etc. 1974, Management of Health & Safety at Work Regulations 1999 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 the Construction (Design & Management) Regulations 2015. Contractors are legally required to provide to the appropriate Estates & Facilities manager a copy of its

safety policy and evidence of the safety of plant and equipment, when requested and associated Risk Assessment & Method Statement pertinent to specific projects commensurate with standard Health & Safety methodology.

(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 Estates and Facilities will similarly make such enquiries as is felt appropriate to be satisfied as to their technical competence.

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 2020 – CORP/FIN 1 (A) v11	CE/Finance	Jon Sargeant/Matthew Bancroft	Existing Policy	July 2021

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: July 2022

Checked by: Jon Sargeant/Matthew Bancroft Date: July 2021

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Standing Financial Instructions

July 2021

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:	July 2021
Approved by (Committee/Group):	Board of Directors
Date of approval:	
Date issued:	
Next review date:	July 2022
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 9	July 2021	• "Chairman" replaced by "Chair" • Updated reference to NHS Improvement/NHS England. • Clarified Procurement process for £25k-£50k	Matthew Bancroft
Version 8	July 2020	• Updated job titles throughout • Updated the NHS Logistics provider details • Updated references to NHSI/NHSE throughout. • Updated references to procurement legislation and the impact of leaving the EU • Updated references to "Estate code" • Updated references to "NHSLA"	Matthew Bancroft
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

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FOREWORD

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

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 Finance and Performance 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;
“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;
"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 England"	means the body corporate known as NHS England;
"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 England/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;

(a) reviewing controls assurance systems, including disseminating relevant information to governors; and

(b) 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 Chair of the committee should raise the matter at a full meeting of the Board. Exceptionally, the matter may need to be referred to NHS England/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).

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 Chair 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 35 of the Constitution. The auditor must be a member of one or more of the bodies referred to in paragraph 11, Annex 6 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 England/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:

- be in accordance with the aims and objectives set out in the annual business plan;
- accord with workload and staffing plans;
- be produced following discussion with appropriate budget holders;
- be prepared within the limits of available funds;
- identify potential risks; and
- comply with NHS England/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:

- income and expenditure to date showing trends, forecast year-end position, and variances against budget;
- balance sheet;
- cashflow;
- movements in working capital;
- capital project spend and projected outturn against plan;
- explanations of any material variances from plan;
- movements in reserves;
- 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 England/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 England/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 England/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 England/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 England/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);

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

(d) 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

(e) 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 England/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 Chair 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 Head of Procurement 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 Head of Procurement 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 England/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 England/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 "The efficient management of healthcare estates and facilities" (previously "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 ""The efficient management of healthcare estates and facilities" 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 The 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 England/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 Supply Chain Coordination Limited (SCCL) 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 England/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 verbal 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 England/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 2019).

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 Fundraising, 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 NHS Resolution

19.2.1 The Board shall decide if the Trust will insure through the risk pooling schemes administered by the NHS Resolution (previously 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 Company 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 Division 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 from £5,000 up to £250,000 as determined by the scheme of delegation. The Chief Executive (or Director of Finance in his absence) must authorise all expenditure from £250,000 to £1,000,000.

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 CIG for review and recommendation to the Board. These 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 UK procurement regulations, any regulations governing procurement within the European Union and any subsequent procurement legislation that become statutes following the UKs exit from the European Union in all cases advice should be sought from the Head of Procurement Head of Procurement 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 Head of Procurement 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. For quotations of between £25,000 - £50,000 these must be undertaken by the Procurement Department.

3.2 Non-competitive quotations in writingmay 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 Head of Procurement in confirmation of such circumstances.

3.3 Officers should involve the Head of Procurement 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 Head of Procurement 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 Head of Procurement 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 in excess of £5,000 and up to £250,000	Director of Finance
- goods/services in excess of £250,000 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 "The efficient management of healthcare estates and facilities" 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 –June 2021 - CORP/FIN 1 (B) v.9	CE/Finance	Jon Sargeant/Matthew Bancroft	Existing Policy	July 2021

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: July 2022

Checked by: Jon Sargeant/Matthew Bancroft Date: July2021

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Reservation of Powers to the Board and Delegation of Powers

July 2021

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:	July 2021
Approved by (Committee/Group):	Board of Directors
Date of approval:	
Date issued:	
Next review date:	July 2022
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 10	July 2021	• Replaced DoN with Chief Nurse • Updated references to NHS Improvement/NHS England • Reference to e-signing of contracts • Ensure Directors sign-off levels are consistent	Matthew Bancroft
Version 9	July 2020	Renaming names of structures/meetings	Matthew Bancroft
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

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INTRODUCTION

SO 6.1 of the Standing Orders provides that "subject to such directions as may be given by NHS England/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 England/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 England/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 England/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 England/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 England/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	Director of Finance – with operational responsibility delegated to the Chief Information Officer
Health and Safety Arrangements	Director of Finance – 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	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	DOF	Ensuring compliance with NHS England/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.
6	DOF	Banking arrangements.

SECTION 4 – SCHEME OF DELEGATION IMPLIED BY STANDING FINANCIAL INSTRUCTIONS

SCHEME OF DELEGATION IMPLIED BY STANDING FINANCIAL INSTRUCTIONS

SFI REF	DELEGATED TO	DUTIES DELEGATED
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.
12.3.8	DoF	Calculate and pay capital charges in accordance with NHS England/NHS Improvement requirements.

SECTION 4 – SCHEME OF DELEGATION IMPLIED BY STANDING FINANCIAL INSTRUCTIONS

SCHEME OF DELEGATION IMPLIED BY STANDING FINANCIAL INSTRUCTIONS

SFI REF	DELEGATED TO	DUTIES DELEGATED
12.4.1	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, CN – Chief Nurse - 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	Corporate Investment Group	
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 £50,000 (£25,000 to £50,000 via Procurement) 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/non pay expenditure: a) Requisitions to £2,000 b) Requisitions to £25,000 c) Requisitions to £50,000 d) Requisitions to £250,000 e) Requisitions over £250,000 Authorisation of contracts for goods & services and subsequent variations to contracts a) Contracts up to £250,000 b) Contracts over £250,000 to £500,000 c) Contracts over £500,000 to £1,000,000 d) Contracts over £1,000,000 (this includes electronic signing of contracts) Authorisation of call off contracts for goods and services covered by a pre-tendered Framework	 Authorised Signatory for Budget Head of Dept. General Manager or Divisional Director Executive Director 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	SFIs Section 10 & SOs Section 11 & Annex

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

Delegated Matter	Authority Delegated To	Reference Document
6. Setting of Fees and Charges		
a) Private Patient, Overseas Visitors, Income Generation and other patient related services	DoF	SFIs Section 7
b) Price of all NHS Contracts	DoF	SFIs Section 8
7. Engagement of Staff Not On the Establishment (Within NHSI price caps)		SFIs Section 9
a) Management Consultancy	Executive Director	
b) Engagement of Trust's Solicitors	DoPOD, MD and DoF	
c) Booking of Bank or Agency Staff		
i) Medical Locums	General Manager or Divisional Director	
ii) Nursing	General Manager	
iii) Clerical	General / Department Manager or Divisional /Executive Director	
Outside NHSI price caps	Executive Director	
8. Expenditure on Charitable and Endowment Funds		SFIs Section 17
Up to £25,000 per request	DoF	
Over £25,000 per request	CEO or DoF after authorisation from the Charitable Funds Committee.	
9. Agreements/Licences		
a) Preparation and signature of all tenancy agreements/licences for all staff subject to Trust Policy on accommodation for staff	DoF and DoPOD	
b) Extensions to existing leases	DoF	
c) Letting of premises to outside organisations	DoF	
d) Approval of rent based on professional assessment	DoF	
10. Condemning & Disposal		SFIs Section 14
a) Items obsolete, obsolescent, redundant, irreparable or cannot be repaired cost effectively	General/Department Manager and Condemning Officer	
b) disposal of x-ray films	Superintendent Radiographer	
c) disposal of controlled drugs	Chief Pharmacist	
11. Losses, Write-off & Compensation		SFIs Section 14
a) Losses and Cash due to theft, fraud, overpayment & others Up to £50,000	CE or Nominated Director and DoF	
b) Fruitless Payments (including abandoned Capital Schemes)		
Up to £100,000	CE or Nominated Director and DoF	

Delegated Matter	Authority Delegated To	Reference Document
c) Bad Debts and Claims Abandoned. Private Patients, Overseas Visitors & Other Up to £50,000	CE or Nominated Director and DoF	
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 ii) £50,000 to £100,000 i) over £100,000 iv) Authorise payment (up to £1,000,000)	 MD CE Board of Directors 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 ii) £25,000 to £100,000 iii) over £100,000 iv) Authorise payment (up to £1,000,000)	 DoPOD CE Board of Directors 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> a) Where a criminal offence is suspected (other than theft or fraud) b) Where a theft is involved c) Where a fraud is involved	 Director with managerial responsibility for the area DoF or DoPOD DoF	SFIs Sections 2 & 14
<u>13. Petty Cash Disbursements (not applicable to central Cashiers Office)</u> a) Expenditure up to £25 per item	 Petty Cash Holder	SFIs Section 10
<u>14. Receiving Hospitality</u>		

Delegated Matter	Authority Delegated To	Reference Document
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	
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	

Delegated Matter	Authority Delegated To	Reference Document
vii) Leave without pay	Executive Director	
viii) Medical Staff Leave of Absence paid and unpaid	MD and CE General Manager or Divisional Director	
ix) Time off in lieu	Automatic approval with guidance	
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	

Delegated Matter	Authority Delegated To	Reference Document
21. Authorisation of Research Projects	CE or MD or Chief Nurse	
22. Authorisation of Clinical Trials	CE and MD	
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)	 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	

Delegated Matter	Authority Delegated To	Reference Document
Temporary Change Permanent Change Contract monitoring & reporting c) Critical Care	Bed Manager with advice from COO & Chief Nurse CE with advice from COO & Chief Nurse DoF CE or Executive Director on call	
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	Company Secretary	
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	

Delegated Matter	Authority Delegated To	Reference Document
42. Retention of Records	COO	
43. Clinical Audit	MD	
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 26).

6.3 The appointment or removal of the Trust's auditors (section 35).

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 31).

6.5 Approve any significant transaction, as defined in the constitution (section 42).

6.6 Approve any merger, acquisition, separation or dissolution proposed (section 42).

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 – CORP/FIN 1 (C) v.9	CE/Finance	Jon Sargeant /Matthew Bancroft	Existing Policy	June 2020

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: June 2021

Checked by: Jon Sargeant/ Matthew Bancroft Date: June 2020

AUDIT AND RISK COMMITTEE ANNUAL REPORT 2020/2021 FINAL

DATE:	**10 June 2021**
PREPARED BY:	**Kath Smart, Chair of the Audit and Risk Committee**

1 INTRODUCTION

1.1 The purpose of this report is to provide the Board of Directors with assurances that the Audit & Risk Committee ("the committee") is discharging its duties, delivering its workplan and complying with the Terms of Reference set by the Board. The Terms of reference were recently reviewed, refreshed and revised and approved by Board in April 2021.
The Audit Committee oversees delivery of Internal and External Auditor plans, the sign off on the Annual Accounts, the arrangements in place to prevent and detect Fraud and improvements to risk management arrangements.

The Committee thanks all those who have attended and presented reports, updates, assurances and progress on recommendations.

The ARC met on 5 occasions throughout the year; 4th June 2020, 16th July 2020, 22nd October 2020, 29th January 2021 and 25th March 2021 (all via videoconferencing).

1.2 This report summarises the key information required against last year's recommendations and each of four elements namely:

a) The role and the main responsibilities of the Committee;

b) Membership of the Committee;

c) Number of meetings and attendance.

2 STRATEGIC CONTEXT

2.1 The Audit and Risk Committee (ARC) is one of the five Board Committees (Quality and Effectiveness Committee, Finance and Performance Committee, People Committee and Charitable Funds Committee) and is responsible for providing assurance to the Board of Directors, independently of the executive directors on the standards of corporate reporting, risk management and internal control principles. The Committee is responsible for critically reviewing the reporting on the relevance and robustness of the governance structures and assurance processes on which the Board places reliance.

2.2 ARC is responsible for ensuring that there are adequate and appropriate audit and risk governance structures, processes and controls in place throughout the Trust to ensure appropriate independent review of the internal control and risk management arrangements in place in DBTH.

3 THE ROLES AND MAIN RESPONSIBILITIES OF THE COMMITTEE

3.1	The main purpose of the Committee is to: a) Provide the Board of Directors with a means of independent and objective review of internal controls and risk management arrangements relating to: - Financial systems, - The financial information used by the Trust, - Controls and assurance systems, - Risk management, - Health and safety, fire and security, - Emergency planning, - Compliance with law, guidance and codes of conduct, - Counter fraud activity. b) Provide detailed scrutiny against internal and external audit, and to provide assurance and raise concerns to the Board of Directors; c) Make recommendations, as appropriate, on audit and risk matters to the Board of Directors.
4	**MAIN ACTIVITIES**
4.1	During 2020/21 the Committee has delivered its key responsibilities and duties as outlined in its Terms of Reference with a caveat that normal systems and processes in place were largely affected during the year due to the COVID-19 pandemic. Meetings have been held in accordance with the agreed schedule.
4.2	All issues for escalation have been continuously reported upwards to the Board of Directors with relevant information being shared with QEC, F&P and PC.
4.3	<u>Governance, Risk Management and Internal Control</u>
4.4	<u>Internal Audit</u> The Committee has reviewed delivery of the risk-based audit plan, the KPIs and the audit reports, to ensure KPMG (Internal Auditors) are providing assurances and highlighting risks to the Trust. Audit Reports are presented at each meeting, with Audit Recommendations being followed up at each Audit Committee. During 2020/21 there were 186.5 assurance days delivered against a plan of 205 (as of 25th March 2021). This slippage did not affect KPMG's HOIA Opinion, which is "our overall opinion for 1 April 2020 to 31 March 2021 is that significant assurance with minor improvement opportunities can be given on the overall adequacy and effectiveness of the organisations framework of governance, risk management and control". This is a positive outcome for the Trust and ARC would like to pass its thanks to those involved. The outcome of all internal audit work carried out is shown in the table below:

#	Review	Assurance	Recommendations Accepted			
			H	M	L	Total
1a	Covid-19 Financial Governance and Controls	Significant assurance with minor improvement opportunities	-	1	1	**2**
1b	Core Financial Controls	Significant assurance with minor improvement opportunities	-	1	4	**5**
2	Clinical and Quality Governance Review: Waiting List Prioritisation	Significant assurance with minor improvement opportunities	-	2	3	**5**
3	Corporate Governance	Significant assurance with minor improvement opportunities	-	2	-	**2**
4	Data Quality	Significant assurance with minor improvement opportunities	-	2	6	**8**
5	Information Governance (Data Security and Protection Toolkit)	N/A – to be reported as part of 2021/22 plan	N/A	N/A	N/A	**N/A**
6	Risk Management and Board Assurance Framework: Design of Controls	Significant assurance with minor improvement opportunities	-	4	5	**9**
	Risk Management and Board Assurance Framework: Operating Effectiveness of Controls	Partial assurance with improvements required				
7	Recruitment and Staff Records: TRAC controls	Significant assurance with minor improvements opportunities	-	3	3	**6**
	Recruitment and Staff Records: ESR controls	Partial assurance with improvements required				
8	Legacy IT	Partial assurance with improvements required	1	2	2	**5**
9	Covid-19: Business Continuity, Pandemic Response Plan and Remote Working	Significant assurance with minor improvement opportunities	-	1	4	**5**
10	Capacity Panning (carried forward from 2019/20)	Partial assurance with improvements required	1	4	2	**7**
11	Job Planning	No assurance	3	4	4	**11**
12	Complaints	Significant assurance with minor improvement opportunities	-	6	2	**8**
Total			**5**	**32**	**36**	**73**

ARC has considered the Partial Assurance outcomes (4) plus especially the No Assurance report (1) and will work with management and KPMG to ensure improvement is made in these areas during 21/22.

The Committee has also undertaken a review of the effectiveness of Internal Auditors which showed a positive outcome. Progress towards tendering the IA service will be concluded during 2021/22.

4.5 Internal Audit Recommendations

	The Committee follows up medium and high audit recommendations at each of its meetings. The table (above) shows the Internal Audit recommendations issued during the year, and these will be followed up during 21/22 and highlights continual progress in reducing the number and risk level of recommendations completed on time.
4.6	Financial Reporting During this unprecedented year, the internal audit plan was flexed to meet the needs of the Trust and KPMG carried out 2 pieces of audit work related to the Trusts core financial reporting; Covid Financial Governance & Financial Controls – Significant Assurance; and Core Financial Controls – Significant Assurance.
4.7	Counter Fraud The Committee has continued to monitor the activities in place to deter, prevent and follow through for any fraud cases. The Local Counter Fraud Officer has provided fraud risk assessments, and annual plan, updates on national anti-fraud initiatives and training to staff. This has given the Committee assurances on the measures in place to protect staff, property and finances. The Committee also receives assurances on fraud cases progressed and their outcome.
4.8	Information Governance The Data Security Protection Toolkit is a key plank of the Trusts arrangements for Information Governance, including Data Protection (GDPR), Confidentiality, FOI, Cyber Security and the standard which Trusts are required to adhere to. Each year the DSPT is audited and the outcome for 2019/20 was "Significant Assurance". The 2020/21 work will be undertaken later due to changes in the national submission timetable and will be reported to ARC. The Trust is managing high risks in this area (eg: Cyber Security) which is managed and reported on the Trusts Corporate Risk Register. The ARC Chair has also attended the Information Governance Group meeting during 2020/21.
4.9	Health, Safety, Security and Fire The Committee continued to monitor these key areas via a quarterly security report and bi-annual Health and Safety report. The Trust is managing a number of high risks related to Health, Safety, and Fire which are reported and recorded on the Trusts Corporate Risk Register. The ARC Chair has also attended the Trust's Health and Safety Committee during 2020/21.
4.10	External Audit The Committee has undertaken a review of the effectiveness of External Auditors which showed a positive outcome. Progress towards the CoG appointment of the External Audit service will be concluded during 2021/22 with audit committee and management support. The 2020/21 External Audit Report (ISA 260) conclusion was presented at the June 2021 meeting and concluded that: "We expect to provide an unqualified opinion on the financial statements in advance of the accounts submission deadline". This is a positive outcome for the Trust, and ARC passes on its thanks to the member of the Finance team who have worked to support this outcome.

5	**REPORTING**
5.1	Minutes of each of the meetings were formally presented to a subsequent meeting of the Board of Directors, with the Committee Chair drawing any key issues to the attention of the Board.
5.2	Assurance was provided to the Board of Directors through a Chair's Log after each Committee meeting. Board was given the opportunity to question the Chair of the Committee. Following the implementation of a new Board and Committee reporting structure, Chairs Logs ceased in March 2021 and assurance to the Board would be provided in the new front sheet format under the assurance section in the business-as-usual reports.
5.3	The Chair of Audit and Risk Committee attended Council of Governors to answer questions and provide assurance to governors.
6	**MEETINGS AND MEMBERSHIP**
6.1	The Committee met on 5 occasions during 2020/21 and the Committee's membership and attendance has been as follows:

Kath Smart – Chair	Non-executive Director	5 of 5
Sheena McDonnell	Non-executive Director	4 of 5
Neil Rhodes	Non-executive Director	5 of 5
Mark Bailey	Non-executive Director	5 of 5

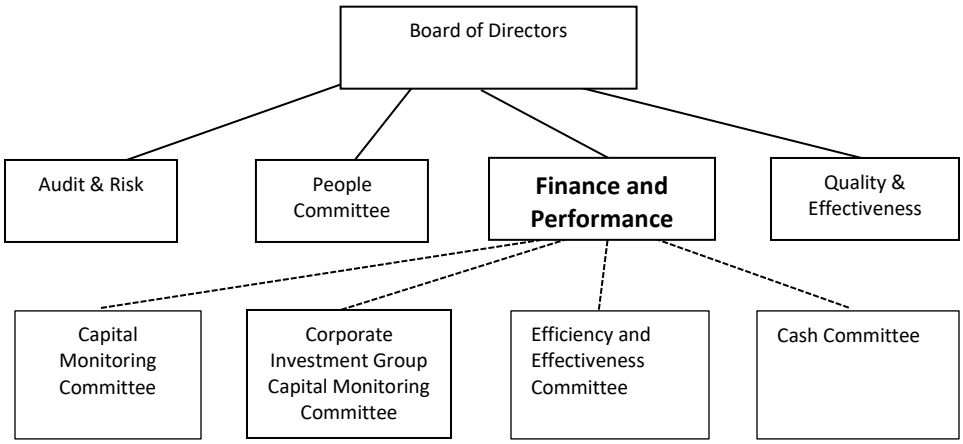
7	**SUB COMMITTEES**
7.1	The committee has the following sub-committee: • Health and Safety Committee • Information Governance Group Minutes of the sub-committees are presented to each meeting of the Committee for information.
8	**WORK PLAN**
8.1	The Committee's work was largely dictated by the committee work-plan was reviewed at each committee and at pre-meetings that took place approximately two weeks before the Committee.
9	**COMMITTEE EFFECTIVENESS**
9.1	The committee would undertake a comprehensive committee effectiveness review following the review of its process at the Board in March 2021. As an interim position the Committee self assessed itself against the HFMA Handbook Standards and there were no areas of concern or action identified in this self assessment.
10	**CONCLUSION AND RECOMMENDATIONS**
10.1	In conclusion, the Committee delivered against its key objectives during 2020/21.

11	WORK FOR 2020/21
11.1	Work to progress in 2021/22 includes: a) Delivery of 2021/22 Internal Audit Plan – including any adjustments required for pausing and re-prioritisation of work due to Covid-19; b) Declarations of Interest – Ensuring continued compliance with DOI and the process to achieve compliance, c) Supporting Council of Governors in the tender of external audit services; d) Supporting management in the tender of internal audit services e) Continuing to drive down the number of outstanding audit recommendations f) Gaining assurance on progress with improvement to the "No assurance" Audit Report on Job Planning g) Completion of the ARC Committee effectiveness process

Finance and Performance Committee

Terms of Reference

Name	Finance and Performance Committee ("the Committee").
Purpose	The Committee will carry out its duties as an assurance Committee of the Board of Directors ("the Board") in reviewing systems of control and governance specifically in relation to operational performance and financial planning and reporting. It is supported by the Audit and Risk Committee which provides the oversight arm of the Board, reviewing adequacy and effectiveness of controls. The work of the Committee is aligned to the Trust's Strategic Objectives and is organised to provide assurance on the progress towards the True North Objectives: - To provide outstanding care and improve patient experience; - Everybody knows their role in achieving the vision; - Feedback from staff and learners in top 10% in UK; - In recurrent surplus to invest in improving patient care.
Responsible to	The Board. The Chair of the Committee is responsible for reporting assurance to the Board on those assurance matters covered by these Terms of Reference through review and update of the Board Assurance framework. The minutes of the Committee shall also be submitted to the Board. The Chair of the Committee shall draw to the attention of the Board any issues that require disclosure to the Council of Governors, or may require executive action. The Committee will present a written annual report to the Board summarising the work carried out during the financial year and outlining its work plan for the future year.
Relationship to other Committees	The Committee will receive information and assurances from the Trust's internal management and operational Committees as required. This includes Capital Monitoring Group, Corporate Investment Group and the Effectiveness and Efficiency Committee. However, the only Committee that is a sub-Committee of Finance and Performance Committee will be the Cash Committee.

	 It is important that the Committee minimises areas of overlap with the Audit and Risk Committee. Therefore, the following specific areas of responsibility will be excluded from the Finance and Performance Committee agenda: Audit – external and internal; Standing Financial Instructions and Scheme of Delegation oversight; Local Counter Fraud Specialist work.
Delegated authority	The Committee is a Committee of the Board and holds those powers specifically delegated to it by the Board and set out in these terms of reference. The Committee is authorised to investigate any activity within its terms of reference. It is further authorised to seek any information it requires from any employee of the Trust and all employees are directed to co-operate with any request made by the Committee. The Committee may make a request to the executive for legal or independent professional advice and request the attendance of external advisers with relevant experience and expertise if it considers this necessary. The Committee will operate at a strategic level as the executive is responsible for the day to day operational financial delivery and performance management of the Trust.

Duties and work programme	(1) To review reports relevant to the Committee that relate to the following matters: - current financial and operational performance and reporting; - financial forecasts, budgets and plans in light of trends and operational expectations; - plans and processes for the implementation of Effectiveness and Efficiency Improvement Plans; - the Trust's financial strategy, in relation to both revenue and capital, - sensitivity and scenario analysis to support financial planning; - major Trust investment plans, maintaining oversight of investments; - any innovative, commercial or investment activity eg proposed joint ventures; - any specific risks in the Board Assurance Framework relevant to the Committee; - issues relating to IT(Digital Transformation) , Medical Equipment, and Estates and Facilities and provide assurance to the Board in respect of their delivery. (2) To consider and review any items identified by, or escalated to the Committee relating to Enabling Strategies that are monitored through the corporate objectives and reported to the Board of Directors. (3) To consider and agree on behalf of the Board: - appropriate measurements to review to provide assurance by which operational and workforce performance is managed in line with the Single Oversight Framework and strategic objectives of the Trust; - appropriate targets and tolerances by which measurements can be assessed, including updated forecasts where necessary, in order to monitor performance in line with the Single Oversight Framework and stated objectives of the Trust; - the Trust's Investment Policy and Procurement Strategy; - any significant variations to the Trust's existing procurement methodology in accordance with the Standing Orders; - NHSI quarterly declarations; - accounting policies.
	(4) To receive, consider and make recommendations to the Board for the final decision on proposals and their respective funding sources for significant transactions which would: - materially change the Trust's service provision;

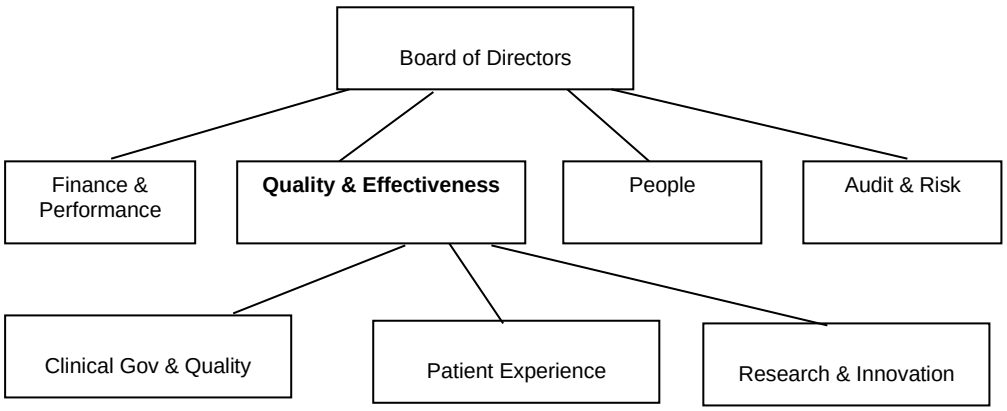
	- seek to merge or partner with another organisation(s) which would change the Trust's independent status; - be transactions that extend beyond the levels of delegation of the Chief Executive. (5) To supervise the setting and monitoring of significant contracts. (6) To make arrangements as necessary to: - ensure that all members of the Board and senior officers of the Trust maintain an appropriate level of knowledge and understanding of key financial issues; - undertake a review of the Committee's effectiveness on an annual basis. (7) To approve terms of reference and membership of reporting sub-Committees and oversee the work of those sub-Committees.
Chairing arrangements	The Chair will be chosen by the Board from among the non-executive members of the Committee. The Vice-Chair will be a non-executive director chosen by the Committee when necessary.
Membership	• Three NEDs • Director of Finance • Chief Operating Officer
In attendance	• Director of Strategy and Improvement (non-voting) • Company Secretary • Corporate Governance Officer (Minutes) • Other Trust staff as appropriate / requested • Governor observers x 2
Secretary	Company Secretary (supported by Corporate Governance Officer)
Voting	Matters will generally be decided by way of consensus. Where it is necessary to decide matters by a vote then each member will have one vote. The Chair will have a casting vote.
Quorum	Three members and at least two NEDs.
Frequency of meetings	Monthly, with other meetings convened as necessary.
Papers	Papers will be distributed three clear days in advance of the meeting.
Permanency	This is a permanent Committee of the Board.

Reporting Committees	None
Circulation of minutes	Board of Directors
Sub-Committee	Cash Committee
Committee Minutes provided	Capital Monitoring Group Corporate Investment Group Efficiency and Effectiveness Committee Medical Equipment Group

Date approved by the Committee:	April 2021
Date approved by Board of Directors:	
Review date:	April 2022

Quality and Effectiveness Committee

Draft Terms of Reference

Name	Quality and Effectiveness Committee ("the Committee")
Purpose	The Committee will carry out its duties as an assurance Committee of the Board of Directors ("the Board") in reviewing systems of control and governance specifically in relation to clinical quality and governance and in delivery of high quality patient care. It is supported by the Audit and Risk Committee which provides the oversight arm of the Board, reviewing adequacy and effectiveness of controls. The work of the Committee is aligned to the Trust's Strategic Objectives and is organised to provide assurance on the progress towards the True North Objectives: - To provide outstanding care and improve patient experience; - Everybody knows their role in achieving the vision; - Feedback from staff and learners in top 10% in UK; - In recurrent surplus to invest in improving patient care.
Responsible to	The Board. The Chair of the Committee is responsible for reporting assurance to the Board on those matters covered by these terms of reference through review and update of the Board Assurance framework. The minutes of the Committee shall also be submitted to the Board. The Chair of the Committee shall draw to the attention of the Board any issues that require disclosure to the Board of Governors, or may require executive action. The Committee will present a written annual report to the Board summarising the work carried out during the financial year and outlining its work plan for the future year.
Relationship to other Committees	The Committee will receive information and assurances from the Trust's internal management and operational Committees as required. This includes Clinical Governance and Quality Committee and Patient Experience Committee below. 

Delegated authority	The Committee is a Committee of the Board and holds those powers specifically delegated to it by the Board and set out in these terms of reference. The Committee is authorised to investigate any activity within its terms of reference. It is further authorised to seek any information it requires from any employee of the Trust and all employees are directed to co-operate with any request made by the Committee. The Committee may make a request to the executive for legal or independent professional advice and request the attendance of external advisers with relevant experience and expertise if it considers this necessary. The Committee will operate at a strategic level as the executive is responsible for the day to day delivery of Trust services and management of its workforce.
Duties and work programme	(1) To review reports relevant to the Committee that relate to the following matters: - the Trust wide quality objectives as part of the Quality Strategy, - the clinical risk management framework and any controls and assurances against relevant clinical risks on the Board Assurance Framework, - the effectiveness of clinical governance, clinical risk management, clinical audit and effectiveness and clinical control, - maternity safety accountabilities, - promoting an honest and open reporting culture, - disclosure statements (in particular the Quality Report and Declarations of Compliance made to NHSI), prior to endorsement by the Board, - the CQC Essential Standards of Quality and Safety as part of the internal assurance process, - compliance with licensing standards of the Care Quality Commission, - any improvement reviews/notices from the Care Quality Commission and other external assessors, - clinical data and patient identifiable information to ensure that it is in accordance with the Caldicott Guidelines and relevant legislation and guidance, - adverse clinical incidents, complaints and litigation and examples of good practice and learning, and trend analysis - the QPIA process for Efficiency and Effectiveness Improvement Plans, - infection control, - mortality, - comments, compliments and complaints, - safer staffing for delivery of high quality patient care

	(2) Through the Teaching Hospital Board the committee will ensure that Research and Innovation and external links with Universities and Colleges are driving forward our ambition to become a University Teaching Hospital (3) Through the Clinical Governance & Quality Committee, the Committee will obtain assurance that clinical governance strategies and plans are embedded and that the clinical governance function is adequately resourced and has appropriate staffing. (4) To undertake thematic reviews and deep dives into quality, governance and safer staffing related issues. (5) To ensure that the Trust has reliable, up-to-date information about what it is like being a patient experiencing care administered by the Trust. (6) To approve terms of reference and membership of reporting sub-Committees and oversee the work of those sub-Committees. (7) To hold the Divisional Directors to account for clinical quality and governance in their areas.
Chairing arrangements	The chair will be nominated from among the non-executive members of the Committee. The vice-chair will nominated from the other two NEDs on the committee.
Membership	• Three members, appointed by the Board from amongst the Non-executive Directors (other than the Chairman of the Trust). • Medical Director • Chief Nurse •
In attendance	• Deputy Chief Nurse • Deputy Director Nursing – Patient Safety • Deputy Director Nursing – Patient Experience • Clinical Governance and Professional Standards Co-ordinator • Deputy Director Corporate Governance /Company Secretary • Director of Education & Research (or Deputy) • Corporate Governance Officer (Minutes) • Other Trust staff as appropriate / requested • Two governor observers
Secretary	Corporate Governance Officer.
Voting	Matters will generally be decided by way of consensus. Where it is necessary to decide matters by a vote then each member will have one vote. The Chair

	will have a casting vote.
Quorum	Three members, including the chair or vice-chair.
Frequency of meetings	Once every two months.
Papers	Papers will be distributed a minimum of three clear working days in advance of the meeting, but ideally a week before.
Permanency	The Committee is a permanent Committee.
Sub-Committees	Clinical Governance & Quality Committee Patient Experience Committee Research & Innovation Committee

Date agreed by the Committee:	April 2021
Date approved by the Board of Directors:	
Review date:	

APPENDIX D – CHARITABLE FUNDS COMMITTEE TERMS OF REFERENCE (ToR)

Name	**Charitable Funds Committee (CFC)**
Purpose	To oversee and manage the Trust's Charitable Funds i.e. Doncaster & Bassetlaw Teaching Hospitals Charitable Funds. To fulfil the sole objective of the Charity which is to support the work of Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust. This is to be achieved through the provision of resources that help contribute to the improved welfare and amenities of patients and staff.
Responsible to	Trust Board (as the Corporate Trustee)
Delegated authority	The Committee has the following delegated authority: • Authorise expenditure from the Charitable Funds as laid down in the Trust's Scheme of Delegation. • Ensure compliance with Charity Commission standards. • Manage the affairs of the Charitable Fund within the terms of the Trust Deed. • Develop and implement a fund raising strategy. • Invest the available fund monies in line with Policy. • Oversee the management and monitoring of the Trust's Charitable Funds. • Ensure that policies and procedures are in place such that all decisions regarding fund expenditure are appropriate and consistent with the objectives of both the Charity and Trust. • Develop and maintain a rolling three year expenditure strategy for the Charitable Funds. • Approve the annual report and accounts of the Charitable Fund. • Appoint an appropriate auditor to report on the annual accounts. • Appoint an appropriate investment consultant to manage the Fund's investments • Manage the investment of funds as laid down by both statute and the charity's reserves investment policy. • To develop and monitor the Funds' approach to risk including risk appetite. • To continue to keep its own effectiveness under regular review.
Chair	• Designated Non-executive Director

Membership	• All Non-Executive Directors of the Trust • Trust Chief Executive • Trust Director of Finance • Trust Medical Director • Director of Nursing, Midwifery and Allied Health Professionals •
In attendance	• Two governor observers of the committee, one of which must hold connections & interest in Mexborough community • As required by the business to be discussed
Secretary	Trust Board Secretary
Quorum	3 (Inc. at least 1 Executive Director AND at least 2 Non-Executive Directors)
Voting	Each member has one vote, with the chair of the meeting having the casting vote in the event of a tie.
Decision making	The Committee may make decisions and approve proposals outside of meetings where the issue is considered urgent. The procedures for such decisions are set out in the Charitable Funds Policy. Any such decisions will then be reported at the next meeting for inclusion in the minutes.
Attendance requirements	Committee members must attend at least 75% of meetings, and all members are expected to nominate alternates when they are unable to attend.
Frequency of meetings	Quarterly, generally subsequent to the Board of Directors.
Papers	Papers will be distributed at least 5 days in advance of the meeting.
Permanency	The committee is a permanent committee.
Reporting committees	• Charitable Funds Development Committee (Above & Beyond Committee) • Other sub-committees for specific significant appeals set up from time to time
Circulation of minutes	Members of the Committee
Date approved by the committee:	June 2021
Date approved by Board of Directors:	July 2021
Review date:	June 2022

NHS
Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Report Cover Page					
Meeting Title:	**Board of Directors**				
Meeting Date:	20 July 2021	**Agenda Reference:**	**H1**		
Report Title:	**Chair & NEDs Report to Board**				
Sponsor:	Suzy Brain England OBE				
Author:	Suzy Brain England OBE				
Appendices:	None				
Executive Summary					
Purpose of report:	To update the Board of Directors on the Chair and NED activities since May 2021's board meeting.				
Summary of key issues:	This report is for information only.				
Recommendation:	The Board is asked to **note** the contents of this report				
Action Require:	~~Approval~~	Information	~~Discussion~~	~~Assurance~~	~~Review~~
Link to True North Objectives:	**TN SA1:** *To provide outstanding care for our patients*	**TN SA2:** *Everybody knows their role in achieving the vision*	**TN SA3:** *Feedback from staff and learners is in the top 10% in the UK*	**TN SA4:** *The Trust is in recurrent surplus to invest in improving patient care*	

Implications	
Board assurance framework:	None
Corporate risk register:	None
Regulation:	None
Legal:	None
Resources:	None

Assurance Route			
Previously considered by:	N/A		
Date:		**Decision:**	
Next Steps:	N/A		
Previously circulated reports to supplement this paper:			

Chair's Report

NHS Providers

NHS Providers' Governor Focus Conference took place during the first week of July; three half day events held between 6 – 8 July welcomed approximately 200 governors each day. The governor-specific programme looked at the sector through the lens of a governor, exploring developments in health and social care and examining issues most directly affecting their role. It was a privilege to have been asked to facilitate the daily breakout sessions, where governors were able to consider pre-defined questions and share their views on the keynote presentation, the daily showcase agenda item and also an opportunity to reflect on their role as a governor.

NHS Provider's Board meeting also took place that same week, where board trustees received the Chief Executive and Director Update, the year-end accounts, 2021-22 budget and business plans and an update and refreshed approach to tackling race equality. I was invited to meet separately with NHS Providers and their policy adviser as part of a consultation to scope out the required race equality offer.

I also attended NHS Providers Governance & Quality conference and their NEDs Network event. Along with fellow Chairs and the Chief Executive of Leicestershire Partnership NHS Trust I was invited to share my experience as Chair of the Board at DBTH and in my previous role as Chair of the SY&B ICS Committees in Common, with regards to the ambitions, impact and future of Provider Collaboratives. Sharing the SY&B journey to date, including lessons learnt and the reason why this change is so important to our workforce and the communities we serve.

1:1s and Introductory Meetings

In addition to my usual 1:1 meetings with the NEDs and Richard I have also met with Abigail Trainer, Deputy Chief Nurse and Gillian Marsden, who recently took up the post of Deputy Chief Operating Officer (Elective) at the Trust. Gillian joins us from Sheffield Teaching Hospital and brings with her a wealth of experience, she is keen to drive forward recovery and stabilisation following the pandemic. I welcomed Hayley Findlow, Corporate Governance Officer and Claudia Gammon, Secretarial Support Officer, who have both joined the Corporate Secretariat to cover periods of secondment for the substantive post holders. I also had 1:1 discussions with Keith Ramsay, Chair of The Mid Yorkshire Hospitals, Antonia Durham-Hall and David Purdue.

Governor Meetings

The quarterly Council of Governors meeting took place at the start of this month, the meeting continues to be held virtually, ensuring a good level of attendance and interaction. Governors received updates from myself, David Purdue in his capacity as Deputy Chief Executive, and the Non-

executive Directors as Chairs of the sub-committees of Board. Finally, governors made excellent use of the question time at the close of the meeting. Since my last Board report governors briefing sessions on End of Life care and the presentation of the Quality Accounts have taken place. I continue to meet with the Lead, Deputy Lead Governor and Fiona Dunn, Company Secretary on a monthly basis.

Associate Non-Executive Director

You will recall in my May's board report I referenced the continuing search for an Associate NED to bring diversity to the board, in addition to exploring the NeXT Director Programme, Karen Barnard and I met with Gatenby Sanderson who were able to support our search through their Insights Programme. As part of this scheme we welcome Malcolm Veigas on a six month placement with the Trust. Malcolm has buddied with Neil Rhodes and in addition to attending Board and the Finance & Performance Committee on a regular basis he will observe a meeting of the remaining sub-committees of Board as part of his development. This is an excellent opportunity for the Board to share their vast experience and support Malcolm throughout his time with us.

The Big Tea

On 5 July it was my pleasure to say a personal thank you to colleagues at DRI and share with them the amazing supplies of tea and cakes we received from our local cafes, bakeries and stores. Recognising the NHS's 73rd birthday and saying thank you to colleagues for all that they have done over the last year was very rewarding. A very special thank you to all those who supplied the birthday treats and to our Corporate Fundraiser, Sarah Dunning and the Communications Team for all their efforts in successfully coordinating the tea party across all three sites.

Other meetings

Following the internal incident in our Women's and Children's Hospital I have continued to raise awareness of the need for maintenance and more importantly redevelopment of our Doncaster estate. Richard and I have met with our Regional Director, SY&B ICS Chief Executive and their senior estates and finance colleagues to keep the needs of the Trust at the forefront of everyone's mind. More recently, I have written to welcome the Rt Hon Sajid Javid MP as Secretary of State for Health and brought to his attention our previous efforts to be considered by the government for a new hospital. Whilst writing, I took the opportunity to extend an invitation to visit Doncaster Royal Infirmary to see first-hand the estates challenge we face. In addition, Jon Sargeant and I met with the local Doncaster MPs to brief them on the impact of the Women's and Children's incident and consider potential next steps and redevelopment opportunities.

I continue in my role as co-opted director on the board of Doncaster Chamber, attending monthly board meetings, development sessions and supporting events. As true advocates of Doncaster the Chamber work with local businesses to encourage opportunities and growth working with local and national government. It is certainly a great connection for the Trust as the largest employer in the town and I know we have the support of Dan Fell, Doncaster Chamber CEO and his team in raising awareness of the need for a new hospital for the town.

Finally, completion of appraisals for my Non-executive Directors is expected by the end of this week and ahead of the official close of the appraisal season at the end of the month. I know this is something you will all be working to complete too.

NED Reports

Mark Bailey

Since the last Board, Mark has participated in the Board Committees for Audit & Risk, People, Quality & Effectiveness and chaired the Trust's Charitable Funds Committee. Board strategy sessions on clinical services, digital transformation and future workforce have been supported, along with virtual attendance at the annual NHS Governance and Quality Conference .

In early June, Mark chaired the first meeting of our new Teaching Hospital Board which has been constituted as a strategic educational and research board to drive forward the Trust's Teaching Hospital ambitions. Excellent contributions and a strong commitment to collaborate were received from external stakeholders which included the Doncaster College and University Centre, Doncaster Public Health, University of Sheffield, Sheffield Hallam University, and Nottinghamshire Healthcare.

Mark has supported the Clinical Specialities and Children & Families divisions in their appointments into the Consultant Microbiologist and Consultant Paediatrics positions respectively.

In addition to the regular catch-up calls with Executive and Non-executive colleagues, individual calls with Governors have been held and he has attended the Governor confidential briefing and development sessions. At the Council of Governors meeting Mark presented on the Trust's Charitable Funds activity and deputised for the Chair of Quality & Effectiveness.

Finally and most recently, Mark was delighted to have the opportunity to meet and show appreciation to some of our team members at Montagu and DRI as part of the NHS Big Tea event.

Kath Smart

In Kath's role as Audit Chair she has chaired two Audit Committees to finalise the year end statements, reports and declarations, including the Trust's Annual Accounts which were signed off on behalf of the Board with a positive (unqualified) External Audit opinion. She has continued to support the Procurement process for tendering both internal and external audit services, including scoring of bids and attending the feedback and bidder day meetings. The tender outcome will be reported separately.

Along with other NEDs she attended the Governor briefing session on Maternity Safety, presented at the July Council of Governors Meeting, attended the NED meetings and had her appraisal with the Chair.

As part of buddying arrangements with the Chief Operating Officer, Kath and Becky visited DRI theatres, who are in the process of stepping up elective activity, and spoke with staff and consultants on the challenges faced. They also visited the newly refurbished DRI theatre changing rooms which had great feedback from staff. They also visited the Pre-operative Assessment Teams at DRI and heard about the progress and challenges in stepping up activity.

Kath has also chaired a consultant recruitment panel for the Emergency Department (ED) and was pleased to make a substantive appointment, and then visited the ED Department on one of their regular huddles and attended the ED Project Group

Finally, she attended her nominated Committees of Finance & Performance; People Committee; Charitable Funds and Board workshop sessions on the Development of DBTH Digital, plus the ongoing work on the Clinical Development Strategy.

Pat Drake

Since Pat's last board report she has facilitated the Chair's appraisal process. She has had a 1:1 with the Chair and joined the NED update meetings.

She has continued her buddying arrangements with governors and the Medical Director and met with some of the deputy directors.

Pat has chaired an Organ Donation Committee (ODC) and also attended a Yorkshire Chairs Collaborative meeting. The regional chair will attend the next ODC and plans are well underway for events for the national organ donation week commencing 20 September.

Pat has attended two Finance and Performance Committee meetings, chaired two planning meetings for the Quality & Effectiveness Committee and chaired the meeting itself. She has attended the Charitable Funds Committee and the board workshops on digital transformation, the clinical strategy and a KPMG healthcare workforce briefing. She joined the shortened public Board Meeting in June, followed by the new approach to board workshops.

Pat has visited the Emergency Department, Frailty Assessment Unit, Ward 17 and the Respiratory Unit to see the changes staff have implemented during the pandemic and to thank them for all their hard work.

In terms of her NED maternity safety role Pat has met with the Chief Nurse, the Divisional Director and the Director of Midwifery on site and took the opportunity to visit the maternity wards and talk to the staff about the recent issues and ward moves and asked how they were feeling. The staff had been very resilient given the water ingress and seemed settled and positive in their new areas. She has also attended two AQUA master classes, two staff safety sessions and the Children and Families Board.

Neil Rhodes

Since his last board report Neil has taken part in the June Board meeting, two Audit & Risk Committee meetings, chaired the Finance & Performance Committee and held the precursor agenda setting meetings. He has had 1:1 meetings with both the Director of Finance and the Chief Operating Officer. Neil has chaired a governor briefing session and attended other sessions. He also attended the Charitable Funds meeting and has met the Chair of the Board on two occasions, to discuss his appraisal and routine business matters.

Neil has chaired a meeting of the wholly owned subsidiary. He has also begun a mentoring relationship with Malcolm Veigas, Associate NED, to assist in the NED's induction and board experience. During this period he has also attended a KPMG briefing and a clinical strategy workshop.

By the date of the meeting Neil will also have attended a NHS Reset Meeting on behalf of the Chair and is scheduled to chair a consultant recruitment process and participate in a grievance hearing.

Sheena McDonnell

This month has seen Sheena participating in her annual appraisal with the Chair. She has also held catch ups with Governor colleagues who are part of the People Committee as well as chairing the People Committee, with a very comprehensive agenda.

Sheena has attended the Council of Governors meeting, where she presented her People Committee update and had a catch up with her NED colleagues as part of a keeping in touch approach.

Sheena attended a NHS Providers event hearing updates from Simon Stevens in one of his last events as CEO of the NHS and Chris Hopson on the current operating context for the NHS.

This month was the anniversary of the NHS, which was celebrated with a national tea break for all NHS colleagues, Sheena was fortunate enough to be able to give out tea and cakes to colleagues at Bassetlaw by way of a thank you for all of the great work they do everyday.

Sheena has attended a two day conference on the digital agenda and innovation in the NHS. She has also attended the Audit & Risk Committee, the Trust Ethics Committee and participated in consultant recruitment.

Chief Executive's Report
July 2021

Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

Prepared by David Purdue, Deputy Chief Executive.

An update on the Trust's response to COVID-19

Unfortunately throughout the past few weeks we have seen a small but consistent increase in the number of patients admitted to our hospitals having tested positive for COVID-19.

While we are not at the levels of activity seen earlier this year, I want to take this opportunity to emphasise the importance of our visitors following the infection, prevention and control measures we have in place, such as wearing a mask at all times, undertaking regular hand washing, as well as maintaining social distancing wherever possible. To aid in these efforts, we have once again taken the difficult decision to restrict our visiting access and we will continue to monitor this for the next few days and weeks.

Earlier this year we vaccinated the vast majority of our workforce throughout the Trust, with more than 13,000 doses delivered to colleagues in the four months of our programme. However, I want to remind everyone that while we have good levels of collective immunity, the overall efficacy of the COVID-19 vaccine sits between 80% and 90%. This means that there is still a small chance of catching the illness, albeit in a much less severe form, but a chance nonetheless. Therefore I must urge our communities not to put themselves at any unnecessary risk – the mantra of hands, face and space still stands and should be followed throughout summer, into autumn and beyond as move towards winter, particular when visiting our hospitals.

We will continue to monitor our position, and will update our partners, colleagues and public as necessary. Thank you for your ongoing support.

Updating our hospital strategy

In late June, we launched a listening exercise to help develop our next hospital strategy, or plan, for the forthcoming five years.

The exercise included a series of online discussions events open to both staff and the public, as well as a digital survey which has been shared with our various communities.

I want to thank everyone who has taken the time to share their thoughts throughout the past few days.

Celebrating the NHS' 73rd birthday

On 6 July, colleagues celebrated the NHS' 73rd birthday with a free cupcake and a cuppa'.

Doctors, nurses and administrative staff at DBTH helped themselves to a free hot drink and sweet treat to start the week (Monday 5 July), as the Health Service marked 73 years of service as well as the 'NHS Big Tea'

Getting into the birthday spirit, and with special thanks to Trust caterers Sodexo, each and every staff member across Doncaster Royal Infirmary, Bassetlaw Hospital and Montagu Hospital was

entitled to a free cup of tea, as well as the choice of a cupcake, donut, brownie, tray bake or cookie. External clinics also received a special delivery which consisting of a hamper of break time goodies.

With special pop-ups stalls setup within the Trust's three hospital sites, colleagues were able to come along and pick out their treat, our instead special deliveries took place throughout the day to wards and services who were busy tending to patients.

The tray bakes and cupcakes, which were largely given out at Doncaster Royal Infirmary, were made by Jimmy Piggs Café in Doncaster, following a marathon baking session during which more than 4,000 buns were crafted, iced and sprinkled.

The Trust also worked with Morrison's in Doncaster, Retford, Worksop and Barnsley, with a range of confectionary delivered on site and to external clinics around the town, and handed out to colleagues.

Throughout the day, a number of local cafes also got involved in the NHS Big Tea in support of DBTH Charity, donating a small portion of the price of a cuppa'. These businesses were: Jimmy Piggs Coffee House, Coffee Corner, Annie's Café, The Leaky Teacup, The Bean Scene, So Good It Yurts, Classic Café at Yorkshire Caravans, No 9, Mooreish Delights, The Chase Tearooms, Meet and Eat, The Old School Tearooms, The Café in Sherwood Forest and Pekish Café.

Other corporate partners also got involved throughout the day, such as Albemarle Homes and Go Green who held their own tea party at home, while The Tea Experience has donated a hamper worth over £200 which will be gifted to one lucky team within the Trust. .

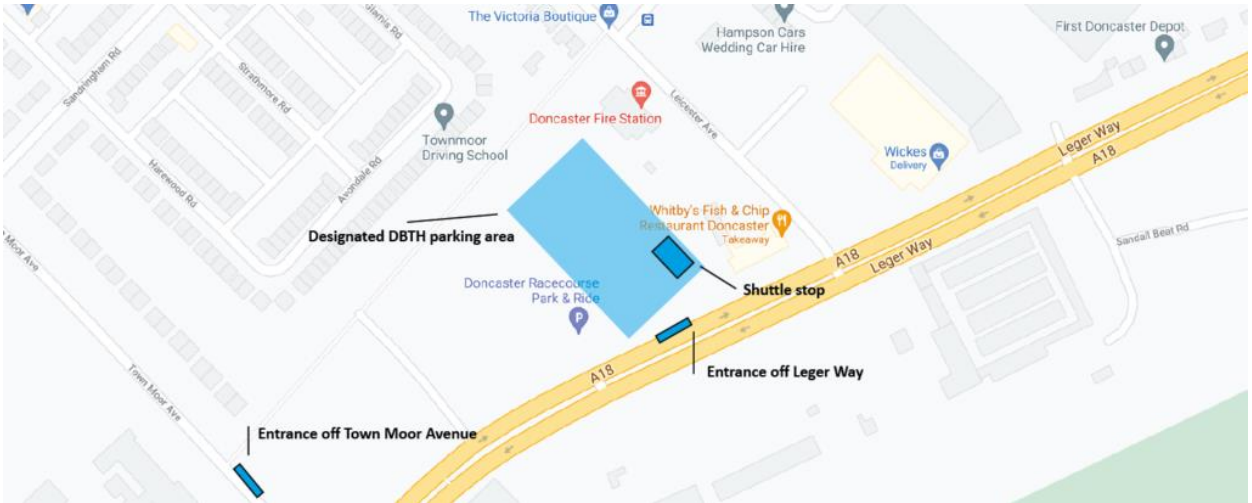
Return of car parking charges on 19 July

Please note from Monday 19 July parking charges will be reintroduced across the NHS, as per Government policy as restrictions ease. Note, there will be a one week's grace period ending 26 July.

Where can I park?

With the reintroduction of parking charges, you are still able to park on-site by paying the appropriate fees, alternatively you may use the Park and Ride at Doncaster Royal Infirmary, or make use off-site spaces near to our sites (but please ensure you are respectful to neighbours, leaving clear access to driveways and so on).

Where is the Park and Ride, and how can I use it?



The Park and Ride is situated opposite the Doncaster Race Course on Leger Way. It can be accessed via the aforementioned road, or Town Moor Avenue. The designated car park for this facility is to the far end near to Whitby's Fish and Chip shop.

The shuttle service

Available for hospital staff, patients and visitors, this shuttle runs between the Park and Ride facility on Leger Way and South Block Outpatients near to Gate 6 of Doncaster Royal Infirmary. The shuttle operates Monday to Friday (excluding Bank Holidays) between 5.50am and 10.00pm.

This service costs 50p per journey for patients and visitors – staff ride for free just show your NHS badge.

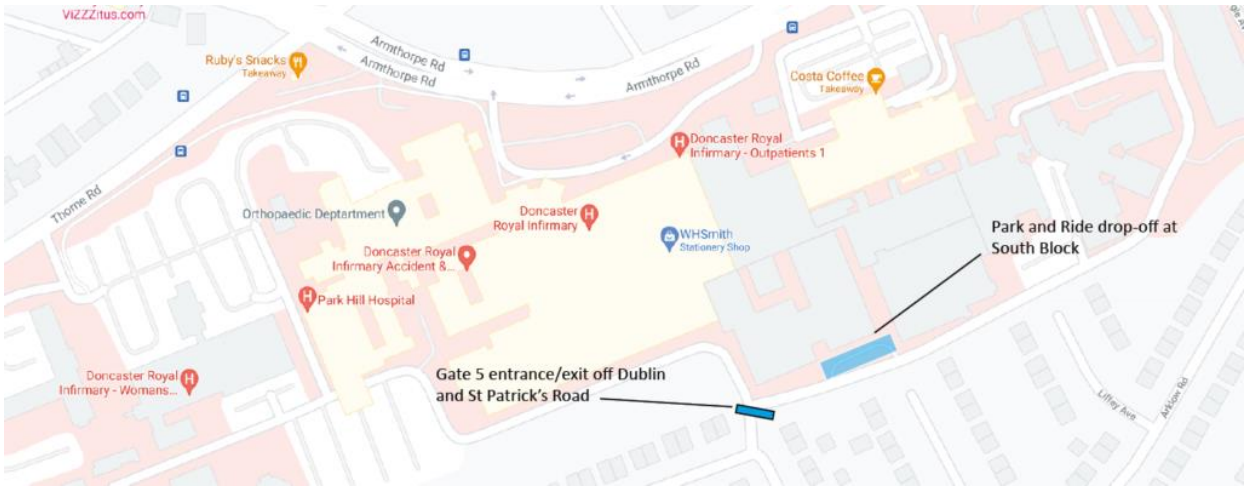
The bus journey normally takes between five and seven minutes. Please allow adequate time to park your vehicle and ride up to the hospital in good time for your appointment. Hospital Security staff are on duty at the Park and Ride car park during operating hours. Click here for the Park & Ride bus timetable (printable version).

The shuttle stop is at the far end of the car park, near to Whitby's Fish and Chip shop. There is a small platform, with seating next to a sign outlining the time table, which can be viewed here.

Please note, as per current COVID-19 restrictions, we ask all users of the shuttle to wear an appropriate face covering unless medically exempt.

Pick up point at Doncaster Royal Infirmary

The current and temporary pick-up and drop-off point at Doncaster Royal Infirmary is outside South Block.



Leaving your vehicle

There is ample room for your vehicle in this car park. Please can we remind visitors, patients and staff to park within the marked bays.

We have lighting available in this area, while security colleagues regularly patrol.

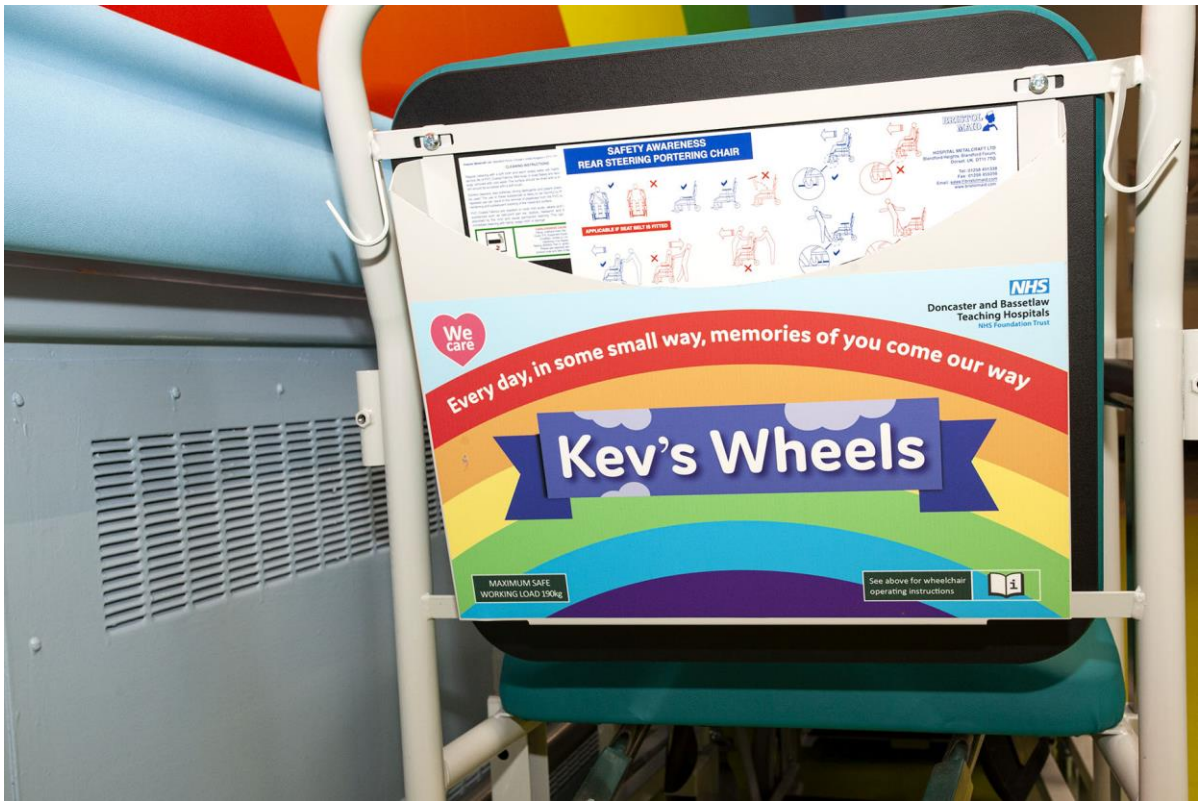
'Kev's Wheels' area opens at Doncaster Royal Infirmary

On 28 June, colleagues at Doncaster Royal Infirmary (DRI) have officially opened the 'Kev's Wheels' area of the hospital, following a fundraiser in memory of a much-loved colleague who sadly passed away in April 2020 following a brief but brave battle with COVID-19.

On Easter Sunday of last year, Kevin Smith, a beloved colleague at the Trust, passed away following treatment for coronavirus. A Plaster Technician at Doncaster Royal Infirmary and a valued and respected member of the team since 1983, Kev, as he was known to friends, cared for thousands of patients throughout his career. So well-known and thought of was the Doncaster resident that he was often stopped and thanked whenever he was out and about by those he had so expertly patched-up, potted and plastered.

Following the announcement of Kevin's passing, thousands of colleagues across DBTH came together and clapped for him for one minute. This was in addition to the countless messages left on Facebook, describing him as the town's 'very best pot man' amongst other heartfelt tributes.

Channelling her efforts into a worthwhile project, Diane Smith, Kev's wife, launched a Just Giving appeal in early May in her husband's honour, to raise money for much-needed wheelchairs at the Trust. In just a few hours she had smashed her original target of £5,000, ultimately raising more than £17,000.



With the money raised, colleagues at the Trust worked with Diane to create a special space reserved for wheelchairs, as well as with the procurement department to purchase a number of new chairs, each of which has been badged with the 'Kev's Wheels' brand.

The area, which is just opposite the Fracture Clinic, Kevin's former place of work, and is now complete with a rainbow motif and dozens of new wheelchairs ready for patients to use. The facility

was opened by Diane, accompanied by friends and family, as well as colleagues of Kevin on Monday 28 June.

Throughout the past year we have experienced some truly heart breaking times, and the loss of Kevin so early in the pandemic was felt deeply within our Trust.

However, from these moments of immense sadness we have also witnessed the kindness of our communities, as well as the desire for us all to collectively pull together to do the right thing, look after one another and send COVID-19 packing from our towns, villages and streets. And this, for all of the sorrow we have felt, has been truly heart-warming.

On a personal note, I am so full of admiration for Diane, and her wider family, who have dealt with their loss with such incredible grace and strength. The area that her efforts has helped to create looks fantastic, and I am confident it will provide a real benefit to our patients, and also to colleagues within their working day. On behalf of all at the Trust, I want to share my thanks to Diane, her friends and family, as well as everyone who has donated to make Kev's Wheels a reality.

Crowd-funded remembrance garden opens at local hospital

Also on Monday 28 June, health professionals at Doncaster Royal Infirmary officially opened a remembrance 'Rainbow Garden' in memory of all those who have lost their lives to COVID-19, following donations of more than £50,000 from local residents and businesses.

In June 2020, colleagues at the Trust began to fundraise with an ambition to create two beautiful spaces in honour of those affected by COVID-19, in particular colleagues, Kevin Smith, Dr Medhat Atalla and Lorraine Butterfield, who sadly passed away from the illness last year.

With a target of £35,000 set for the project, with the help of almost 300 supporters and donations large and small, in just eight weeks the goal had been met, with over £50,000 raised allowing the work on the gardens spaces to get underway.

The Rainbow Garden at Bassetlaw Hospital was completed in September 2020, with the help of staff at Anpario, as well as gardener John Fox and his wife Carolyn an NHS accountant. Since that time, work had been underway designing and creating the Doncaster space, which was officially unveiled in June.

With over £50,000 raised for this project, any leftover monies will be used to improve infrastructure across the Trust such as placing benches so that health professionals, visitors and patients can take a break or rest outside on hospital grounds, weather permitting.

A number of sponsors have supported the Rainbow Garden campaign, either donating funds, their time or resources (or a mixture of all three). These include: Wilko, Anpario, Polypipe Building Products, Taylor Wimpey, Morgan Sindall, Lindrick Construction, RJ Electricals, PSL Print, NHS Professionals, Bassetlaw Hospital League of friends, Pandrol Worksop, Hall Fencing, Notcutts Welbeck Garden Centre, Shedcetra of Retford, Viridor, SharpSmart, MechFS, Ikea, Reshaped, Johnsons of Whixley and AWS Landscapes Ltd, Keepmoat and AWS Landscapers Ltd.

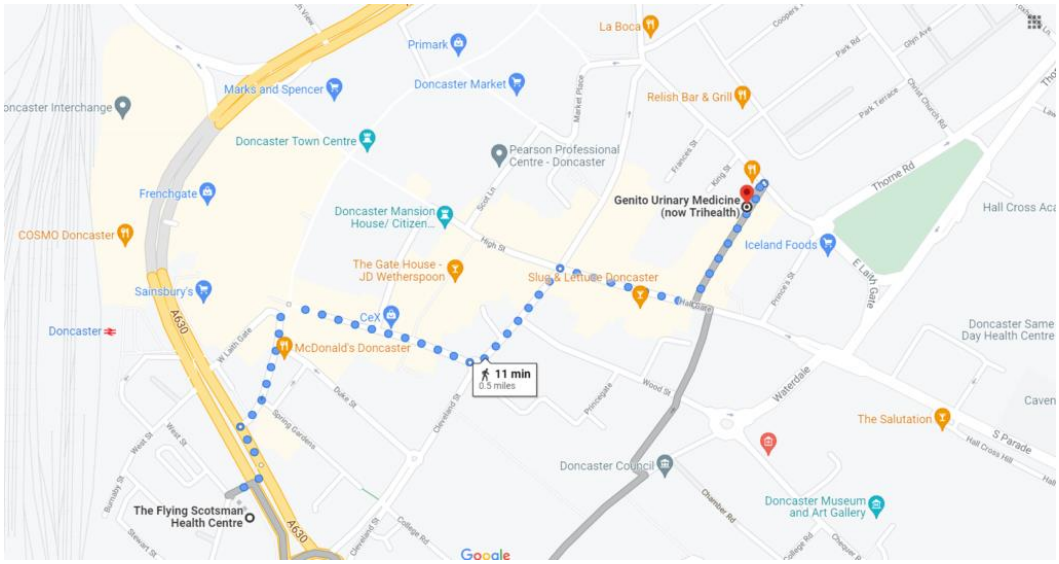
Throughout the project, the Trust has relied on the kindness of local companies, for example Bradley and Trotter Restoration LTD donated their time and labour to create an incredible stone bench. With all of the masonry work completed by Simon Trotter, the husband of Annette, a nurse specialist within the hospital's Department of Critical Care, the bench takes pride of place within the garden with the inscription 'Take a seat to remember loved ones'.

Movement of sexual health services

Project3 and TriHealth have moved from East Laith Gate House to the Flying Scotsman Centre, St Sepulchre Gate, Doncaster, DN1 3AP. The contact details for the services remain the same:

- Contraception: 01302 640040
- GU Med: 07884547705

The new premises are just an 11 minute walk away from where they were previously.



Department of Health and Social Care White Paper

Since the last Board meeting, a number of national documents have been produced that relate to the Department of Health and Social Care's (DHSC's) Integration and Innovation White Paper published in February this year. NHS England and NHS Improvement (NHSE/I) published the Integrated Care System (ICS) Design Framework on 16th June 2021. This sets out the next steps for how NHSE/I expects NHS organisations, working with system partners, to continue developing ICSs during 2021/22, in anticipation of establishing statutory ICS NHS bodies from April 2022.

In addition The Health and Care Bill has now also been published (6th July). This is a substantial piece of legislation covering the following:

- Part 1 – Health service in England: integration, collaboration and other changes
- Part 2 – Health and adult social care: information
- Part 3 – Secretary of state's powers to transfer or delegate functions
- Part 4 – The Health Services Safety Investigations Body
- Part 5 – Miscellaneous
- Part 6 - General

The NHS Confederation notes that this is the first major piece of primary legislation on health and care in England since the Health and Social Care Act 2012. The Bill contains many of the reforms set out in the earlier white paper and focuses largely on the detail of how a new health and care system, based on integration rather than competition, will be structured. This includes specifications on how integrated care systems (ICSs) are to be set up and the distinct statutory functions for the integrated care board (ICB) and integrated care partnerships at place.

As a Trust we continue to work with partners across place and the ICS to prepare for this legislative change.

A New Further and Higher Educational Facility in Worksop

Bassetlaw District Council, with the support of the Bassetlaw Integrated Care Partnership (which includes DBTH), has secured investment for 'Bridge Court' – a new educational facility in Worksop which presents an exciting opportunity for local employers, such as yourselves, to support local education and training for Bassetlaw residents and to act as a resource for your current and future staff.

This new facility will have a particular focus on health and care as we employ so many local people, have a significant need for well-educated and trained staff and can offer excellent career opportunities for local residents. Currently, people in Bassetlaw wishing to undertake further and higher level training in health and care have to leave the district to study, which reduces options for those unable to travel and results in local people being 'lost' to the care system to other areas outside of the district.

Bridge Court will act as a local bespoke learning centre. It will provide the facilities for education providers to deliver further and higher education tailored to the needs of local employers. Learning can take place physically and through virtual learning environments delivering locally tailored provision in response to skills gaps and needs including for health and care for up to 300 students.

The next phase of the Bridge Court initiative is for DBTH, and other health care services in Bassetlaw to work with education providers to develop a detailed and locally tailored prospectus.

Appointments:

- Ken Anderson was named Chief Information Officer following a period as interim within the position.
- Jodie Roberts was named Director of Allied Health Professionals, following a period at the Trust a Deputy Chief Operating Officer.

South Yorkshire and Bassetlaw Integrated Care System

Chief Executive Report

Health Executive Group

13th July 2021

Author(s)	**Andrew Cash**
Sponsor	

Is your report for Approval / Consideration / Noting

For noting and discussion

Links to the ICS Five Year Plan (please tick)

Developing a population health system

- ☑ Understanding health in SYB including prevention, health inequalities and population health management
- ☑ Getting the best start in life
- ☑ Better care for major health conditions
- ☑ Reshaping and rethinking how we flex resources

Strengthening our foundations

- ☑ Working with patients and the public
- ☑ Empowering our workforce
- ☑ Digitally enabling our system
- ☑ Innovation and improvement

Building a sustainable health and care system

- ☑ Delivering a new service model
- ☑ Transforming care
- ☑ Making the best use of resources

Broadening and strengthening our partnerships to increase our opportunity

- ☑ Partnership with the Sheffield City Region
- ☑ Anchor institutions and wider contributions
- ☑ Partnership with the voluntary sector
- ☑ Committment to work together

Where has the paper already been discussed?	
Sub groups reporting to the HEG:	**System governance groups:**
☐ **Quality Group**	☐ **Joint Committee CCGs**
☐ **Strategic Workforce Group**	☐ **Acute Federation**
☐ **Performance Group**	☐ **Mental Health Alliance**
	☐ **Place Partnership**
☐ **Finance and Activity Group**	
☐ **Transformation and Delivery Group**	

Are there any resource implications (including Financial, Staffing etc)?

N/A

Summary of key issues

This monthly paper from the System Lead of the South Yorkshire and Bassetlaw Integrated Care System provides a summary update on the work of the South Yorkshire and Bassetlaw health and care partners for the month of June 2021.

Recommendations

The SYB ICS Health Executive Group (HEG) partners are asked to note the update and Chief Executives and Accountable Officers are asked to share the paper with their individual Boards, Governing Bodies and Committees.

Chief Executive Report

SOUTH YORKSHIRE AND BASSETLAW
INTEGRATED CARE SYSTEM

Health Executive Group

13th July 2021

1. Purpose

This paper from the South Yorkshire and Bassetlaw (SYB) Integrated Care System (ICS) System Lead provides an update on the work of the South Yorkshire and Bassetlaw health and care partners for the month of June 2021.

2. Summary update for activity during June

2.1 Coronavirus (COVID-19): The South Yorkshire and Bassetlaw position

Like other parts of the country, SYB is seeing a similar rapid increase in rates of Covid. This is linked to the increases in social mobility (back to pre-pandemic levels) and the Delta variant, now dominant throughout England.

Cases of Covid are doubling in SYB on average every seven days which is a strong indication of how quickly infections are rising. The spread is largest among unvaccinated groups with the 20-24s and under 20s attributing to the latest surge in cases.

Fortunately, we are still not seeing any significant concern across our acute trusts in terms of bed occupancy. Levels of occupancy are slowly rising, mostly with unvaccinated individuals but there have not been any Covid-related deaths for seven days.

Public health data is still showing no clear evidence of stacking (passing of the virus between younger to older and more clinically vulnerable members of the same household), but there is a strong consensus among public health teams that cases will continue to rise sharply over the next few weeks with current forecasting analysis anticipating cases will flatten-off during August.

In terms of our vaccination progress, SYB is performing well and targeting new eligible age groups and improving access for greater numbers of our population.

As at 6th June, 96% of cohorts 1-4 have had their first dose and 89.9% have had their second dose. For cohorts 5-9 this is 92% for first dose and 87.1% for their second. In cohort 10, the first dose is 85.6% and second dose is 69.4%. For cohorts 11 and 12 (30 to 39-year-olds and 18-24-year-olds), the first dose drops to 68.5% and 24.2% for second dose. This is not surprising given the vaccination offer has only recently been available to cohort 12 and there is a minimum eight-week gap between doses.

Additional locations across SYB, including Montgomery Hall (Rotherham), Priory Campus (Barnsley) and Bramall Lane (Sheffield), have been set up recently along with many others. This has been especially useful in increasing our numbers of 18-20 year-olds vaccination numbers which is encouraging, despite an overall slowing-down in the overall take-up of vaccines.

The ‘grab a jab’ campaign has enhanced the opportunities for individuals to come forward as this is being offered on a drop-in basis leading up to the planned easing on the 19th July. The SYB

programme is working hard to meet the targets set for each cohort by July 18th and every effort to promote the offer is being made in the final two weeks

I would like to acknowledge SYB's Vaccination Steering Group for co-ordinating the fantastic work of primary, community and secondary care colleagues and the incredible support of local authorities and volunteers throughout the vaccination programme.

2.2 Regional update

2.2.1 Leaders meeting

The North East and Yorkshire (NEY) Regional ICS Leaders meet weekly with the NHS England and Improvement Regional Director. During June, discussions focused on the ongoing Covid response and vaccination programme, urgent and emergency care and winter resilience, planning and recovery and ICS development (including feedback from the NEY transition oversight group).

2.3 National update

2.3.1 Health and Care Bill

The government has now published a bill setting out how it intends to reform the delivery of health services and promote integration between health and care in England. This is the first major piece of primary legislation on health and care in England since the Health and Social Care Act 2012.

The bill will now make its way through Parliament which includes a second reading in the House of Commons and then to Committee stage (expected in September).

It is structured in six parts:

Part 1: Health service in England: integration, collaboration and other changes
Part 2: Health and adult social care: information
Part 3: Secretary of State's powers to transfer or delegate functions
Part 4: The Health Service Safety Investigations Body
Parts 5 and 6: Miscellaneous and general

The bill is on course to pass into law by April 2022 but is recognised that timescales are tight and there much work to be done to finalise key elements of the bill.

The link to the bill is here: https://publications.parliament.uk/pa/bills/cbill/58-02/0140/210140.pdf

2.3.2 ICS Design Framework

NHS England and Improvement (NHSE/I) has set out the next steps for the development of integrated care systems (ICS') in the Integrated Care Systems Design Framework, which was published in June.

The document sets out the headlines for NHS leaders and organisations to operate with their partners in ICSs from April 2022. It is intended to help ICSs as they put in place the practical steps to prepare for new functions that are expected to be enabled by legislation in. In SYB, our system leaders had already started to sketch out future ways of working and are now carefully considering the Design Framework within the established design and transition workstreams. As these important areas of work progress, we will be incorporating both the framework and subsequent guidance and resources into the SYB approach.

2.4 Embrace Children's Transport Service re-accredited

Embrace Yorkshire and Humber Infant and Children's Transport Service has been re-accredited in recognition of its life-saving care and commitment towards delivering quality patient care and safety.

The transport service, part of Sheffield Children's NHS Foundation Trust, provides a team of specialist doctors and nurses who travel with their patients by road ambulances, helicopters and planes. It has been re-accredited by the Commission on Accreditation of Medical Transport Systems (CAMTS) Global after being assessed on patient care and safety in the transport environment.

2.5 Tailored approaches in primary care to support the support Covid vaccination delivery programme.

Firefighters from South Yorkshire Fire and Rescue have been supporting Sheffield GP practices with the Covid vaccination delivery programme. A number of fire service volunteers were trained up as vaccinators by St John Ambulance as part of a national effort from fire services across the country to help with the pandemic response.

This approach sits alongside the development of walk-in clinics in locations close to where people live to encourage as much uptake as possible. This includes locations such as the St Charles Borromeo Church in Attercliffe, Sheffield, leisure centres in Thorne, Adwick and the Dearne Valley in Doncaster, the market in Barnsley town centre, the leisure centre in Maltby and Rawmarsh customer services centre in Rotherham and the Kilton Forest Community Centre in Worksop.

2.6 Acute Provider Collaborative among the finalists for the Procurement Project of the Year at the Health Service Journal Partnership Awards.

During the early stages of the coronavirus outbreak a collaboration of nine trusts in South Yorkshire, Bassetlaw and Lincolnshire worked with Crown Commercial Services (CCS) to establish a single supplier contract for the purchase of multidisciplinary temporary healthcare personnel with the prime group being doctor locums.

As a result, more than £1 million pounds was saved, which is around 6 per cent of the total locum doctor spend. A collaborative tender on this scale is rarely seen across the NHS and a result, the Collaborative reached the finals in the Health Service Journal Partnership Awards.

Ongoing work as part of the collaboration is expected to see agency fees for doctors in the area fall which would deliver additional annual savings.

Congratulations to the procurement teams in each of the acute hospital trusts for reaching the final in the Procurement Project category.

2.7 Your Covid Recovery campaign

A localised 'Your Covid Recovery' campaign was launched across SYB in June following engagement with local people who said that they were unsure where to go or who to ask when they had health questions after having Covid.

Uncertainty over issues such as how long should the cough last, when would taste and smell come back, when to re-start exercising, and being unable to source advice and support from family members were issues raised by the members of the public taking part in the insight.

Partners in SYB came together to develop a local social media campaign using channels and connections already in place to raise awareness of the national website, which addresses the issues: https://www.yourcovidrecovery.nhs.uk/

2.8 SYB ICS Cancer Alliance

2.8.1 Virtual Showcase

The SYB ICS Cancer Alliance held a virtual showcase event on Friday, 25 June, which displayed the breadth of work taking place to provide high quality, personalised care for anyone affected by cancer in our region. After a challenging year, the event was an opportunity to reflect on the achievements and advancements made by the broad range of people involved in cancer care.

Over 70 people attended the event which heard from the National Director for Cancer, Professor Peter Johnson, Local MP and Mayor of the Sheffield City Region, Dan Jarvis, people directly involved in the work of the Alliance from primary through to secondary care and beyond as well as some key community and voluntary sector partners.

2.8.2 Do it For Yourself (DIFY) lung cancer awareness campaign launched

The pandemic has unfortunately impacted on the number of people coming forward with lung cancer symptoms. In partnership with MSD, the Alliance has launched a lung cancer awareness campaign to encourage people to make an appointment with their GP if they have had a cough or have been breathless for three weeks or more.

The campaign features targeted advertising in Barnsley and Rotherham on buses, at bus stops, at local amenities, on pharmacy bags and on local radio.

2.9 QUIT launches across SYB

The QUIT Programme, which has the potential to save up to 2,000 lives and 4,000 hospital readmissions a year, has launched across South Yorkshire and Bassetlaw.

As partners are aware, the groundbreaking stop smoking programme is being delivered by SYB ICS in partnership with Yorkshire Cancer Research, five local authorities and local Stop Smoking Services.

Based on evidence from successful smaller schemes in Ottawa and in Greater Manchester, QUIT is the largest project of its kind in the world and will transform the way smoking is tackled by the NHS in the region. Rather than seeing smoking as a lifestyle choice, hospital staff across the eight NHS Trusts in South Yorkshire and Bassetlaw now recognise it as tobacco addiction – a medical condition they have a responsibility to treat as part of patients' routine hospital care.

Every hospital patient in the region over the age of 12 years who smokes will now have access to nicotine replacement treatments (NRT) and specialist stop smoking support during their hospital stay from 45, trained Tobacco Treatment Advisers funded by Yorkshire Cancer Research.

Community-based stop smoking services will play a key role, ensuring medication and support is continued after patients leave hospital to give them the best chance of beating their tobacco addiction.

2.10 Queen's Birthday Honours

Nurse Adele Hague, team leader for Sheffield Children's 0-19 team, was awarded a British Empire Medal (BEM) in the Queen's Birthday Honours for her dedicated work in the community and for her work setting up a testing service and vaccination clinics at Sheffield Children's during the Covid pandemic.

Adele has worked at Sheffield Children's for six years. Her normal role supports the coordination of healthcare for children and young people across the city. She is a key part of the 0-19 service, which helps ensure children are on track with their development and supports parents with the challenges of parenthood, including helping them to learn new skills.

In March 2020, Adele volunteered to help with the Covid response. Adele trained as a Covid tester, oversaw the admin team who running the testing service, organised the logistics of the testing service and personally swabbed more than 2,000 people. Later in the year Adele was also instrumental in launching the Covid vaccination clinics, being part of the team and personally vaccinating hundreds of colleagues at Sheffield Children's.

Dr Thushan de Silva, Honorary Consultant Physician in Infectious Diseases at Sheffield Teaching Hospitals NHS Foundation Trust and Senior Clinical Lecturer at the University of Sheffield was appointed a Member of the Order of the British Empire (MBE).

Since the start of the pandemic in the UK, Dr de Silva spearheaded the University's research into SARS-CoV-2. He leads the Sheffield Covid-19 Genomics group, which was formed in March 2020 as part of the national Covid-19 Genomics UK (COG-UK) Consortium to track the spread and evolution of the virus.

Much of Dr de Silva's work has been done in collaboration with the South Yorkshire Department of Infection and Tropical Medicine at Sheffield Teaching Hospitals NHS Foundation Trust, where he is an Honorary NHS Consultant. He cared for some of the UK's first Covid-19 patients and has continued to do so throughout the pandemic.

The annual Birthday Honours recognise individuals in society who have committed themselves to serving and helping Britain. They often honour individual achievements such as making a difference to a community, or in a field of work which changes or improves lives.

2.11 Rainbow garden opens at Doncaster Royal Infirmary

A remembrance 'Rainbow Garden' in memory of all those who have lost their lives to Covid opened at Doncaster Royal Infirmary in June. It was made possible following donations of more than £50,000 from residents and businesses.

In June 2020, colleagues at Doncaster and Bassetlaw Teaching Hospitals (DBTH) started to fundraise with an ambition to create two spaces in honour of those affected by Covid, in particular colleagues, Kevin Smith, Dr Medhat Atalla and Lorraine Butterfield, who sadly passed away from the illness last year.

3. Finance

As at month two (May) the system has a surplus of £17.8m which is £14.2m favourable to plan. Financial plans at Month 2 exclude Elective Recovery Funding (ERF) and accelerator funding of £49m and £8.5m respectively. No margin has been assumed on ERF funding. This will be reflected in the Month 3 reporting. The ICS budgets including Cancer have a small underspend at month 2 (£3k). £9.8m has been spent on capital in the first 2 months which is £0.7m greater than plan. The ICS are still awaiting to hear what the financial framework for the second half of the year will look like.

Andrew Cash
System Lead, South Yorkshire and Bassetlaw Integrated Care System

Date: 7th July 2021

South Yorkshire and Bassetlaw Integrated Care System

SYB ICS Digital Transformation Strategy

SYB ICS Acute Federation Meeting

7th June 2021

Author(s)	Kate Mansfield (Digital Strategy and Engagement Lead, SYB ICS) Ben Gildersleve (Digital Programme Director, SYB ICS)
Sponsor	Dr Richard Cullen (GP, Rotherham CCG Chair, SYB ICS Digital SRO)

Is your report for Approval / Consideration / Noting

For formal endorsement

Links to the ICS Five Year Plan (please tick)

Developing a population health system

- ☑ **Understanding health in SYB including prevention, health inequalities and population health management**
- ☑ **Getting the best start in life**
- ☑ **Better care for major health conditions**
- ☑ **Reshaping and rethinking how we flex resources**

Strengthening our foundations

- ☑ **Working with patients and the public**
- ☑ **Empowering our workforce**
- ☑ **Digitally enabling our system**
- ☑ **Innovation and improvement**

Building a sustainable health and care system

- ☑ **Delivering a new service model**
- ☑ **Transforming**
- ☑ **Making the best use of resources**

Broadening and strengthening our partnerships to increase our opportunity

- ☑ **Partnership with the Sheffield City Region**
- ☑ **Anchor institutions and wider contributions**
- ☑ **Partnership with the voluntary sector**
- ☑ **Committment to work together**

Are there any resource implications (including Financial, Staffing etc)?

Yes, but will be dealt with as part of more detailed planning following endorsement of the strategy.

Summary of key issues

1. Introduction /Purpose

The SYB ICS Digital Transformation Strategy was shared with the Acute Federation Meeting in May-21 for review and feedback, with the group confirming they were happy with the direction of travel, and the Strategy should be presented back to this group for formal endorsement prior to presentation at the SYB Health Exec Group. An investment requirement summary has been included, which provides a 'rough order of magnitude' investment requirement to deliver the strategy. This requires further work to review and agree, including identifying relevant funding

sources and any baseline spend that could offset any new requirement.

This paper and the full Strategy document, and Investment Summary are now presented for formal Acute Federation Meeting endorsement, with an additional request that Acute Provider Trusts take the strategy to their Organisation Boards for their approval in the next month.

2. Endorsement Request

The SYB ICS Digital Transformation Strategy aims to provide a strategic approach/framework to align digital delivery across all SYB ICS partner organisations for the benefit of all. It seeks to raise digital maturity and support innovation, cognisant there are differing levels of digital maturity for the public, staff and in the way digital services are delivered. Based on consultation and engagement to date, it is assumed current Organisation Digital Strategies and Plans are congruent to the ICS Digital Strategy. Over time, through greater collaboration across SYB, the SYB ICS Digital Strategy can guide and align digital delivery, achieving the potential outcomes in the strategy.

Based on this approach, the endorsement being sought from SYB Acute Provider Trust Boards is focussed on the rationale and proposed approach set out in the SYB ICS Digital Transformation Strategy, specifically an endorsement of the proposed missions and capabilities, target outcomes, and the underpinning enablers (principles, standards and change management).

The investment requirement summary included in the strategy does not require an endorsement at this stage. It has been included to give a 'rough order of magnitude' indication of the investment required to enable the strategy. Further assurance work is required to understand the funding approach for this strategy, including external transformation funding (digital specific and wider transformation that can be allocated to digital), as well as current baseline or planned expenditure, which may align or offset some of the funding requirement. This work will be coordinated via the SYB ICS Finance function, working in partnership with Finance Teams in all SYB Partner Organisations. Furthermore, the roadmap in the strategy does not require endorsement either. As with the investment requirement summary, the roadmap is illustrative and requires progress with the investment requirement assurance activity before it can be confirmed. This activity should be completed in the next 3-6 months, with more detailed business cases put forward as the work concludes or where funding opportunities are identified.

3. Context

The ICS Digital Transformation Strategy 2021-2024 provides a digital response to key challenges and opportunities including the COVID-19 pandemic and the impact it has had on our population, health and care system, and workforce. It also reflects the changing needs of our System as commissioners and providers come together to plan and manage services at a greater scale. This strategy is an iteration and evolution from the digital strategy in the SYB 5-year Plan in 2019/20.

The Strategy outlines a three-year roadmap to deliver the capabilities required by our stakeholders to deliver safe, efficient, integrated care, and to meet obligations outlined through National guidance and plans including NHS 2021/22 priorities and operational planning guidance (F3) which specifically sets out the need for ICSs to develop the underpinning digital and data capability to support population-based approaches including a Shared Care Record by April 2022.

F3 Develop the underpinning digital and data capability to support population-based approaches

Meeting population need requires smart digital foundations, connected health and care services, locally joined-up person-level data across health and care partners, and robust analytical capability aligned across system partners. This will be described in the forthcoming NHSX What Good Looks Like framework, which will support ICSs to benchmark and enable regional teams to develop an appropriate support offer.

To underpin this, systems should commence their procurement of a shared care record so that a minimum viable product is live in September and roadmap for development to include wider data sources and use for population health is ready for April 2022.

4. Why have an ICS Digital Transformation Strategy?

While many of our SYB organisations have their own Digital Strategy, the ICS Digital Strategy acts as an 'umbrella' strategy which aims to 'loosely couple' all digital delivery, raise digital maturity and support innovation across SYB. Further to this, this strategy aims to:

- ensure no-one within SYB is excluded from digital transformation, either public or staff, and digital does not cause greater inequalities
- have greater impact with limited resources, realise economy of scale, solve common problems once
- support common and personalised experiences across health and care for people
- share good practice and learning, avoid re-inventing the wheel
- efficiently and consistently meet statutory requirements
- allow all staff to own and support digital transformation
- identify what 'good looks like' and provide direction through missions, goals, capabilities and roadmaps to achieve that Vision
- track progress and benefits of digital investment

5. Digital Transformation Strategy Themes

We have engaged with all stakeholders throughout development of the strategy to identify 5 key themes and developed missions to address these as outlined in the attached diagram. The strategy document has been shared with the Acute Federation Meeting as a separate paper.

6. Engagement and Assurance

This strategy has been tested and assured across SYB, with other ICSs and national bodies such as NHS England/Improvement and NHS X. The feedback has been overwhelmingly positive, with a series of iterations made to the strategy based on positive feedback. Further assurance is required to gather formal endorsements over the next two months.

The strategy was shared with the Acute Federation at the May-21 meeting for review prior to seeking formal endorsement from the Acute Federation and other bodies. All assurance activity is tracking toward gathering SYB Health Exec Group endorsement of the strategy in August-21.

Recommendations

Recommendation 1: The Acute Federation to formally endorse the SYB ICS Digital Transformation Strategy at the at the June-21 Acute Federation meeting.

Recommendation 2: Acute Provider Trusts take the SYB ICS Digital Transformation Strategy to their Organisation Boards for endorsement before the end of July.

Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

FINANCE AND PERFORMANCE COMMITTEE

Minutes of the meeting of the Finance and Performance Committee
Held on Thursday 15th April 2021 at 12:00 via Microsoft Teams

Present:	Neil Rhodes, Non-Executive Director (Chair) Pat Drake, Non-Executive Director Rebecca Joyce, Chief Operating Officer Kath Smart, Non-Executive Director
In attendance:	Alex Crickmar, Deputy Director of Finance Fiona Dunn, Deputy Director Corporate Governance/Company Secretary Katie Shepherd, Corporate Governance Officer (Minutes) (KAS) Jane Tombleson, Deputy Chief Operating Officer
To Observe:	Bev Marshall, Public Governor Lynne Schuller, Public Governor
Apologies:	Marie Purdue, Director of Strategy and Transformation Jon Sargeant, Director of Finance

ACTION

FP21/04/A1 **Welcome, Apologies for Absence and declarations of interest (Verbal)**

The Chair welcomed the members and attendees. The apologies for absence were noted. The Interim Deputy Chief Operating Officer was welcomed to the meeting.

No conflicts of interest were declared.

FP21/04/A2 **Requests for any other business (Verbal)**

Kath Smart raised that she had sent some suggestions to the Company Secretary on how Estates and Facilities risk on the corporate risk register should be assigned (Finance and Performance Committee or Audit and Risk Committee) to ensure that they would be reported to the right committee.

Pat Drake advised the committee that a food strategy was in place and would be reported to the Quality and Effectiveness Committee.

Pat Drake asked that the Estates and Facilities Report (Item H6) include clear identification of risks within the Estates and Facilities portfolio.

Action: Future Estates and Facilities Reports would include a clear identification of risks within the Estates and Facilities portfolio. **KEJ**

FP21/04/A3 **Action Notes from Previous Meeting (Enclosure A3)**

Action 1 – 5, and 9 were closed.

Updates were provided on the below actions:

Action 6 – Going Concern – On the basis that there was a substantial update paper at the meeting, with a further update due at Board the following week, this action would be closed.

Action 7 – 52-Week Wait Profile – It was agreed that the decision to close this action would be made following the presentation at Item C1.

Action 8 – Performance Reports – Performance reporting would be adapted in light of planning requirements, an important part would be that activity would be based on 2019/20 standards. It was expected that this would be completed in time for the next meeting.

Action 10 – Patient Communication – The Chief Operating Officer advised that she would circulate a response to the committee on this action prior to the next meeting.

Action 11 – Escalation to the People Committee – This had been escalated to the People Committee, therefore the action as closed.

Action 12 – Corporate Risk Detail – This action was not due until May 2021, however the Company Secretary advised that she would meet with the Chair and Kath Smart to discuss further.

Action 13 – Risk Review Dates – This action was not yet complete, however it was agreed that once the meeting related to action 12 was complete, that this could be closed.

In response to a question from Pat Drake regarding when the Foureyes consultation work would be finalised, it was confirmed that an update would be provided as part of Item C1.

The Committee:

- ***Noted the updates and agreed, as above, which actions would be closed.***

Action: Katie Shepherd would update the Action Log.

FP21/04/A4 **Request for Any Other Business (Verbal)**

None.

FP21/04/C1 **Draft Business Plan Update (Enclosure C1)**

Operational Planning Update

The national guidance received outlined specific performance and quality requirements, alongside a duty to collaborate and a system wider approach to financial planning and incentives. There was a requirement to deliver as a minimum 70/75/80/85% (April – July 2021) elective value thresholds alongside clinical priority, cancer and wider performance standards. There remained significant risk in this.

There were some specialities that require careful scrutiny to ensure that issues identified were addressed. The majority of specialities were within Surgery. Other risks included some of the requirements of the plan including the new-to-follow-up activity. A priority for the Trust in the focus of stepping up activity was ensuring that all support systems and processes were robust.

The Trust must collaborate with the collective ICS wide solutions (specialty specific, Cancer Alliance plans etc.), and must deliver breakeven on financial plans, as agreed with ICS partners. It was noted that the second half of the year, posed a significant risk with a potential that the system top up funding would be removed causing a significant deficit in the second half of the year c£14m.

Areas of focus would include the balance between delivery to address back logs, long waiting patients and backlog patients that have not yet been seen whilst maintaining and delivering the financial plan. This would be paramount to the Board this year.

National Planning Guidance

A phased return of elective activity from 70% in April to 85% in July onwards, as a percentage of the value of 2019/20 activity and address gateway criteria to the Elective Incentive Fund. The five gateway requirements were:

- Addressing health inequalities
- Transforming outpatient services (25% telephone / video attendance and focus on Advice and Guidance)
- System led recovery – top quartile performance plus focus on MSK, Eyes & Cardiac
- Clinical validation & prioritisation, waiting list data quality and reducing long waits
- People recovery.

It was noted that access to elective incentive scheme was on a system basis and not organisational.

There was a need to restore cancer services fully which include the following:

- Return to the number of patients waiting over 62-days from February 2019 (or national average) by March 2022,
- meet increased levels of referrals and treatment through 20/21,
- Deliver 75% Faster Diagnosis Standard from Q3,
- Focus on health inequalities & Cancer Alliance approach.

A further area of focus during Q1 would be the Emergency Care Data Set to all services. A same day emergency care (SDEC) model would be adopted with the supported use of booked time slots in the emergency department via 111. The Trust must deliver timely and appropriate discharge from hospital inpatient settings and improve the average length of stay. It was noted that there was a theme of health inequalities throughout the guidance.
From a finance perspective, SY&B ICS had agreed that each organisation needs to develop their own plan with each organisation required to break even within the funding allocations provided by the ICS.

In response to a question from Pat Drake regarding the specifics related to the health inequalities requirements, it was confirmed that this would require a review of the patient tracking list (PTL) against areas of known deprivation and against race. Discussions had taken place with the commissioners on how this could be done.

It was assumed for the in SYB ICS plan that there would be no patients waiting more than 52-weeks by the end of the 2021/22 financial year. The Chair suggested that the activity targets should be hard targets as opposed to aspirational, if the waiting list was to reduce as assumed, and noted that 42% of the 52-week waiters were in Orthopaedics.

In response to a question from Pat Drake regarding how these assumptions would be reporting against performance, it was confirmed that the cancer team would have developed trajectories in time for the deep dive that would take place at the next Finance and Performance Committee, with ongoing work with the performance team taking place to ensure that reports were reflective. It was agreed that the Chair and Chief Operating Officer would meet to ensure that metrics were relevant to meeting key targets.

Pat Drake noted the challenge in meeting the 28-day target in outpatients and therefore expected that there may be further issues and gaps. Pat Drake advised that the need to be a clear and managed process for the use of virtual consultations.

Following a question from Kath Smart regarding the number of 52-week waiters the Trust had in comparison to the larger Trust in the region, Sheffield Teaching Hospitals, it was confirmed that although the Trust had the most 52-week waiters in the SYB region, that across the North East and Yorkshire this was comparative with other Trusts. It was noted that prior to the COVID-19 pandemic, that Sheffield Teaching Hospitals had a different waiting list profile to that of the Trust, and maintained more activity throughout the pandemic.

Financial Framework

The Deputy Director of Finance, advised that the financial framework for months 1-to-6 of 2021/22 (referred to as H1) had been received, however there was none for months 7-to-12 (referred to as H2). H1 system funding envelopes were based on H2 of 2021/22 system envelopes, with adjustments for known pressures including inflation. It was reported that the system must break-even within the envelopes. Block contracts would remain in place for H1, with no requirement signed contracts. An efficiency requirement of 0.28% (this would equate to c£0.6m for DBTH) had been built into the system financial envelopes. Some additional funding had been provided for within system envelopes and included non-NHS incomes losses, and car parking income losses reflecting the national policy on car parking charges during the COVID-19 pandemic. Funding outside the system envelope would continue for most areas, and it was confirmed that independent sector funding would cease, with organisations required to locally contract with the independent sector again.
There were centrally constructed plans for H1, however SYB ICS had agreed that each organisation needed to develop their own plan with each organisation required to break-even within the funding allocations of the ICS.

Kath Smart noted that H1 was based on Q3 of 2020/21, which was when DBTH was in its second wave of COVID-19, and therefore the expenditure during that time was different. The Deputy Director of Finance advised that whilst the figures were pre-populated, there was the opportunity to amend these, as long as the system overall reports a break-even position. Following a question from the Chief Operating Officer regarding whether this meant that the SYB ICS was therefore disadvantaged because of this, it was confirmed that whilst SYB ICS spent less during Q3 of 2020/21, it did not impact the funding envelope.

Timelines

The Efficiency Director set out the timeline for submission on a system basis and the deadlines for the key tasks. The first draft plan submission to the ICS was required on 29th April 2021. Following this there would be a number of Place based meetings to ensure that the plans aligned.

Business Planning Update

The business planning process had focussed on developing granular speciality level plans alongside the clinical leads and operational management to accurately forecast activity and workforce for the coming year, which had produced capacity plans, workforce plans and performance plans. Throughout the process there had been 29 workshops with different specialities in attendance, an identification of 162 planning quality developments within the four clinical divisions, the development of six-models to plan capacity and the development of workforce plans with forecast recruitment and attrition across all clinical specialities.

A comprehensive update was provided to outline the draft activity forecast for the organisation. Challenges throughout the process including that a significant data cleanse was required to develop the capacity plans from existing information, certain activity streams were not previously visible to the specialities so some activity forecasts were difficult to agree, some actions were yet to be completed, and the level of buy in for corporate areas had been variable. Next steps would be to finalise the challenge process for the areas of accountability framework to provide assurance of outputs, challenge areas where capacity had been lost from 2019/20 to the 2021/22 forecast, demand modelling against the planned capacity to understand the activity in the context of performance and how it would affect the waiting list size and undertake further work within People and Organisational Development Directorate to identify where there were areas that required further support from a workforce aspect.

In response to a query form the Chair regarding any themes identified with the lack of engagement from corporate areas, it was confirmed that it appeared that within clinical divisions there was structure to the planning, whereas in corporate areas this wasn't as structured.

Pat Drake outlined that it appeared the biggest challenge was the workforce, and that this should be reported to the People Committee, to ensure that the right processes were in place.

Following a question from Kath Smart regarding how annual leave had been factored into capacity planning, it was confirmed that CPD for medics had been taken into account also, and an assumption had been made that 42-weeks of activity would be delivered.

Draft Activity Forecasts

The output form the capacity work indicated that the Trust would meet the activity thresholds for H1, however further analysis was required on the annual leave adjustment, case mix adjustment, new to follow-up ratio and the bed plan. A summary was provided on the expected activity point of deliver for H1 2021/22 based on activity volumes and not tariff. Key points to note included that the forecast had not been normalised for working day differences between months in 19/20 and 21/22, the baseline period was also volatile

which created issues when comparing monthly forecasts. The carryover of annual leave had not been adjusted for in the forecast but would have a c.5% impact on the planned figures. This would be included for the submission. March 2020 actuals were impacted by the COVID-19 outbreak which would over-inflate the percentage reinstatement quoted.
A detailed update of the activity assumptions for outpatients, theatres and non-theatre specific was presented.

In response to a question by Pat Drake regarding the number of cataract procedures were outsourced, it was confirmed that the Trust did not currently outsource for this procedure.

Following a question from Neil Rhodes it was confirmed that non-COVID-19 and non-elective was increasingly replacing elective demand, and there were some long waiting surgical patients presenting as emergencies. The future position of non-elective demand was unclear. It was agreed following a discussion regarding long-waiting surgical patients presenting as emergencies, that the risks associated with this, would be included in future Integrated Performance Report.

Draft Financial Forecasts

Actions had been taken since the phase 1 budget, in which there was a deficit of £22m was presented at the previous meeting including a review of the funding settlement and an update to the income position for the system allocations for H1. There was a review of all pay and non-pay in the context of Divisional capacity and workforce plans, a review of all corporate budgets, a review of any cost pressures and a further review of non-clinical income. The risks outlined included the delivery of the operational plan, the level of influence within the ICS, delivery of the elective recovery fund, lack of guidance for H2 and the underlying run rates.

Following a question from Kath Smart in relation to the elective recovery fund that it had not been assumed for in the H1 deficit financial position.

In response to a question from Kath Smart regarding the assumptions made for agency, it was advised that the assumptions for agency had been aligned to the workforce plans that Divisions had presented.

It was agreed that the board assurance framework would be updated to reflect the risks outlined.

Capital Plan

The Trust submitted a capital plan totalling £18.9m to the ICS and NHSI/E on 12th April 2021 in line with the planning timetable. Capital plans form all areas and have been collated and reviewed by each of the capital sub-committees (Estates, Medical Equipment and IT) with a focus undertaken on risk and priority. The capital plan would go to Board on 20th April 2021.

Delivering the plan

An overview of the actions that would be taken to deliver the plan was outlined against the operational plan for outpatients, beds, patient and delivery risks and the financial and wider risks. There would be a focus on operational improvement which would include getting the basics right in terms of the administrative support towards elective recovery.

Kath Smart left the meeting.

The Chair noted that the presentation had been comprehensive in covering all areas required.

Pat Drake noted the significant challenge with the delivery of the plan.

Governor Observations

Bev Marshall advised that a short report on the business plan would be helpful to Governors. Bev noted that the ICS was central to budget planning and decision making and welcomed a presentation to Governors later in the year on this matter. The Company Secretary advised that a briefing session would be scheduled on business planning later in the year.

Lynne Schuller noted the due diligence and clarity throughout the presentation and commended the strategy in place to get the basics right in terms of the administrative support towards elective recovery as the thing that would underpin the whole plan.

Action: The Chair and Chief Operating Officer would meet to ensure that the metrics were relevant to meeting key targets. **NR/ RJ**

Action: Following the business planning update, it was identified that the workforce challenge was significant, and it was suggested that this be escalated for discussion at the People Committee. **FD**

Action: It was agreed following a discussion regarding long-waiting surgical patients presenting as emergencies, that the risks associated with this, would be included in future Integrated Performance Report. **RJ**

Action: A Governor briefing session be scheduled on business planning. **FD**

The Committee:

- ***Considered and noted the draft business plan.***
-

FP21/04/C2 **Financial Performance (Enclosure C2)**

The draft year-end financial position was presented and it was noted that the numbers presented may therefore change.

The Trust's surplus for month 12 (March 2020) was £4.3m (excluding donated assets), which was c. £5.2m favourable to plan. The Trust's year-to-date position was a £4.1m surplus excluding donated assets (£5.5m including donated assets). Therefore, the Trust achieved its forecast required financial performance for the year which was a break-even position. The favourable variance against the breakeven forecast, was driven in by the Trust receiving c£4m of additional funding from NHSE/I relating to the additional costs of increased annual leave (due to increase in carried forward leave due to COVID).
The annual leave accrual funding (notified in month 12) and 'lost' NHS income (received in month 11) was subject to change post submission of the Trust's key data return on the 19th April. Therefore, this position was draft and was subject to change. The other key area under

review was a potential staff pay issue that we have been made aware of and was being assessed by P&OD.
Capital expenditure in month 12 was £11.0m, with annual capital expenditure being £36.3m, including COVID-19 capital spend of £1.5m and donated asset spend of £1.9m. This was £1.0m behind the £37.4m original plan but was £0.1m ahead of the forecast (excluding donated assets). Thereby the Trust achieved its revised capital plan.
The cash balance at the end of March was £51.7m (February: £77.1m). Cash had fallen as a result of the Trust not receiving Block income in the month, reversing that the Trust received two months' worth of the block income in April 2020 as a cash advance (which was the same for all Trust's nationally). The Trust also received £10.1m of PDC Dividend for capital schemes in month, and there were capital creditors of £11.6m at March 2021.
A key transaction included within the position was the Flower case totalling £1.1m for the Trust.
The deadline for the key data return was 19th April 2021, with the deadline for the draft accounts on 27th April 2021. External Audit would audit the annual accounts from this date through to June and the final accounts would be due on 15th June 2021.

The Chair noted that the Finance and Performance Committee had tracked the financial position responsibly throughout the year, and indicated that the Trust had spent money wisely and accounted for it accurately.

Kath Smart arrived at the meeting.

The Committee:

- ***Noted the financial performance update.***

FP21/04/C3 **ICS Financial Position (Enclosure B3)**

The Deputy Director of Finance provided an update on the ICS financial position which highlighted that there was a significant surplus of £21m at month-11. Overall, the ICS forecast performance against the breakeven system envelope was a £32.4m surplus. Commissioners were forecasting a £5.5m surplus. The Provider forecast position was a surplus position of £26.9m. This was largely due to elective activity levels being lower than plan due to COVID-19.
It was noted that these forecast positions were also adjusted for annual leave accrual increases and reduction in non-NHS income. Therefore, the expectation was that the ICS would deliver its financial performance requirements.
The system capital forecast shows a potential year end slippage of £13.7m (£21m last month) on capital.

The Committee:

- ***Noted the update provided on the ICS financial position.***

FP21/04/C4 **Going Concern (Enclosure C4)**

International Accounting Standard (IAS) 1 requires the management of all entities to assess, as part of the accounts preparation process, the bodies' ability to continue as a going concern. This was further enforced by Department of Health requirements to review the trust's going concern basis on an annual basis. The going concern principle being the

assumption that an entity would remain in business for the foreseeable future. This was to facilitate the accounting basis to be used in the preparation of the Trust's annual accounts. The Committee received a comprehensive overview of the NHSE/I guidance and of the assessment undertaken to form judgement. The Committee considered and approved that it would recommend to the Board of Directors that the Trust would produce its annual accounts on the basis of it being a going concern. The annual report would clearly statement this assessment whilst outlining the risks facing the Trust.

Following a question from Kath Smart, It was agreed that in the absence of a national contract, that sight of the cash flow would be welcomed by the Committee. This would be included as part of the financial report at future meetings.

Action: It was agreed that in the absence of a national contract, that sight of the cash flow would be welcomed by the Committee. This would be included as part of the financial report at future meetings. **JS**

The Committee:

- ***Considered and agreed to commend that the Trust was a going concern.***

FP21/04/D1 **Operational Update/Recovery Update (Enclosure D1)**

The vaccination programme progressed well in Doncaster and Bassetlaw. Attendance in the Emergency Department (ED) had increased rapidly with a specific increase seen in paediatric cases, in line with schools reopening. An analysis had been undertaken on the increase in ED attendance and it was evident that a small number of GP practices have seen significant changes in patient behaviour, however there had also been a significant rise in patients advising that they were unable to access the GP. These issues had been escalated to Doncaster CCG, Bassetlaw CCG and Wakefield and Barnsley. COVID-19 occupancy had reduced, the total COVID-19 occupancy was 6.7%, the active case occupancy reported at 4%. A rise had been seen in the demand for non-COVID-19 emergency beds. Pressures had reduced in the intensive care unit (ITU). This had allowed for the Trust to move Theatre staff working in ITU. Key elective issues included the 52-week wait position, with 2,394 reported at 31st March 2021. There was a growing focus by NHSE/I on the delivery of P2 patients within 28-days, which was an important metric for urgent patients. The Cancer Team continued to perform well in comparison to partner organisations. There was a small number of patients waiting 104-days. The Finance and Performance Committee would undertake a deep dive into cancer services in May 2021. The key next steps included implementing the Theatre step up plan, finalising the bed plan, to strengthen delivery in outpatients, mitigate risks, finalise performance trajectories and focus on process and delivery.

Kath Smart noted that there had been comments on Facebook from people advising that they couldn't get access to their GPs, which was contributing to the high levels of attendance seen in the Emergency Department. The Chief Operating Officer advised that the from the analysis of data, it demonstrated that this was a key issue associated with 5-6 GP surgeries. Discussions had been had with the Primary Care Network and specific actions had been agreed. Further discussion was required with Wakefield and Barnsley CCG.

Action: Following a discussion regarding patient access to GPs and the identified difficulties seen in some practices, it was confirmed that actions had been agreed with **RJ**

Doncaster and Bassetlaw Primary Care Networks, however further discussions were required with Wakefield and Barnsley CCG. The Chief Operating Officer would take this action and report back at the next meeting.

The Committee:

- ***Noted the operational update/recovery update.***

FP21/04/D2 **Integrated Performance Report (Verbal)**

The Integrated Performance Report was not ready in time for the meeting, however the Chief Operating Officer provided the key highlights. Activity was strong in March 2021. As of 31 March 2021 there were 2,394 52-week waiters which was slightly higher than in February 2021. 84.3% of patients were seen within 4-hours, however it was noted that there had been an increase in attendance in month.

The Committee:

- ***Noted the verbal update on performance for March 2021.***

FP21/04/E1 **Board Assurance Framework (Enclosure E1)**

This item was deferred to the next meeting.

The Committee:

- ***Agreed to defer the board assurance framework for Strategic Aim 1 and Strategic Aim 2 to the next meeting.***

FP21/04/E2 **Corporate Risk Register (Enclosure E2)**

This item was deferred to the next meeting.

The Committee:

- ***Agreed to defer the corporate risk register to the next meeting.***

FP21/04/F1 **Governor Observations (Verbal)**

There were no further Governor observations.

FP21/04/G1 **Escalation (Verbal)**

There were no issues were identified for escalation to/from:

- G1.1 F&P Sub-Committees
- G1.2 Board Sub-Committees
- G1.3 Board of Directors:

FP21/04/H1 **Any Other Business**

None.

FP21/04/H2 **Sub-Committee Meetings (Enclosure F1):**

The Committee noted the sub-committee meeting minutes:

- ***Capital Monitoring Group 18/02/2021***

FP21/04/H3 **Minutes of the meeting held on 22nd March 2021 (Enclosure f2)**

The Committee:

- ***Noted and approved the minutes from the meeting held on 22nd March 2021.***

FP21/04/H4 **Draft Committee Annual Report (Enclosure H4)**

FP21/04/H5 **Finance and Performance Committee Terms of Reference (Enclosure H5)**

Kath Smart highlighted that there was no reference to Estates and Facilities in the terms of reference. Following discussion it was agreed that the Company Secretary would liaise with the Director of Finance regarding which committee should have oversight of the governance of medical equipment, IT and Estates and Facilities.

Action: The Company Secretary would liaise with the Director of Finance regarding which committee should have oversight of the governance of medical equipment, IT and Estates and Facilities. **FD / JS**

FP21/04/H4 **Date and time of next meeting (Verbal)**

Date: **Monday 17th May 2021**
Time: **09:00**
Venue: **Videoconference**

Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

FINANCE AND PERFORMANCE COMMITTEE

Minutes of the meeting of the Finance and Performance Committee
Held on Monday 17th May 2021 at 09:00 via Microsoft Teams

Present: Neil Rhodes, Non-Executive Director (Chair)
Pat Drake, Non-Executive Director
Rebecca Joyce, Chief Operating Officer
Jon Sargeant, Director of Finance
Kath Smart, Non-Executive Director

In attendance: Ken Anderson, Chief Information Officer (Item FP21/05/C4)
Lesley Barnett, Deputy Director of Nursing, Cancer and Chemotherapy (Item FP21/05/B1)
Alex Crickmar, Deputy Director of Finance
Fiona Dunn, Deputy Director Corporate Governance/Company Secretary
Olu Olubowale, Lead Cancer Clinician (Item FP21/05/B1)
Katie Shepherd, Corporate Governance Officer (Minutes) (KAS)
Jackie Simpkin, Cancer Services Manager (Item FP21/05/B1)

To Observe: Bev Marshall, Public Governor
Lynne Schuller, Public Governor

Apologies: Marie Purdue, Director of Strategy and Transformation

ACTION

FP21/05/A1 **Welcome, Apologies for Absence and declarations of interest (Verbal)**

The Chair welcomed the members and attendees. The apologies for absence were noted. No conflicts of interest were declared.

FP21/05/A2 **Requests for any other business (Verbal)**

The Director of Finance wished to discuss the Women and Children's water leak incident as an item of other business.

FP21/05/A3 **Action Notes from Previous Meeting (Enclosure A3)**

Actions closed: 1, 3, 4, 6, 8, 11, 12 and 16.

Updates were provided on the below actions:

Action 2 – 52-week wait profiling – The Information Team were underway with modelling of trajectories, however it had not been finalised at speciality level as yet. This would be discussed further as part of item D1.

Action 5 – Patient Communication – The Chief Operating Officer advised that an acknowledgement of referral letter was sent to patient, along with a text message receipt of acknowledge.

Action 7 – Corporate Risk Detail – The meeting had not yet taken place, however it was agreed that now the Trust was in receipt of the draft KPMG report, this would take place with the Chair, Company Secretary and Kath Smart. The Company Secretary advised that the process already agreed at Board would not change, however the agreed process would be implemented. The target date was changed to June 2021.

Action 12 – Escalation to People Committee – Pat Drake noted that there was a workforce challenge and there was a requirement to connect the business plan with performance delivery. There were vacancies in Theatres and this team was crucial to meeting restoration plans.
Post meeting note: A substantial item would be received at the People Committee on 6th July 2021 on Recruitment and Retention including Workforce Planning Update which would take consideration of this action, also escalated from the Quality and Effectiveness Committee.

Action 13 – Integrated Performance Report – Surgical Waiters – The target date was moved to June 2021.

Action 15 – Cash Flow – The Deputy Director of Finance would circulate.

Action 17 – Governance of Medical Equipment, IT and Estates and Facilities – It was confirmed that these three functions would report directly to the Finance and Performance Committee. Kath Smart advised that the terms of reference would need to be updated to reflect this.

Action: The Finance and Performance Committee terms of reference would be updated to reflect that medical equipment, IT and Estates and Facilities would report directly into the Finance and Performance Committee. **FD**

The Committee:

- ***Noted the updates and agreed, as above, which actions would be closed.***

Action: Katie Shepherd would update the Action Log.

FP21/05/ B1 **Deep Dive: Cancer Services (Enclosure B1)**

The Committee received a comprehensive presentation on Cancer Services which highlighted several issues. The cancer pathway had been affected throughout the COVID-19 pandemic, which had impacted on cancer patients in many ways including increased anxiety and fear in seeking help and attending services, isolation and lack of family/peer support, financial worries, impact of shielding and impact of virtual appointments.
There had been a significant impact on staff due to the COVID-19 pandemic including the impact of redeployment to other areas, increased new ways of working, new pathways and treatments, impact of personal circumstances and shielding and the emotional effort required and burnout from the outlined changes.
The Cancer Service had seen changes in treatment and regimes, with the introduction of pre-COVID-19 planning required for swabbing as required from national guidance.

There had been an increase seen in patients presenting with advanced cancers, including emergency admissions. There had been reduction in patients attending in the age group of 60-80 years.
The COVID-19 pandemic had created backlogs and had impacted the PTL (patient tracking list). In order to keep patients safe, and therefore reduce harm, a clinical harms meeting was in place to undertake breach analysis and provide shared learning. There was a cancer dashboard in place where all cancer patients were monitored. A Cancer and Quality Governance meeting was in place.
An overview of activity changes were shared which highlighted the difference in patient seen over a two-year period.
The key risks to recover and restoration were outlined which included that there had been an increase in referrals in some areas, with a change in presentation. There had been challenges with imaging capacity, theatre capacity, Histopathology recruitment and the retention of the workforce. It was noted that if there was a forth wave of COVID-19, this would be a significant risk to the service and the resilience of the workforce.
Priorities include tackling inequalities, the recovery, transformation and ensuring that pathways were sustainable, ensuring earlier and faster diagnosis and providing personalised care.
The forward plan included:

- To ensure cancer services were fully recovered following the COVID-19 pandemic.
- Specifically address the reduction in number of people who should have started treatment.
- Renew our drive to improve operational performance against the Cancer Waiting Times Standard.
- Continue to deliver the Long Term Plan for cancer.

The Chair noted the challenging picture, and thanked the Cancer Team for the excellent presentation. Following a question from the Chair regarding the top risks that the Cancer Team were concerned about, it was advised that the workforce challenge in Histopathology was a concern which had continued to put strain on cancer work, however, the Trust was exploring collaborative work with Sheffield Teaching Hospitals to look at different ways of working. The second key risk was the workforce vacancies within Cancer Services. Imaging had been a continued challenge for Cancer Services, however the implementation of the Community Diagnostic Hub would be exciting for the Trust.

The Chair asked for information on the services that would continue if there was a forth wave of COVID-19. It was advised that if a forth wave took place, key decisions would lie with GPs and ensuring that patients could continue to access their services. The Chief Operating Officer advised that there was ongoing dialogue with primary care and noted there had been feedback from patients that GPs were less accessible to pre-COVID-19.

Pat Drake thanked the Cancer Team for their continued hard work and noted that the risks outlined were similar to that of other departments.

Kath Smart echoed the thanks and noted it was evident in the presentation that there was a grip on the monitoring of patients. Kath Smart had undertaken a walk-around in Theatres, and advised that a Theatre Nurse held the Cancer Services Team in high-regard following the work undertaken with pathways and supporting patients during the COVID-19 pandemic.

Following a question from Kath Smart regarding vacancies, it was advised that the Cancer Team had been unable to recruit to a Band 7 secondment role, an administrative post and project manager post. There had been added support and resource from Macmillan.

The Chair noted that the Committee had a high interest in Cancer Service performance and thanked the team for attending. The Chief Operating Officer echoed the thanks to the team and noted that they had grip on the performance and experience for patients.

The Committee:

- ***Noted and took assurance from the information provided in the deep dive into cancer services.***

FP21/05/ C1 **Financial Performance (Enclosure C1)**

The Director of Finance wished to thank his team for producing the month-1 financial accounts alongside the undertaking of year-end accounts and the budget planning.

Overall, the financial position in month 1 was positive with a surplus position of £366k which was £166k favourable to plan. However there remained a number of financial risks to note including:

- Impact of theatres staffing gaps on agency spend over the next few months.
- Delivery of ERF (elective recovery fund) including any non-activity related requirements.
- H2 financial arrangements – There remained no guidance for the second half of the year with regards to financial arrangements. Thereby there remains the significant potential risk that system top up funding received under current arrangements would be removed, causing a potential significant deficit in the second half of the year.
- Impact of major incident at Women and Children's Hospital on delivery of 21/22 capital and revenue plan.
- There remained a lack of clarity in terms of the Trust's bed plan and therefore costs of workforce plans.

Capital expenditure in month-1 was £0.8m, which was in line with the plan. There were no significant variances to report.
The cash balance at the end of April was £44m (March: £51.7m). Cash had reduced by circa £7.7m as a result of the Trust paying capital invoices totalling £8m in month. These were within capital creditors at year-end.

The Chief Operating Officer advised that a meeting had taken place to review options for bed plans, and a paper on the governance for different options would be created. There was particular pressure on the elective surgical bed base which had reduced the ability to use gynaecology theatres for female surgeries. There was further work required to match the bed plan to the nursing establishment.

In response to a question from Kath Smart regarding the use of the HSDU ward for paediatrics, a discussion took place regarding capacity issues from the impact of the Women and Children's

Hospital water leak incident. The Director of Finance highlighted the risk with the lack of alignment between the nursing budget and bed base as a contributing factor to this. It was agreed that this would be raised with the Board of Directors. An update on the resolution to the lack of alignment between the bed plan and nursing budget was required at the Finance and Performance Committee in June 2021.

Kath Smart noted that the table highlighting the turnaround times of invoices did not align to the annual report. The Deputy Director of Finance would look into this.

Action: An update on the resolution to the lack of alignment between the bed plan and nursing budget was required at the Finance and Performance Committee in June 2021. **RJ**

Action: The Deputy Director of Finance would review the annual report data relating to the turnaround time of invoices as it did not appear to match that of the finance report. **AC**

The Committee:

- ***Noted and took assurance from the financial performance report***

FP21/05/ C2 **ICS Finance Update (Enclosure C2)**

The Director of Finance advised that all providers and CCGs had submitted a break-even plan, and thereby the ICS submitted a balanced plan to NHSEI.

The Committee:

- ***Noted the update provided on the ICS financial position.***

FP21/05/ C3 **SBS Finance Renewal (Enclosure B3)**

The current finance and accounting contract with Shared Business Services (SBS) for the Finance and Procurement system (Oracle) would expire on the 31st May 2021. It was proposed that the Trust continued with the current arrangement and directly award the contract to SBS on a 3+1+1 year basis. The key reason being:

- The system had supported the Trust in significantly improving its Procurement and Financial Controls since the financial misreporting as supported by feedback from external and internal audit.
- The contract form of 3 years plus 2 optional years would allow the Trust to have flexibility in terms of being able to move to an ICS Provider wide system in the future should that be the direction of travel.
- Cost of changing supplier including cost of procurement process and potential cost of changing supplier if SBS were unsuccessful.
- Time and cost to train Trust staff in a new system was significant.
- No TUPE impact.

There would be a slight reduction in cost. This contract would allow the Trust to align to other providers within the SYB ICS, with an aim to have a centralised system in the future. In response

to a question by Kath Smart, it was confirmed that the contract would not be a single tender waiver as it would be undertaken through the procurement route.

The Committee:

- ***Agreed to support the renewal of the finance and accounting contract with Shared Business Services on a 3 + 1 +1 year basis.***

FP21/05/ C4 **IT Contracts Management (Enclosure C4)**

A comprehensive update was provided on the review of IT related contracted for which the Digital Transformation Directorate was accountable for. The existing IT Contracts Register (prior to 2019) was incomplete with a significant number of inaccuracies. During 20-21 the IT Contract & Purchasing Team took the following action:

- Enhanced and updated the IT Contracts Register.
- 91% of contracts verified with a total value £17m.
- Introduced triggers and workflow i.e. to manage review dates.
- Initiated formal contract management reviews.
- Placed an emphasis on adopting fully compliant procurement exercises.
- Produced a contract management dashboard.

There would be eight major clinical systems see their contract end date within the next 18-24months, which would provide the opportunity to work collaboratively within the ICS to secure an integrated service to reduce costs. Whilst cost improvement programmes could not be confirmed until the budget was set, further enhanced improvements would take place to rationalise contracts from the Contract Analysis and Treatment list would continue with an aim to work towards in-year cost improvements. It was recommended that the centralisation of IT systems contracts takes place only once contract management processes were fully embedded.

The Chair commended the progress.

In response to a question from Kath Smart as to whether it was felt that there was better value received from contracts, the Chief Information Officer advised that the more value was created through increased market testing. The contracts had been reviewed in detail to ensure that the Trust was gaining the best value possible. Collaborative activity within the ICS would see better deals. Kath Smart noted that value was not only cost, but included the whole of the contract.

In response to a question from Kath Smart regarding closer working with the Procurement Team to help with processes, it was advised that there was a tripartite arrangement between the IT Team, Procurement and Finance Teams to improve the process, and where learning could be taken.

Following a question from Pat Drake regarding any risk associated with the eight clinical systems contracts ending within an 18-24month period of each other, it was advised that there was no risk with the timeline and each contract had the option to extend if they were unable to undertake the procurement process.

The Committee:

- ***Noted and took assurance from the IT contracts management update***

FP21/05/ C5 **Annual Accounts (Enclosure C5)**

The draft financial accounts were submitted to NHSI/E (and external audit) on the 27th April 2021 in line with national timetable requirements. It was noted that the final surplus position for the Trust (excluding impact of donated assets) was £4.1m. The Trust received an additional £422k of income in Month-12 from NHSI/E since the draft position was discussed at the previous Finance and Performance Committee. The accounts were in process of being externally audited by Ernst Young.

Kath Smart advised that the annual accounts would be received at the Audit and Risk Committee, however asked if the water leak incident that took place in the Women and Children's Hospital, although it took place after year-end, required the addition of a post meeting note on the balance sheet. The Director of Finance advised that he would check that with External Auditors.

In response to a question from Kath Smart, it was confirmed that the Trust was members of HFMA and therefore for it was agreed that the Company Secretary would source and identify the HFMA guidance which would be useful to non-executive directors and Governors when reading accounts.

Action: The Director of Finance would check if a post year-end note needed adding to the balance sheet in relation to the water leak incident that took place in the Women and Children's Hospital. **JS**

Action: The Company Secretary would source and identify the HFMA guidance which would be useful to non-executive directors and Governors when reading accounts. **FD**

The Committee:

- ***Noted the annual accounts.***

Bev Marshall noted the cancer patients that had presented late due to anxiety in relation to the COVID-19 pandemic, and the difficulty in relaying the message that the hospital was safe.

Bev Marshall asked for clarification on if the Doncaster and Bassetlaw Healthcare Services (outpatients) pharmacy accepted green prescriptions. The Director of Finance advised that inpatients would be given the drugs from the onsite pharmacy, as opposed to a prescription and therefore would have no need to attend the outpatient pharmacy, however asked for Bev Marshall to forward any further information to the Director of Finance to review further.

FP21/05/ D1 **Operational Update/Recovery Update (Presentation)**

The vaccination programme had progressed well in Doncaster and Bassetlaw. The link between the number of community cases and hospital admissions had further distanced. The total COVID-19 occupancy was reported as 0.9%, and the active case occupancy was 0.3% demonstrating a significant reduction. There were no COVID-19 patients within the intensive care unit. There was national modelling work underway in line with the Indian variant of COVID-19 which was a significant area of concern.
There was continued high attendance at the Emergency Departments, mostly minor demand and paediatrics. There were ongoing discussions with the primary care networks and CCGs regarding this high attendance following feedback from patients regarding accessibility to GPs.

The Theatre step up planned had commenced, with 68% of sessions undertaken on 19th April 2021 and 100% on 1st May 2021 at Doncaster and Bassetlaw. It was expected that theatre activity would reach 100% at Montagu by 1st June 2021. The independent sector continued to provide support and would undertake 30 cases per-month from 1st May 2021 for six-months.
The Trust was reported as best in the region for day case procedures, and average for outpatient's activity.
The 52-week position, had continued to improve over an 8-week period, however, modelling for this was yet to be finalised and the trajectories for the year were unclear. The PTL (patient tracking list) continued to grow with over 35k patients waiting. The Trust had seen an improved position on priority 2 patients dated within 28-days, however further work was required.
The key risks were outlined and included theatre staffing challenges which were a risk to both activity and finance. An options paper was in development to review the bed plan. There was a risk to patients due to the backlog and unknown clinical risk. Efforts would continue to ensure that oversight and governance arrangements were robust.
Next steps included the implementation of one meter social distancing rule to increase throughput within outpatients. Further escalation meetings would take place to resolve the theatre staffing pressures. The 52-week trajectories were to be finalised and 'confirm and challenge' events on the annual plan would commence at the end of May 2021.

In response to a question from Pat Drake regarding the need for a patient communication strategy and improved digitalisation, it was advised that there was a requirement for something more dynamic and work was underway to improve this alongside other restoration work.

Pat Drake noted that the Emergency Department were seeing increased attendance from minor and late cancer presentation would impact on length of stay and the discharge process, and asked if within the performance report, there could be an indication on acute emergencies presenting. It was agreed that this would be added into the performance report. Pat Drake asked for assurance that diagnostics would deliver their trajectories, as a core service that underpins wider service delivery. The Chief Operating Officer advised that there was focused work taking place within the radiography team, and noted that diagnostics had caused issues with some cancer pathways.

Pat Drake noted that although there was some excellent work being undertaken, clarification on what can be achieved needed to be clearer.

Accelerator Programme

The Chief Operating Officer informed the Committee that SYB ICS had been selected as one of eleven systems for the Accelerator Programme which required 100% activity delivery based using the 2019/20 activity as a baseline by July 2021. The finer detail was unknown however it was expected that this would be based on the value of activity and not total activity alone. The incentive would be £20m provided to North East and Yorkshire, with £10m to be allocated per ICS, £7.5m of which would be for transformation work.
The Trust had asked for £2.05m revenue and £1.1m capital to support the proposal submitted on 13th May 2021 which included the creation of a day base elective hub at Montagu, transformation of the trauma and orthopaedic pathways on all three sites, a minor operations suite, small scale tests of change to the trauma and orthopaedic service and further focus on using the independent sector.
The key risks and mitigations for this were highlighted which included that the small print was unclear on the programme as penalties for non-delivery was not clear, which contributed to the financial risk associated with the programme. It was noted that the delivery of the core

capacity plan would be a challenge, therefore this programme could provide a distraction to that. There were continued workforce challenges which included fatigued frontline staff.

Women and Children's Water Leak Incident

An update was provided on the water leak incident that took place within the Women and Children's Hospital at DRI on 27th April 2021. There had been a need to stand down routine elective operating which saw a loss of seven half-day lists within the April position. There had been a loss of routine outpatients in gynaecology for six days, however this had recommenced on 6th May 2021. In addition to this there had been a loss of some paediatric emergency work and routine paediatric surgery. A divert was in place for maternity from 28th April to 31st April 2021. Obstetric emergencies had moved to the main theatres at DRI, however had since returned to the restored Women's Theatre since 1st May 2021. Additional workforce plans were in place to support the changes.
The incident had affected capacity and the neonatal unit were down to 11 cots from 18. The temporary paediatric ward had 13 beds and there were some issues with the environment, a reduction from 18 pre-incident, and 30 pre-fire works. There were no capacity changes within maternity.
A number of children had been transferred to partners and a standard operating procedure was in place for transfer and divert. Further capacity was required and the interim bed plan for H1 was under discussion. There was a concern regarding the anticipated level of paediatric respiratory admissions looking forward to autumn and winter. A hot debrief had taken place, with an in depth debrief would take place and include the refinement of emergency planning.

The Chair noted that the outline of the risk and mitigations was helpful and provided assurance that the Chief Operating Officer was focused on the issues. The Chair asked for assurance on the capacity issues highlighted within the presentation. The Chief Operating Officer advised that further was required to stem demand, however the independent sector were key to the delivery of activity and work was underway to develop more efficient ways of working within pre-operative assessment.

Kath Smart noted that there should be a focus on priorities and control of what can be achieved in light of short timescales for bids. In response to a question from Kath Smart regarding when it was expected that there would be learning from the Women and Children's Hospital water leak incident, it was advised by the Director of Finance that immediate action had been taken to undertake a full visual check on both routes and lagging had been removed to do that. The immediate issue identified was that the water pipes were on the roof and in close contact to electrical cables. It was agreed that the Director of Estates and Facilities would provide an update at the Finance and Performance Committee in June 2021 of any learning identified as part of the debrief on the Women and Children's Hospital water leak incident.

Action: The performance report would include information on the acute emergencies presenting within the Emergency Department. **RJ**

Action: The Director of Estates and Facilities would provide an update at the Finance and Performance Committee in June 2021 of any learning identified as part of the debrief on the Women and Children's Hospital water leak incident. **KEJ**

Action: An update of the Accelerator Programme was required at subsequent Finance and Performance Committee meetings. **RJ**

The Committee:

- ***Noted the operational update/recovery update.***

FP21/05/D2 **Integrated Performance Report (Verbal)**

This was discussed as part of item FP21/05/D1.

The Committee:

- ***Noted the verbal update on performance for April 2021.***

FP21/05/E1 **Board Assurance Framework (Enclosure E1)**

The key risks were discussed as part of item FP21/05/C1.

The Committee:

- ***Took assurance from the board assurance framework for Strategic Aim 1 and Strategic Aim 2.***

FP21/05/E2 **Corporate Risk Register (Enclosure E2)**

The Company Secretary advised that the internal audit report on risk management would be received at the Audit and Risk Committee on 21st May 2021.

The Committee:

- ***Noted the update provided on the corporate risk register.***

FP21/05/F1 **Governor Observations (Verbal)**

Bev Marshall noted the cancer patients that had presented late due to anxiety in relation to the COVID-19 pandemic, and the difficulty in relaying the message that the hospital was safe.

Bev Marshall asked for clarification on if the Doncaster and Bassetlaw Healthcare Services (outpatients) pharmacy accepted green prescriptions. The Director of Finance advised that inpatients would be given the drugs from the onsite pharmacy, as opposed to a prescription and therefore would have no need to attend the outpatient pharmacy, however asked for Bev Marshall to forward any further information to the Director of Finance to review further.

In response to a question from Lynne Schuller regarding the impact that the modular buildings would have on patient flow, and patient accessibility to site, it was advised by the Chief Operating Officer that a location near to the Women and Children's Hospital had been identified. The Director of Finance advised that it may impact on the number of car parking spaces, however plans were yet to be finalised.

FP21/05/G1 **Any Other Business**

FP21/05/G1i Women and Children's Hospital Water Leak Incident

The Director of Finance advised the Committee that work was underway to identify how the issue could be rectified as soon as possible. The Director of Estates and Facilities was in liaison with a company that provide modular ward and theatre buildings as part of an interim plan. It was mandated that non-clinical insurance was with NHS Resolution as standard insurance carried by all NHS Trusts. The buildings insurance covered the Trust for £1m per incident, with excess at £20k. The scheme to buy the modular theatre and modular ward would cost in the region of £10m. This did not include any work required to make the current Women and Children's hospital safe. This would have a significant impact on the capital plan and therefore discussions had taken place with NHSEI and the ICS regarding this. The Director of Finance advised that he required approval from the Committee to proceed with the ground works and enabling works for the modular buildings, and to confirm a slot in the factory to build the modular buildings. It was noted that the urgency for approval was due to a 5-6 month wait until the modular buildings would be received. It would be reported to the Board on 18th May 2021. The cost to lease the modular building would total £38k per month, however if bought the Trust would need to use the modular build for 10-years to achieve time value of money. The Director of Finance noted the risk associated with this.

Following a question from Kath Smart regarding the likelihood that the Trust would receive emergency capital to fund this, it was advised by the Director of Finance that this was unknown. This issue had been discussed with NHSEI at length who had acknowledged the risk.

In response to question from Pat Drake regarding the business plan for the modular wards, it was confirmed that this had not yet been confirmed but it was expected that this would hold gynaecology theatres and the paediatric ward.

The Committee were supportive of the modular buildings and approved for the Director of Estates and Facilities to place the order.

FP21/05/G 1ii

Job Planning Internal Audit Report

It was discussed and agreed that a decision would be made at the Audit and Risk Committee on 21st May 2021 which Committee would have oversight of the internal audit report on Job Planning.

FP21/05/ G2

Sub-Committee Meetings (Enclosure F1):

The Committee noted the sub-committee meeting minutes:

- ***Capital Monitoring Group 18/03/2021***
- ***Cash Committee – 11/03/2021***

FP21/05/ G3

Minutes of the meeting held on 15th April 2021 (Enclosure G3)

The Committee:

- ***Noted and approved the minutes from the meeting held on 15th April 2021.***

FP21/05/ G4

Finance and Performance Committee Terms of Reference (Enclosure G4)

As discussed during action – take out and tweak and bring back next time. ACTION.

FP21/05/ G5 **Assurance Summary (Verbal)**

The Committee:

- ***Were assured from matters discussed at the meeting,***
- ***There were no items of escalation,***
- ***Were assured that Committee associated Executive objectives were progressing well,***
- ***Were assured that Divisional compliance was aligned to the Trust's risk management process.***

FP21/05/ G6 **Date and time of next meeting (Verbal)**

Date:	**Thursday 17th June 2021**
Time:	**09:00**
Venue:	**Videoconference**

Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

AUDIT AND RISK COMMITTEE

Minutes of the meeting of the Audit and Risk Committee
Held on Thursday 25th March 2021 at 09:30 via Microsoft Teams

Present:
Kath Smart, Non-Executive Director (Chair)
Sheena McDonnell, Non-Executive Director
Neil Rhodes, Non-Executive Director
Mark Bailey, Non-Executive Director (MCB)

In attendance:
Ken Anderson, Acting Chief Information Officer (Item AR21/03/F1)
Matthew Bancroft, Head of Financial Services (MB)
Chris Bloomfield, KPMG (Item AR21/03/D1)
Mark Bishop, NHS Accredited Counter Fraud Specialist
Fiona Dunn, Deputy Director of Corporate Governance/Company Secretary
Harriet Fisher, Internal Audit Manager, KPMG (Item AR21/03/D1 onwards)
Rob Jones, Internal Audit Manager, KPMG
David Linacre, Head of IT Operations and Cyber Security (Item AR21/03/F1)
Hassan Rohimun, Engagement Lead, Ernst Young
Jon Sargeant, Director of Finance
Dan Spiller, External Audit Manager, Ernst Young
Katie Shepherd, Corporate Governance Officer (Minutes)
Roy Underwood, Head of Information Governance (Item AR21/03/F1)

To Observe:
Dennis Atkin, Public Governor
Bev Marshall, Public Governor

Apologies:
Kirsty Edmondson Jones, Director of Estates and Facilities
Sean Tyler, Head of Compliance, Estates

ACTION

AR21/03/A1 **Welcome and Apologies for Absence (Verbal)**

Kath Smart welcomed the members and attendees. The apologies for absence were noted. The Committee welcomed Hassan Rohimun as the new Engagement Lead from Ernst Young.

AR21/03/A2 **Conflict of Interest**

No conflicts of interest were declared.

AR21/03/A3 **Request for any other business**

There were no requests for any other business.

AR21/03/A4 **Action Log from Previous Meeting (Enclosure A4)**

The following actions were closed:

Action 1, 2, 4, 5, 6, 9, 10, 11, 12, 14 and 20 were closed.

Updates were provided on actions below:

Action 1 – Register of Interests – It was reported that compliance amongst medical colleagues was 98% as of 23rd March 2021. This action was closed.

Action 2 – ARC Appraisal – Self-Assessment Process – Board approved the process at the March 2021 meeting. Questionnaires would be developed electronically, to be trialled with the Audit and Risk Committee once complete.

Action 3 – Discharge Planning – There were two recommendations outstanding on the audit tracker. Although the Company Secretary advised that the recommendations were complete as national guidance was followed on delayed transfer of care, it was agreed that the Chief Nurse was required to provide evidence to that affect.

Action 4 – KPMG – This had been added to the People Committee action log and was therefore closed.

Action 6 – Communications on Fundraising Rules – The Director of Finance advised that there had been a discussion at the Charitable Funds Committee regarding committee governance on this issue. A regular meeting was in place in between the Charitable Funds Committee meetings. This action was closed.

Action 7 – Job Planning Update – The audit was not complete in time for this meeting. Feedback had been provided from the Director of Finance. Limited assurance was received on the report. It was noted that there was a widespread lack of adherence across the sample, and the reason for the delay was because the plans selected took longer than expected to gather. It was agreed that KPMG would circulate the report prior to the next meeting, and the Medical Director would be required to attend the next Audit and Risk Committee to discuss the outcome.

Action 8 – P&OD HR Systems Team Review 2019/20 – Carried forward as the requirements have not been met.

Action 16 – Risk Assessments – The Chair of the Committee would meet with the Director of Estates and Facilities to take this action forward.

Action 18 – Single Tender Waiver and Action 19 Loss and Compensations – The forms had been changed as required and would be circulated by the Director of Finance.

Action: The Chief Nurse was required to provide evidence against the two outstanding recommendations of the Discharge Planning audit report. **DP**

Action: The Medical Director would be invited to the next Audit and Risk Committee meeting to provide an update on job planning. **FD**

The Committee:

- ***Noted the updates and agreed, as above, which actions would be closed.***

AR21/03/B 1 **External Audit Progress Report (Verbal)**

Hassan Rohimun, Engagement Lead, Ernst Young outlined the audit planning report for the year ended 31 March 2021, which provided an overview of the 2020/21 audit strategy and the initial significant risks and areas of focus. There had been a reduction in risk level from the prior year on going concern assessment and disclosures. Valuation of land and buildings would be an area of focus, as they were subject to a number of assumptions and judgements. Materiality levels were based on the prior years financial statements which may change.
Ernst Young's responses to significant risks were outlined in the paper.

The Chair advised that Going Concern had been discussed at the Board meeting, however asked for further clarification. Hassan advised that Auditors practice note 10 outlined that auditors must make considerations of going concern of public sector organisations and whether they would continue to provide a service in the foreseeable future. Areas of focus were liquidity of organisations and the cash position 12-months from the data sign off to gain assurance that the Trust would have satisfactory liquidity in the future. The Director of Finance advised that it had been agreed at the Finance and Performance Committee that the Trust was a going concern. Further communications were expected from NHSE/I that may provide further assurance.

There had been a change in the value for money conclusion responsibilities for 2020/21, following an update in the code of practice that there was a requirement for EY to consider whether the Trust had put in place 'proper arrangements' to secure economy, efficiency and effectiveness on its use of resources. However, there was no longer overall evaluation criterion which they need to conclude on. Instead the 2020 Code required the auditor to design their work to provide them with sufficient assurance to enable them to report to the Trust a commentary against specified reporting criteria on the arrangements the Trust had in place to secure value for money through economic, efficient and effective use of its resources for the relevant period.

The remainder of the report outlined materiality levels, which the Audit and Risk Committee were required to confirm its understanding of, and agreement to, these materiality and reporting levels.

Following a request from the Chair for clarity of the change in requirements for auditing of the Quality Accounts for the purpose of Governor observers, it was confirmed that the requirements to undertake an audit of the Quality Accounts had been paused for 2019/20 and would be the same for 2020/21. It was agreed that an update be provided to the Council of Governors later in the year to report the findings.

The Chair noted the fees table in appendix B of the report, and noted the fee increase due to COVID-19, and assumed that the audit would be undertaken remotely, and asked if there were any anticipated impact of this. Hassan advised that it was unknown but would liaise with the Director of Finance throughout the course of the audit and ensure that the Committee were kept abreast of any updates.

Action: The Council of Governors would receive a briefing on Quality Accounts. **FD**

The Committee:

- ***Confirmed its understanding of, and agreement to, these materiality and reporting levels.***
- ***Noted the External Audit, Audit Planning Report for the year ended 31st March 2021.***

AR21/03/C 1 **Local Counter Fraud Specialist (LCFS) Progress Report (Enclosure C1)**

The Counter Fraud and Security Services Manager provided the highlights from the report which outlined that the Counter Fraud Operational Plan (CFOP) for 2021/22 together with a revision of the local Fraud Risk Assessment had been discussed and agreed with the Director of Finance on 15th March 2021. The CFOP was built around the new Government Functional Standard, which for 2021/22 had replaced the NHS Standards for Providers. The new standard was confirmed in January, which an assessment expected in April or May 2021. It was not expected that the Trust be compliant in all areas as the Trust had not been operating against the areas for the entire year. A plan had been produced to map across areas from the old standard. It was noted that there was a big focus on risk. The following year would be a transitional year with an aim to be fully compliant by March 2022.

A requirement of the Government Functional Standards was a requirement that risks were mapped properly into risk registers. There were 84 fraud risks recognised, however it was suggested that they may be amalgamated under sub-headings. The Cabinet Office have 125 fraud risks identified. Work would be undertaken on this over the following 12-months.

Statutory and essential training on Fraud Awareness remained high at 98%.

Whilst there had been no new fraud prevention notices reported in the report, following this, there had been one reported received which related to the prior purchase of COVID-19 vaccinations where private companies were soliciting the NHS to buy left-over vaccines which presented as a fraud risk. This presented no problem for the organisation, and staff had been made aware of the risk.

North East and Yorkshire had seen a significant rise in fraud reporting over the previous quarter.

A scam was highlighted relating to a BT/Virgin internet fraud. The calls were form overseas and of cloned numbers and there was no ability to block numbers in the Trust as it could result in the blocking of a genuine number.

There had been two new investigation referrals, one of which was related to a locum Doctor employed at other Trust who had falsified timesheets for locum activity to the sum of £50k. A review at been undertaken within the Trust and the current sum stood at £17k that could have occurred. The Director of Finance was aware. Evidence building was underway to support as a criminal case.

Neil Rhodes noted the change in CFOP standards and an understanding that the assessment against the new standards in 2021/22 would align to the new way of working, however asked if there had been an impact assessment of where the gaps were and the impact this would have to ways of working. It was advised that five Trusts within the collaboration were working together to peer review to create an action plan to allow the identification of gaps with follow up work to mitigate them. The main piece of follow up work would include the

mapping of risks; however, this could not take place until in receipt of the 2021/24 Counter Fraud Authority strategy.

A discussion took place regarding the number of fraud risks, and the potential distortion of the risk register. In response to a question from Neil Rhodes regarding this, it was confirmed that the majority of fraud risks would not meet the corporate risk register rating score of 15+. There was one risk on the corporate risk register already relating to fraud. It was noted that the NHS Accredited Counter Fraud Specialist role could not the risk owner so further work was required to identify those. It was confirmed that the risks would be combined into sub-headers.
It was confirmed following a question from Neil Rhodes regarding the mode of work following the COVID-19 pandemic, that the only significant impact was the police investigations which had taken place via videoconferencing since the start of the pandemic. It was hoped that this would change.

It was confirmed following a question from Mark Bailey that the 84 fraud risks would be worked on at a collaborative level to identify general categories. Work was required to map this to the organisation.

The Chair asked for clarification on the steps taken to identify if the locum Doctor reported, had not and could not work elsewhere. Mark Bishop advised that all Trusts that use the same bank system as the Trust had been alerted to the fraud case. It was also reported on the case management system therefore if the individual applied at any other organisation, it would flag up. The next steps would include an interview under caution.

Following a question from the Chair regarding the increase in cyber fraud and phishing emails, it was confirmed that the Trust had in the past undertaken an exercise in which a test phishing email had been circulated to colleagues, which proved to be a useful exercise, and would therefore consider this in the future.

<u>Post meeting note</u> – Mark Bishop had contacted the IT Security Manager regarding the discussion had in regards to issuing a test 'Phishing' email to staff. Apparently, this had recently been approved by Ken Anderson, Chief Information Officer, and they were looking at issuing something in Q1 of 21/22 once approved with NHS Digital. The initial plan was to identify 100 email addresses, but this was hoped to be pushed to 500 email addresses to give a representative test across approximately 10% of the staff group. Details would be included in my future reports if not reported.

A request was made by Sheena McDonnell for further information on the increase in fraud reporting figures within the North East and Yorkshire, as this increase had not been seen in the Trust. Mark Bishop advised that he could offer no explanation, however advised that the likely reason could be a change in the fraud reporting process in an organisation, or that a new counter fraud provider had commenced, or a potential change in the culture. It was expected that there would be a rise in reported cases within the region as two new Trusts were to join the collaboration.

The Committee:

- ***Noted the information provided in the Local Counter Fraud Specialist (LCFS) Progress Report.***

AR21/03/C 2 **Counter Fraud Operational Plan 2021/22 (including Fraud Risk Assessment) (Enclosure C2)**

There were no questions or comments.

The Committee:

- ***Noted the information provided in the Counter Fraud Operational Plan 2021/22 (including Fraud Risk Assessment)***

Harriett Fisher and Chris Bloomfield joined the meeting.

AR21/03/D 1 **Demonstration on the JIRA Tracker System (Presentation)**

The Committee received a demonstration on the JIRA tracking system, a tool developed in house by KPMG using a Microsoft solution to help to automate the recommendation follow up process. Each risk would have an action owner, who would have access to log-in and update the system in relation to the recommendations. Certain fields would be mandated so that the action owners had no option but to complete the updates fully. If the system did not meet the needs of the organisation it could be altered to do so. There was a dashboard functionality in which reports could be produced in real time as the system updated the dashboard data every fifteen minutes. Notifications could be sent to action owners via email when updates were required, or when target dates had not been met. The Director of Finance and Company Secretary had already seen a demonstration on the system and had agreed that the Trust would take this forward.

The Chair advised that this system would offer the opportunity for efficiency within the process and for one source of the truth as the previous method used had been bulky and required large attachments for evidence, where this could be uploaded into the system. It was confirmed that each risk would have restricted views for security purposes.

Following a question from Neil Rhodes it was confirmed that the software was not part of the Office suite.

The Director of Finance advised that the Executive Team had identified that the current system in place for receiving responses on recommendations wasn't fit for purpose and had therefore asked KPMG if they had any system solution of use several months ago, JIRA being a solution that was in use with other organisations. There would be no additional cost for use of the system under the current contract arrangements, and would be included as part of any potential future contracts. Harriet Fisher advised that the use of the system would remove the administrative efforts required in chasing actions and collating them for submission.

Mark Bailey asked if the system could be utilised for other areas. The Director of Finance advised that this specific system would be used for the follow up of audit recommendations.

The Committee:

- ***Noted and thanked KPMG for the demonstration on the JIRA Tracker System.***

Chris Bloomfield left the meeting.

AR21/03/D2 **Internal Audit Plan 2021/22 (Enclosure D2)**
AR21/03/D3 **Internal Audit Progress Report (including Recommendation Tracker) (Enclosure D3)**
AR21/03/D4 **Complaints Handling Internal Audit Report (Enclosure D4)**
AR21/03/D5 **Core Financial Control Internal Audit Report (Enclosure D5)**

Internal Audit Plan 2021/22

The Head of Internal Audit shared the Internal Audit Plan for 2021/22 and outlined the proposed schedule for delivery. The schedule was aligned with the planned dates of the Audit and Risk Committee to ensure a smooth and balanced cycle of reporting throughout the year. The audits had been agreed following discussions with the Board of Directors. The long list of reviews that were not included as part of the 2021/22 plan were outlined along with the reasoning why they did not form part of the years plan.

Internal Audit Charter

The Committee reviewed the Internal Audit Charter, and were asked to approve it in line with the requirements of the Public Sector Internal Audit Standards.

The Director of Finance confirmed that colleagues had provided input to the Internal Audit Plan 2021/22. It was confirmed that whilst Workforce Planning would not be audited, a recruitment plan led by the People and Organisational Development Directorate would be created to ensure that there were targets set and achieved in a staged way, and would be monitored by either the People Committee or Finance and Performance Committee.

Neil Rhodes advised he would be supportive of a two-year flexible plan. The Director of Finance advised that this would need to be revisited following the Internal Audit tender process completion.

Internal Audit Progress Report (including recommendation tracker)

Final reports had been produced for the 2020/21 audits on Complaints Handling and Core Financial Controls. Fieldwork was ongoing for the Risk Management and BAF audits and fieldwork dates had been agreed with contracts for the DSP Toolkit review. It was likely that the report on the DSP Toolkit would not be available for the May 2021 meeting, however it was expected that KPMG would be able to issue an opinion. Fieldwork for the Job Planning audit was complete and draft reports would be issued.

The number of responses received for the recommendation tracker had improved with 22 recommendations showing as implemented and a further 15 recommendations received a progress update and a revised implementation date. There were seven recommendation's overdue with no revised due date. It was noted that the new JIRA software would mandate that an update had to include a revised due date. The Chair noted the much improved position from the previous Audit and Risk Committee meeting, however noted that for those still outstanding, the Chief Operating Officer was awaiting key members of staff to commence in her team.

Complaints Handling Internal Audit Report

The Complaints Handling Internal Audit provided significant assurance with minor improvement opportunities. The rating was given on the basis that there was found to be

appropriately designed controls in place in relation to complaints handling for the areas tested. The Complaints Policy was still in draft format and a revised process flow chart was introduced in July 2020 which linked to the draft policy, which was used as the basis for the compliance testing.

A comprehensive discussion took place regarding the assurance rating of the report. Mark Bailey raised a concern regarding the how the audit was undertaken as the policy had not been implemented yet, and noted that the interviews had taken place with the corporate team as opposed to Divisional leads regarding their involvement in the complaints process. Harriet Fisher advised that in liaison with the audit sponsor, it was agreed that there was a desire for this audit and the Deputy Director of Nursing (Patient Experience) was keen to use the findings as a baseline to assist in tackling any issues.

Kath Smart (on the behalf of Sheena McDonnell who was not at the meeting) agreed that it felt like there was a significant amount of work to undertake despite the audit receiving significant assurance and advised that it would be considered at the Quality and Effectiveness Committee.

Neil Rhodes suggested that the evidence did not meet the level of assurance. Rob Jones advised that discussions had taken place regarding the assurance rating, which was offered on the basis of the recommendations and follow up and advised that it was useful that the audit was undertaken at that time as it provides the Trust with an opinion of policy management processes. It was noted that the Deputy Director of Nursing's (Patient Experience) view was that there wasn't a degree of ownership at Divisional level which reflected in the way that the audit was undertaken. Mark Bailey challenged the position on Divisions as a fundamental aspect of the change process.

It was agreed that the Complaints Handling Internal Audit Report would be escalated to the Quality and Effectiveness Committee.

Following a comment from Neil Rhodes regarding the use of Datix to manage complaints, Harriet Fisher advised that Datix was being largely used as intended and had seen the process, however noted that the only one person could authorise a deadline extension to a complaint. The Director of Finance advised that each area has key performance indicators against complaints and should be reported to the Executive Team.'

Following a discussion regarding the rating it was advised that a focus would remain on the improvement aspects of the report.

<u>Core Financial Control Internal Audit Report</u>

The review formed part of the agreed 2020/21 Internal Audit Plan to review controls around key financial systems, undertaken on an annual basis. The controls underpin the financial activity in the Trust. The two topics audited were SBS Reconciliation Packs and IFRS 16. Testing had shown the SBS reconciliation packs were completed monthly and that there was a process for discussing any issues highlighted between the Finance team and SBS. Actions arising from this process and the Trust's formal review of the reconciliations was not formally documented. One low priority recommendation was raised in relation to this issue. The Trust took steps to prepare for the original IFRS16 implementation date and had continued those preparations now that the date has been deferred. Evidence was seen that NHS guidance had been followed as part of this preparation process but there was a need

to formalise the Trust's ongoing approach to identifying leases and assessing them against the criteria of IFRS16. KPMG have raised two low priority recommendations in relation to this issue. Through the sample testing of five leases, there were some issues identified with the level of detail in which the Trust evidence its assessment of individual leases and how lease calculations were reviewed. There was one medium and one low priority recommendations in relation to these issues. Given the low priority nature of the majority of recommendations it was raised that the Trust still has to carry out its lease assessments prior to the implementation of IFRS16. The current control framework was rated with significant assurance with minor improvement opportunities.

The Chair advised that a brief update had been provided at the Finance and Performance Committee in March 2021 and was pleased to see the report.

Action: The Internal Audit report on Complaints would be escalated to the Quality and Effectiveness Committee. **FD**

The Committee

- ***Reviewed and approved the Internal Audit Plan 2021/22;***
- ***Reviewed and approved the Internal Audit Charter2021/22;***
- ***Reviewed and approved the Internal Audit Progress Report, including the recommendation tracker,***
- ***Noted the Complaints Handling Internal Audit Report,***
- ***Noted the Core Financial Control Internal Audit Report.***

AR21/03/E1 **Governor Observations (Verbal)**

Bev Marshall advised that fellow Governors may not have an understanding of the benefit that internal audit provides to the operation of the Trust through auditing various initiatives and would therefore share this with Governors.

Bev Marshall noted that the charity audit was out of sequence with the overall accounts audit and advised that they both used to conclude at 31 March with one overall report, and asked if they could be realigned, as it would be helpful for Governors. The Director of Finance advised that upon commencement at the Trust, there had been no accounts submitted to the Charity Commissioners for four years and therefore this was the reason that the two accounts were out of sync. It was advised that the two could not be undertaken at the same time.

Dennis Atkin commended the Local Counter Fraud Specialist Progress Report and asked if bank and agency staff were at a higher risk of fraud because they were not employed by the Trust. Mark Bishop advised that since NHS Professionals had been the Trust's core bank supplier this had not been the case.

AR21/03/F1 **Data Security and Protection Toolkit (DSPT) Compliance (Enclosure F1)**

The current position was as expected given that the team were just 3 months into the DSPT Gap Analysis review against the evidential requirements as described in the DSPT Big Picture Guides, which was a better position than the previous year. The Information Governance Committee (IGC) had agreed with the Trust Auditors to carry out the 'Point in Time' audit in May 2021, to give colleagues the opportunity to make best progress with the necessary DSPT

'Gap Analysis' against the BPG's, and to carry our any necessary remedial work to secure the necessary evidence.
The Trust had commissioned NHSD's Cyber Essentials Specialists 'Dionach' to review and report on DBTH current position vis-a-vis the relevant Cyber Essentials + Equivalence Assertions within the DSPT in late March 2021 to report back in April 2021. Again, to give us time to complete any necessary and appropriate actions raised, by the June DSPT reporting deadline.
The IGC was working closely with the Trust Educators in the People and Organisational Development Directorate to ensure all staff who can complete their SET Training were helped and encouraged to do well so before the DSPT reporting deadline June 21.
There were a number of minor concerns outlined in the report which were being addressed. The main risks and mitigating actions were outlined and would continue into the next quarter. The Trust would work with the National Cyber Security Centre to undertake a tabletop response exercise.
The change to working was highlighted with more colleagues working remotely which had changed the risk profile on the external side of the firewall. A capital bid would be submitted for the increase in malware protection to support people working remotely.

The Chair advised that remote working had been a concern raised by KPMG in an audit and therefore was glad to see that action was being taken reduce the risks associated with this.

In response to a question by Mark Bailey regarding the use of personal devices, it was advised that this was an ambition, however, would only be implemented once there was a robust infrastructure in place to support it. Where possible, colleagues had been provided with laptops to work remotely. Following a question from Neil Rhodes regarding the use of mobile devices for work use, it was confirmed that colleagues do use personal mobile devices to access NHSmail and Microsoft Teams and they have their own privacy policies and users were required to tick an acceptable user policy prior to use.

The Chair advised that she attended the Information Governance Group meeting as an observer and asked that when the Dionach report was available, it be provided or circulated to the Audit and Risk Committee for assurance.

The Chief Information Officer advised that David Linacre had been promoted to the Head of IT Operations and Cyber Security.

The Committee:

- ***Noted the update provided on data security and protection toolkit compliance.***

AR21/03/G1 **<u>Corporate Risk Register (Enclosure G1)</u>**

Action had been taken and continued in the review the existing risks and in the identification of new risks. Risk ID 2664 had been escalated to the corporate risk register following approval at the Management Board on the Consultant staffing shortage in DCC. A robust action plan had been developed to address risk mitigations. The risk rating was 20 and the Medical Director was the lead for this risk.

In response to a question from Kath Smart regarding the need to review risks currently allocated to the Finance and Performance Committee, and whether they should be allocated to the Audit and Risk Committee, the Company Secretary advised that a discussion had taken

place at the Finance and Performance Committee to confirm that each Committee Chair would review.

The Company Secretary advised that she would meet with Mark Bishop to commence the process to align fraud risks to the Trust risk register.

Following a question from Mark Bailey seeking assurance on the delivery of training to those responsible for risk, it was advised that this did not sit within the Company Secretary's remit however would be included as part of the Risk Management Policy once refreshed.

Action: The Company Secretary would meet with Mark Bishop to discuss process for aligning fraud risk to the Trust risk register. **FD**

The Committee:

- ***Noted the corporate risk register.***

AR21/03/G2 **<u>Corporate Hospitability and Sponsorship – Review of Process (Enclosure G2)</u>**

The gifts and hospitality register for the period April 2020-March 2021 was received. This excluded any gifts and hospitality received relating to COVID-19 as that was managed via the Communications and Engagement Department. The numbers were low due to the number of events that were cancelled during the year due to the COVID-19 pandemic.

The Chair advised she was perturbed to see that one form had been signed illegibly. The Company Secretary advised that an update to the system would be undertaken which would take action against forms received that have illegible signatures.

<u>Action</u>: The Audit and Risk Committee work plan would be updated to include an update of the gifts and hospitality register regularly. **FD**

The Committee:

- ***Noted the update provided on corporate hospitality and sponsorship.***

AR21/03/G3 **<u>External Audit Effectiveness (Enclosure G3)</u>**

The Director of Finance advised that he was content for KPMG and Ernst Young to remain in the meeting for item AR21/03/G3 and AR21/03/G4. Work had continued with both teams and noted that each year collaborative working had improved. There had been no issues following the changes in the KPMG team during the year and noted that Rob Jones and Harriet Fischer were an asset and was pleased with their performance. The quality of work was good, reliable and challenging when required.

The Chair noted that the annual evaluation of performance had been undertaken, notwithstanding that the procurement process was ongoing.

The Committee:

- ***Noted the external audit effectiveness report.***

AR21/03/G4 **Internal Audit Effectiveness (Enclosure G4)**

Discussed as part of Item AR21/03/G3.

The Committee:

- ***Noted the internal audit effectiveness report.***

AR21/03/G5 **Audit Services Procurement Update (Enclosure G5)**

Attendees from KPMG (Internal Audit) and Ernst Young (External Audit) left the meeting.

The Director of Finance advised that a paper had been received at the Council of Governors on 29 January 2021 to outline the process, draft specification & timeline for the procurement process of internal and external auditors. Nominations had been sought and it was agreed that Bev Marshall, Dennis Atkin and Phillip Beavers would represent CoG. The tender process would commence in March 2021, with the expectation to provide a recommendation to the Audit and Risk Committee at its July 2021 meeting, with contracts to commence in October 2021 following the Annual Members Meeting. It was noted that External Audit was a CoG appointment, and Internal Audit was a management appointment and reports would continue to be provided to the Council of Governors. It was reiterated that the process would be undertaken together to provide openness and transparency for both. The timetable had been agreed by the Council of Governors.

Bev Marshall noted the good idea to run the two procurements together to maximise the prospect of a better outcome. Following a question from Bev Marshall, it was confirmed that interested parties would be encouraged to apply for both IA and EA.

The Committee:

- ***Noted the update provided on the procurement of audit services.***

Attendees from KPMG (Internal Audit) and Ernst Young (External Audit) re-joined the meeting.

AR21/03/G6 **Information Governance Assurance Framework (Enclosure G6)**

The Head of Information Governance presented the Information Governance Assurance Framework. It was advised that Dr T J Noble, Medical Director was the Caldicott Guardian.

There were no questions.

The Committee:

- ***Approved the Information Governance Assurance Framework.***

AR21/03/H1 **Single Tender Waiver Report (Enclosure H1)**

Matthew Bancroft advised that at the previous meeting it had been agreed that the process undertaken by the Trust to sign off Single Tender Waivers would be included on the front sheet of future reports.

The Committee:

- ***Noted the single tender waiver report.***

AR21/03/H2 **Losses and Compensations (Enclosure H2)**

There had been four cases reported since the previous meeting, all of which had been through the approved process. Tt had been agreed that the process undertaken by the Trust prior to getting to ARC would be documented on the front covering sheet.

The Committee:

- ***Noted the losses and compensations paper.***

AR21/03/H3 **Board Certification for the Provider License (FT04 and Full Standards Assessment (Enclosure H3)**

The Director of Finance advised that effort would be made to provide the self-certifications to the Audit and Risk Committee meeting in July 2021. The full Board provide license had not previously been presented to the Audit and Risk Committee before, however upon recommendation from KPMG it would be part of the ongoing workplan. Assurance was provided that KPMG had sampled ten requirements of the provider license in January 2021 which provided significant assurance.

The Committee:

- ***Noted the update provided on the board certification for the provider license.***

Governor Observations (Verbal)

None.

AR21/03/J1-J2 **Information Items (Enclosure J1 – J2)**

- ***Information Governance Group – 23/11/21 and 25/01/21***
- ***Health and Safety Committee Minutes – December 2020***

AR21/03/K1 **Any Other Business (Verbal)**

There were no items of any other business.

AR21/03/K2 **Minutes of the Audit and Risk Committee – 29 January 2021**

The committee:

- ***Approved the minutes of the Audit and Risk Committee – 29 January 2021.***

AR21/03/K3 **Audit and Risk Committee Terms of Reference (Enclosure K3)**

A request was made that the audit and risk committee terms of reference reflected the review of the Board Assurance Framework and process and how it would work in the future.

It was also requested that the role of Information Governance and Cyber Security be reflected in the Audit and Risk Committee terms of reference.

<u>Action</u>: It was agreed that the Audit and Risk Committee terms of reference be updated to include the future risk management process, and be reflective of information governance and cyber security work of the committee.

The committee:

- ***Approved the terms of reference of the Audit and Risk Committee, subject to the above amendments.***

AR21/03/K 4 **<u>Escalation (Verbal)</u>**

No issues were identified for escalation to/from:

- H1.1 ARC Sub-Committees;
- H1.3 Board of Directors.

Issues for escalation:

- H1.2 Board Sub-Committees – It was agreed that the Complaints Audit Report would be escalated to the Quality and Effectiveness Committee for a focus on the recommendations and progress.

AR21/03/K 5 **<u>Date and time of next meeting (Verbal)</u>**

	Year-end Meeting	**Committee Meeting**
Date:	**21st May 2021**	**15th July 2021**
Time:	**09:30**	**09:30**
Venue:	**Microsoft Teams**	**Microsoft Teams**

FINAL

Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

AUDIT AND RISK COMMITTEE

Minutes of the meeting of the Audit and Risk Committee
Held on Friday 21st May 2021 at 09:30 via Microsoft Teams

Present:	Kath Smart, Non-Executive Director (Chair) Sheena McDonnell, Non-Executive Director Neil Rhodes, Non-Executive Director Mark Bailey, Non-Executive Director (MCB)
In attendance:	Suzy Brain England OBE, Chair of the Board (until AR21/05/C4 and item AR21/05/E2) Richard Parker OBE, Chief Executive Officer (until AR21/05/C4 and item AR21/05/E2) Fiona Dunn, Deputy Director of Corporate Governance/Company Secretary Harriet Fisher, Internal Audit Manager, KPMG Rosie Kelly, Assistant Manager, KPMG Hassan Rohimun, Engagement Lead, Ernst Young Jon Sargeant, Director of Finance
To Observe:	Dennis Atkin, Public Governor Bev Marshall, Public Governor
Apologies:	Katie Shepherd, Corporate Governance Officer (Minutes via video recording)

ACTION

AR21/05/B1 **Welcome, Apologies for Absence AND declarations of interest (Verbal)**

Kath Smart welcomed the members and attendees. The apologies for absence were noted. No conflicts of interest were declared.

It was noted that the Draft Annual Accounts and Financial Statements 2020/21 and the ISA 260 Report items were deferred to a Committee date yet to be arranged.

AR21/05/B2 **Action Log from Previous Meeting (Enclosure B2)**

Updates on actions were provided:

Action 1 – ARC Appraisal – Self-Assessment Process – The Chair had trialled the electronic questionnaire & fed back minor comments to the Deputy Director of Corporate Governance. Once fully progressed it would be rolled out to this Committee, and other Board committees. Action closed.

Action 2 – Discharge Planning – Further clarification was required. This action to remain open.

Action 3 – KPMG – The session had been arranged and would take place the following week. Action closed.

Action 6 – P&OD HR Systems and Team Review 2019/20 – Action closed.

Actions 10-12 were due, and updates would be expected at the July 2021 meeting.

Action 16 – Fraud Risk – The Chair advised that she had signed off the Counter Fraud Standard with Mark Bishop, NHS Accredited Counter Fraud Specialist and the Director of Finance. Over the coming year one of the key actions is to align the fraud risk register with the Trust's risk register and risk assessment process. Action closed.

Action 18 – Audit and Risk Committee Terms of Reference – The Committee terms of refence had been approved by the Board. Action closed.

Actions closed: 1, 3, 4, 5, 6, 7, 9, 14, 15, 16, 17 and 18.

The Committee:

- ***Noted the updates and agreed, as above, which actions would be closed.***

AR21/05/B3 **Request for any other business**

There were no requests for any other business.

AR21/05/C1 **Draft Annual Report (Enclosure C1)**

The Chief Executive presented the draft Annual Report for 2020/21, which included the statement from the Chief Executive Officer and Chair. The report outlined in significant detail the Trust's response to the COVID-19 pandemic that commenced in March 2020 and had continued to date. The report detailed the how the Trust ensured that strategic objectives were delivered as much as they possibly could have been throughout the year, and how the Trust ensured that emergency, urgent and cancer patients continued to receive the care required, and that remaining patients continued to receive care in priority order to reduce inequality.
The remainder of the report included the usual statement of accountability, board composition, income and remuneration, attendance at meetings and the foundation trust code of governance, single oversight framework and statement of accounting officers' responsibilities. There were still some sections to be completed, as with the Quality Accounts.

Neil Rhodes commended that the report contained a lot of detail relating to testing of COVID-19 and queried if this was excessive. The Chief Executive advised that he was content to amend the document if the Committee felt that it was required. The Chair of the Board noted that this information was added to the report to highlight that those who undertake the testing of COVID-19 had continued to do a tremendous job throughout the pandemic. The Chief Executive noted that it was important to reflect that testing capacity was very limited at the start of the COVID-19 pandemic, and point of care testing did not become available until later when the Government made pathology equipment available for Trusts. Once point of care testing became available within the Emergency Department, this contributed greatly to the pathway management of patients.

Mark Bailey noted that the report provided an excellent summary of the innovation and activity throughout the pandemic. Mark Bailey suggested that clarification on when the

Trust hit its peak of COVID-19 in relation to other parts of the country as there were differing points across the country. Mark Bailey noted that whilst many services were reduced, innovation continued throughout. Mark Bailey asked that the sums within the Diversity and Inclusion section be checked as it appears that the percentages were incorrect. It was agreed that this would be reviewed. The Chief Executive advised that the Trust hit the first peak at the same time as the rest of the country, however met the second peak during October 2020, whereas the remainder of the country hit the second peak during the Christmas period. A lower third peak was reached in January 2021.

Hassan Rohimun advised that the external audit process was still in progress, however comments had been provided to the Trust regarding the annual report.

Sheena McDonnell noted that the annual reported demonstrated the activity of the previous year well through the timeline of activity, which documents the challenges and critical decisions made.

Sheena McDonnell noted that there was no mention within the Diversity and Inclusion section of the Trust's adoption of the RACE Equality Code and suggested that this be referenced.

Sheena McDonnell noted that the infographics were good within the staff survey section, however noted that more positive results could be included within the section, such as results relating to equality, diversity and inclusion.

Mark Bailey suggested that the 'One Team' story reflected the efforts of front-line staff only and suggested that this be inclusive of all colleagues that had supported during the pandemic.

The Chair noted that the report provided a comprehensive story of 2020/21, written in a compassionate way, particularly to the three members of staff that sadly lost their lives due to COVID-19.

<u>Action</u>: The sums within the Diversity and Inclusion section of the annual report would be reviewed for accuracy. **RP**

The Committee:

- ***Approved the Annual Report subject to the amendments discussed.***

AR21/05/C2 **<u>Draft Annual Governance Statement (Enclosure C2)</u>**

The Chief Executive presented the annual governance statement which provided a narrative of the scope of responsibility, purpose of the system of internal control, capacity to handle risk, and the risk and control framework. The report concludes with the use of resources and an overall statement in respective information governance, the CQC and effectiveness. The Chief Executive advised as outlined within the report:

'Following my review, my opinion was that Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust had a sound system of internal control that supports the achievement of its policies, aims and objectives. No significant internal control issues have been identified.'

The Chief Executive advised that in preparing this report, he had met with KPMG to discuss the internal audit programme for 2021/22, including any issues or concerns, therefore based upon that assessment, the Chief Executive was content to recommend the Annual Governance Statement to the Audit and Risk Committee for approval.

Hassan Rohimun reiterated that the external audit process was still in progress, however comments had been provided to the Trust regarding the annual governance statement, which included several minor omissions in relation to the guidance. It was noted that the report presented was in draft format and amendments would be made as requested.

Kath Smart noted that the internal audit report on Job Planning received 'no assurance' and asked for the Chief Executives comments on this. The Chief Executive noted that this was the first report in his tenure where 'no assurance' had been received following an internal audit, however this had formed part of the discussions with KPMG. The internal audit report formed part of the solution, as the risks required quantification so that all parties were aware of the improvements to be made, which supports the Annual Governance Statement.

Harriet Fisher advised that whilst the internal audit report achieved 'no assurance', the report had been constructively received by the Trust which was positive. In response to a question by Kath Smart regarding the requirement of any negative outcomes from internal audit reports in the Annual Governance Statement, it was advised that this was not a requirement, as it had been reflected in the Head of Internal Audit report.

The Committee:

- ***Approved the Annual Governance Statement subject to the suggested amendments and final feedback from KPMG/ EY.***

AR21/05/C 3 **Draft Annual Accounts and Financial Statements 2020/21**

This item was deferred as the report had not yet been finalised. Good progress had been made; however further testing work was required by External Audit. Hassan Rohimun advised that work on this progressed and there were further conclusions to be made relating to the value for money conclusion. A further date would be scheduled for the Audit and Risk Committee to receive the Draft Annual Accounts and Financial Statements 2020/21 and ISA 260.

Action: A further date to be scheduled to receive the draft annual accounts and financial statements for 2020/21 and ISA 260. **KS**

The Committee:

- ***Agreed to defer the item.***

AR21/05/C 4 **Audit and Risk Committee Annual Report (Enclosure C4)**

The Chair presented the Audit and Risk Committee Annual Report and highlighted that the two gaps, Head of Internal Audit opinion and the ISA 260 opinion, would be inserted prior to submission to the Board.

The Committee:

- ***Approved the Audit and Risk Committee Annual Report subject to the above additional information that would be included prior to submission to the Board.***

AR21/05/D 1 **ISA 260 Report**

This item was deferred.

The Committee:

- ***Agreed to defer the item.***

AR21/05/E 1 **Annual Report and Head of Internal Audit Opinion (Enclosure E1)**

Harriet Fisher summarised the findings for all reviews undertaken in 2020/21, the majority of which received ratings of 'significant assurance with minor improvement opportunities'. This data was used to form part of the Head of Internal Audit opinion. The fieldwork for the review of the Information Governance (Data Security and Protection Toolkit) concluded on 20th May 2021, and whilst the internal review was still to be completed, it was expected that the report would receive 'significant assurance with minor improvement opportunities' with four key areas of improvements recommended.

Harriet Fisher advised that there were three areas that formed part of the Head of Internal Audit opinion:

- The design and operation of the Assurance Framework and associated processes.
- The range of individual opinions arising from risk-based audit assignments, contained within our risk-based plan that have been reported throughout the year.
- The process by which the organisation had assurance over the registration requirements of its regulators.

The assessment had taken account of the relative materiality of these areas. The overall opinion for the period 1st April 2020 to 31st March 2021 was:

'Significant assurance with minor improvement opportunities' can be given on the overall adequacy and effectiveness of the organisation's framework of governance, risk management and control.'

The Chair noted that this was a positive opinion, and whilst there were several minor improvements required, the Audit and Risk Committee would drive these and monitor progress. Mark Bailey supported the comments.

The Chair wished to thank the Executive Team and their teams as many reports received significant assurance throughout the year despite the operational challenges due to the COVID-19 pandemic.

The Committee:

- ***Noted the Annual Report and Head of Internal Audit Opinion.***

AR21/05/E 2 **Internal Audit Report: Job Planning (Enclosure E2)**

Harriet Fisher highlighted the internal audit concluded with a rating of 'no assurance' following the identification of issues with the design and operation of the controls, and cultural issues relating to this. There were some issues with relative guidance available, with no clear indication of roles and responsibilities and when the annual cycle should take place. There hadn't been approval from the local negotiating committee of job planning guidance, and the local negotiating committee had not agreed to set up a job planning consistency committee. There was widespread non-compliance with the controls in place. Cultural work was required to ensure engagement with the process.

The Executive Medical Director noted that the Trust was aware that there was issues with job planning and that it was disappointing that a rating of 'no assurance' had been received, however understood how the conclusion had been drawn. A key issue identified was the recognition that job planning was labour intensive and required adequate resources. The Executive Medical Director presented the action plan to achieve reformed job planning processes within the Trust which included the headline responses of the audit, and the topics of the eleven recommendations from the report:

- Centralised filing,
- Annual review,
- Consistency of process,
- Activity detail,
- Service objectives,
- Private work,
- Consider demand and capacity,
- Policy ratification,
- Consistency committee (for content),
- Training
- Resources administrative support.

The Trust policy was in line with NHSE/I guidance, however further clarification was required on roles and responsibilities. A plan was in place to gain external support to review the policy for approval by the Local Negotiating Committee (LNC). The terms of reference had been devised for a Job Planning Consistency Committee, however the LNC would not engage to ratify the terms of reference. It was recognised that the administrative demand for job planning would require review to ensure that the requirements were met. The existing job planning template was inadequate which meant that some data was not captured. The standards of business conduct were held elsewhere within the Trust.

The anticipated work plan was shared, with many immediate actions to be taken, some of which had commenced. The key risk was outlined including the available staffing resource to deliver all of the requirements within the recommendations as the business case for further administrative support would not be complete until month 4. The adverts were out for additional resource within the Medical Director function. The LNC had not approved the current job planning guidance, which may result in a risk that approval would not be achieved within the proposed timescales.

Neil Rhodes recognised that to receive a report with 'no assurance' was disappointing and now the Audit and Risk Committee must follow progress closely. Neil Rhodes observed non-compliance and cultural issues which would be a challenge. Neil Rhodes requested that there be formal programme management support to the achievement of the action plan, so

that the Committee can be assured that progress was made. The Executive Medical Director agreed that the project required further support.

Sheena McDonnell advised that report positively outlined the steps required to achieve assurance, particularly relating to the cultural issues and what work was required. Sheena McDonnell noted that she was content for progress to be reported to the People Committee. Sheena McDonnell noted that the message to colleagues involved in the process of job planning fully understand their involvement in the process and the importance of it.

The Chair of the Board advised that the urgency of the actions required to improve this process and support would be provided to ensure that project support was received. The Chair of the Board advised that she wished to see every team within the organisation with a clear analysis of their roles and responsibilities which would be linked to funding, commissioning and referrals and waiting lists so that the Trust had a clear ability to determine accurate demand. The Chair of the Board reiterated that whilst organisation was in a period of increased activity following the COVID-19 pandemic, the Trust's duty of care to colleagues was a priority and it would not be expected that colleagues undertake more work than their contracted hours. It was noted that through the review of the job planning process, it may be identified that colleagues were working too many hours and that a reduction was required which would require proper processes. The Chair of the Board advised that this review may also lead to a need for further recruitment and noted the Board's target to have no vacancies, and therefore this should be considered. The Chair of the Board advised that the Board have a duty of leadership and whilst there were mechanisms in place to ensure that the Trust had a good working relationship with trade unions, if non-agreement continued, the Trust would continue to proceed in the interest of its management duties.

Mark Bailey supported the comments made by non-executive director colleagues.

The Chief Executive noted the responsibility and ownership of this challenge was now required at leadership level, within the responsibility that systems and processes were in place to support the delivery of high-quality care. Consultants deliver the majority of care to patients and therefore it was particularly important that job planning for that cohort of staff be reflective of these expectations. The Chief Executive provided assurance that this action plan would be delivered as a priority. It was noted that recruitment to the Medical Director posts would provide the leadership function to ensure that this work was completed.

The Chair noted that the Committee view this action plan as a priority and advised that it would be escalated to the Board as 'no assurance' was received. Regular progress updates would be required at the People Committee on the achievement of actions as outlined within the action plan presented to the Audit and Risk Committee on 21st May 2021, following a 'no assurance' outcome within the internal audit report on job planning. The Executive Medical Director would be required to provide an update to the Audit and Risk Committee in October 2021 to review the evidence submitted to KPMG on the implementation of the recommendations.

<u>Action</u>: The internal audit report on Job Planning would be escalated to the Board for review. **KS**

<u>Action:</u> Regular progress updates would be required at the People Committee on the achievement of actions as outlined within the action plan presented to the Audit and Risk **TN**

Committee on 21st May 2021, following a 'no assurance' outcome within the internal audit report on job planning.

Action: The Executive Medical Director would be required to provide an update to the Audit and Risk Committee in October 2021 to review the evidence submitted to KPMG on the implementation of the recommendations. **TN**

Action: The Executive Team would ensure that the Executive Medical Director receives appropriate support to achieve the Job Planning action plan, following a 'no assurance' rating from the internal audit report. **ET**

The Committee:

- ***Noted the Internal Audit Report: Job Planning.***

AR21/05/E3 **Internal Audit Report: Capacity Planning (Enclosure E3)**

The report received 'partial assurance with improvements required'. The Chair advised that the responsible officer, Chief Operating Officer was unable to attend today, however would attend the July 2021 Audit and Risk Committee meeting to provide an update on progress. Harriet Fisher advised that the audit commenced in autumn 2020 and concluded in March 2021. The internal audit included a review of the capacity planning process in place across a number of areas. Key issues identified within elective service capacity planning included that there was no clear process in place with limited evidence for the output of the processes. Work was underway to develop the capacity model. Key issues identified within non-elective service capacity planning was more positive.
It was noted that the reason that this report received a 'partial assurance with improvements required' rating, and the job planning report received a 'no assurance' rating, was because the when the internal audit commenced on capacity planning, there was already a large investment of work underway to improve the process.

The Chair noted that capacity planning had been a focus of the Finance and Performance Committee, and the audit report had clear recommendations for the Trust to have standardised processes in place. The Director of Finance noted that the report was helpful and acknowledges partially some of the work already undertaken to improve the position.

Mark Bailey note the useful report and asked if this work would be dovetailed with the job planning work. The Director of Finance advised that it was an aim to have job planning and capacity planning aligned.

In response to a question from Mark Bailey regarding the involvement of multiple divisions and specialities in the capacity planning process, the Director of Finance advised that this challenge was previously identified, and this was part of the action plan to improve.

Sheena McDonnell reflected that the action plan to achieve the recommendations should form a similar project management approach to delivery, to provide the Committee with assurance of progress at future meetings.

The Chair advised that this would be escalated to the Finance and Performance Committee to receive an update on progress. Neil Rhodes agreed to this, a date to be agreed following a discussion with the Chief Operating Officer.

<u>Action</u>: An update would be required at the Finance and Performance Committee on the progress on actions taken, following a 'partial assurance, with improvements required' outcome within the internal audit report on capacity planning. **RJ**

The Committee:

- ***Noted the Internal Audit Report: Capacity Planning.***

AR21/05/E4 **<u>Internal Audit Report: Risk Management (Enclosure E4)</u>**

Harriet Fisher presented the internal audit report on risk management, which had been split into two assurance areas. The design of the risk management framework received 'significant assurance with minor improvement opportunities' and the operating effectiveness of risk management processes received 'partial assurance with improvements required', due to the length of time that it took to update the board assurance framework in readiness for reporting to the Board. The corporate risk register presented to Board and Committee meetings during the year had not included an appropriate level of information to provide assurance that the risks were being managed effectively. There were a large number of high scoring risks that were not on the corporate risk register. These risks required re-escalation to the corporate risk register, downgrading where appropriate or consolidating before inclusion on the CRR.
Whilst there were issues identified within the 'business-as-usual' process, it was recognised that this had not been a 'business-as-usual' year due to the COVID-19 pandemic, and the Trust had received 'significant assurance with minor improvement opportunities' from the business continuity internal audit report in autumn 2020, therefore when the Head of Internal Audit opinion was concluded on whether there had been an assurance framework in place, monitored effectively and managed by the Board, the evidence was there.

The Company Secretary advised that she was supportive of the report. Some actions were completed, and plans were in place to achieve the remaining actions. It was agreed that an update would be provided at the Audit and Risk Committee in October 2021.

Mark Bailey was supportive of the report.

In response to a question from Sheena McDonell regarding the risk management process, and the functionality of the Datix system, it was advised that changes had been made in the system which had helped, however acknowledged there was further training required to ensure that Datix was used effectively more widely. Sheena McDonnell noted that embedding this within the Trust would be a challenge and requested further assurance on the process to review risks rated 15+, and how it the system in place was embedded within the Trust and the impact this had had on risk scores.

<u>Action</u>: A progress update would be required at the Audit and Risk Committee meeting in October 2021 against the recommendations outlined within the Internal Audit report on risk management. This would include an update on the process to review the risks rated 15+, how the system had been embedded, and the impact this had on risk scores. **FD**

The Committee:

- ***Noted the Internal Audit Report: Risk Management.***

AR21/05/E5 **Internal Audit Follow Up (Enclosure E5)**

Harriet Fisher advised that since the last Audit and Risk Committee, there had been eleven recommendations implemented, and sixteen recommendations had received updates, which were still in progress. There were seven recommendations that did not receive an update. It was noted that, as revised dates were not provided for seven recommendations, they could not be approved by the Committee. It was advised when revised due dates were provided, the Committee would approve that they were content with the changes. It would be easier following the implementation of the JIRA tracking system.
The Chair advised that the waiting list prioritisation report update was provided at Board in May 2021.
Sheena McDonnell noted that the report summarised the activity against recommendations throughout the year 2020/21. Sheena McDonnell noted that the majority of recommendations that had not received an update for this report, had been discussed at Board. It was noted by Sheena McDonnell that the number of outstanding recommendation responses was an improvement on the previous meeting.

The Committee:

- ***Noted the Internal Audit Follow Up report.***

AR21/05/F1 **Governor Observations (Verbal)**

Bev Marshall noted that the Council of Governors would be required to approve the Annual Report and Accounts in due course, and asked that Governors receive the report in good time to allow them to read the report and make any comments in a timely manner. Bev Marshall noted the internal audit report on job planning, demonstrated how useful internal audits were.

Dennis Atkin supported Bev Marshall's comments, and noted that it in reference to the internal audit report on job planning, there were proactive responses and if the action plan was achieved this would provide an improved picture towards year-end.

AR21/05/G1 **Any Other Business (Verbal)**

There were no items of any other business.

AR21/05/G2 **Minutes of the Audit and Risk Committee – 25th March 2021 (Enclosure G2)**

Harriett Fisher requested that paragraph 6, on page 224 of the papers be amended from:

'Following a comment from Neil Rhodes regarding the use of Datix to manage complaints, Harriet Fisher advised that Datix was being largely used as intended and had seen the process, however noted that the only one person ***can be an authoriser of a complaint****. The Director of Finance advised that each area had key performance indicators against complaints and should be reported to the Executive Team.'*

To:

*'Following a comment from Neil Rhodes regarding the use of Datix to manage complaints, Harriet Fisher advised that Datix was being largely used as intended and had seen the process, however noted that the only one person **could authorise a deadline extension to a complaint**. The Director of Finance advised that each area had key performance indicators against complaints and should be reported to the Executive Team.'*

The committee:

- ***Approved the minutes of the Audit and Risk Committee – 25th March 2021 subject to the above amendments.***

AR21/05/G3 **Escalation (Verbal)**

No issues were identified for escalation to/from:

- G1.1 ARC Sub-Committees.
- G1.2 Board of Directors – Internal Audit Report: Job Planning.
- G1.3 Board Sub-Committees – Capacity Planning to Finance and Performance Committee, and Internal Audit Report: Job Planning to People Committee.

AR21/05/K5 **Date and time of next meeting (Verbal)**

	Committee Meeting	**Further Year-End Meeting date to be confirmed**
Date:	**15th July 2021**	
Time:	**09:30**	
Venue:	**Microsoft Teams**	

FINAL

Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

AUDIT AND RISK COMMITTEE

Minutes of the meeting of the Audit and Risk Committee
Held on Wednesday 9th June 2021 at 14:00 via Microsoft Teams

Present:	Kath Smart, Non-Executive Director (Chair) Neil Rhodes, Non-Executive Director Mark Bailey, Non-Executive Director (MCB)
In attendance:	Alex Crickmar, Deputy Director of Finance Fiona Dunn, Deputy Director of Corporate Governance/Company Secretary Harriet Fisher, Internal Audit Manager, KPMG Hassan Rohimun, Engagement Lead, Ernst Young Jon Sargeant, Director of Finance Katie Shepherd, Corporate Governance Officer (Minutes) Dan Spiller, External Audit Manager, Ernst Young
To Observe:	Dennis Atkin, Public Governor
Apologies:	Bev Marshall, Public Governor Sheena McDonnell, Non-Executive Director

ACTION

AR21/06/A1 **Welcome and Apologies for Absence (Verbal)**

Kath Smart welcomed the members and attendees. The apologies for absence were noted.

AR21/06/A2 **Conflict of Interest**

No conflicts of interest were declared.

AR21/06/A3 **Request for any other business**

There were no requests for any other business.

AR21/06/B1 **Draft Annual Report 2020/21 including Annual Governance Statement (Enclosure B1)**

The draft annual report for 2020/21 including the annual governance statement had been approved at the meeting held on 21st May 2021 subject to the minor amendments discussed. It was included as part of this papers for this meeting for completeness. The Director of Finance noted that there may be a further addition to the report required relating to the estimated figure of the Chief Executives pensionable pay, who had deferred membership of the pension scheme as he had now left the scheme. . This figure was held by NHS Pensions and has not been provided to Trusts. Hassan Rohimun advised that this was a national issue and NHSI/E were reviewing whether an estimate was required within the annual report.

Following a question from the Chair regarding whether the Annual Report would have the final sign off, it was requested by the Director of Finance that this be delegated to him due to the imminent deadline. This was approved.

Mark Bailey reiterated that the sums within the annual report that still required a review as the percentages did not appear to be correct. Katie Shepherd had contacted the Communications and Engagement Team to chase this.

The Committee:

- ***Approved the amended Annual Report and Annual Governance Statement, subject to the agreed amendments.***
- ***Agreed to delegate approval of the Annual Report to the Director of Finance.***

AR21/06/B 2 **Draft Annual Accounts and Financial Statements 2020/21 (Enclosure B2)**

The Director of Finance presented the draft annual accounts and financial statements for the year ending 31 March 2021, which had been shared with the Finance and Performance Committee.
During the audit process, the draft annual accounts have had the following amendments:

- The downward revaluation of £2.4m which was previously within Revaluation Reserve had been split between downwards revaluation in the income and expenditure (£4.9m) and upwards revaluation to the revaluation reserve (£2.4m). This had an impact on the reported income and expenditure performance, but does not impact on the adjusted finance performance reported to NHS E/I.
- Reduced prepayments and accruals by £0.7m, with no impact on the Trust income and expenditure performance.
- Reduced capital creditors by £1.3m, with an equal increase to trade payable, with no impact on the Trust I&E performance.
- Minor presentational adjustments.

Following a request from Neil Rhodes, it was agreed that a summary of key issues would be devised for future years, to provide an overview of the Annual Accounts and Financial Statements, the DoF gave a verbal summary as follows.

The Director of Finance advised that the year-end position was good with a surplus achieved, when a deficit had been forecast. The Trust was the only one within SYB ICS to spend all of its capital. The license conditions relating to the fire improvement notice had been cleared. The Trust achieved a positive outcome from the Internal Audit Report which reviewed COVID-19 processes and systems, demonstrating a strong assurance on how the Trust managed the COVID-19 pandemic and the financial regimes.

The Head of Financial Control noted that the Annual Accounts had been prepared on a going concern basis, which had been subsequently agreed by the Board. It was noted that a post-year-end note was not required within the Annual Accounts following the significant water leak incident that took place within the Women and Children's Hospital on 27th April 2021. There were no changes from the month-12 position that was reported to the Finance and Performance Committee. It was noted that the Trust received £71m of Public Dividend Capital (PDC) Equity from the Department for Health and Social Care in 2020/21, which was used to repay all revenues loans that were outstanding as of 1st April 2020.

The Chair noted that there was c. £14m outstanding from the Department for Health and Social Care. The Director of Finance advised that this was historical, ands was the debt to equity swap to support the revenue position.

The Chair advised the Committee that detail on the annual leave accrual had been received at the Finance and Performance Committee, who were assured that this had been a detailed piece of work. The Chair asked for comments from the External Audit team on this process. Hassan Rohimun advised that the level of annual leave accrual was similar to that of other Trusts. Dan Spiller advised that as 86% of people had responded as part of the process, it had been viewed as a good source of evidence by EY to support the management judgement.

Following a query from the Chair regarding the impairment issue, the DoF explained there was not one single area which had impacted upon the impairment, and there was a multitude of factors. He advised that revaluation of certain buildings under the modern equivalent asset basis, meant that whilst there was an increase in capital spend to undertake backlog maintenance, it did not necessarily increase the value of the asset.

In response to an update request from the Chair on the Flowers case, it was advised by the Deputy Director of Finance that c.£1m had been included within the year-end position, and a central assessment was underway to identify future costs associated with this.

The Chair noted that private patient income was low and asked if this was due to the COVID-19 pandemic. The Director of Finance advised that the COVID-19 pandemic had affected this section and the flow of private patients, mainly as Park Hill was block contracted via the Department for Health and Social Care. It was expected that the position would be similar for 2021/22. Hasssan Rohimun advised that this was similar within other Trusts.

The Committee:

- ***Approved the Annual Accounts and Financial Statements for 2020/21.***

AR21/06/B3 **Letter of Representation (Enclosure B3)**

The Trust's external auditors, Ernst & Young, had requested a Letter of Representation from the Trust, in order to complete their audit. This was a standard audit procedure and confirmed a number of assumptions that the Trust had made. The letter had been reviewed already and requires signature from both the Director of Finance and the Chair of Audit and Risk Committee. Once sign-off dates had been agreed, the letter would be dated appropriately.

The Committee:

- ***Approved the letter of representation.***

AR21/06/C1 **ISA 260 (Enclosure C1)**

Hassan Rohimun presented the audit results report which summarised Ernst Young's (EY) preliminary audit conclusion in relation to Doncaster & Bassetlaw Teaching Hospitals NHS Foundation Trust's financial position and results of operations for 2020/21. The audit was undertaken in accordance with the plan outlined to the Audit and Risk Committee on 25th

March 2021, which the exception of changes in materiality. Based on EYs materiality measure of profit before tax adjusted for pre-tax exceptional items, they had updated their overall group materiality assessment to £9.05m (Audit Planning Report —£8.61m). This results in updated performance materiality, at 75% of overall materiality, of £6.79m. The threshold for reporting misstatements remained unchanged at £0.3m as it was set in line with EYs requirements as a component auditor reporting to the NAO for their audit of the consolidated NHS Providers account.

Under the new Code of Audit Practice 2020, the reporting criteria had changed, which required EY to prepare an annual auditors report and annual report which included commentary on the arrangements the Trust had in place to secure value for money through economic, efficient and effective use of its resources for the relevant period, however this could not be completed until the annual report had been issued. EY expected to have this completed by 30th June 2021. The Chair advised that the next Audit and Risk Committee was on 15th July 2021, and it was agreed that EY would present their value for money opinion and annual report at that meeting.

Dan Spiller presented the summary of adjusted differences which highlighted that during the course of the audit, there was a £5.9m understatement of impairment charges that arose due to difficulties experienced in the Fixed Asset Register, meaning that transactions related to the annual revaluation exercise were calculated manually. There was a £0.8m reduction to prepayments and accruals for 2021/22 invoice that was incorrectly included in both balances in the 31st March 2021 Statement of Financial Position. Other adjustments had been made in relation to the audit fee disclosure note, remuneration report, maturity analysis of financial liabilities and the accounting policy in relation to inventory. Misstatements to the financial statements and/or disclosures which were not corrected by management. EY requested that these uncorrected misstatements be corrected or a rationale as to why they were not corrected be considered and approved by the Audit and Risk Committee and provided within the Letter of Representation. Following the assessment of the control environment, there were two rated as 'high' and recommendations were made. One related to the quarter 4 capital accounting transactions that were not input to the Fixed Asset Register, and the other was a result of the system issues impacting the Fixed Asset Register which led to an increased manual intervention to perform valuation transactions and create working papers.

Following a query from the Chair regarding the Fixed Asset Register, It was agreed that general progress with the implementation of the Fixed Asset Register would be reported via F&P Committee, with a full update on all the ISA 260 Recommendations to come back to ARC in October.

The Director of Finance thanked his team for their work during this period.

The Chair noted that whilst there had been improvements within the assessment of the HR/Payroll environment, it was disappointing that this had occurred for the three external audits that she had chaired the Audit and Risk Committee of. The recommendation was that a control should be implemented within appropriate timescales following an employee's start date, to ensure that contracts were signed and retained. Dan Spiller advised that this was a recurring issue within other organisations. The Director of Finance advised that legally, once employees were paid, they were contracted, however the centralisation of recruitment would support this. The test to ensure that employees exist was undertaken based on the annual leave accrual process.

Neil Rhodes noted that the report was received on the morning of the meeting and therefore had not had the opportunity to read the report in detail, however, noted that in light of the challenging year the Trust had been through, it was acceptable that the Trust would accept the report and make improvements as recommended. Mark Bailey echoed these comments.

The Chair noted that the ISA260 report had been received late and should have been received in the days before the meeting to allow members to read thoroughly.

The Chair noted that the total fees section stated 'TBC'. Hassan Rohimun advised that the figure would be entered once a discussion had taken place with the Director of Finance, however, would endeavour to include an estimate in future reports.

Action: The Value for Money Opinion and External Audit Annual Report would be presented to the Audit and Risk Committee in July 2021. **EY**

Action: It was agreed that general progress with the implementation of the Fixed Asset Register would be reported via F&P Committee, with a full update on all the ISA 260 Recommendations to come back to ARC in October. **JS**

The Committee:

- ***Approved the ISA 260, with the exception of the value for money opinion which would be presented at the Audit and Risk Committee on 15th June 2021.***

AR21/06/E 1 **Governor Observations (Verbal)**

Dennis Atkin observed that there had been a reduction in activity in all areas during the previous year due to the COVID-19 pandemic and asked if the Trust had taken into account the increase in general activity. The Chair advised that this was reviewed at the Finance and Performance Committee. Plans were in place for H1 (Month 1-6 2021/22), however there was uncertainty regarding H2 (month7-12 2021/22) as the financial regime was unknown.

AR21/06/F 1 **Any Other Business (Verbal)**

There were no items of any other business.

AR21/06/F 2 **Escalation (Verbal)**

No issues were identified for escalation to/from:

- H1.1 ARC Sub-Committees;
- H1.3 Board of Directors.
- H1.2 Board Sub-Committees

AR21/06/F 3 **Date and time of next meeting (Verbal)**

Committee Meeting

Date: **15th July 2021**

Time: **09:30**
Venue: **Microsoft Teams**

Meeting closed at 14:55.

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

QUALITY AND EFFECTIVENESS COMMITTEE

Minutes of the meeting of the Quality and Effectiveness Committee
Held on Tuesday 6 April 2021 at 13:00 via Microsoft Teams

Present:
Mark Bailey, Non-Executive Director
Pat Drake, Non-Executive Director (Chair)
Dr T J Noble, Medical Director
David Purdue, Chief Nurse
Sheena McDonnell, Non-Executive Director

In attendance:
Simon Brown, Deputy Director of Nursing (Clinical Specialities) (Item QEC21/04/D2)
Sam Debbage, Deputy Director of Research and Education
Fiona Dunn, Deputy Director Corporate Governance/Company Secretary
Karen Lanaghan, Lead Nurse End of Life Care Services and Quality (Item QEC21/04/B2)
Stacey Nutt, Deputy Director of Nursing (Patient Experience)
Katie Shepherd, Corporate Governance Officer (Minutes) (KAS)
Cindy Storer, Deputy Director of Nursing (Patient Safety)

To Observe:
Peter Abell, Governor
Lynne Logan, Governor

Apologies:
Karen Humphries, Clinical Governance & Professional Standards Co-ordinator
Marie Purdue, Director of Strategy and Transformation
Alasdair Strachan, Director of Education and Research
Abigail Trainer, Deputy Chief Nurse

ACTION

QEC21/04/A1 **Welcome and Apologies for Absence (Verbal)**

The Chair welcomed the members, attendees and governor observers. The apologies for absence were noted. The Chair noted that the past year had been difficult and asked that colleagues in attendance pass on the heartfelt thanks for all that they do.

QEC21/04/A2 **Conflict of Interest**

No conflicts of interest were declared.

QEC21/04/A3 **Action Notes from Previous Meeting (Enclosure A3)**

The following actions were closed – 2, 3, 4, 5, 7, 8, 9, 11, 12, 13 and 14.

Updates were provided on actions below:

Action 14 – Missing patients – Sheena McDonnell requested an update on whether the issues identified in the Health and Safety Committee minutes reported to the Audit and Risk Committee had been cross referenced. The Chief Nurse advised that the Trust worked with South Yorkshire

and Nottinghamshire Police in which there were joint policies for missing patients. The safe and well checks no longer took place, however escalation systems were in place. The police had received more missing patient calls that normal. It was noted that this issue had not been escalated to the Audit and Risk Committee, but was reported within the Health and Safety Committee minutes, and it was suggested that it would have been appropriate for an escalation from the Health and Safety Committee. The Chief Nurse agreed and advised that as the named contact person for the police, nothing had been raised directly with him. Action 14 would be closed.
The Chief Nurse would address the lack of escalation through the governance framework relating to the missing patient information identified in the Health and Safety Committee minutes. An update would be provided in June 2021.

<u>Action</u>: The Chief Nurse would address the lack of escalation through the governance framework relating to the missing patient information identified in the Health and Safety Committee minutes. An update would be provided in June 2021. **DP**

<u>Action</u>: Katie Shepherd would update the Action Log.

The Committee:

- ***Reviewed the action log and agreed to close actions.***

QEC21/04/A4 **<u>Request for Any Other Business (Verbal)</u>**

There were no requests for any other business.

QEC21/04/B1 **<u>Ockenden Report Action Plan (Enclosure B1) (Presentation)</u>**

The Chief Nurse presented an update on the Ockenden Report action plan which highlighted that good progress had been made in relation to the objectives previously presented. It was noted that the regional oversight local maternity system (LMS) still required agreement and implementation, which would also require an external review of all serious incidents within the LMS. The requirement for a Senior Advocate role was still to be developed, the delay because the Trust was awaiting the national job description.
The Chair noted that the action for her as the Non-Executive Director lead in attendance at the Maternity Voices Partnership (MVP) meetings, that the Chair for Doncaster's MVP had resigned, and the Bassetlaw MVP met on the same day as the Trust's Board meeting, therefore further contact would be made.
The action relating to the implementation of robust pathways for managing women with complex pregnancies had not progressed as the maternal medicine unit had not been implemented within the ICS.
Work was required to understand how often audits would take place of the risk management process within K2.
The action that states that the Trust must ensure women have access to accurate information to enable their informed choice of intended place of birth and mode of birth, including maternal choice for caesarean delivery was reported red because the Trust did not have a dedicated midwifery led unit. It was reported that the maternity theatres on level 6 were under refurbishment, due for completion in June 2021. Once completed there would be two rooms available for use for a midwifery led unit which would have a separate entrance.

In response to a question from Sheena McDonnell regarding the benefits the Senior Advocate role would bring, the Chief Nurse advised that the role would provide an independent view to discuss birth concerns and to support women much more effectively. The role could not be a part of an existing role.

It was confirmed, following a question from Sheena McDonnell that work to update to the website of information was underway.

Sheena McDonnell asked if external funding had been secured for training related to the Ockenden actions. The Chief Nurse advised that there was £90m government funding for this, with an aim for 1,000 more midwives and 80 obstetricians nationally. It was unknown how the money would be allocated on a Trust basis. Bids would commence in May 2021. The Trust had funding for the number of midwives required against Birthrate Plus, however not all posts were recruited to.

Following a question from Mark Bailey regarding the timescales for the midwifery led unit, it was confirmed that capital works would commence in June 2021, and include a total refurbishment of the central delivery suite at Doncaster.

The Chair advised that the Senior Advocate role would provide support to women so that they felt listened to.

Action: The Ockenden Report was escalated for review by the Board of Directors. **DP**

Action: The Maternity Voices Partnership report would be received at the June 2021 Quality and Effectiveness Committee. **PD/ DP**

Action: A progress update against Ockenden actions would be received at the August 2021 Quality and Effectiveness Committee. **DP**

The Committee:

- ***Noted and took assurance from the Ockenden Report progress update.***

QEC21/ 04/B2 **End of Life Care (Enclosure B2) (Presentation)**

The Committee welcomed Karen Lanaghan, Lead Nurse End of Life Care Services and Quality to update on the End of Life Care (EOL) services that deliver high-quality patient centred care with full involvement of families. During the first wave of COVID-19, all visiting ceased in the organisation following national guidance and the EOL team were depleted due to individual risk assessments associated with redeployment and shielding. The Chaplaincy ceased all congregational gatherings of any faith, and all volunteer roles were stopped, including that of the Butterfly volunteers. Services were reconfigured based on local and national restrictions and guidance. During the pandemic providing EOL support had been challenging and the majority of support had taken place over the telephone, and staff found this difficult as they weren't able to support as they did prior to the COVID-19 pandemic, because of the impact of infection prevention and control guidance.
Since the start of the pandemic the EOL team had supported many initiatives including that of the comfort hearts, which were knitted hearts donated by members of the community that were paired together, one of which was kept with the inpatient and one was sent to a relative with a card expressing that their loved one had the other heart, so that they were able to share

something tangible that linked them to their relative. Other initiatives included that of virtual visiting via the use of videoconferencing and letters to loved ones. Lessons from the COVID-19 pandemic had been reviews which included that lack of visiting had been one of the most challenging aspect, however changes to legislation had improved the bereavement pathway.

Sheena McDonnell commended the End of Life Care team that had undertaken a phenomenal amount of work during the pandemic. Mark Bailey extended his thanks to the team and commenced the personal touch and thought that had gone into the service and how they aligned to Trust values.

Pat Drake noted that the level of care was exceptional and suggested that the Council of Governors receive a briefing session.

The Medical Director echoed the thanks to the team and extended the thanks to Karen Lanaghan who had undertaken a significant amount of work with the family of Medhat Atalla, a colleague who sadly passed away from COVID-19 in 2020.

It was agreed that a thank you email would be circulated to the End of Life Care team for their support during the COVID-19 pandemic.

Karen Lanaghan left the meeting.

Following a discussion regarding the work that the End of Life Care Team had undertaken during the COVID-19 pandemic, it was agreed that Stacey Nutt would liaise with the Communications and Engagement Team to nominate them for an award.

Action: The Governors would receive the End of Life presentation. **FD**

Action: An email thanks would be circulated to the End of Life Care Team. **KL**

Action: Following a discussion regarding the work that the End of Life Care Team had undertaken during the COVID-19 pandemic, it was agreed that Stacey Nutt would liaise with the Communications and Engagement Team to nominate them for an award. **SN**

The Committee:

- ***Noted the information provided in the End of Life Care presentation.***

QEC21/04/C1 **Board Assurance Framework (Enclosure C1)**

The Committee received the up-to-date board assurance framework risks to the achievement of the Trust's strategic aim 1 – to provide outstanding care and improve patient experience.
The Chief Nurse advised that the board assurance framework had been updated to reflect the outcome of the internal audit report, with an addition relating to the Ockenden Report action plan added under the assurance section. Following a review of the Corporate Risk Register, some risk had been reduced in risk rating. There had been one risk added to the Corporate Risk Register to include Risk ID 2664 – Consultant Staffing shortage DCC. Robust action plans were to be developed to address risk mitigations.

A request was made by the Chair that the Chief Nurse and Medical Director reports to Board were reflective of any concerns for escalation to the Board as accountable officers.

Sheena McDonnell suggested that a review be undertaken to identify what the mitigating actions of the risks were and that the mitigating actions should be descriptive and understandable. Following a request from Sheena McDonnell, it was agreed that hyperlinks to action tables would be added to the Board Assurance Framework.

Action: A request was made by the Chair that the Chief Nurse and Medical Director reports to Board were reflective of any concerns for escalation to the Board. **DP / TN**

Action: Hyperlinks to action tables would be added to the Board Assurance Framework. **FD**

The Committee:

- ***Noted the board assurance framework.***

QEC21/ 04/C2 **Quality Framework and Strategy (Enclosure C2)**

The Chief Nurse presented the Quality Framework Strategy which would include an organisational approach to improvement. A consideration would be made on the overlap of committees for supporting elements include leadership, culture and performance. The long-term process would include a continual improvement underpinned by quality management systems. The elevator pitch includes the following questions and considerations:

- Where were we going? Formed from the True North and breakthrough objectives,
- How were we going to get there? As part of the Quality and Delivery Frameworks,
- How would we know that we've arrived? Through embedding ownership and assurance.

The proposed quality framework was shared, which outlined how the Trust would achieve a CQC good rating for safety and ultimately an overall rating of outstanding through the delivery of the True North Objectives, by four areas of quality: quality planning, quality control, quality improvement and quality assurance. Organisational values would be embedded through the framework.

The Medical Director advised that as part of the Clinical Governance Review, the meeting structure had been reviewed to avoid duplication. It was expected that there would be a sub-committee of the Quality and Effectiveness Committee with three further sub-committees to that.

A further update on progress would be provided at the next Quality and Effectiveness Committee meeting. Divisional and Directorate ownership of the quality framework would be key to its success.

Following a question from the Chair, it was confirmed that a Maternity strategy would be incorporated. Meetings were planned in to create a maternity strategy.

In response to a question from Sheena McDonnell, it was confirmed that all leaders would have the opportunity to contribute towards the creation of their Divisional and Directorate quality framework.

Action: A further update would be provide don the Quality and Framework Strategy. **DP**

The Committee:

- ***Noted the update provided on the Quality Framework Strategy development process.***

QEC21/04/C3 **Stabilisation and Recovery (Enclosure C3)**

Risk Stratification Assurance Body

In response to a question from the Chair regarding the low numbers of patients that had been risk stratified, the Medical Director advised that in areas such as Cardiology where there were no delays, slots be available for patients to attend clinics. It was requested that where identified in the report that the percentage of patients risk stratified were low, an explanatory note would be added to the report to explain why.

Following a question from Sheena McDonnell regarding the opportunity that patients have to escalate their needs, it was confirmed by the Medical Director that patients have a variety of channels in which to do this, including contact through the GP and through the Trusts secretaries.

The section of the report that included the link to view the weekly COVID-19 report would be embedded in the report, as opposed to a link to the drive so that all could view.

It was requested by the Chair that an update be provided at the next meeting on the priority 2 national planning guidance.

Action: Where identified in the report that the percentage of patients risk stratified were low, an explanatory note would be added to the report to explain why. **TN**

Action: The section of the report that included the link to view the weekly COVID-19 report would be embedded in the report, as opposed to a link to the drive so that all could view. **TN**

Action: It was requested that an update be provided at the next meeting on national planning guidance for priority 2 patients. **TN / DP**

The Committee:

- ***Considered and noted the update provided on the risk stratification assurance body.***

QEC21/04/C4 **Quality Assurance Report (Enclosure C4)**

Summary of Clinical Governance Committee

The Organ Donation Committee had continued to function and the terms of reference for the Committee were under review.

The Chair noted that it would be good to see the Organ Donation Committee terms of reference once approved. Following a question from the Chair regarding software for infection prevention and control, it was confirmed that a business case would be submitted to the Capital Investment Group next month.

An issue had been raised as patients had arrived at the Trust with skin damage, therefore the Skin Integrity Team had worked within the community to improve this.

Following a request from the Chair it was agreed that further information to be provided on the wards seeing category 3 and 4 hospital acquired pressure ulcers.

Following a question from the Chair regarding the requirement for a Nutritional Support and Catering Dietician, it was confirmed that discussions would take place with Sodexo for this.

The Chair advised the Committee that the Finance and Performance Committee would receive a deep dive into Cancer Services on 17 May 2021.

Incident and Serious Incidents Action Plan Position Statement

The review of the incidents had been undertaken with the clinical governance leads but it was noted that 123 incidents were within non-clinical directorates. Of the open incidents, 468 (79%) were graded as 'No Harm' and 108 (18%) graded as low harm, with four incidents graded as severe (n=2) or death (n=2). All the incidents that were moderate and above had been reviewed by the Lead Nurse for Patient Safety, with E-mail communication sent to the handlers to review the incidents. Of the incidents, two were linked to serious incident investigations and one linked to an inquest, an Internal Investigation Report was underway. One incident had been completed and moved to the "Being approved" rather than "Final approval".
The DATIX dashboard was live and the Clinical Governance Committee would receive regular updates.

Sheena McDonnell noted that within the Serious Incident Action Plan they were categorised into either high, medium and low, but it was unclear how many serious incidents were within each category. The Deputy Director of Nursing (Patient Safety) advised that there were 69 actions and work was ongoing to make these SMART (specific, measureable, achievable, realistic and time-specific). Forty-six had been completed, twenty-four were to be completed and six were overdue between 1-6 months. There were no HSIB recommendations for the Trust. Following a question from Sheena McDonnell it as agreed that it would be made clear in future reports, whether any overdue serious incidents were within the high category.

Following a question from Mark Bailey regarding the identification of the effectiveness of actions, the Deputy Director of Nursing (Patient Safety) advised that it depends on the action and the severity of the action to be implemented. It was advised that when a serious incident was declared, a subject matter lead was assigned who forms the action plan, action of which were input into DATIX and assigned to an individual owner. The learning from the serious incident was reported to the Patient Safety Review Group.

Sheena McDonnell noted the good practice of learning across the organisation including the Sharing How We Care newsletter, however asked if there was anything further to implement to improve the learning within the organisation. It was advised that in addition to the Sharing How We Care newsletter, work was underway to drive the national patient safety syllabus. The use of Sharing How We Care encourages conversations about patient safety amongst colleagues. Mark Bailey noted that all colleagues have a role in learning and contributing towards the aim to be an outstanding organisation. It was noted that work was ongoing in liaison with the education team to provide human factors training. The Chair noted that it was important to reflect in any training the key themes of serious incidents relating to documentation, however would need to include the support element also.

Serious Incidents and Never Events within the ICS during COVID-19

Work was undertaken in March 2021 to look at the total number of Serious Incidents reported on the Strategic Executive Information System (StEIS), by Trusts to have occurred in the SYB ICS in January 2021 compared to January 2020. This report was presented and discussed at the Trust Clinical Governance Committee on Friday 19 March 2021. The headlines were that the largest decrease was seen in the slips/trips/falls meeting SI criteria type. The largest increase in the number of SIs was seen for three types of SIs:

- Disruptive/ aggressive/ violent behaviour meeting SI criteria
- Medication incident meeting SI criteria
- Sub-optimal care of the deteriorating patient meeting SI criteria

A position statement was required at future meetings related to the reasons for overdue actions and incidents.

Action: Further information to be provided on the wards seeing category 3 and 4 hospital acquired pressure ulcers. **DP**

Action: It would be made clear in future reports, whether any overdue serious incidents were within the high category. **CS**

Action: A position statement was required at future meetings related to the reasons for overdue actions for serious incidents. **CS**

The Committee:

- ***Noted the update provided on clinical governance activity,***
- ***Noted the Incident and Serious Incidents Action Plan Position Statement,***
- ***Noted the update provided on Serious Incidents and Never Events within the ICS during COVID-19.***

QEC21/ 04/C5 **Safer Staffing (Enclosure C5)**

Despite a number of areas reporting 10% reduction against planned to actual, all areas were risk assessed using professional judgement, staff redeployment or utilisation of other key roles such as therapy staff to ensure patient safety wasn't compromised. Ward A4 had escalation wards open. Following a review of the senior nursing workforce, internal expressions of interest recruitment had commenced to recruit a Band 8B Head of Nursing in each Division. Following a request from the Chair it was agreed that a presentation would be received at the August 2021 Quality and Effectiveness Committee on Perfect Ward. It was agreed that a paper would be sent to the People Committee on the processes and plans in place. In response to a question from Mark Bailey re the risk of volatility when moving patients three times per day, it was confirmed that if patients were moved to a different ward the Trust endeavours to move within the Division, however if required patients may be moved outside of the Division. The decisions were made at the Operations Meetings which takes place three times per day.

Action: Abigail Trainer would provide a presentation on Perfect Ward in August 2021. The Chief Nurse would give an update at the June 2021 meeting. **AT**

Action: Workforce plans in place for the Nursing and Midwifery workforce would be escalated for discussion at the People Committee. **DP/AT**

The Committee:

- ***Noted the update on safer staffing.***

QEC21/04/C6 **Learning from Deaths Report – Quarter 3 (Enclosure C6)**

The bereavement and medical examiner teams had been involved with 872 deaths which saw a 154% increase on the previous quarter when there were 343 deaths.
The Medical Examiner team had either screened or scrutinised 765 deaths, which accounted for 87% of all deaths.
The three themes of learning identified were:

- Documented evidence on the nursing admission assessment to confirm a Patient ID bracelet was in place must be completed, dated and signed accurately.
- Consideration must be given on an individual basis with regards visiting, using individual judgement and compassion.
- Senior ward managers to explore ways to address the difficulties families have in being able to get through when they phone the wards.

The Committee:

- ***Noted the Learning from Deaths Report for Quarter 3.***

QEC21/04/C7 **COVID-19 Update Overview (Enclosure C7)**

At the time of the meeting there were 23 active COVID-19 cases within the Trust, and both intensive care units were back to normal bed requirements. Redeployed colleagues had returned to their usual areas of work. Discharge pathways and policies were in place with no issues raised.
There had been one active outbreak of COVID-19 within Paediatrics. One patient and twelve staff had been affected, three of which were from RDASH. Patient visiting recommenced on 29th March 2021 within the SYB ICS, and would be staged in line with the Government roadmap. A meeting would take place to agree a policy regarding active COVID-19 patients that week as there had been complaints received about that.
A task and finish group had been set up to undertake an internal review of the communication with families of all patients that were probable and definite hospital acquired COVID-19 infection that lead to death. Phase two of this work would include a review of patients who had been admitted to intensive care or admitted to the respiratory ward for intensive ventilation.
The work would be cross checked against the medical examiner database to review whether clinicians had conversations individually with the families of patients.
Phase three of this work would include a post implementation review of the three colleagues that passed away from COVID-19 and whether it was thought it was hospital acquired. If so it would be reportable under RIDDOR.

The Committee:

- ***Noted the COVID-19 update.***

QEC21/04/D1 **Patient Experience Report (Enclosure D1)**

The Deputy Director of Nursing (Patient Experience) presented the report which highlighted that the actual number of complaints was less than the actual number of subjects as a result of many complaints including more than one particular subject. The subject of 'competence' had been reviewed, as it had been established that this was the highest complaint subject, however upon

review all 'competence' related complaints input onto DATIX had been done so by the same individual. There was no specific guidance for the input of subjects into DATIX and they were subjective. A task and finish group had been set up to review the subject choices within DATIX. Key Achievements include that there had been a 30% reduction in overdue complaints. Following the outcome of the internal audit report on complaints, it was agreed that a deep dive would take place at the Quality and Effectiveness Committee in June 2021. Mark Bailey noted that the internal audit reported significant assurance however, there were a number of recommendations and requested a further update once the policy had been embedded at Divisional level. The new process had been implemented in July 2020 the current Deputy Director of Nursing (Patient Experience) did not commence in post until December 2020 and upon review identified that further changes were required to make the process more robust, and the audit confirmed that. The Committee would receive a deep dive into complaints at the next meeting. Mark Bailey noted that the audit did not include evidence of ownership within Divisions. Sheena McDonnell noted that there were several ways to capture patient feedback and there was a need to capture that to understand what the data tells the Trust. Sheena McDonnell added that she would like to see pace on the completions of the recommendations. The Deputy Director of Nursing (Patient Experience) advised that actions were being taken at pace, however noted that further work was required to understand the usage of DATIX. A complaints forum would be set up made of public members to scrutinise the complaints process and to identify key themes.

The Chair asked that the deep dive on complaints includes an update on the recommendations action plan, any known issues, the quality of letters and how Divisions deal with them, and how the PALS Team define what the complaints are.

The key challenges were the coding of subjects in DATIX and there were some vacancies in the PALS Team which were out to advert.

Regular engagement meetings were taking place with Healthwatch and the CCGs which incorporated health inequalities.

Action: The deep dive planned for June 2021 meeting would include a plan to mitigate issues and the timescales for this. **SN**

The Committee:

- ***Noted the Patient Experience Report.***

QEC21/04/D2 **Learning Disability Strategy Update (Enclosure D2)**

Simon Brown, Divisional Director of Nursing advised that there had been good progress made on the Learning Disabilities Strategy objectives. The trust currently had a flagging system in place and was constantly reviewed by our LD Liaison nurses for inpatients. Further work was needed to extend to outpatients. A new Acute LD Liaison nurse had joined Bassetlaw Hospital and commenced in post on 15 March 2021. Her post was commissioned by Bassetlaw CCG.
The trust food and drink strategy 2021 -2024 had incorporated this, in addition to this, conversations have commenced with SODEXO about an accessible information menu for our most vulnerable patients in addition to raising awareness of a "finger menu".
The 2019 submission to NHSEI was completed in January 2021, and the Trust was awaiting the final finding analysis and would action as appropriate. It was agreed that this would be added to the next Patient Experience report.

The Trust was involved in both the Bassetlaw and Doncaster CCG LEDER steering groups. The national LEDER process was about to change and further guidance would be received on how this would be rolled out. All Learning Disability deaths within the Trust were subject to structured judgement review (SJR).
A LD flag was now also available on incident and complaints in relation to our patients living with LD this again allows us to monitor real time themes and take action and learn in a timely way.
Following a successful recruitment process, 130 ambassadors from a variety of disciplines have signed up to be LD ambassadors. Induction training takes place throughout May 2021 with further training in relation to Deaf Awareness and basic sign language course procured and due to commence throughout June 2021.
An audit of all six inpatients at DRI living with a learning disability on 24 March 2021 provided assurance "Learning Disability" wasn't used as a condition / decision to apply Respect. All six patients were receiving appropriate care treatment and none of them had a Respect form in place.
The Oliver McGowan Mandatory Training trial was being carried out by the Department for Health and Social Care which would inform a wider rollout of the training.
Oliver's training was about awareness and understanding and does not include training about treatments or specific interventions. It would give staff the right skills to ensure people with a learning disability and autistic people have positive health and social care outcomes.

Sheena McDonnell noted the good progress seen in a short space of time. Following a question from Sheena McDonnell, it was confirmed that there would be three tiers to the learning disabilities training and it would form part of mandatory training for all staff, however the Trust was awaiting further guidance from HEE.

An update on the Mental Health Strategy would be received at the August 2021 meeting. This would include the refresh of the strategy due to the element of wellbeing and mental health support required for staff.

A progress update would be provided at the October 2021 Quality and Effectiveness Committee.

In response to a question from Sheena McDonnell regarding the flag in the system, it was confirmed that the flag only confirming that the patient had a learning disability and wasn't sophisticated enough to include notes.

The Chief Nurse advised that mental health first aid would form part of the Trust's statutory and essential training programme.

Action: Learning Disabilities benchmarking data would be added to the next Patient Experience Report received to the Quality and Effectiveness Committee. **SN**

Action: An update on the Mental Health Strategy would be received at the August 2021 meeting. This would include the refresh of the strategy due to the element of wellbeing and mental health support required for staff. **DP**

Action: A learning disabilities progress update would be provided at the October 2021 Quality and Effectiveness Committee. This would include and update on related training. **DP**

The Committee:

- ***Noted the update.***

QEC21/04/E1 **Research and Innovation Annual Report (Enclosure E1)**

The Deputy Director of Education and Research advised that COVID-19 research activity had assisted the Research Team in engaging with the workforce. During 2021/22 the Trust had successfully applied for a number of additional funding streams through the Clinical Research Network, and whilst the target was removed in-year, the Trust had delivered beyond the original target. COVID-19 research had impact local delivery and therefore the Research Team were in the process of identifying where the focus for local research would be going forward.
A key pressure for expanding some significant research activity, specifically in relation to Oncology, was the capacity within pharmacy.
The current staffing model required the Trust to be very commercially active, however, due to COVID-19, the number of studies had significantly decreased in the UK over the last 12-months. There was a national push to redress this and as a Trust, were actively involved in engaging with industry to ensure placement and study activity within DBTH.
A clinical academic bid was approved which would assist the Trust in its ambition in becoming a university teaching hospital. The research strategy would align to local universities and the academic work they deliver.
The Trust had engaged with leads from the Born in Bradford study to undertake a Born in Doncaster study. Roll out was expected in Q3 of 2021/22, which would commence the first long-term cohort study that could help to influence the way that care was commissioned.

Sheena McDonnell noted it was good to see the breadth of areas that were under study, however asked for clarification on the additional pressures that research could have on staff. It was confirmed that there was a challenge required to engage in a cultural shift to ensure that all staff see research as part of their core functionality.

Following a question from Mark Bailey regarding the Trust's service lines, it was confirmed that the this was mapped out in accordance of the clinical portfolio and expertise to support it.

The Chair requested an update on progress against the Born in Doncaster study early 2022.

Action: A progress update was required on the Born in Doncaster study early 2022. **SD**
The Committee:

- ***Noted the Research and Innovation Annual Report.***

QEC21/04/F1 **Corporate Risk Register (Enclosure F1)**

Risk ID 1854 (Q&E13) – Initial ED BDGH triage assessment processes rating had reduced from 16 (extreme) to 9 (high). Navigation and alternative pathways to the Emergency Department were in place.

Risk ID 1855 (Q&E14) – Registered Paediatric staffing ED BDGH rating had been reduced from 16 (extreme) to 12 (high). Recruitment continued and mitigations in place had been agreed with the CQC.

One new risk had been escalated to the corporate risk register from the Management Board: Risk ID 2664 – Consultant Staffing shortage DCC. Robust action plans were to be developed to address risk mitigations. The risk grading was 20. The Medical Director was the lead Executive for the risk. An action plan was to be submitted to the Executive Team.

Internal audit were undertaking an audit and review of 15+ rated risk at random.

The Committee:

- ***Considered and noted the corporate risk register.***

QEC21/04/F2 **CQC and Regulatory Visits – including CQC Action Plan Update (Verbal)**

The Deputy Director Corporate Governance/Company Secretary advised that engagement meeting continued. The second one with the new team had taken place. The majority of actions from the CQC action plan had been closed. The Chief Nurse advised that the CQC had changed their approach to review which would be aligned to risk-based assessment reviews and pathway reviews as opposed to whole hospital reviews.

The Committee:

- ***Considered and noted the update provided on CQC and regulatory visits.***

QEC21/04/F3 **Quality and Effectiveness Committee Annual Report (Enclosure G3)**

The Committee:

- ***Approved the Quality and Effectiveness Committee Annual Report which would be reported to the Board of Directors.***

QEC21/04/F4 **Quality and Effectiveness Committee Terms of Reference (Enclosure F4)**

It was agreed that the Quality and Effectiveness Committee Terms of Reference would be updated to include the Quality Framework.

Action: It was agreed that the Committee terms of reference would be updated to include the quality framework and reported back for approval at the Quality and Effectiveness Committee in June 2021. **FD**

The Committee:

- ***Deferred the approval of the Quality and Effectiveness Committee Terms of Reference to the June 2021 meeting.***

QEC21/04/G1 **Complaints Internal Audit Update (Enclosure G1)**

The Committee:

- ***Considered the complaints internal audit report and agreed to undertake a deep dive into complaints at the Quality and Effectiveness Committee in June 2021.***

QEC21/04/H1 **Governor Observations (Verbal)**

Peter Abell asked for further information on the table on page 50 of the meeting papers. It was confirmed that it was the numbers of hospital acquired COVID-19 infection by definite, probable

and indeterminate. It was confirmed that the Deputy Director or Nursing (Patient Safety) would undertake work relating to this as part of a national inquiry.

Peter Abell noted the interesting amount of learning that was taken from serious incidents without any harm.

Following a query from Peter Abell on how e-observations was involved in the Safer Nursing Care Tool (SNCT), it was confirmed that the SNCT was undertaken bi-annually to assess staffing levels against funding and to benchmark against skill mix. E-Observations and the SNCT were not interlinked.

Peter Abell noted the comprehensive meeting and noted that the End of Life Care presented was fantastic, however acknowledged that the CQC had previously noted policies had not been up to date and therefore would be interested to se how this work progressed.

QEC21/04/I1 **Sub-Committee Meetings (Enclosure I1):**

The Committee noted:

- ***Minutes of the Clinical Governance Committee – January 2021 and February 2021.***

QEC21/04/J1 **Any Other Business (Enclosure J1):**

QEC21/04/J1i **NHS Food Panel Review**

This item had been escalated from the Management Board. The Director of Estates and Facilities had undertaken an internal review in line with the NHS Food Panel Review. A Food Group had commenced chaired by the Chief Nurse with and action plan in place. It was confirmed that this matter had been delegated to the Quality and Effectiveness Committee. An update on patient food would be provided within the Patient Experience report on this at every other meeting.

In response to question from the Chair regarding preparation areas for colleagues during the night, it was advised that there were vending machines in place which could be used to heat food. It was noted that as part of HEE requirements the Trust had in place space for trainee doctors.

It was noted that one requirement of the report was how the Trust would ensure that food was from sustainable sources, and therefore the Trust would endeavour to achieve this with Sodexo.

Action: An update on patient food would be provided within the Patient Experience report on this at every other meeting. **SN**

QEC21/04/J1ii **Overdue Policy Update**

The Chair requested an update on overdue policies at the June 2021 Quality and Effectiveness Committee meeting. The Deputy Director of Nursing (Patient Experience) advised that the governance process for policy review was under review with an expectation that each overdue policy would have an executive sponsor. There was a requirement to utilise a digital solution to make the management of policies more efficient. The Medical Director noted that this was a large task to complete, however work to be completed would ensure that policies were

appropriate and fit for purpose, were accessible and tracked. A further consideration was the support that would be required for policy owners into new roles.

Action: The action plan for overdue policies would be reported to the Quality and Effectiveness Committee in June 2021. **TN**

QEC21/04/J1 **Safeguarding Children Level 3 Update (Enclosure J2):**

The Committee:

- ***Noted the safeguarding children level 3 update.***

QEC21/04/J3 **Minutes of the meeting held on 2 February 2021 (Enclosure J2)**

The Committee:

- ***Noted and approved the minutes from the meeting held on 2 February 2021.***

QEC21/04/I1 **Issues escalated from/to (Verbal)**

i) QEC Sub-Committees
ii) Board Sub-Committees
iii) Board of Directors – Ockenden Report and Infection Prevention and Control Board Assurance Framework

QEC21/04/G4 **Any Other Business (Verbal)**

There were no items of any other business.

QEC21/04/G4i **Date and time of next meeting (Verbal)**

Date: **Tuesday 1 June 2021**
Time: **13:00**
Venue: **Video-Conference**

Post Meeting Note: The meeting date has changed to Monday 14th June 2021 at 13:30.

Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

CHARITABLE FUNDS COMMITTEE

Minutes of the meeting of the Charitable Funds Committee
Held on Tuesday 11th February 2021 via StarLeaf Videoconferencing

Present: Mark Bailey – Non-Executive Director (Chair)
Suzy Brain England – Chair of the Board
Pat Drake – Non-Executive Director
Sheena McDonnell – Non-Executive Director
Dr T J Noble – Medical Director
Richard Parker – Chief Executive
Neil Rhodes - Non-Executive Director
David Purdue – Chief Nurse/Deputy Chief Executive
Jon Sargeant – Director of Finance
Emma Shaheen – Head of Communications and Engagement
Kath Smart – Non-Executive Director

In attendance: Matthew Bancroft – Head of Financial Control
Sarah Dunning – Corporate Fundraiser
Katie Shepherd – Corporate Governance Officer (Minutes) (KAS)

To Observe: Phil Beavers – Public Governor

Apologies: Fiona Dunn – Deputy Director Corporate Governance/Company Secretary

ACTION

CFC21/02/A1 **Apologies for Absence (Verbal)**

The Chair welcomed the members and attendees, including Peter and Norma Brindley. Peter being the executor of Fred and Ann Green's will. The apologies for absence were noted. It was noted that the new Chair of the committee was Mark Bailey.

CFC21/02/A2 **Conflicts of Interest**

No conflicts of interest were declared.

CFC21/02/A3 **Actions from previous meeting (Enclosure A3)**

All actions were reviewed and closed.

The Committee:

- ***Noted the updates and agreed, as above, which actions would be closed.***

Action: Katie Shepherd would update the Action Log. **KAS**

CFC21/02/B 1 **Report and Recommendation of the Fred and Ann Green Legacy Advisory Group (Enclosure B1)**

Sheena McDonnell, Chair of the Fred and Ann Green Legacy Advisory Group, presented to the committee, a recommendation report presented to the Fred and Ann Green Legacy Advisory Group on 29 October 2020 to consider merging the advisory group with the Charitable Funds Committee. To ensure that the voice of Fred and Ann Green Legacy Advisory Group would be heard, it was suggested that Peter Brindley attend the Charitable Funds Committee meetings where decisions would be made in relation to spend. If Peter was unable to attend at any time, his wife Norma Brindley would be invited to attend. Following the meeting on 29 October 2020, Sheena McDonnell had received a letter, in February 2021, dated November 2020, suggesting the views of the Fred and Ann Green Legacy Advisory Group were to object to the merge of the two meeting groups. The points in the letter had been considered and a conclusion had been drawn to continue the recommendation that the two meeting groups merge. Sheena McDonnell advised that she had spoken with Peter and Norma Brindley and Susan McCreadie – community representative of the Fred and Ann Green Legacy Advisory Group, who had since agreed to be join the Charitable Funds Committee as a public Governor with an interest in Mexborough. The terms of reference would be updated to reflect that at least one Governor observer of the meeting have an interest in Mexborough.

Norma Brindley advised that she and Peter Brindley have had extensive discussions regarding the merge of the two meeting groups, and that the main worry related to ensuring that the views of Mexborough people were heard; however, suggested that if Susan McCreadie joined the Charitable Funds Committee as a Governor observer with an interest in Mexborough, that this would allow that to happen. Norma Brindley asked that this be reflected in the terms of reference. A discussion took place regarding the use of charitable funds for additionality as opposed to general expenditure, and it was confirmed that the legacy would be adhered to and for the purposes of additionality only.

Suzy Brain England OBE advised that the duty of the committee was to consider and approve how charitable funds were best utilised, and provided assurance that members had a duty to the charity commissioner as trustees of the charity. It was agreed that an additionality clause would be added to the terms of reference. It was noted that only comprehensive business cases would be considered for charitable fund expenditure and that two criteria should be met:

- The request for funds had to be for a purpose over and above normal NHS spend,
- Outline how value would be added to patients and staff.

Sheena McDonnell echoed that the Governors were representatives of the population.

Matthew Bancroft advised that external audit scrutinise any Fred and Ann Green legacy expenditure to ensure that the contents of the legacy have been adhered to and assured that this was provided a secondary external review on expenditure of the funds.

Peter Brindley advised that the discussions had been very reassuring.

The proposal to merge the Fred and Ann Green Legacy Advisory Group together with the Charitable Funds Committee was considered, and the committee unanimously agreed.

The Chair thanked Peter and Norma Brindley for their participation in the discussions.

***Action**: The Charitable Funds Committee terms of reference would be updated to include:* **FD**

- ***that there would be two Governor observers of the committee, one of which must hold an interest in Mexborough,***
- ***an additionality clause to ensure that charitable funds were used for general expenditure.***

The Committee:

- ***Approved the recommendation to merge the Fred and Ann Green Legacy Advisory Group together with the Charitable Funds Committee,***

- ***Agreed to update the Charitable Funds Committee terms of reference to include that there were would two Governor observers of the committee, one of which must hold an interest in Mexborough,***

- ***Agreed to amend the Charitable Funds Committee terms of reference to reflect the agreed changes proposed.***

Phil Beavers arrived at the meeting.

CFC21/02/B2 **Fundraising Strategy Update (Enclosure B2)**

Rainbow Garden Appeal

Emma Shaheen, Head of Communications and Engagement presented the Fundraising Strategy Update, which highlighted that following the Rainbow Garden Appeal which was launched in June 2020 following the deaths of two colleagues, Kevin Smith and Dr Atalla from COVID-19, a total of £14,099 had been raised to have two gardens, one at DRI and one at Bassetlaw as a memorial. Colleagues would be able to utilise the gardens to remember, reflect and recharge. A Worksop landscape gardener, John Fox had offered his services free of charge as a thank you for the care the Trust provided to his mother-in-law before she passed away from COVID-19 in March 2020. John's wife, Carolyn drafted the designs for the gardens. It was noted that although there were costs attached to the delivery of the gardens, that not all donations were of monetary value and the services provided from community members made a difference too. The Bassetlaw memorial was completed in September 2020 and it was expected that the DRI memorial garden would be complete at the end of March 2021.

Corporate Fundraiser Position Update

Following approval at the March 2020 committee to recruit for a Corporate Fundraiser, Sarah Dunning commenced in post on 28th September 2020. With experience in corporate and community fundraising, having worked for a local hospice and a national health charity Sarah brings a wealth of experience to the position. Although employed through Doncaster and Bassetlaw Health Care Services Sarah works within the communications and engagement team. Since beginning in post, Sarah was set some short-term objectives to deliver, whilst developing longer term corporate fundraising priorities. The short-term objectives included delivering a charity Christmas Campaign. The DBTH Stars campaign was supported by 67 donors and raised £40k.

Dr Noble joined the meeting.
The Committee:

- ***Noted the fundraising strategy update.***
-

CFC21/02/B 3 **Introduction and Highlights – Sarah Dunning – Corporate Fundraiser (Presentation)**

Sarah Dunning, Corporate Fundraiser was introduced to the committee and provided a presentation on the key achievements to date which included:

- The Trust's first successful Christmas campaign raised £40k and included a £6k donation from Amazon and £10k donation from DFS,

- Since the new year, two new charity partnerships have commenced. One with XPO Logistics who were one of the Christmas star sponsors. XPO Logistics had committed to making the Trust their charity of the year, with a target to raise £6k for the Children's Ward. The second was a long-term partnership with Albemarle Homes, who had pledged to donate £100 from every new home that they sell at two of their developments, totally £40k by the end of the projects,

- Keepmoat would support the Trust with a renovation project of the maternity ward as part of the Better Births Appeal, with the support of DFS who would donate furniture,

- A new charity website was being developed to provide a focus on the Trust charity with its own branding. This website would provide the opportunity for supporters to donate directly through the website,

- A charity database was in the development states which would provide the opportunity to track supporters and where their donations have been utilised,

- Further campaign ideas for 2021 included marking one-year from the start of the COVID-19 pandemic. Work was underway with DMBC and the British Ironwork Centre to create a rainbow sculpture to be placed in Doncaster Town Centre. Members of the community would be provided the opportunity to purchase a heart in memory of a loved one or to say thank you to a key worker,

- A further campaign in development was a business focused campaign called 'Here Together', where businesses would be asked to participate in donating to the Trust charity in return for support in raising their platform via adverts in the digital staff magazine and via the dedicated charity website,

- 'Make a would month' would be a further campaign where solicitors across South Yorkshire and Bassetlaw would provide their time to write wills in return for a donation to the charity,

- A new corporate volunteering process was in the development stages to work with businesses who wish to donate their time and support for different schemes identified.

Following a comment from Pat Drake regarding corporate volunteering and ensuring that this was done in conjunction with current volunteering practices, it was confirmed that all normal health and safety checks would take place and volunteering rules would be adhered to.

The Chief Executive noted the great work undertaken with the Christmas Stars Campaign and asked that the iron rainbow sculptures be replicated at Doncaster, Bassetlaw and Mexborough on behalf of the Board of Directors and Council of Governors as a thank you and lasting memorial. Sheena McDonnell suggested that a sculpture be created on behalf of the Fred and Ann Green Legacy.
It was clarified that the rainbow sculpture development was a Doncaster project, not just at Trust project and therefore it wouldn't be replicated at Bassetlaw or Mexborough as it would be in the centre of Doncaster.

The Chief Executive advised that the committee need to agree the due diligence process for working with corporate partners, in line with who the Trust was willing to invest with. The Director of Finance advised that this goes through the normal procurement process and provided assurance that checks were undertaken as part of the routine process.

Kath Smart commended the work undertaken to date and asked that a consideration be made of colleagues as key fundraisers for the organisation, to share their stories and demonstrate where the funds raised had been spent.

Neil Rhodes noted the substantive progress made since the previous meeting in March 2020. It was confirmed that the Corporate Fundraiser post was funded via the charitable funds with remuneration attached when agreed targets were achieved.

The Chair thanked Sarah Dunning for her introduction and progress update and noted that the committee would provide support where required.

Action: Ensure that Doncaster, Bassetlaw and Mexborough sites are recognised on behalf of the Board of Directors and Council of Governors as a thank you and lasting memorial. **ES/SD**

Action: The due diligence process was to be agreed by the committee on working with corporate partners in line with who the Trust would invest with. **ES/SD**

The Committee:

- ***Noted the Corporate Fundraiser progress update.***

CFC21/02/B4 **Charitable Funds Expenditure Strategy – Including Captain Tom monies (Enclosure B4)**

The Director of Finance advised that as of 31st March 2021 the draft accounts show that the charity had available funds of £7,859k. During 2019/20, overall expenditure was £1,252k, resulting that there were substantial levels of funds available for the current year.

As the charity had a Corporate Fundraiser to improve the profile of the charity and subsequently, increase corporate donations, it was discussed that a fundraising target be established. In 2019/20, corporate donations were £73k, and overall income (excluding legacies) were £288k. As such, the base level was extremely low and provides scope for improvement. Other NHS Charities in the region used a cost-to-income ratio of 1:5 for their fundraisers, although they were established and as such, it should be easier to fundraise. As such, it was suggested that a sliding scale over the next 3 years should take place, meaning that the cost-to-income ratio should move from 1:3 to 1:4 to 1:5 over the next 3 years, starting in 2021/22, over and above the 19/20 baseline. This would apply to all donations, as it was expected that there would be an element of the work having a positive impact on individual donations, as well as corporate. It was suggested that the Above and Beyond Committee had a similar target, of 25% of the allocated budget assigned to them in-year. This would equate to circa. £725k per year. It was clarified that this would be an auditable and managed process.

A comprehensive discussion took place regarding suggested schemes for 2021/22 and included the need to support staff with a comprehensive health and wellbeing offer. The Chief Executive suggested that a similar scheme be set up for the year where the Director of People and Organisational Development would have delegated authority to use funds for this purpose. It was suggested that monies received from NHS Charities Together would support this. It was noted that stage 2 element of funding from NHS Charities Together would be allocated to support partnerships across geographical areas that support communities affected by COVID-19. SYB ICS had been allocated £620k. Sheffield Teaching Hospitals had volunteered to be the lead Trust. It was suggested that working with Doncaster Place on a donation could provide support to the health and wellbeing package to colleagues.

Pat Drake suggested working at a place level with partners on health and inequalities for the local population.

Kath Smart noted that £66k had been spent on staff welfare and amenities during 2019/20, and advised that it had been recognised at the People Committee that staff were fatigued and that health and wellbeing offers should be put into place based on what they would like. The Chief Nurse advised that the Leadership and Development Team had an allocated fund for health and wellbeing, however noted that the approach for staff to put bids in, particular the Above and Beyond Committee should be simple, and suggested that one committee would do this. With more committees, there would be the risk that there would be less understanding of where bids should be made. It was noted that the fund with the Leadership and Development Team was the staff lottery fund. Sheena McDonnell noted that there was a requirement for further health and wellbeing support to colleagues that sit outside of normal expenditure, which had been discussed at the People Committee. The decisions on funds should reflect the key themes picked up at the People Committee.

It was agreed that a consideration be made of the suggestions discussed on how the process for bidding for charitable funds would be as simple as possible for colleagues. This would include the promotion aspect so that colleagues were aware of where to go for funds if required. It was agreed that the Above and Beyond Committee would remain the sole committee for bids under an agreed amount to be determined. A meeting would take place monthly to monitor the bids/spend.

Following a comment from Neil Rhodes regarding the length of time between meetings, it was confirmed that provisions were in place for chairs action if a bid required urgent consideration prior to next planned meeting.

Action: The Director of Finance and Chief Nurse would formalise the budget allocated to the Above and Beyond Committee. This would be circulated to the Charitable Funds Committee members. **JS/DP**

Action: The Above and Beyond Committee would meet monthly following this meeting. **DP**

Action: The Director of Finance, Chief Nurse, Head of Communications and Engagement and Corporate Fundraiser would meet monthly to review Above and Beyond Committee bids and spend. **JS/ DP / ES/ SD**

Action: Action would be taken to identify how charitable funds would be promoted so that colleagues were aware of what charitable funds were available for and where they would need to make a bid. **ES**

The Committee:

- ***Noted the update on the Above and Beyond Committee and agreed with the above actions.***

CFC21/02/C1 Draft Committee Annual Report (Enclosure C1)

There were no questions.

The Committee:

- ***Approved the committee annual report.***

CFC21/02/C2 Charitable Funds Annual Accounts/Annual Report (Enclosure C2)

The Charitable Funds audit was in its final stages of sign off by the external auditors and the Trust had until 31st March 20210 to file the accounts with the charity commission. The draft annual report and accounts was circulated for information.

The Committee:

- ***Noted the draft charitable funds annual accounts and report.***

CFC21/02/C3 Above and Beyond Committee Terms of Reference (Enclosure C3)

The Chief Nurse advised that communications had been circulated to promote bids and therefore it was expected that there would be an increase. The meetings had not taken place due to COVID-19 however, would recommence. The Above and Beyond Committee terms of reference would be amended following the discussions at item B4.

Action: The Above and Beyond Committee terms of reference would be updated to reflect the agreed formalised budget for the year 2021/22. The terms of reference would be presented to the Charitable Funds Committee in June 2021. **DP**

The Committee:

- ***Agreed to postpone approval of the Above and Beyond Committee terms of reference due to required changes following this meeting.***

CFC21/02/D 1 **Review of Fund Balances (Enclosure D1)**

The Trust funds at Month 9 (December) were £9,135k (£7,859k March 2020), with the increase in funds mainly due to a gain on investments of £1,236k.

Kath Smart asked if the Trust would aim to reduce the number of funds by writing to fund holders if there had been no activity. It was confirmed that the funds were reviewed frequently and if there had been no movement, an exercise would be undertaken to sort through the funds by contacting fund holders.

Suzy Brain England OBE advised that funds tended to fit into the categories of capital and general need/staff related matters and therefore suggested amalgamating funds into two pots dependant on what the original purpose was, so when bids were made, they could be used from multiple funds. Neil Rhodes suggested a policy be in place in relation to the purpose on which funds could be spent to indicate that if funds remained unspent, they would fall into the general fund. The Director of Finance advised that there were several charitable funds that were restricted under the Charities Act 2011, but noted that the departmental funds were a sub-part of general funds and where funds remained unspent for a period of time, they would be moved into the general funds. The donation form did state this.

The Committee:

- ***Noted the update on the fund balance.***

CFC21/02/D 2 **Investment Update (Enclosure D2)**

The committee received the Aberdeen Standard Capital Quarterly Investment Report dated 31 December 2020. The Director of Finance noted that Aberdeen Standard ran their financial year from 1st January to 31st December. Quarterly performance indicated 7.70% growth.

It was agreed that Aberdeen Standard would be invited to the June 2021 committee meeting to provide an update on investments.

Kath Smart highlighted the letter addressed to Matthew Bancroft dated January 2021 which outlined the portfolio restrictions, and noted that these did not coincide with what was agreed at the workshop during 2020 and asked for clarification on this, as areas such as proactive investment in green companies was agreed, as was a restriction on investment in companies engaging in pornographic materials.
The Director of Finance would review this and advise the committee.

<u>Action</u>: Aberdeen Standard would be invited to the June 2021 committee meeting to provide an update on investments. **JS**

***Action**: The Director of Finance would review the portfolio restrictions outlined in the letter to Matthew Bancroft dated January 2021, as this did not coincide with what was agreed during a workshop in September 2020 with Aberdeen Standard.* **JS**

The Committee:

- ***Noted the investment update.***

CFC21/02/E1 Minutes of the Sub-Committee Meeting

The Committee noted:

- ***Minutes of the Above and Beyond Committee 3rd July 2020 and 7th August 2020.***

CFC21/02/E2 Minutes of the Minutes of the Fred and Ann Green Legacy Advisory Group meeting 16th June 2021

The Committee noted:

- ***Minutes of the Fred and Ann Green Legacy Advisory Group meeting – 16th June 2020.***

The draft Fred and Ann Green Legacy Advisory Group minutes dated 29th October 2021 would be reviewed and approved at the June 2021 Charitable Funds Committee meeting.

CFC21/02/E3 Minutes of the Meeting held on 16 June 2020 (Enclosure E3)

The Committee:

- ***Approved the minutes of the meeting held on 16 June 2020.***

CFC21/02/E4 Any Other Business

Phil Beavers apologies for his late attendance at the meeting. Phil Beavers noted the good news surrounding the Christmas Stars Campaign and advised that the corporate fundraising concept was first rate and was looking forward to seeing how it would progress further.

CFC21/02/E5 Date and time of next meeting (Verbal)

Date: 10 June 2021
Time: TBC
Venue: Videoconferencing

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

TRUST EXECUTIVE GROUP
(Previously Management Board)

Minutes of the meeting of the Trust Executive Group
Held on Monday 10th May 2021 at 15:00 via Microsoft Teams

Present:
Richard Parker – Chief Executive (Chair)
Karen Barnard – Director People, Organisational Development
David Purdue – Deputy Chief Executive and Chief Nurse (Item TEG21/05/G2 onwards)
Marie Purdue – Director of Strategy and Improvement
Dr Tim Noble – Executive Medical Director
Rebecca Joyce – Chief Operating Officer
Mr Eki Emovon, Divisional Director, Children and Families
Ken Anderson – Chief Information Officer
Jon Sargeant (JS) – Director of Finance
Dr Jochen Seidel (JSe) – Divisional Director, Clinical Specialities
Alasdair Strachan – Director of Education and Research
Dr Nick Mallaband – Divisional Director, Medicine
Ms Antonia Durham–Hall – Divisional Director, Surgery & Cancer Division
Kirsty Edmondson Jones – Director of Estates and Facilities

In attendance: Fiona Dunn – Deputy Director Corporate Governance / Company Secretary

Apologies: Katie Shepherd – Corporate Governance Officer (Minutes via video recording)

ACTION

TEG21/05/A1 **Welcome and Apologies for Absence (Verbal)**

The Chair welcomed the members and attendees. There were no apologies for absence. The Chair noted the title change of the meeting and reiterated that the aim of the new format and focus was to provide Divisional Directors with the opportunity to be involved in decision making relating to matters and issues that affect the delivery of organisational objectives which would usually be discussed as part of the Extended Executive Team meeting.

TEG21/05/A2 **Matters Arising / Action Log**

Updates were received on actions:

Action 1 – ICS Update – Pathology – The Chair advised that the ICS had submitted a capital and revenue bid to develop this service further, at short notice. It would facilitate IIMS, digital pathology and work towards a target operating model. The two keys decisions outstanding were how many essential service laboratories (ESL) there would be, and whether the extended ESL would be at Doncaster or Barnsley. Once a decision was made it would allow for a provider agreement to be established to determine how the rules of business would be organised in the future as the precursor to the network coming into

formal existence. Sarah Bayliss had secured a further secondment as the Accelerator Programme Lead which adds a further dimension to moving to the next phase.

It was expected that progress would be made on joint appointments to reduce gaps in Histopathologists.

Action 5 – Transfer of Payroll and Pensions Service – An amendment to the action was requested. 'The presentation would be received at the Medical Advisory Committee, and not the Trust Medical Committee.' which was due to take place on Friday 14th May 2021. Action closed.

It was confirmed that the planning for the transfer of the payroll and pension service was going well.

Action 9 – Patient Administration Proposal – The Chief Operating Officer advised that she had further discussed with Divisions with an agreed approach. Recruitment had commenced for internal validators and the approach to management oversight of that strand had been agreed. Action closed.

The following actions were closed: 5, 8, 9 and 10.

The Committee:

- ***Noted the updates and agreed, as above, which actions would be closed.***

Action: Katie Shepherd would update the Action Log.

TEG21/05/A3 **Conflict of Interest**

No conflicts of interest were declared.

TEG21/05/A4 **Requests for any other business (Verbal)**

The Divisional Director for Surgery requested to discuss Theatre staffing.

The Divisional Director for Children's & Families requested a post incident discussion relating to the water leak that led to an electrical fire in the Women and Children's Hospital the previous month.

TEG21/05/B1 **Urgent Issues (Verbal)**

None.

The Committee:

- ***Noted the discussions.***

TEG21/05/C1 **Community Diagnostic Hub/Rapid Diagnostic Service (Presentation)**

The Director of Strategy and Improvement advised that Community Diagnostic Hubs (CDH's) were a key recommendation of Professor Sir Mike Richard's review commissioned by the

NHS Chief Executive. The primary aim of CDH's was to reduce improve population health, reduce health inequalities and increase diagnostic capacity, enabling productivity and efficiency gains by separating elective and emergency diagnostics.

Capital funds totalling £105m had been allocated nationally for this, with £23.2m allocated to the North East and Yorkshire region. The Trust had submitted a draft bid the previous week, following a two-day turnaround request, with the final bid to be submitted by 14th May 2021. Discussions had taken place with colleagues within the Diagnostics Team and Endoscopy Team on how a bid could support a Community Diagnostic Hub at Mexborough Hospital similar to the Rapid Diagnostic Model. Other areas to review include mobile scanning and a permanent endoscopy room and scanning room which would house the scanners permanently. The main challenge included staffing. Partner organisations had agreed to submit this bid along with one from Barnsley. The Acute Federation had considered and supported the proposal.

The Medical Director advised that there was an unmet need for further diagnostic capacity support and the use of private providers was one option available, however highlighted that the responsibility for the patient stood with the referrer, and asked for clarification on where the clinical interpretation of the diagnostic would be undertaken within this model. The Chair advised that the interpretation of this aspect would be included as part of the contractual agreement, however the national model would develop further.

Following a question from the Divisional Director for Clinical Specialities regarding staffing the Community Diagnostic Hub, it was confirmed that there had been significant caveats to the bid that whilst the Trust could create the buildings but would not currently have the ability to staff the facility. Workforce plans would be required within the SYB ICS to manage this aspect. The Chair noted that the proposal was a collective proposal by the ICS on behalf of acute providers, and therefore whilst the Trust would be the lead provider as it would on site, it would be the responsibility of the wider SYB ICS. Following the Health and Social Care Bill legislative changes commence in April 2022, the Trust and the SYB ICS would have statutory responsibility to collaborate to improve the outcomes for patients in South Yorkshire and Bassetlaw and use public money wisely and efficiently.

The Committee:

- ***Noted the update on the Community Diagnostic Hub bid.***

TEG21/05/ D1 **<u>Sepsis Management in ED and Paediatrics (Verbal)</u>**

The Chair made the Trust Executive Group aware that a Coroner's inquest the previous week concluded with confirmation that the Trust would receive a Section 28 – Prevention of Future Death Notice, following the death of a child as a result of failure to follow up on requested diagnostics. This alongside of evidence which was submitted and which demonstrated poor compliance with the use of the sepsis screening tool was viewed by HMC as indicating that the outcome was contributed to by neglect.

HMC's view on the sepsis audits was that the Trust had previously received two Prevention of Future Death Notices relating to sepsis screening and management in 2016 and 2017 and that progress had not been made. The audit results did confirm sepsis care had been generally at a good level.

The Chief Executive, Chief Nurse and Executive Medical Director had met with DAC Beechcroft to understand and clarify the immediate action required by the Trust:

- The Trust would include children as part of the learning from deaths process,
- A Consultant discussion must take place prior to the discharge of any paediatric with a diagnosis of infection/ sepsis,
- Take action to ensure that the sepsis screening tool was mandated via the IT systems in the Emergency Department and Paediatric assessment areas.
- The EMD would meet HMC to ensure that all of the concerns were identified

More detailed actions plans were underway, to be completed prior to submission to the Magistrates Coroner within 56-days.

The Chair highlighted the escalation issue as part of the sepsis screening tool and this would form part of the ongoing action plan.

The Chief Information Officer advised that the mandatory check had been implemented on Symphony the previous week where any score of 5 would require escalated and details to be logged onto the system. Work was ongoing to replicate this approach in Symphony for paediatrics.

The roll out of e-observations in paediatrics had commenced and would conclude in autumn 2021. This work was a priority and would be reported through Clinical Governance Committee on 21st May 2021.

The Committee:

- ***Noted discussion on sepsis management in the Emergency Department and Paediatrics.***

TEG21/05/ D2 **<u>Accelerator Programme (Presentation)</u>**

SYB ICS had agreed to become one of the accelerator ICS as part of a national programme with the intent to return to 100% of pre-COVID-19 activity levels by July 2021, different to 85% target as previously stated within the national planning guidance. This was against value, not volume. There was an expectation that 100% of activity would be sustained beyond July 2021, with an incentive of between £10-20m transformational funding for SYB, in addition to any monies achieved via the elective incentive scheme.

The risks and penalties of involvement with the programme were not clear. The Trust was required to engage in discussions regarding the additional use of the independent sector and to review the internal infrastructure to meet the increase activity requirements.
Risks to the delivery of this include staffing in Theatres. The Director of Finance advised that full guidance was required before the Trust could understand the full risks associated with the accelerator programme.

Following a question from the Director of People and Organisational Development regarding the balance between the use of the independent sector and internal capacity workforce challenges, the Chief Operating Officer advised that due to workforce challenges, specifically within Theatres, it would limit the Trusts ability to deliver additional capacity, and therefore

whilst the use of the independent sector would be significant, there was a requirement to identify alternative options.

The Director of Finance raised a concern regarding colleague fatigue and the impact this programme would potentially have on them; and in ensuring that the transformational monies received from partaking in the programme go to the areas that require it the most.

The Chair advised that a consideration of the required administrative support and responses required for the achievement of the programme would need to be taken, as this was a collaborative exercise.

The Divisional Director for Medicine highlighted that there had been an increased attendance in the Emergency Department and advised that flexibility was required between the emergency and elective pathways to ensure that any changes are sustainable for both.

The Chief Operating Officer advised that as part of the programme there was a requirement for there to be 0 52-week breaches by 31 March 2022 and all priority-2 patients seem within 28-days by the end of Q1 2021/22. The 52-week wait was a risk to the organisation with over 2k patients waiting over 52-week, which was replicated in other Trusts.

The Committee:

- ***Noted the information provided on the accelerator programme.***

TEG21/05/E1 **<u>Freedom to Speak Up – Emergency Department (Verbal)</u>**

The Chair advised that following a number of concerns raised regarding relationships within the Emergency Department, a Freedom to Speak Up investigation was commenced, and an action plan was formed, and ongoing targeted work had taken place since. A further two anonymous reports had been received, one suggesting it was on behalf of all nurses and the other on behalf of all band 7 colleagues. The issues raised were of those raised previously and therefore the Chief Executive met with all band 7 colleagues in the Emergency Department to discuss further. The Chair of the Board, who received the second letter wrote to the nursing workforce within the Emergency Department to advise them to make contact with their concerns, subsequently only three had made contact to advise that they were not aware, of nor supported the concern.

As some concerns had been raised directly with the CQC it was anticipated that there would be an unannounced inspection of services and therefore the Trust was taking steps to prepare.

There would be an increased weekly focus within the Emergency Department for colleagues to meet with HR personnel and the Health and Wellbeing Team should they wish to do so.

The Director of People and Organisational Development advised that there was a monthly programme board meeting in which the Chief Nurse, Medical Director and Divisional Director for Medicine attended to review progress against actions, which aligned to the six pillars: patient experience, staff experience, education and research, leadership, IT innovation and flow and pathways. The approach to this was shared governance and good discussions are formed from the listening events that take place. Regular culture questionnaires would also be circulated to ensure that all colleagues have the opportunity

to feedback. It was expected that the work commenced in the Emergency Department would be evolved across the organisation.

The Divisional Director for Clinical Specialities asked if the Trust could provide feedback pertaining to the HR concerns raised to close the matter, understanding that such matters were confidential. The Chief Executive advised that colleagues had been kept informed as part of the wider programme.

It was noted that it had been reiterated to colleagues that the submission of anonymous letters were not helpful as they could not be properly investigated or discussed.
The Committee:

- ***Noted the update provided on Freedom to Speak Up within the Emergency Department.***

TEG21/05/ F1 **Finance Update (Verbal)**

The Director of Finance advised that budgets had been issued within the past week. Guidance for H1 (Q1 and Q2) of 2021/22 had been circulated, however no further guidance had been received for H2 (Q3 and Q4) of 2021/22. The month-1 had not yet been finalised; however, early indication was that there would be no issues.

The Committee:

- ***Noted the finance update.***

TEG21/05/ F2 **Consultant Vacancies (Verbal)**

None for approval

TEG21/05/ G1 **Items for escalation to the Corporate Risk Register (Verbal)**

There were no items identified for escalation to the corporate risk register. The Chair informed the Trust Executive Group that an internal audit had been undertaken on risk management. A significant requirement was to ensure that the corporate risk register was reflective of the current risk. The water leak incident that took place in the Women and Children's Hospital had been entered onto DATIX and added to the corporate risk register relating to the integrity of the pipework. The mitigations to this was to undertake an audit of all pipework within the organisation.
Work would be undertaken to review the corporate risks to align them to the board assurance framework.

Action: The Risk ID number relating to the water leak incident within the Women and Children's Hospital would be forwarded to the Company Secretary. **KEJ**

The Committee:

- ***Noted the discussed relating to the corporate risk register***

TEG21/05/ G2 **Board of Directors Meeting Agenda – 18th May 2021 (Enclosure G2)**

The draft Board of Directors meeting agenda was shared for comments. The Report from the Guardian for Safe Working would be received at the Board on 18th May 2021. It was noted that Mr Jay Dugar was stepping down and would be replaced by Dr Anna Pryce, Consultant in Sexual Health.

The Chair advised that partner organisations within the Acute Federation had taken the decision to hold their Board meetings bi-monthly, to allow the Board to have more time for development and strategy. It was noted however that the month where there was not a meeting held in public, that there would be a short public meeting to receive urgent business and report such at the Ockenden Report action plan.

It was noted that the Medical Director update would include an update on the recruitment timeline for the Deputy Medical Director posts.

The Committee:

- ***Noted the discussions regarding the Board of Directors meeting.***

TEG21/05/H1 **Any Other Business (Verbal)**

TEG21/05/H1i Paediatric Capacity Issues

The Chief Nurse advised of the paediatric capacity issues which were now exacerbated by the building works now required in the Women and Children's Hospital due to the water leak. It would cause significant issues if the capacity wasn't returned to normal levels by September 2021. The Chief Nurse would liaise with the Director of Estates and Facilities regarding this issue and risk.

TEG21/05/H1ii Theatre Staffing

The Divisional Director for Surgery advised the Trust Executive Group that there was a 22.11 WTE vacancy rate amongst nursing staff within Theatres, which would cause issues in staffing the scheduled theatres going forward. Due to this there have been eleven theatre lists cancelled this week. The Trust Executive Group were assured that the cancelled lists were of routine surgery and all category 2 surgeries had taken place. It was expected that the staffing issue would affect theatres for at least a three-month period, and could impact over 27 theatre lists per week, which would have a significantly impact on the delivery of the activity requirements and be a risk to patients. It had been identified that the Trust paid agency staff lower that other Trusts in the ICS, and expected that this was a contributing factor. This was further confirmed by the Chief Nurse. Discussions had commenced and would continue with the Divisions, Chief Operating Officer and Chief Nurse to appraise options to reduce the risk of the need to cancel theatre lists.
The Chief Nurse advised that the 22.11 WTE post vacancies had been filled, however 10 of those vacancies were overseas recruitment from India which had been delayed due to the COVID-19 pandemic challenges in India.

The Director of Finance requested a copy of the briefing document as it had not been shared, and noted that the overseas nurses were not due to commence in post until July 2021 and therefore this risk should have been escalated earlier, and identified as part of the workforce planning process that was concluded in April 2021.

The Divisional Director of Clinical Specialities advised that it was a known issue however, assumptions were made based on previous use of overtime and agency staff.

The Chair supported that this should have been an issue identified six-weeks ago when lists were planned and more specifically four-weeks ago when lists were confirmed, which seemed to indicate that the 6:4:2 planning process was not in use or the system had not worked was required.

The Divisional Director for Medicine noted that as plans had been based on pre-COVID-19 activity two drivers may be at play. The first being that colleagues are fatigued from the COVID-19 pandemic, and the second that agency rates are lower than within the ICS region. There was a general consensus that colleagues were likely not to wish to work additional hours following the COVID-19 pandemic.

It was confirmed that there was an agreement within the SYB ICS that if there were any changes to substantial pay rates that they would inform partner organisations in advance.

Further detail would be required from SYB ICS colleagues and from the Head of Procurement to understand the difference in agency pay rates.

Action: The options paper for Theatre staffing would be shared with Trust Executive Group members. **JSe**

Action: Further detail would be required from SYB ICS colleagues and from the Head of Procurement to understand the difference in agency pay rates. **KB / JS**

TEG21/05/H 1iii

Women and Children's Incident

An update was provided on the water leak incident that took place in the Women and Children's Hospital which highlighted that engagement with the insurers was underway and an intermediate plan had been devised, expected costs within the region of £7-10m capital. There would be a longer-term plan. Discussions had taken place with NHSEI regarding how the Trust could access capital for this. It was noted that the Director of Finance had suggested that whilst half of the building was not in use that further works be undertaken to improve the building to make it more sustainable for the future, which had been accepted by NHSEI. A temporary theatre and ward would be implemented on site whilst works were undertaken within the Women and Children's Hospital. It was expected that this would be in place for June 2021.

The Committee:

- ***Noted the items of any other business.***

TEG21/05/ H2

Sub-Committee Reports/Minutes (Enclosure H2)

The Committee:

- ***Noted the minutes of the CIG meetings dated 22 February 2021 and 12 April 2021.***

TEG21/05/ H3

Minutes of the Meeting – 12th April 2021 (Enclosure H3)

A request was made to amend the wording on page 3 from:

The Medical Director asked if a presentation to the Trust Medical Committee could be arranged as the presentation provided reassurance on the transition process

To:

The Medical Director asked if a presentation to the Medical Advisory Committee could be arranged as the presentation provided reassurance on the transition process.

The Committee:

- ***Approved the minutes of the meeting dates 12th April 2021 subject to the above amendment.***

TEG21/05/H4 **Date and time of next meeting (Verbal)**

Date: **Monday 7th June 2021**
Time: **14:00**
Venue: **Videoconference**

The meeting closed at 17:00.

FINAL

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

TRUST EXECUTIVE GROUP

Minutes of the meeting of the Trust Executive Group
Held on Monday 7th June 2021 via Microsoft Teams

Present:	Karen Barnard – Director People, Organisational Development David Purdue – Deputy Chief Executive and Chief Nurse (Chair) Marie Purdue – Director of Strategy and Improvement Dr Tim Noble – Executive Medical Director Rebecca Joyce – Director People, Organisational Development Mr Eki Emovon, Divisional Director, Children and Families Ken Anderson – Chief Information Officer Jon Sargeant (JS) – Director of Finance (Present until TEG21/06/E2) Alasdair Strachan – Director of Education and Research Dr Nick Mallaband – Divisional Director, Medicine Kirsty Edmondson Jones – Director of Estates and Facilities Dr Jochen Seidel (JSe) – Divisional Director, Clinical Specialities Emma Shaheen – Head of communication and Engagement	
In attendance:	Lucy Hammond – General Manager (T&O General surgery and Endoscopy) (Present until TEG21/06/E2) Joanne Wright – General Manager of Clinical Specialities (Present until TEG21/06/E2) Hayley Findlow – Corporate Governance Officer (Minutes)	
Apologies:	Richard Parker – Chief Executive Ms Antonia Durham–Hall – Divisional Director, Surgery & Cancer Division Fiona Dunn – Deputy Director Corporate Governance / Company Secretary	
		ACTION
TEG21/06/A1	**Welcome and Apologies for Absence (Verbal)**	
	The Chair welcomed the members and attendees. The apologies for absences were noted Divisional Director, Clinical Specialities Informed the group of the passing of a dear colleague Chris Richardson. Chris was an ODP at Doncaster for fifteen years, he would be greatly missed. A collection would be organised by the department.	
TEG21/06/A2	**Matters Arising / Action Log**	
	Updates were received on actions: **MB14/10/5** Action 1 ICS update Pathology The Divisional Director (DD), Clinical Specialities outlined that there were no further updates from the pathology network over the last six weeks. How ever there was someone finishing her registration in Histopathology in Liverpool, and the department was in contact with her to undertake a short term locum of 2 to 3 weeks in the near future.	

	MB21/04/A2i Action 2 New Speciality Doctor The Director People, Organisational Development advised that a discussion had taken place with the group to outline who can transition over to the specialist role. A discussion would be scheduled with the DD to look at this going forward. An update would be provided at the next meeting. The Director of Finance asked for an update on potential pay inflation and advised that a business case was required. The Director People, Organisational Development came back that there would be a transition period and where people have the right to transition over and was supposed to be fully funded, it's introducing the higher specialist grades that would need to be built into the process. Director of Finance asked to have a CIG paper regarding costs. **MB21/04/A2ii** Action 3 SAS Doctor ICE Access The Executive Medical Director confirmed a number of debates had happened, but no answers yet, however it was agreed that this item would be discussed at the SAS Group. Action closed. **MB21/04/B2** Action 5 Terms of Reference for the Trust Executive Group The Chair advised the group that he had not yet met the Divisional Director for Surgery & Cancer Division, but would do so prior to the next meeting to go through the terms of reference. The target date was changed to July 2021. **MB21/04/B3** Action 6 Division/Directorate Quality Framework The meetings regarding the framework, were planned in. The target date was changed to July 2021. **TEG21/05/G1** Action 10 Risk ID The Director of Estates and Facilities advised that this action was completed. Action closed. **TEG21/05/H1ii** Action 12 Agency Rates There were differing rates of agency pay across the ICS. The Chair Approved the 20% uplift to increase the fill rates. Bank rates for theatre staff caused a bidding war and that's where the standardisation needs to come in. Data from Richard suggested that others were higher, no consistency of levels of pay. There needs to be a common approach with levels of pay. Following a question from the Divisional Director, Clinical Specialities regarding the individual rate of pay for medical staff, it was advised by the Director People, Organisational Development that rates had been hiked up and were behind the rates of individual pay. How rates compare across the ICS gets looked at on a regular basis. Actions closed: 3,4,7,8,9,10 and 11.	
	The Committee: - ***Noted the updates and agreed, as above, which actions would be closed.***	
	Action: Hayley Findlow would update the Action Log.	

TEG21/06/ A3	**Conflict of Interest (Verbal)**	
	No conflicts of interest were declared.	
TEG21/06/ A4	**Requests for any other business (Verbal)** No specific AOB discussions.	
TEG21/06/ B1	**Urgent Issues (Verbal)**	
	It was agreed that this item would be removed from the agenda.	
	Action : Hayley Findlow to remove the "Urgent Issues" from future agendas.	**HF**
	The Committee: - ***Agreed to the above action.***	
TEG21/06/ D1	**Same Day Emergency Care (Enclosure D1)**	
	This topic was not discussed at this meeting. Dr Nick Mallaband to take this agenda to the Task and Finish Group for this item around bed capacity.	
	The Committee: - ***Agreed for this item to be deferred to the task and finish group.***	
TEG21/06/ D2	**Operational Update Including Elective Restoration and Accelerator Programme (Enclosure D2)**	
	Core position The Director People and Organisational Development emphasised that the slide presentation was slightly out of date, as they now have May's data. The latest on infection and admission Covid rates are low and have remained low for some time now. The Delta variant was of concern, and planning would take place to address this. There had been high levels of attendance and it's become a challenge for volume and admissions and beds. The work on bed modelling would help this. The delivery of the activity plan was linked to the value and the activity which was how we were being judged on elective incentive funds. The Trust delivered 80% over a plan of 77% of 19/20 activity. It was reported that there was an 80% over achievement over core capacity and RTS, with a slight under performance on elective. The report indicated Plan was 88% of 19/20 activity plan, we delivered 88.62% that's value not activity. Stepped up lots of activity from April to May. The key things to note included: • day case work is under for speciality Ophthalmology, Haematology, and general surgery • under on inpatients for general surgery and ENT and these areas need more focus Key risk updated since the pack was sent out; see the diagnostic plan outlines. The division has been working towards setting them out and working towards and they need to be considered when the finally plan comes out.	

	Risks relating to the PTL continue to grow. There is an administrative training and development plan to mitigate short term pressures to cover staffing arrangements until we get permanent staff into post. The third Key plan was the bed plan linked to the Medicine Division. The Director of Finance noted a "well done" against the figures and requested a review of the figures in the ICS submitted plan as other trusts had appealed against their base line and wanted this to be reduced. The Trust had benefitted from having endoscopy in our activity numbers, but lots of the work that was there was the bowel screening work which was done at Sheffield and wasn't in the Trusts baseline, so it was a positive variant for us. Barnsley and Sheffield Trusts had asked for that to come out of the baseline and if that does then the positive figure may drop and effect our baseline. This may be a risk. The 52week position was better; improving particularly in Surgery around scheduling. Thanks to Lucy Hammond and the team. <u>Accelerator Programme</u> One of 11 accelerator programmes funding was 2.7 million for the ICS. Re -plan the annual submission for getting back to 100 % capacity by July (one of the conditions of obtaining the funds). Thanks to the teams that contributed to the plan. It was broadly achieved , at 98 % July, 100 % August and September was 91 % . This reflects that 19/20 was a bumper month in September. More work to take place to plan additional schemes. - Focus on increased independent sector work particularly in orthopaedics - Limited internal outpatient work across medicine, women's / families and surgery. - Limited insourcing funding agreed on a month to month basis. That's the expensive aspect. Minimise the impact on staff internally especially theatre staff. Transformation elements - The Bassetlaw plan - doing different things with orthopaedics particularly at the weekends no activities projected into the plan as yet. There were several risks surrounding the accelerator plan; getting the core capacity delivered and focus on improving the basic processes as well as meeting the accelerator requirements. Accelerator deliverer cell established. The Director of Strategy and Improvement noted that in relation to Trauma and Orthopaedics, there was nothing from a strategy aspect to update. The governance process was for the wider group systems that sit on the edge of the accelerator programme but could impact them massively. Making sure that it was tied in with the governance arrangements that have been established, the single site was separate and not related to the accelerator programme. It needs to be linked as they would be more ICS work going on and looking at the GIRFT stuff that seems to be more system wide. Transformation work with the accelerator programme needs to move forward. The Director People, Organisational Development wanted to note to the group that no one tested positive in her team over the last few weeks, and three staff have tested positive in a few days towards the end of May. The Director of Education and Research asked a question about the communication around theatre staff.	

	The Director People, Organisational Development had had a few meetings with seven theatre staff, orthopaedics and ophthalmology and to share what the accelerator programme was, to listen to ideas and pick up any concerns raised. There were lots of interest, helpful ideas and good suggestions and that Bassetlaw would be looked at in particular. Not gone into detail as yet but the meetings were helpful. The group to be kept updated. The Director People, Organisational Development shared with the group that paediatrics had had to divert children to other providers. David Purdue had been working on a provisional plan with the senior nursing team and Jodie Roberts in terms of what the operational plan may look like. Further discussion to take place within the group to finalise it. The Chair stated that more pressure was being faced from the ICS about the children's unit and that it should have 38 beds open , currently we only have 11. Interim plans for a double storey modular build maybe in place for October / November 2021. There has to be a return for capacity plan for paediatrics this year as it's believed that they may have a terrible year in that department with relation to chest disease in the young. Discussions ongoing regarding children's services to try and get it moving. The Director People, Organisational Development raised concerns on Critical Care (DCC) and to pick up on the temporary options available. The Executive Medical Director asked about the accelerator program as a key risk was workforce, but where does it link in? As the workforce was the most important step in all of this. How were we sure that we have the workforce in the right position to be able to do the work that was expected. • Linked to the focus on the initially phase one on additionally independent sector activity some in sourcing activities so less impact on our workforce and services have identify where the risks capacity was for additional internal out patients where it was feasible teams have identified that • Theatre staff remains a risk to our core capacity as does annual leave. Surgeons need to have a look and see how it would impact on them. The team were looking at the Bassetlaw module as the first option which would have an impact on our workforce and any assumptions of that can be delivered. It had been discussed with the teams concerned. The outsourcing, in sourcing and limited internal additional out-patients activities, arrives at the figures stated above, assuming that the Trust can deliver the core capacity plan including the risks that have been described. There would be an expectation that it was sustained and that in September onwards there was still a big risk. Paediatrics and Surgical S11 re – location onto ward 22. This doesn't immediately impact on DCC beds as a neighbouring ward but not for long. It puts us in a position where the only DCC beds available to us for any respiratory variant such as Flu or COVID was the 20 commissioned beds in the ITU, as neither ward 22 or HSDU would be available. The earlier discussion about the Paediatrics build not being available till Autumn would effect the Trust and beyond. The ward couldn't repatriate DCC patients to the cardiac	

	ward because they are no side rooms. If COVID patients have to be in one zone DCC would be running out of isolation facilities in days. The Chair acknowledged the issue and proposed to look at how to use ward 22 and what we can be freed up. If the number of cases started to rise. The Director of Finance pointed out that the Women's and Children's Hospital would not get any funding as this would have to come from the ICS. The Trust now has to manage all of that and is being pushed by the local NHS England team on how to do this. The insurance would not cover all the costs even for the modular build. The timeline may have risks that need to be look at, but solution may be to go ahead with the module build.	
	The Committee: - ***Noted the update on the Operational Update including Elective Restoration and Accelerator Programme.***	
TEG21/06/ D3	**<u>NHS National Standards of Healthcare Cleanliness 2021 (Enclosed D3)</u>**	
	The Director of Estates and Facilities informed the group that the National standard had been published of April 2021 was delayed from April 2020 due to COVID. The gap analysis was to act and develop a plan. • Main changes were to functional risk categories. The level of cleanliness would increase from 4 to 6. • Changes to frequency and performance, cleanliness percentages and cleaning responsibilities. A commitment to introduction a star rating to be displayed outside of ward areas, an annual peer review and commitment to the Cleanliness Charter would adapted the current standards to the new standards. • Looking ahead the roles and responsibilities, a cleaning scheduled and a schedule of functional areas across the sites would be implicated by a multi discipline team. It was discussed at the health and estates management association that fed back. An analysis would be done and the case would be bought to the committee and the CIG panel for further discussion as resource may be needed to comply with the standards. The Director of Finance shared with the group that a further discussion would be required, as the requirements were not included within the baseline, and therefore it was questioned if the Trust should undertake this. This needs to be assessed. The Chair asked if there was an external cleaning contract and how it would that work? And who would be responsible? The Director of Estates and Facilities reported saying that it was a change in contract and to facilitate it and bring in the new standards it would leave financial gaps. This needs to be looked at ICS level. The Chair then asked who gives the star rating? The rating was done through internal audits and on an electronic device using MY CFC. One of the changes was that it also scores the nursing elements with servicing elements which may become problematic.	

	The Committee: - ***Noted the update on the NHS National Standards of Healthcare Cleanliness 2021.***	
TEG21/06/ E1	**<u>Emergency Department Staffing (Verbal)</u>**	
	The Divisional Director, Medicine raised 2 issues: 1. the Emergency Department (ED) remains very busy. They were staff challenges. 2. Current changes in medical contracts have made it difficult to staff the Emergency Department at weekends safely. This included limits on trainee grades to 1 in 3 weekends and limited on SAS of 1 in 4 weekends. It was noted that approximately 70% of work within the ED was out of hours which presented a significant challenge in staffing the department. This would be discussed at the Medical HR group.	
	The Committee: - ***Noted the update on Emergency Department Staffing.***	
TEG21/06/ E2	**<u>Medical Workforce Plans including International Recruitment Plan (Enclosed E2)</u>**	
	The Director People, Organisational Development outlined the work that had been undertaken to date, discussing the pressures relating to medical workforce plans for the hot specialties identified. These include the agreed action plans and the inclusion of the Trust wide international recruitment project. The intention moving forward was to monitor the delivery of specialty action plans and offer any support via the accountability meetings required. Initially the international recruitment paper was considered by the Executive Team in January 2020, just prior to the pandemic, to seek approval in principle to implement an international medical recruitment project to fill some of the Trusts long standing, hard to recruit to positions. Unfortunately, due to the onset of the global pandemic, commencement of the project was temporarily placed on hold The existing procurement framework had been identified which enables the Trust to engage a number of specialist recruitment agencies to go out to the international recruitment market and recruit suitable candidates on the Trusts behalf. The Executive Medical Director asked how the gaps in histopathology were currently beer covered, including how new histopathology would be supported. The gaps have been covered by out sourcing but still had cost and time implications. The Director of Education and Research discussed the preceptorship for international nurses which contained clinically support. The time taken for overseas consultants to be fully in post would mean extra pressures on current staff. More inductions would be needed working alongside the GMC. The Divisional Director, Clinical Specialities suitability of candidates for intensive care had seen challenges. The international recruitment was a way forward, but problems may still arise.	

	A discussion took place regarding the current histopathology arrangements, and the process that needs to be undertaken to make improvements. The Director of Finance advised that the costs needed to be worked through. The Director People, Organisational Development International recruitment was part of the medical work force plans and DD would be involved	
	The Committee: - ***Approved the Medical Workforce Plans including International Recruitment Plan.***	
TEG21/06/ E3	**<u>Leading to Outstanding (Enclosure E3)</u>**	
	The Director People, Organisational Development discussed with the group about leading to outstanding programme in relation too Clinical Directors, Matrons, Business Managers and Corporate Business Partners roles. It was a combination of the Quality improvements leading into outstanding work. Alongside was a survey to where the senior leaders were and where they were going next by division and coaching appraisals. It was discussed that this would be on an offsite venue focusing on achievement supportive developments. The Director of Education and Research asked how the programme was supported and how the evaluation would be successful moving forward. leadership behaviours and approach, we need going forward was different from the management skills once rewarded. A leadership culture that supports and cares for patients and our people, leads with civility and respect, grows staff engagement and inclusion, was results focused, driven to continuously improve and was aspirational and Investment in the development of leadership teams by creating a protected space where they consider themselves, the business needs would transform our organisational culture The Director of Finance asked who it was aimed at and this was stated to the group at the beginning of the discussion. The Divisional Director, Children and Families commented to the group that to run this programme, they would need external links to mediators and coaches so that the programme would run effectively. The Executive Medical Director Clinical directors explained that they aren't part of the group and how would this incorporate thrive programme. The Director People, Organisational Development explained that Professional heads were not to be included in the programme, that a survey would be coming out and this would set out the Quality service outcomes and performances and doing what was best for the patients. The Director of Strategy and Improvement believed that Quality improvement would be better off digital system and more around ICS, but not exclusive.	
	The Committee: - ***Noted the update for the Leading to Outstanding.***	

TEG21/06/ E4	**Car Parking (Enclosure E4)**	
	The Director of Estates and Facilities advised the group of the re-introduction of patient car parking charges. Free parking for non-permit holders impacts on patient's ability to park. NHS Free Parking manifesto commitment to provide free car parking for the following four specific groups: - Free parking to blue badge (We do) - Frequent outpatients who have to attend regular appointments to manage long term conditions, (don't do) - Parents of sick children staying in hospital overnight (We do) - Staff who work nights – (don't do) Staff that regularly work nights shifts. **Recommendation** Is that we agree the 33% discount for staff working regular nights shifts. The Divisional Director, Clinical Specialities asked what proportion of staff do work nights. The financial impact had been worked out but wasn't included on the paper but would agree to add and was it only permit holders that would be able to receive the discount. Night shifts worked equated to 73,561 shifts of which 12,532 delivering an overall percentage of night shifts worked by permit holders of 17%. None of the trusts were putting forward that it was done on an individual basis. An option of a tier system rather an individual basis, was discussed but not agreed. The Divisional Director, Children and Families asked if they were enough parking for all the staf in the first place and would current permits be offered the discount. There was a ratio of permits to car parking spaces, current permit holders only were to be given the discount. Frequent outpatients' attendees The options were to give Saba the contract £83,000 a year lease of the accommodation, but this could be negotiated further, or the other option was to use Trust cash office based in Doncaster, but this would cause problems over the other two sites this could be taken to the CIG group as to the costs implicated on this. **Recommendation** in order to provide the service required to ensure that the Trust were compliant with the NHS Free Parking Manifesto Commitment it was recommended that the Trust consider to approve a variation to contract to enable Saba to administer the process of approval of tariff re-imbursement on production of receipts from frequent outpatient attenders. Re introduction of patient car parking charges	

	Re introducing of cark parking charges for all patients from the 5th July for all patients across all the ICS. Free parking for staff would cease on the 21st June. **Recommendation** ICS have car parking charges re introduced in line with the final lockdown lifting. The Director People, Organisational Development asked if the 21st June lockdown rules change would this then have an impact to the trust on re- introducing car parking charges in line with the government. It isn't likely to impact on the staff car parking charges unless they were a surge in hospital admission with Covid patients. The Executive Medical Director responded regarding about frequently attendees this was defined as coming to an out-patients hospital for an appointment at least three times within a month and for an overall period of at least three months. A 'month' was defined as a period of 30 days and without widely impacting on other contracts already in place. It would be delivered and managed by Saba who would identify a suitable office location where they can base this function from at both Doncaster Royal Infirmary and Bassetlaw. Saba's experience shows that the availability of new concession categories would drive patient footfall to the location where they available and Saba's experience was that creating a one stop "Parking Shop" gives the best possible patient experience.	
	The Committee: - ***Approved for staff working regular night shifts with a 33% car parking discount.*** - ***Approved the variation to contract to enable Saba to administer the process of approval of tariff re-imbursement on production of receipts from frequent outpatient attenders.*** - ***Approved the* re-*introduction of car parking charges in line with other ICS providers.***	
TEG21/06/ F1	**<u>Finance Update (Verbal)</u>** This Item was deferred.	
	The Committee: - ***Noted the item was deferred.***	
TEG21/06/ G1	**<u>Items for Escalation to the Corporate Risk Register (Verbal)</u>** This item was deferred.	
	The Committee: - ***Noted the item was deferred.***	
TEG21/06/ G2	**<u>Internal Audit Annual Plan (Enclosure G2)</u>** This item was deferred.	
	The Committee: - ***Noted the item was deferred.***	
TEG21/06/ H1	**<u>Any other Business (Verbal)</u>**	

	This item was deferred.		
	The Committee: - ***Noted the item was deferred.***		
TEG21/05/ H2	**Sub-Committee Reports/Minutes (Enclosure H2)**		
	The Committee: - ***Noted the minutes of the CIG meetings – 22/02/2021 and 29/03/2021***		
TEG21/05/ H3	**Minutes of the Trust Executive Group meeting dated Monday 10th May 2021 (Enclosure H3)**		
	The Committee: - ***Approved the minutes of the meeting dates 10th May 2021.***		
TEG21/05/ H4	**Date and time of next meeting (Verbal)**		
	Date: Time: Venue:	**Monday 12th July 2021** **15:00 – 17:00** **Via Microsoft Teams**	
	The meeting closed at 16:45.		

FINAL

Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

PEOPLE COMMITTEE

Minutes of the meeting of the People Committee
Held on Tuesday 4th May 2021 at 09:00am via Microsoft Teams

Present:	Sheena McDonnell, Non-Executive Director (Chair) Mark Bailey, Non-Executive Director (Left after item PC21/03/C1iii) Pat Drake, Non-Executive Director Kath Smart, Non-Executive Director Karen Barnard, Director of People and Organisational Development (Left after item PC21/03/H2) Anthony Jones, Deputy Director of People and Organisational Development Jayne Collingwood, Head of Leadership and Organisational Development Dr Tim Noble, Executive Medical Director (Left after item PC21/03/C1iii) David Purdue, Deputy Chief Executive & Chief Nurse (PC21/03/C1i - PC21/03/H2) Dr Sam Debbage, Deputy Director of Education and Research	
In attendance:	Fiona Dunn, Deputy Director Corporate Governance/Company Secretary Kirby Hussain, Equality, Diversity and Inclusion Lead Rebecca Joyce, Deputy Chief Operating Officer (Item PC21/03/C1ii) Katie Shepherd, Corporate Governance Officer Kelly Turkhud, Vocational Education Manager	
To Observe:	Mark Bright, Public Governor – Doncaster Kay Brown, Staff Governor	
Apologies:	Sue Shaw, Partner Governor Alasdair Strachan, Director of Education and Research	
		ACTION
PC21/03/A1	**Welcome, apologies for absence and declarations of interest (Verbal)**	
	The Chair welcomed the members and attendees. There were no apologies for absence. No conflicts of interest were declared.	
PC21/03/A2	**Requests for Any Other Business (Verbal)**	
	There were no requests for any other business.	
PC21/03/A3	**Actions from previous meeting (Enclosure A3)** Action 2 – Workforce Assurance Report – A discussion took place regarding the data set that would be included as part of the workforce assurance report. It was agreed that if, following the item on the agenda today, it didn't include the required data set, Pat Drake was to liaise with the Director of People and Organisational Development to advise further. It was agreed that this action would be reviewed at the next meeting. The target date was amended.	

	Action 3 – On call accommodation rooms – Following a discussion regarding feedback gathered from overseas students on their experiences of accommodation, and landlord responsibilities it was agreed that KEJ would provide a paper to the next meeting to outline progress to date. Action 7 – Equality, Diversity and Inclusion (EDI) – The EDI Lead Kirby Hussain would be a regular attendee at the Patient Experience Accessible Information Group. Action closed. Action 11 – Use of Personal Devices – Pat Drake noted that whilst the policy wasn't due for renewal until September, work would need to commence earlier than September to ensure that the policy was ready in time for September 2021. This would be added to the work plan for presentation and discussion at the September 2021 meeting. Action closed. Action 12 – Workforce Planning Risks – This would be discussed as part of the Workforce Assurance Report. Action closed. Action 15 – Paediatric and Neonatal Resuscitation – To be discussed as part of item C2. Action closed. Action 21 – Charitable Funds – Wellbeing Offer – This would be discussed as part of the Health and Wellbeing update. Action closed. Action 27 – Board Workshop – Freedom to Speak Up – This had been added to the Board of Directors meeting log. Action closed. Action 32 – COVID-19 Positive Staff by Ethnicity – Kath Smart asked if percentages could be added to the numbers so that conclusions could be drawn. The Director of People and Organisational Development advised that this had been done as a one-off exercise. Action closed.	
	The Committee: - ***Noted the updates and agreed, as above, which actions would be closed.***	
	Action: Katie Shepherd would update the Action Log.	**KAS**
PC21/03/ C1i	**Workforce Assurance Report (Enclosure C1i)**	
	The Director of People and Organisational Development provided the highlights of the report. The report detailed a higher vacancy level that previous seen with a corresponding increase in bank and agency spend resulting in overall staffing levels being over funded establishment levels. This data would back up the increases in recruitment activity during quarters 3 and 4 of 2020/21. Within the report there was concern raised over the gaps in data held on Trac; however, where that full data does exist it indicated that from the point of advertising to unconditional offer was within the target KPIs. Recruitment activity was high, with 702 vacancies within the previous six-month period. The Trust was expecting Indian nurses to commence in July as part of the national international recruitment campaign, however due the COVID-19 pandemic in India, this would need to be further discussed with the Executive Team. The staff turnover rate was outlined by staff group, and it was advised that there were approximately 1,700 employees of staff that would reach retirement age within five-years times. The age of the workforce was proportionate in all staff groups.	

	Work was being undertaken to validate the sickness absence data, following a request from NSHE/I for the data which demonstrated that the Trust had a higher absence rate than neighbouring Trusts. A business case would be submitted to the Capital Investment Group to maintain the sickness absence line which commenced during the COVID-19 pandemic to make the process more robust. Work was underway to link the health and wellbeing agenda to sickness absence to identify ways that the colleagues could get the right treatment to return to work as soon as possible. The annual leave carry-over position was outlined which demonstrated that the average days carried over for medical colleagues was 10.92-days, with an average of 3.2-days carried over for agenda for change colleagues. Approximately 140 members of staff had sold their annual leave back to the Trust. Mark Bailey noted the high number of vacancies within the Trust at any one time, and the high number of colleagues reaching retirement age within the year and asked for further clarification on how the position could be evaluated further. The Deputy Director of People and Organisational Development advised that reports rely on the quality of information in Trac, and advised that from the 702 vacancies, only 92 vacancies had a complete data set that allowed for the detailed analysis presented to the Committee. The Trust continued to work with partners within the ICS on speciality recruitment. The Trust offered flexibility to those that reach retirement age. The Director of People and Organisational Development advised that the Trust worked collaboratively with NHS Professionals and the ICS, and that the recruitment of international nurses was to fill vacancies presently, whereas longer-term work would be undertaken to ensure that the workforce in the future was sustainable. In response to a question from Mark Bailey regarding the expected number of vacancies the Trust would have within the next one-year, it was advised that it was unknown currently and further work would need to be undertaken, but the Deputy Director of People and Organisational Development advised that international nurses had rejected job offers at Doncaster due to the crime rate in the area, and therefore the Trust would engage in discussions with local authority to work collectively on the workforce perspective. *David Purdue arrived at the meeting.* Pat Drake noted that the vacancy figures presented in the report did not demonstrate the risk to the organisation and asked for further information on what the short-term and long-term solutions were. Pat Drake advised that the Finance and Performance Committee had been assured that the vacancy control process was quick and asked if an audit could be undertaken on how long the process took in total so this could be confirmed. It was agreed that a random audit would be undertaken to identify how long the entire vacancy process took in different areas. Following a discussion, it was agreed that the reasons for long term absence would be added to the Workforce Assurance Report. In response to a question by Pat Drake regarding the workforce plan for the areas which had a high level of colleagues reaching retirement age, it was advised that turnover of staff was part of the workforce plan, and further detail would be provided at the next meeting. In relation to the retention strategy, further work was required to improve this, which included an improvement in manager capability to encourage developmental conversations. This was already undertaken through the appraisal route. The Deputy Director of People and Organisational Development would link with the work associated with developing DBTH as an	

	anchor institution. Succession planning would take place to identify potential gaps in the workforce for the future which would include a consideration of the specialist roles. Following a question from Pat Drake regarding the support to colleagues with long-COVID-19, it was agreed that the number of colleagues on long-term sickness absence would be reviewed at the People Committee with a consideration of those with COVID-19 related absence. *Rebecca Joyce arrived at the meeting.* Following a request from Kath Smart regarding the conclusion of each item within the workforce assurance report, it was agreed that future reports would include a concluding statement for each section of the Workforce Assurance Report. Kath Smart noted that the vacancy report did not demonstrate the delays in the recruitment process as discussed previously, and therefore the action to undertake the random audit to identify how long the entire vacancy process would be helpful. Following a question from Kath Smart regarding how the Trust benchmarked against other Trusts, it was advised that management activity in relation to sickness absence management had slowed during the COVID-19 pandemic, however, action would be taken to improve this. A business case would be submitted for a HR case work database that would allow the HR team to remain in contact with individuals absent from work to follow the correct process once they return to work. There would be more proactive sign posting to services available to staff to support them to return to work sooner. Following a request from Kath Smart regarding the Trusts position on the shielding staff that had returned to work, it was advised that the Trust had support colleagues who had shielding during the COVID-19, through the risk assessment process and personal circumstances form. Where individuals had indicated that they were unable to work within their substantial post, redeployment options had been explored. The Committee was informed that there was an expectation that social distancing guidelines would change in June 2021, however that hospitals would be one of the last public areas to undergo changes. Sheena McDonnell advised that the agreed timescale for the recruitment process should be communicated more widely. In response to a question from Sheena McDonnell regarding the selling of annual leave and whether this was a reasonable approach, it was advised by the Executive Medical Director that the process for medics was different as their leave year runs from the date they were appointed, with a standard five-days allowed to be carried over. A number discussions had taken place regarding the reasonable maximum period of annual leave that medics could take to ensure that the Trust had a sustainable service during that time. The Director of People and Organisational Development advised that this had been allowed due to the COVID-19 pandemic but assured the Committee that the frequency of annual leave taken was monitored via the e-roster system. Colleagues had been advised to take their annual leave equitably over the two-year carry-over period.	

	In response a query from Sheena McDonnell regarding the number of colleagues that had received their second COVID-19 vaccination, it was advised that the campaign had concluded the previous week, however it had been difficult to gather the data due to the number of methods that colleagues could receive their vaccine. A	
	Action: It was agreed that a random audit would be undertaken to identify how long the entire vacancy process took in different areas.	**AJ**
	Action: The reasons for long term absence would be added to the Workforce Assurance Report.	**KB**
	Action: The Deputy Director of People and Organisational Development would link with the work associated with developing DBTH as an anchor institution.	**AJ**
	Action: A concluding statement would be added to each section of the Workforce Assurance Report.	**KB**
PC21/03/ C1ii	**Patient Administration Consultation (Enclosure C1ii)**	
	The Chief Operating Officer presented the patient administration workforce proposal for development and sustained performance. It was noted that this was not a consultation paper. The report outlined the current status of patient pathway management and validation activity and the shortfall in patient administration workforce capacity and the proposed initiatives for developing and sustaining the skill, capability and responsibility of the divisions to effectively and efficiently undertake patient administration activity for which they were accountable to deliver and sustain. There were eight proposed interventions: - Establish a formal competency assessment process for all patient administration staff to determine role-based training /refresh requirements in relation to standard IT operations, RTT, HR, CAMIS and other systems. - Establish formal training programme for all patient administration staff (c.450 staff). - Creation of a new expert role dedicated to pathway management and validation - Creation of a Patient Access Manager role dedicated to administrative governance. - A review of the lines of responsibility between the central structure and devolved structures. - Undertake a structured recruitment process and career development programme. - Review volume of paper records and the filing system. - Establish a single patient tracking list. This had been discussed at the Management Board meeting on 12th April 2021 who had agreed to the recruitment of three validators and a Patient Access Manager role. This infrastructure would allow for the proposal to move forward in a positive way. Kath Smart was supportive of the approach, however, was concerned with the use of the wording 'competency' as part of the competency assessment that would be required for the admin training programme, as this did not demonstrate engagement with colleagues. The Chief Operating Officer advised that the Communications and Engagement Team would assist in the promotion and appropriate communication with colleagues affected to ensure that it was positively received. Engagement with the administrative staff would be vital to the achievement of the process. It was also suggested that 'confirm and challenge' be amended to 'confirm and enquire'.	

	In response to a question from Pat Drake regarding the expectation that the administrative vacancies would be filled, it was advised that there would be a focused effort on the recruitment process as there was a high turnover of staff and therefore career progression opportunities and a robust training and development package had been built into the internal plan.	
PC21/03/ C1iii	**<u>Consultant Staff Shortages (Verbal)</u>**	
	The Medical Director presented to the Committee an update on the planned approach to the reduction of Consultant grade vacancies. The prediction of retirement was difficult amongst medical staff as there was no defined retirement age, and although a period of six-month notice was required, there remained a three-month gap in the process as the recruitment to these posts was a lengthy process. Meetings had commenced to identify where the gaps in the medical workforce were, and to stratify the gaps to identify how long posts had been vacant, how many attempts to fill the post had been undertaken and the prospects of service failure. Although the Trust had vacancies, it was reported that services were stable. Current vacancies included two posts in Diabetes and Endocrine, two in the Emergency Department, one post in Respirator, two posts in Dermatology, three posts in Care of the Elderly, and further posts within Haematology. The future model of the Medical Director office function would be to offer support to Divisions with recruitment strategies. The Director of People and Organisational Development advised that recruitment strategies would be differ depending on the speciality department that required support, and it would therefore need to be tailored to their needs. Pat Drake added that it was important to ensure that the Consultant posts had the right support structure. The Chief Operating Officer advised that support to the Clinical Specialities Division had commenced. The Head of Leadership and Organisational Development advised that work had been undertaken to draft a comprehensive induction and leadership programme for Consultants. *Mark Bailey and Tim Noble left the meeting.*	
PC21/03/ C1iv	**<u>Widening Participation including Education Commissioning and Learning Needs Analysis (Enclosure C1iv)</u>**	
	The annual summary of all widening participation activity undertaken within the Trust for 2020/21 was presented by the Vocational Education Manager, who advised that widening participation, and in particular apprenticeships, continued to be a priority within the workforce plans to enable widening access, and to maximise the use of the levy funds, ultimately supporting socio economic recovery whilst enabling workforce growth by attracting talent from the surrounding communities. Despite the pandemic, the Trust had endeavoured to adhere to its commitment to recruiting entry level jobs as apprenticeships, with only a slight decline seen during 2020/21. Due to the COVID-19 pandemic, there had been a delay in completions, posing a risk to overspend and recruitment. Work was ongoing with providers to accelerate the completions. An exercise was underway with the Finance Team to forward plan the next five-years, as it was expected that there would be a significant overspend. This would include a review of the workforce requirements to optimise the use of the apprenticeship levy. There had been a significant	

	increase in requests for degree apprenticeships and less entry level apprenticeships. The IT Team had developed a workforce plan for entry level and beyond. A doctor apprenticeship was in the development stages which would provide more opportunities for the workforce. In response to a question from Pat Drake, regarding the uptake for English and Maths qualifications, it was advised that through the appraisal process, there had been a significant number of colleagues identified to undertake these qualifications. Following a question from Pat Drake regarding T Level qualifications and whether the Trust would support these, it was advised that local providers had commissioned to deliver those, however a further understanding of the industry requirements was needed. The masters certification had been removed from the level 7 qualification, meaning that colleagues undertaking level 7 qualification would receive an academic qualification, however the option would be there for colleagues to self-fund, or departments to fund to top up the qualification to a masters qualification. All entry level apprenticeships had been shared with secondary schools in Doncaster. Following a question from the Chair, it was advised that there was a fund available for request if organisations did overspend their levy, however level 6 qualifications and above were not eligible for the levy transfer. Following a question from the Chair regarding the risks associated with the review of the national living wage, it was advised that work was underway to align the pay sale to the legal requirements. There was a target of 70% for the number of apprentices that would lead to employment. It was reported that the Trust achieved 84%, a reduction from 87%.	
	The Committee: - ***Noted and took assurance from the workforce assurance report.*** - ***Noted and took assurance from the patient administration consultation paper.*** - ***Noted and took assurance from the update on consultant staff shortages.*** - ***Noted and took assurance from the update on widening participation.***	
PC21/03/ C2	**<u>Education Assurance Report (Enclosure C2)</u>**	
	April 2020 saw the introduction of centrally allocation continuing professional development (CPD) funding for nursing associates, registered nurses, midwives, and allied health professionals in the NHS, to invest in ongoing development training. For the Trust, this equated to £734k per-year based on 2,202 registrants. Statutory and Essential Training was reported as 84.65% as of 31st March 2021. A risk assessment process was implemented during the COVID-19 pandemic to ensure that staff who formed part of the emergency response teams were given access to training places for resuscitation training. Following a question from Pat Drake, the Deputy Director of Education and Research confirmed that the Trust was appropriately covered for Advanced Neonatal Resuscitation Training.	

	Kath Smart, noted that some areas had low training compliance levels, and asked for further information on how this would be improved. The Deputy Director of Education and Research advised that compliance had slipped during the COVID-19 pandemic as there had been that challenge, however the training reports were disseminated to managers to take action.	
	The Committee: - ***Noted and took assurance from the education assurance report.***	
PC21/03/ C3	**<u>Health and Wellbeing Report (Enclosure C3)</u>**	
	There had been an increase in management referrals to Vivup, which validated that managers were signposting colleagues into the health and wellbeing offer. There had been an average of 18 new clients per month, with healthcare workers the biggest user group. It was reported that the majority of colleagues reported a positive score following the receipt of therapy. The Trust was exploring the use of charitable funds for an enhanced health and wellbeing offer for colleagues, and the use of a 'pod' would be explored at each site to provide a wider offer of health and wellbeing interventions for staff. The Trust had engaged with the charity, Climbing Out, who were keen to support the NHS to help staff deal with, and process life changing injury, illness, or trauma. The Deputy Director of Education and Research advised that the Trust continued to work with colleges to ensure that learners had access to psychological services. Kath Smart noted the good report and that the data presented demonstrates that the Trust was able to reach employees, however noted that the number of males accessing service was significantly lower than females, and suggested that work was required to encourage males to access the services available. The Head of Leadership and Development advised that the Trust had worked with Andy's Man Club, a network created to support men and encourage them to reach out for support if required. In response to a query from Kath Smart regarding the dedicated rest/break areas available to colleagues and the proposed pods for an increased health and wellbeing offer, it was advised that the pods would be used for complimentary therapies whereas the dedicated rest/breakout areas were specifically for breaks. Kath Smart advised that the Job Planning internal audit received partial assurance, and it was therefore agreed that this would be received at the next People Committee.	
	<u>Action</u>*: *The internal audit report on job planning would be presented to the next People Committee meeting.	**FD**
	The Committee: - ***Noted and took assurance from the health and wellbeing report.***	
PC21/03/ E1	**<u>Leadership Development Offer (Enclosure E1)</u>**	

	The Leadership Development Offer had been reviewed and updated, which would follow the usual 'Develop, Belong, Thrive, Here' with an additional strand of 'Everyone Counts – Civility and Respect' which would be an offer available to all colleagues, designed to embed the Trust's values into daily work. There would be a coaching offer to leaders to build to skills required to be an effective coach. Work was ongoing with the Chief Operating Officer and Executive Medical Director to create a Leading to Outstanding programme for Consultants. Pat Drake noted the great opportunities that the offer would create, and asked for assurance on how this would link in with personal professional development. It was advised that the Leadership Team discuss with managers the aspects of the Leadership Development Offer and noted that the appraisal process was a key part of the development process. There was a challenge with the number of non-attendance at training sessions, however as the programme would be delivered virtually, it was anticipated that this would improve. The Director of People and Organisational Development added that there would be a matrix outlining what leadership training was required for specific roles to make it clearer what the expectations were. The education team and quality improvement team had contributed toward the development of the programme.	
	The Committee: - ***Noted the update on the leadership development offer.***	
PC21/03/ E2	**<u>Progress on the delivery of the People Plan Priorities (Enclosure E2)</u>**	
	There would be the introduction of a quarterly staff survey, expanded from the Staff Friends and Family Test to form the nine questions as part of the staff engagement score within the annual staff survey. It was noted that colleagues were asked two open-ended questions as part of the annual staff survey relating to their experience of working through the COVID-19 pandemic, and the lessons learned and what they believed to have worked well and what changes should be continued. There were over 1,600 comments received for each question and it was noted that what some colleagues identified as a negative, others identified as a positive experience. Feedback indicated that colleagues felt there was some inconsistency in the messages conveyed regarding changes, there was a lack of visibility of leaders, however it was noted that leaders were working, only from home. In response to a question from Pat Drake regarding the feedback provided as part of the staff survey, it was agreed that a 'you said, we did' would be published in Buzz to inform staff that the Trust had listened to the free-text comments part of the staff survey. Following a question from Kath Smart, it was agreed that a paper would be presented on learning from agile working over the previous one year. It was noted that this would include how virtual working would be managed from a wellbeing perspective. The Chair noted the 5% improvement in WRES and WDES feedback in the 2021/22 results, however asked if the performance assurance framework had been developed. It was advised that it had been developed, however had since been refreshed. The performance assurance framework would be used as part of the accountability meetings. The Performance Assurance Framework would be circulated to Committee members.	

	Action: It was agreed that a 'you said, we did' would be published in Buzz to inform staff that the Trust had listened to the free-text comments part of the staff survey.	**KB**
	Action: A paper would be presented on learning from agile working over the previous one year.	**KB**
	Action: The Performance Assurance Framework would be circulated to Committee members.	**KB**
	The Committee: - ***Noted the progress on the delivery of the people plan priorities.***	
PC21/03/ F1	**Emergency Department Organisational Development Update (Enclosure F1)**	
	A part of the Emergency Department Organisational Development workstream, six pillars had been formed and launched in the area. The work had progress well to date, and there have been lots of engagement work taking place and positive feedback received. The Highfive App had been launched, which was a peer-to-peer recognition tool to acknowledge and thank individuals for their contribution and hard work. In response to a question from Kath Smart regarding how the milestones in the action plan would be assessed and monitored, it was advised that the Head of Leadership and Development would review how this could be undertaken so that the Committee could receive assurance. Following a question from Pat Drake in relation to the wider opportunity for colleagues to continue to raise issues, it was advised that team huddles took place in the Emergency Department twice a week, and there were a number of ways that feedback could be provided, including the offer of a confidential one-to-one meeting.	
	The Committee: - ***Noted the update provided on the Emergency Department Organisational Development programme.***	
PC21/03/ G1	**Board Assurance Framework – True North SA 2 & 3 (Enclosure G1)**	
	The Committee reviewed the Board Assurance Framework aligned to the True North Objectives 2 and 3, which had been updated to reflect the new breakthrough objectives and the feedback provided as part of the staff survey.	
	The Committee: - ***Reviewed and took assurance from the Board Assurance Framework.***	
PC21/03/ G2	**Corporate Risk Register (Enclosure G2)**	
	The Company Secretary outlined that there had been no additional risks to the corporate risk register. An action plan had been formed for Risk ID 2664 relating to staffing challenges within the Department of Critical Care. It was agreed that once a full review had been undertaken	

	of 15+ rated workforce related risks, a report on those that remain rated 15+ would be reported back to the People Committee. Following a question from Kath Smart, it was agreed that the risk associated within the incident that took place on the Women and Children's Hospital on 27th April 2021 would be added to the Corporate Risk Register. The Chief Nurse advised that progress against the fire works in the Women and Children's Hospital would be affected by the incident.	
	Action: Once a full review had been undertaken of 15+ rated workforce related risks, a report on those that remain rated 15+ would be reported back to the People Committee.	**FD**
	Action: It was agreed that the risk associated within the incident that took place on the Women and Children's Hospital on 27th April 2021 would be added to the Corporate Risk Register.	**FD**
	The Committee: - ***Considered and noted the corporate risk register.***	
PC21/03/ H1	**RACE Equality Code Action Plan (Enclosure H1)**	
	The outcome of the assessment of the Trust against the RACE Equality Code was outlined which confirmed that the Trust completed all the required stages of the assessment and demonstrate a good level of compliance. Completion of stage 2 and 3 of the assessment process provided confidence that based on the discussions that took place, and the evidence provided at stage 1, the Trust was applying the principles of the RACE Equality Code. The Race Equality Code assessment highlighted seventy-one actions. The Equality, Diversity and Inclusion Forum would ensure that work continued at pace, and this would be monitored at the People Committee. *Karen Barnard left the meeting.*	
	The Committee: - ***Noted and took assurance from the RACE Equality Code Action Plan.***	
PC21/03/ H2	**Equality, Diversity and Inclusion Update (Enclosure H1)**	
	The report was taken as read. Pat Drake noted the good progress and was supportive of the work being undertaken. In response to a question by Pat Drake regarding the knowledge of staff in how to support patients in Ramadan, it was advised that work had been undertaken regarding patient experience. *David Purdue left the meeting.*	
	The Committee: - ***Noted and took assurance from the equality, diversity and inclusion update.***	
PC21/03/ I1i	**Governor Observations (Enclosure I1)**	

	Kay Brown advised that in relation to the discussions undertaken regarding the length of the recruitment process, it was the time in-between a member of staff leaving a post, to a new person commencing that takes a long time. Kay Brown advised that she was supportive of development training programme for administration. Kay Brown advised that she had trained as a coach as part of the coaching offer for colleagues, however, had only ever had one person referred to her. Mark Bright observed that it would be helpful to group different apprenticeships within the report by level and the length of the programme. It was advised that this information was embedded within the appendices. Mark Bright observed that there were apprenticeships available for new recruits, existing staff, and senior colleagues. The Chair advised that apprenticeships were approved to maximise the use of the funding. Apprenticeships were promoted as part of the appraisal process. In response to a question from Mark Bright regarding the relative balance of positive or negative free-text comments as part of the staff survey, it was agreed that an update would be provided at the next meeting to advice on the balance of positive and negative comments from the free text comments received as part of the staff survey.	
	Action: An update would be provided at the next meeting to advice on the balance of positive and negative comments from the free text comments received as part of the staff survey.	**KB**
	The Committee: - ***Thanked the Governors for their observations and agreed with the above actions.***	
PC21/03/ I1ii	**Minutes of the Sub-Committee Meeting**	
	The Committee noted: - ***Equality Diversity and Inclusion Forum Minutes dated 12/10/2020,*** - ***Health and Wellbeing Committee Minutes dated 08/02/2021.***	
PC21/03/ J	**Any Other Business (Verbal)**	
	Physical Health of Colleagues Pat Drake requested that an update be provided on the provisions in place to support the physical health of colleagues. An update would be provided at the next meeting.	
	Action: An update would be provided on the provisions in place to support colleague's physical health.	**JC**
	The Committee noted: - ***Approved the Knowledge, Library & Information Service Strategy 2018-2022.***	

PC21/03/ J1	**Minutes of the Meeting held on 2nd March 2021 (Enclosure J1)**		
	The Committee: - ***Approved the minutes of the meeting held on 2nd March 2021.***		
PC21/03/ J2	**Committee Work Plan (Enclosure J2)**		
	The Committee: - ***Noted the work plan.***		
PC21/03/ J3	**Items of escalation to the Board of Directors (Verbal)**		
	There were no items of escalation. The Chair thanked all that had prepared reports and participated in the meeting.		
PC21/03/ J4	**Date and time of next meeting (Verbal)**		
	Date: **Time:** **Venue:**	6th July 2021 09:00am Videoconferencing	

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Minutes of the meeting of the Public Session of the Council of Governors
Held on Thursday 29th April 2021 at 15:00
Via Microsoft Teams

Present:			
Chair	Suzy Brain England OBE, Chair		
Public Governors	Peter Abell	Linda Espey	Steve Marsh
	Mike Addenbrooke	David Goodhead	Susan McCreadie
	Dennis Atkin	Jackie Hammerton	David Northwood
	Phil Beavers	Maria Jackson-James	Pauline Riley
	Hazel Brand	Lynne Logan	Lynne Schuller
	Mark Bright	Ainsley MacDonnell	Mary Spencer
Staff Governors	Kay Brown	Vivek Pannikar	Mandy Tyrrell
	Duncan Carratt		
Partner Governors	Wendy Baird	Joanne Posnett	Sue Shaw
	Phil Holmes		
In attendance	Richard Parker OBE – Chief Executive		
	Dr Tim Noble – Medical Director		
	Pat Drake, Non-Executive Director and Senior Independent Director		
	Emma Shaheen – Head of Communications and Engagement		
	Kath Smart – Non-Executive Director		
	Neil Rhodes – Deputy Chair/Non-Executive Director		
	Mark Bailey – Non-Executive Director		
	Fiona Dunn – Deputy Director Corporate Governance/Company Secretary		
	Adam Tingle – Senior Communications and Engagement Manager		
	Katie Shepherd – Corporate Governance Officer (Minutes)		

Apologies:			
Governor Apologies	Ann-Louise Bayley	Alexis Johnson	Bev Marshall
	Anthony Fitzgerald	Geoffrey Johnson	Sally Munro
	Sophie Gilhooly	Victoria McGregor-Riley	Clive Tattley
	Tina Harrison		
Board Member Apologies	Karen Barnard - Director of People and Organisational Development		
	Rebecca Joyce – Chief Operating Officer		
	Sheena McDonnell – Non-Executive Director		
	David Purdue – Deputy Chief Executive and Chief Nurse		
	Marie Purdue – Director of Strategy and Transformation		
	Jon Sargeant – Director of Finance		
	Alasdair Strachan – Director of Education and Research		
	Kirsty Edmondson Jones – Director of Estates and Facilities		
	Ken Anderson – Acting Chief Information Officer		
	Katie Shepherd – Corporate Governance Officer (Minutes)		

ACTION

PC21/04/A1 **Welcome and Apologies for Absence (Verbal)**

The Chair welcomed the Council of Governors and those in attendance to the meeting. The apologies for absence were noted.

PC21/04/A2 **Declaration of Governors' Interests (Enclosure A2)**

The following amendments were made:

Susan McCreadie was no longer the community representative of the Fred and Ann Green Legacy Advisory Group. Susan McCreadie was now a member of St Leonard's PCC.

The Council:

- ***Noted and confirmed the Declaration of Governors' Interests.***

PC21/04/A3 **Actions from previous meetings (Enclosure A3)**

There were no outstanding actions from the meeting held on 28th January 2021.

PC21/04/C **Reports of Activity, Performance and Assurance (Presentation)**

PC21/04/C1.1 **Richard Parker – Chief Executives Report (Presentation)**

Women and Children's Hospital Water Leak Incident – 27th April 2021

The Chief Executive provided an update on the major water leak that took place within the Women and Children's Hospital on 27th April 2021. At approximately 17:20 nurses had noticed a water leak within the Neonatal Unit which soon became significant. An immediate decision was made to move the babies from the area via horizontal evacuation. The Estates and Facilities team were immediately contacted, and site manager moved to the area to offer assistance. Shortly after a loud bang was heard which triggered the fire alarms, and it was later identified that the water had leaked into a high voltage electricity box on the east side of the building on level 3. At approximately 17:30 the Incident Commander arrived. There were no evident flames, however the doors in front of the electricity box had been blown off and there appeared to be smoke. Cracking could be heard on three floors. An immediate decision was made to evacuate the whole of the Women and Children's Hospital. This required the movement of 67 patients, including 7 babies in incubators, women in the labour ward, antenatal and post-natal ward, the children's ward, and the remainder of patients within outpatients. The full evacuation was completed by 19:10. A full assessment was undertaken of both the east and west wing to determine the causes, and it was confirmed that the west side of the building was unaffected by water and had its own electricity supply, and therefore power was restored to the west side which allowed the use of some services for those that had been displaced. Patients were moved to the main block at Doncaster and Bassetlaw which was facilitated by Yorkshire Ambulance Service. A full divert was put in place whilst the Trust ensured that patients were moved to the most appropriate areas for overnight care.

A debrief took place the following morning where it was understood that there was significant damage to the electricity supply, caused by a leak from the ventilation system on the roof of the hospital. The water pipe had been covered in lagging which made the pipe non-visible. Upon removal of the lagging it was identified that the water pipe had rusted, causing the leak.

Due to the incident, the Trust had lost the use of the east side of the block and some central services including three operating theatres. Remedial work would commence to restore power to the west wing, and the lower part of the east wing so that antenatal clinics could recommence.

It was expected that the west side of the building would be available for use from 30th April 2021, and a review would be undertaken on 1st May 2021 to identify if the divert of patients could be removed.

The Chief Executive advised that colleagues involved had reacted remarkably and reported that no colleagues or patients were injured during the incident and subsequent evacuation.

Operational Update

The number of inpatient COVID-19 patients had continued to fall, remaining stable at approximately ten. In SY and Humber, COVID-19 cases remain high, one of the highest areas for COVID-19 in the country. Few patients require inpatient care, which was positive. No patients currently receiving intensive care as a result of COVID-19. The total number of patients that had been cared for by the Trust totalled 3,280, 815 of which sadly passed away. It was expected that if there was a third wave, that hospitalisations would not be as high as previously seen due to the positive impact of the COVID-19 vaccination programme. The Trust had planned for the recovery of elective activity, whilst planning for the next winter period where it was expected that COVID-19 would be in circulation. There would be a requirement for three pathways, COVID-19, non-COVID-19 and influenza. It was outlined that the Trust aimed to have no patients waiting over 52-weeks by 31st March 2022.

The Chair and the Chief Executive attended the Doncaster Chamber Annual Award Event, in which for the first time four awards were dedicated to the NHS for all that had been achieved over the previous year. It was noted that the Trust had won the Outstanding Contribution Award, Dr Ken Agwuh, Director of Infection and Prevention and Control had won the Compassionate Care Award and Adam Tingle, Senior Communications and Engagement Manager had won the Unsung Hero Award.

The sad passing of colleague Elaine Doughty was marked. Elaine had been a healthcare assistant for a number of years, who had retired and returned to the Trust as a volunteer. A clap for Elaine would be organised and a memory book was available for colleagues to sign, which would be presented to her Husband, Richard and sons.

PC21/04/ C1.2 **Suzy Brain England – Chairs Report (Presentation)**

The Chair wished to thank team DBTH for their unwavering dedication throughout the beginning of 2021 and into spring. Whilst much of the Chair's work had remained remote and through digital channels, one-to-ones and discussions had taken place with the Executive Team, Clinical Leaders, Lead and Deputy Governors, Non-Executive Directors, along with senior additional posts in the Trust.
The Chair advised that she had undertaken an observation of each of the Board committee and organisational meetings.
The Chair had assisted in the diagnostic for the RACE Equality Code and the adoption of the scheme within the Trust.
Plans for the Annual Members Lecture to take place in June 2021 were underway, in which a week-long event would take place.
Workshops had been undertaken to prepare for a new Clinical and Trust Strategy.
A Board-to-Board session had taken place with Sheffield Children's Hospital.
The Chair continued to observe and engage with various NHS Providers, the ICS and other regional meetings and briefings.

PC21/04/ C1.3 **Hazel Brand – Lead Governor Update (Presentation)**

Hazel Brand, Lead Governor provided an update on behalf of the Council of Governors that highlighted the key points formed by Governors. Congratulations was given to Peter Abell, Public Governor on his re-election to the NHS Providers' Governor Advisory Committee. The Council of Governors had contributed to the Chief Executive Officers' annual appraisal and would follow with the Chair and Non-Executive Director appraisals. The Council of Governors had received a number of excellent training and briefing sessions since the last meeting. It was advised that the Governors would soon be in receipt of new guidance relating to the Quality Accounts and the role of the Governors in that. The Lead Governor would meet with the Deputy Director Corporate Governance Company Secretary and Director of Nursing (Patient Engagement) to discuss open surgeries.

Although Clive Tattley was not in attendance at the meeting his wished to pass on his comments:

'I am proud of DBTH's very professional response to the recent water inundation.'

PC21/04/ C1.4 **Neil Rhodes – Finance and Performance (Presentation)**

Neil Rhodes provided an update on the most recent Finance and Performance Committee meeting that took place on 15th April 2021. Neil Rhodes commended the exceptional leadership that had taken place during the COVID-19 pandemic. Despite the challenges and spend that the COVID-19 pandemic had presented; the Trust reported a year-end surplus of c.£4m. The Trust commenced the new year (2021/22) with a cash balance of c.£51m. The Trust had made excellent use of capital and had one of the best uses of capital within the ICS. The financial regime for 2021/22 would see the Trust allocated money in two halves (H1 for Month 1-6 and H2 for Month 7-12), which meant that there was uncertainty on the financial regime for H2. There had been the development of financial skills in senior clinicians. The Finance and Performance Committee had pursued business with a close eye on the development of ICS and Place based thinking.

Neil Rhodes noted that the year ahead would be challenging, however advised that the Trust was well placed to achieve this with the key staff in place to do so.

PC21/04/ C1.5 **Pat Drake – Quality and Effectiveness (Presentation)**

Pat Drake provided an update on the most recent Quality and Effectiveness Committee meeting that took place on 6th April 2021 included:

- The Ockenden Report and action plan had been received at the Quality and Effectiveness Committee, who had continued to monitor progress. The Perinatal Mortality Dashboard had been presented to the Quality and Effectiveness Committee and Board. Pat Drake met with the Maternity Voices Partnership in Bassetlaw on a monthly basis, however noted that one had not been set up for Doncaster yet. Feedback had been provided through Facebook and would be presented at the Quality and Effectiveness meeting.

- The Council of Governors had received a presentation from the End of Life Care Team and noted the fantastic work of the team for their support for families and carers throughout the COVID-19 pandemic.

- The Quality Strategy and Framework had been received at Board and Quality and Effectiveness Committee in April 2021, and regular updates would be provided on progress. A Clinical Governance review was underway, and the terms of reference were being reviewed.

- 95% of long-waiting patients had been risk stratified, and a letter had been sent to all long-waiting patients to identify if they wished to remain on the waiting list or be removed. Only small numbers had responded to be removed from the waiting list. There had been changes to operational guidance regarding priority 2 patients, however this would be discussed at the Quality and Effectiveness Committee.

- The Quality and Effectiveness Committee would see a deep dive into complaints in June 2021.

- The operational pressures due to COVID-19 had improved over the previous month.

- It was reported that the Infection Prevention and Control Board Assurance Framework had been received at the Quality and Effectiveness Committee, and at Board, and the Trust was achieving in all areas.

PC21/04/ C1.6 **Kath Smart – Audit and Risk (Presentation)**

Kath Smart provided an update on the most recent Audit and Risk Committee meetings that took place on 29th January and 25th March 2021 and highlighted that the year-end meeting would take place in May to sign off the annual report and accounts. Five internal audit reports had been reviewed. The internal audit on the waiting list prioritisation looked at the governance framework, flow of information and the control processes in place to oversee the prioritisation of patients held as a pause of elective activity due to the COVID-19 pandemic. The outcome was significant assurance with some recommendations and therefore the Council of Governors were assured that the Audit and Risk Committee followed up on all recommendations made until they had been actioned and closed.
The internal audit report on complaints handling received significant assurance, however there were eight recommendations that would be followed up at the Quality and Effectiveness Committee.
Other internal audits including Core Financial Controls, Data Quality and Corporate Governance received significant assurance.
A review of both Internal Audit (KPMG) and External Audit (Ernst Young) concluded satisfactory performance. There were further improvements to the declaration of interest process with a completion rate of 99% at 31st March 2021.
Governors, Dennis Atkin, Phillip Beavers and Bev Marshall had received training on the procurement process to appoint External Auditors, alongside other members of the procurement panel included Kath Smart, the Director of Finance and Head of Procurement. The timetable had been revised by one-week. The tender procurement was live on the portal and all dates were planned in diaries to the process to continue.

PC21/04/ C1.7 **Sheena McDonnell – People (Presentation)**

Kath Smart provided an update on behalf of Sheena McDonnell on the most recent People Committee meeting that took place on 2nd March 2021 which highlighted that a people planning workshop had taken place which included Governors, Divisions and the People Committee members to identify the Trusts people priorities. These had been approved at the Board in April 2021.
The People Committee undertook a deep dive into workforce planning in March which included the approach to planning, timelines to ensure that work had taken place and three pilots were underway currently.
A presentation had been received from the Freedom to Speak Up Guardian (FTSU) presenting the FTSU annual report and an update on the Emergency Department Organisational Development programme in place which was working well. Regular updates would continue to be received on this.

An update had been provided by the Equality, Diversity and Inclusion Lead on the reciprocal mentoring programme which had commenced to focus on the inclusive culture of the Trust. A number of senior leaders had signed up to be part of the programme.
A response rate of 50% had been seen from the annual staff survey, despite it being undertaken whilst the Trust was in wave 2 of the COVID-19 pandemic. Positive scores had been received in area such as bullying and harassment and lack of discrimination. An action plan was in development for areas that required improvement. Staff Health and wellbeing remained a priority and focus for the Committee.

PC21/04/ C1.8 **Mark Bailey – Charitable Funds (Presentation)**

Mark Bailey provided an update on the most recent Charitable Funds Committee meeting that took place on 11th February 2021 which highlighted that Mark Bailey had taken over as Chair of the Committee. Due to COVID-19 the frequency of the meetings had been reduced, however the dates had been planned in for 2021 and would follow the normal schedule. A review would be undertaken to identify how charitable funds could be utilised for additionality of care and to supplement the health and wellbeing agenda for colleagues.
The charitable funds accounts had been reviewed and approved. An update had been received on the strategy for fundraising. A Corporate Fundraiser was in post who had made good progress to date and had made contact with local communities and firms who had made charitable donations.
A Christmas Star appeal had been undertaken, and a new scheme had commenced for a rainbow sculpture.
A Charitable Funds briefing session would be delivered to Governors in June 2021. Although the investment of the charitable funds was affected due to the COVID-19 pandemic, there was a healthy cash balance. A priority for this year would be to identify how charitable funds could be used positively for staff wellbeing. A contract had commenced to provide psychological support to colleagues within the Department of Critical Care and Respiratory. A thank you event would take place for colleagues at the Yorkshire Wildlife Part.

PC21/04/ C1.8 **Governor Questions (Verbal)**

Question from Peter Abell

Peter Abell wished to thank the Trust for its fast response to the water leak incident in the Women and Children's Hospital on 27th April 2021, and asked if there was NHS or CQC regulation that required an inspection of the damage so that there was learning in the Trust to provide assurance?

The Chief Executive advised that the Women and Children's Hospital was built in the late 1950s. The Fire Officer had been on site during the debrief the following day to discuss any learning to be taken from the incident. Although there were no harm or injuries form the incident, the Trust had informed the Health and Safety Executive (HSE) had been notified. Regular Estates reviews had been undertaken and there were no apparent leaks at the time of the last inspection. Work would continue with the HSE and Fire Service. It had already been agreed that any learning identified would be shared with local and national colleagues.
Early lessons identified relate to the communication of the incident, so this would be worked on. The HSE had not indicated that they want to inspect the incident, however if they do so, the Trust would facilitate their access to the area.
The Fire Service had raised an issue that the electronic access forms had not released at the time of the incident and keys were not readily available, however noted that evacuation had been completed in one-hour of the request by the fire service.

Question from Hazel Brand

Hazel Brand noted that the Trust was unsuccessful with a bid several years ago that would be seen remedial work undertaken to the Women and Children's Hospital, and noted that the Trust was unsuccessful last year with their bid for a new build hospital and therefore asked if this incident would support any bids and what Governors could do to assist?

The Chief Executive advised that three years ago the Trust placed a substantial capital bid for a full refurbishment within the Women and Children's Hospital, and when the bid entered the process within the ICS, it was originally prioritised, however in the final stages it was changed to the second priority and subsequently lost the bid. The water leak incident had further highlighted the risk that the NHS had with buildings of this age, and the intention was to raise this formally once the country was out of the purdah period.

Comment from Susan McCreadie

Susan McCreadie echoed the thanks for the support and noted that she had previously worked on a neonatal ward and could understand the work required to undertake a full evacuation. Susan McCreadie echoed Hazel Brand's comments regarding any support that would be required from Governors.

The Chief Executive advised that at the time of the incident a note was put onto the Staff Facebook page, and within thirty minutes, colleagues who were off duty arrived to assist with the evacuation. Colleagues had to evacuate patients over the uneven group to the main hospital building, and therefore a 'sling' evacuation where the baby was held and managed by a neonatal nurse, to make it a smoother transition for the babies. The efforts of colleagues were fantastic; however, it was noted that a debrief would be undertaken with the staff so that they had the opportunity to relay their experience and provide the opportunity for them to talk.

The Chair advised that the Trust would write to colleagues individually to thank them for their contributions during the incident.

Question from Dennis Atkin

When hospitals were built, was there an indication of the life span of key components that go into the building?

The Chief Executive advised that all equipment had an asset life and depreciates over time. The building had been there for over fifty-years; however, a lot of components depreciate much sooner. Manual checks were undertaken regularly and contribute to the capital bids. Backlog critical maintenance would cost in the region of £50m and therefore a replacement hospital would be a much better use of spending the public purse, as this estimated cost would be for critical maintenance, and does not include other maintenance required, which could total approximately £120m. The Chair advised the Council of Governors that the Trust was not solely in control on how much capital was available for the Trust as monies were allocated on a system basis and allocated based on priority. Additional capital requests could be made to the treasury and NHS England.

Question from Mike Addenbrooke

Is the Trust covered by insurance?

The Chief Executive advised that the Trust had indemnity insurance, however further work was required to identify the cost of the significant repairs required.

Question from Lynne Schuller

Lynne Schuller was pleased that a debrief would take place with colleagues involved and wondered if there would be one for patients involved.

The Chief Executive advised that it had been agreed a letter would be sent to each patient, or parent/carer of patient outlining what had happened during the incident, and to thank them for their support and patience throughout.

Question from Dave Northwood

Were staff trained in these types of incidents and would the incident influence any training in the future?

The Chief Executive advised that horizontal evacuation was practiced, however full evacuations were not practiced. Following the full evacuation there would be lessons to be learned and training would be updated to reflect this learning. Early learning from the Fire Service included that they were unsure which switches to turn off and how long that batteries for the incubators lasted. Communication had been difficult as the incident took place out-of-hours.

Question from Mike Addenbrooke:

Mike Addenbrooke noted that it had been reported that Selby had a high number of COVID-19 cases and asked for an explanation on why the local community was not in the same position?

The Chief Executive advised that there were two contributing factors. The first was that during December 2020 the country had a significant outbreak of COVID-19, however, as Doncaster was already in lockdown due an earlier outbreak in October 2020, it affected the Trust and local community differently.

Question from Mark Bright

In moving to the recovery and restoration of services, does this distract the Trust from its preparedness to respond to any new variant?

The Chief Executive advised that this would not be the case, as the Public Health medics deal with the vaccine roll out and identification of new COVID-19 variants. It was expected that there be a booster dose of the COVID-19 vaccine in winter.

Question from Lynne Schuller

Due to the lack of clarity within the ICS, what impact has this had on planning, specifically in Bassetlaw, as commissioning will move to Nottinghamshire?

The Chief Executive advised that the hospital, as a statutory body was required to undertaken normal planning. The ICS then coordinates the planning. In April 2022 the ICS would become a statutory body. The Trust had submitted plans to the ICS against national timelines. South Yorkshire and Bassetlaw is one of the most developed ICS. In relation to the co-terminousity

of Bassetlaw with Nottinghamshire, the Trust had represented its views and would need to further understand the benefits of this at local authority level. These legislative changes would not see Bassetlaw moved to Nottinghamshire healthcare.

The Council of Governors

- ***Noted the information provided in the presentations and through the question and answer session.***

PC21/04/D1 **Chair and Non-Executive Director Appraisal Process (Enclosure D1)**

The Company Secretary outlined the process that would be undertaken to complete the Chair and Non-Executive Director appraisals. The NHSE/I Framework for conducting appraisals of NHS provider Chairs would be used. The outcome of the appraisal would be presented to the Council of Governors in November 2021. It was requested that the Council of Governors acknowledge the continued use of the Chair and Non-Executive Director appraisal process that was agreed the previous year.

The Council of Governors

- ***Approved the process for the Chair and Non-Executive Director appraisals to be undertaken in line with the process agreed the previous year.***

PC21/04/D2 **Minutes of Council of Governors held on 28th January 2021 (Enclosure D1)**

Dave Northwood requested an amendment in the first paragraph of section PC21/01/C1.1 from:

The Chief Executive provided an update on the Trust's current operational position which highlighted that the number of admissions with COVID-19 remained stable with no current evidence of increased community transmission but noted that the Trust needed to remain ***vigilante*** *as there were severe pressures in other areas of the country.*

To

The Chief Executive provided an update on the Trust's current operational position which highlighted that the number of admissions with COVID-19 remained stable with no current evidence of increased community transmission but noted that the Trust needed to remain ***vigilant*** *as there were severe pressures in other areas of the country.*

The Council of Governors

- ***Approved the minutes of the public Council of Governor meeting held on 28th January 2021 subject to the above amendment.***

PC21/04/E1 **Questions from members or the Public (verbal)**

There were no questions submitted by the public.

PC21/04/F1 **Any Other Business (Verbal)**

There were no items of any other business.

PC21/04/F2 **Items for escalation to the Board of Directors (Verbal)**

There were no items of escalation.

PC21/04/F3 **Governor Board/Meeting Questions Database**

The Council of Governors

- ***Noted the governor board meeting question database.***

Date and time of next meeting:

Date **1st July 2021**
Time **15:00**
Venue **Microsoft Teams - Videoconferencing**

PC21/01/G Meeting closed at 16:50.

Suzy Brain England
Chair of the Board

Date
1st July 2021

DRAFT

Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

BOARD OF DIRECTORS – PUBLIC MEETING

Minutes of the meeting of the Trust's Board of Directors held in Public on Tuesday 15th June 2021 at 09:30 via Star Leaf Video Conferencing

Present:	Suzy Brain England OBE - Chair of the Board (In the Chair) Mark Bailey – Non-Executive Director Karen Barnard - Director of People and Organisational Development Pat Drake - Non-Executive Director Rebecca Joyce – Chief Operating Officer Sheena McDonnell – Non-Executive Director Dr T J Noble – Executive Medical Director Neil Rhodes – Non-Executive Director and Deputy Chair Richard Parker OBE – Chief Executive David Purdue – Deputy Chief Executive and Chief Nurse Marie Purdue – Director of Strategy and Transformation Jon Sargeant – Director of Finance Kath Smart – Non-Executive Director	
In attendance:	Fiona Dunn – Deputy Director Corporate Governance/Company Secretary Emma Shaheen – Head of Communications and Engagement Katie Shepherd – Corporate Governance Officer (Minutes)	
Public in attendance:	Peter Abell – Public Governor Hayley Findlow – Corporate Governance Officer Maria Jackson-James – Public Governor Dennis Atkin – Public Governor Steve Marsh – Public Governor Clive Tattley – Partner Governor Mark Bright – Public Governor Pauline Riley – Public Governor Susan McCreadie – Public Governor	
Apologies:	None	**ACTION**
P21/06/A1	**Welcome, apologies for absence and declaration of interest (Verbal)**	
	The Chair of the Board welcomed all in attendance at the virtual Board of Directors and extended the welcome to the Governors and members of the public in attendance via the audience functionality. There were no apologies for absence. No declarations of interest were declared, pursuant to Section 30 of the Standing Orders.	
P21/06/A2	**Actions from Previous Meetings (Enclosure A3)**	
	Updates were provided on actions:	

	Action 1 – Committee Structures – The Executive Medical Director advised that a meeting was planned to finalise the structure. An update would be provided at the next meeting. The target date was changed. Action 4, 7 and 8 were not due until July 2021. Action 14 were not due until September 2021. Actions closed: 2, 3, 5, 6, 9, 10, 11, 12 and 13.	
	The Board: - ***Noted the updates and agreed which actions would be closed.***	
P21/06/ B1	**Maternity Update (Enclosure B1)**	
	Perinatal Dashboard The Chief Nurse presented the Perinatal Maternity Dashboard which highlighted that during the quarter from 1st October 2021 to 31st December 2020 there were three stillbirths with gestation ranging from 22-weeks to post-term. Lessons learned had been discussed and shared at the Perinatal Mortality, Morbidity and Maternal Morbidity Meeting. Lessons learned had been circulated via the 'What's Hot Newsletter', a newsletter specific for colleagues within Maternity Services. There were three incidents that required a perinatal mortality review by the multidisciplinary team. The action plan for Q3 2020-21 was shared with the Board. A cold cot would be obtained for the purpose of parents being able to take their baby home. Health Service Investigation Branch (HSIB) Cases There were two recommendations: - The Trust was to ensure that intermittent auscultation (IA) was carried out in line with national guidance ensuring early consideration was given to monitor a baby's heart rate by CTG when IA was not possible. - The Trust was to ensure that guidance and training supports staff in recognising the immediate transfer of mothers from the birthing pool in emergency situations. Both recommendations had been addressed prior to the receipt of the report as these were identified during the initial scoping before presentation to the SI panel. An email was sent to all midwives from the Director of Midwifery about immediate evacuation from the pool was a shoulder dystocia was identified when the scope identified this as an issue. 100% of Consultants had received PROMPT training, and 80.9% of SPRs and SHOs had received this training also. A plan was in place to reach 100% compliance for PROMPT training within a two-month period. There were two CTG Midwives and Lead Consultant who undertook the training for all Maternity colleagues. An action plan was in place to reach 100% compliance. The Maternity Service User Voice Feedback Facebook page received a lot of positive feedback and active work was undertaken to answer any questions in a short turnaround period. There were four open complaints and Matron's continued to work actively with complainants to improve the service for women and their families.	

	The Chair of Doncaster Maternity Voices Partnership (MVP) had stepped down. An interim plan was in place. There had been no meetings of the Doncaster MVP or Bassetlaw MVP since the last report to Board. There were no concerns raised from HSIB, NHS Resolution or the CQC. There had been no Coroner Regulation 28 made directly to the Trust. Maternity Services were on target to achieve the ten safety actions as part of CNST. The NE&Y Regional Perinatal Quality Oversight Group Highlight Report was shared, which outlined the standards that the Trust should achieve and an explanation of each. It was highlighted that there had been delays within induction of labour during May 2021. Work was underway to review how the process was undertaken. It was noted that at peak times there could be up to seven inductions per-days. A new standard operating procedure would be implemented to ensure that the management of the pathway was effective. There were 20WTE vacancies in Maternity Services from an establishment of 189WTE. Work continued with NHS Professionals; however, job offers had been provided to 28.4 newly qualified midwives who would commence in October 2021. The caesarean section rate at Bassetlaw remained high, due to a cohort of women with increased risk. There had been an 11% reduction from April to May 2021 in the number of women smoking at the time of delivery. Through learning from incidents and reports, the Trust continued to focus on the key themes and address them. It was identified that there was a lack of infant feeding support, however it was noted that there were infant feeding leads at Bassetlaw and Doncaster. Work was ongoing with RDASH to further support the development of the team. The two main themes from complaints included poor communication and medical staff attitude. This was being addressed. Virtual Safety Champion sessions were planned, and the Chief Nurse had visited all areas at both sites. A maternity quality and maternity strategy session had been undertaken with Consultants and Matrons in which positive feedback was received. Following a request from Suzy Brain England, it was confirmed that CTG was cardiotocography, which was a small device that was placed on a woman's stomach to listen to the baby's heartbeat to give an interpretation of a CTG. In response to a question from Suzy Brain England regarding the responsibility of ensuring that MVP were effective, it was advised that the MVP reported to the CCG and Place. There were strong partnerships in place at Bassetlaw, however a new Chair was required. Following a comment from Suzy Brain England regarding the training compliance for Anaesthetists, it was advised that PROMPT training was virtual and therefore it was expected that training compliance would improve. Following a request from Neil Rhodes, the Chief Nurse summarised that previously, the recruitment of newly qualified midwives was undertaken by respective Trusts which meant that on occasion midwives rejected their offer as they had received another offer elsewhere, however this year, local maternity services had joined to coordinate a join recruitment	

	programme in which newly qualified midwives were required to submit their first and second choice locations, followed by interview and selection to avoid this taking place. Kath Smart noted that the Board had received the same narrative regarding the need for a new Chair of the MVP and asked for further information on when this would be solved. The Chief Nurse advised that Doncaster had appointed a Chair, however meetings were yet to be organised. The Chief Nurser advised that there were no concerns with this. Following a query from Kath Smart regarding the data lag, as the report was for Q3 2020/21, it was advised that there was a delay as the data was reviewed at the MDT meeting prior to Board reporting. The Board would review Q4 2020/21 at the July Board meeting. Following a request from Kath Smart for further information on the caesarean section rate, the Chief Nurse advised that the rate of caesarean sections related to the population and the number of high risk pregnancies It was noted that the Trust had the second lowest still birth rate in North East and Yorkshire. Following a query from Sheena McDonnell regarding the dissemination of the 'What's Hot Newsletter', it was advised that the majority of discussions took place during staff meetings to ensure that the learning was portrayed correctly. The 'What's Hot Newsletter' was disseminated to all Maternity Services colleagues via email. In response to a question from Mark Bailey regarding the myriad of requirements for maternity reporting, and how this was analysed effectively, it was advised by the Chief Nurse that the Trust used a system called K2 to collate all evidence. The Trust had an IT dedicated midwife who was responsible for inputting data into the K2 system. Following a query from Mark Bailey regarding any future associated work within Maternity Services, it was advised that the actions from the Ockenden Report would be a priority and the action plan would require a multidisciplinary approach to it. In response to a question from Mark Bailey regarding the wellbeing of the Maternity team, the Chief Nurse advised that the team were well. The Trust was expecting the East Kent Maternity Report early autumn, and part two of the Ockenden Report in December 2021. Work was underway with the Professional Midwifery Advocate to provide support to colleagues. In response to a question by the Chair, it was advised that the Trust delivered in excess of 5k babies each year and noted the proportionality against the 13 cases referred to HSIB. Pat Drake had visited the Maternity Services and noted that there seemed to be a great resilience and feeling of positivity amongst colleagues. Pat Drake advised the Board that Maternity Services featured high on the Quality and Effectiveness Committee agenda. It was noted that the national audit tool work with chairs of MVPs had not commenced yet as it was still not available nationally. Following a question from Pat Drake regarding the lack of evidence to demonstrate that 90% of all staff groups had attended neonatal training, it was advised that there was a plan in place to ensure that compliance reached where it should be, however noted that a lack of space due to social distancing rules had factored into this. A thorough training needs analysis had been undertaken to ensure that there was capacity to deliver the training.	

	In response to a question from Pat Drake regarding the capital bid for maternity items such as cots, it was advised that it formed part of the capital plan for January 2022. <u>CNST</u> The service was on target to achieve the ten safety actions for upload by 15th July 2021. Further work was required to evidence that the Trust was compliant with the Anaesthesia Clinical Services Accreditation (ACSA) standards. The Trust was awaiting letters from the CCGs to confirm remuneration available for the chair and out of pocket expenses, and the MVP action plan would be sent with this. Final evidence would be the submission of minutes for oversight. Sheena McDonnell noted that a discussion had taken place at the Quality and Effectiveness Committee on 14th June 2021 regarding the effective system of workforce planning to a required standard. Assurance was provided at the Quality and Effectiveness Committee regarding skills mix and asked for further information. The Chief Nurse advised that the Trust utilised Birthrate Plus, which was a tool in place to ensure that the Trust had the correct number of midwives. The maximum skill mix was a ratio of 90% midwives to 10% Midwifery Support Workers, however, an output from the Ockenden Report was a bid to change this to a 95%-to-5% ratio to allow for a higher rate of midwives. The Trust had a fully compliant plan, with the exception of requirement four of safety action no.7 which asked that 'Do you have a written confirmation from the service user chair that they were being remunerated for their work and that they and other service user members of the Committee were able to claim out of pocket expenses?'. It was agreed that an update would be provided at the next meeting on this.	
	<u>Action</u>: An update would be provided on the achievement and submission of CNST actions.	**DP**
	The Board: - ***Noted and took assurance from the Chief Nurse update.***	
P21/06/C1	**<u>Minutes of the Meeting held on 18 May 2021 (Enclosure I1)</u>**	
	The Board: - ***Received and Approved the Minutes of the Public Meeting held on 18 May 2021.***	
P21/06/C2	**<u>Any Other Business (Verbal)</u>**	
P21/06/C2i	<u>Executive Medical Director Office Recruitment</u> Following a request from the Chair, the Executive Medical Director advised that the advertisement for the two Medical Director posts had closed and had progressed to the shortlisting phase in which it had been identified there were both internal and external candidates. The Associated Medical Director post would be advertised shortly, and the General Manager post required final grading before advertisement. Plans were in place to interview for the Medical Director posts on July. There would be a partnership interview panel in addition to the main interview panel.	
P21/06/C2ii	<u>ED Attendance</u>	

	The Chief Executive Officer advised that since the end of the national lockdown, the numbers seen in the Emergency Department and the wider Trust had continued to increase. A number of Trusts had seen record attendance in the Emergency Department. The Trust had seen 411 people at DRI on 14th June 2021, of which 64 required admission, which was noted as a low conversation rate. It was believed that there was some public confusion regarding availability of GP appointments. Bassetlaw had seen 203, with 24 requiring admission to site. Due to this the Trust was unable to see, treat and discharge patients within the four-hour target as it does not have the resource in place to support this, in addition to the social distancing measures in place. It was expected that attendance may continue to increase as the lockdown further eases, however this would further increase the difficulty in seeing and treating patients in a timely manner, which the Trust endeavours to do. In response to a question from the Chair regarding work with partners regarding the availability, it was advised that this was a key challenge and primary care were seeing 60% of patients face-to-face in comparison to pre-COVID-19 levels.	
P21/06/C 2iii	<u>Bassetlaw Emergency Care Village</u> The Director of Finance advised that the Trust had received a letter from the Department for Health and Social Care agreeing to the £17.6m for the Bassetlaw Emergency Care Village scheme. Business cases would be submitted to get approval to commence the work. It was noted that this would not be adjusted for inflation and technical issues. A value analysis would be undertaken. The Board noted the positive news. The Chair advised that the timeline for completion was important in ensuring that colleagues were aware of the benefits that the Bassetlaw Emergency Care Village would provide, as a patient centred service.	
P21/06/C 2iv	<u>Women and Children's</u> The Director of Finance advised that orders had been submitted for the modular buildings which would include a Theatre and recovery area and two wards totalling 32 beds in total. It was expected that the Theatre would be commissioned in August 2021 and the wards by October 2021. Further work was required within the Women and Children's Hospital to turn the electricity back on at an estimated cost of £2m. The cost for full repairs to the East Block of the building would be c.£39m, however, repair work for the whole of the Women and Children's Hospital building would be c.£50m. It was expected that any repair work would take in excess of 12-months. The Chief Nurse advised that some ward moves were planned to increase the number of paediatric beds which would be completed within days.	
P21/06/C 2v	<u>Secondment Appointment of David Purdue, Chief Nurse as Regional Director of Nursing for Yorkshire and Humber, NHSE/I.</u> The Chief Executive wished to inform the Board, and congratulate David Purdue on his successful appointment into a secondment role of Regional Director of Nursing for Yorkshire and Humber, NHSE/I. The Board wished David Purdue the best of luck in the role.	
P21/06/C 2vi	<u>Annual Members Lecture Series – 14th – 17th June 2021</u> The Chair advised that it was Annual Members Lecture week, in which a series of videos would be shared featuring a range of health professionals from within our organisation, each speaking	

	on a specific theme of topic. There had been 1,800 views per session to date, with Facebook viewing being the most popular. ***Post Meeting Note: There had been approximately 30k views of the Annual Members Lecture Series.***	
P21/06/C3	**Governor Questions Regarding the Business of the Meeting (Verbal)**	
	There was an issue in relation to a bereaved family being able to hear the cries of babies in their accommodation post-bereavement. A review of bereavement facilities had begun. After completion in November, can this be reported to governors with the next update on maternity services to governors? It was agreed that this would be included as part of a Maternity Services update to Governors. The paper shows a high rate of emergency C-sections, across both hospital sites though a little less at Bassetlaw Hospital. was there an explanation for this? This had been discussed as part of item P21/06/B1. Figures for multi-disciplinary training in neonatal resuscitation were below the 90% required. I'm sure there would be an action plan to address this, but I wonder if we can again have some explanation as to why the figures were low. This had been discussed as part of item P21/06/B1.	
	The Board: - ***Noted the comments raised, and information provided in response.***	
P21/06/C4	**Date and Time of Next meeting (Verbal)** **Date:** Tuesday 20 July 2021 **Time:** 09:30am **Venue:** Star Leaf Videoconferencing	
	The Board: - ***Noted the date of the next meeting.***	
P21/06/C5	**Withdrawal of Press and Public (Verbal)**	
	The Board: - ***Resolved 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.***	
P21/06/D	**Close of meeting (Verbal)**	
	The meeting closed at 10:30.	